WHO COUNTRY OFFICE FOR GHANA

ANNUAL REPORT 2014

THEME – Working towards better Health

JUNE 2015

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Executive summary

The World Health Organization (WHO) is the agency of the United Nations system which has the constitutional mandate by the Member States to direct and coordinate international health work. Its mission is "the attainment by all peoples of the highest possible level of health"

WHO provides support to countries through 6 programme categories such as:

1. **Communicable Diseases Control** which covers five programmes such as: HIV/AIDS, Malaria, Tuberculosis Neglected Tropical Diseases (NTDs) and Vaccine-Preventable Diseases (VPDs) including immunization;
2. **Non- Communicable Diseases Control** which are – The Non-Communicable Diseases (NCD) Mental Health, Violence and Injuries, Disabilities and Rehabilitation, and Nutrition;
3. **Promoting Health through the Life Course** which covers - Reproductive, maternal, newborn, child and adolescent health (MCH), Healthy ageing, Gender, equity and human rights mainstreaming, Health and the Environment and Social determinants of health ;
4. **Health Systems** which covers National health policies, strategies, and plans; Integrated people-centred health services; Access to medical products and strengthening regulatory capacity and Health system information and evidence;
5. **Preparedness, Surveillance and Response** which are alert and response capacities, Epidemic- and pandemic-prone diseases, Emergency risk and crisis management; Food Safety and Outbreak and crisis response; and
6. **Corporate Services and Enabling Functions** which also covers leadership and governance, strategic planning, resource coordination and reporting; strategic communications; transparency, accountability and risk management; and management and administration.

Dr Magda Robalo is the WHO Representative (WR) to Ghana since 09 February 2014. The Country office has staff strength of 32 comprising of 11 technical officers (including the WR) and 21 general staff made of administrative staff and drivers.

The total financial support provided by WHO in 2014 to Ghana, especially Ministry of Health and its Agency amounted to GHC14, 840,411.30. Out of this amount, Immunization and VPD activities amounted to GHc11, 633,460.00 representing 78.4% of the total support.

WHO's financial and technical support in 2014 include (i) the certification process for the Guinea worm eradication programme (ii) review and adaptation of guidelines on the prevention and control of micronutrient deficiency (iii) training for effective surveillance during the cholera outbreak (iv) development of medicine policy (vi) integrated child and maternal health activities and (vii) Ebola virus epidemic preparedness (viii) development of Health Financing Strategy, Medium Term Development Plan (2014 – 2017), Staffing Norm, Development of 2014 PoW among others. Other areas of WHO support in collaboration with other partners and stakeholders which are being sustained include break in transmission of wild polio virus in Ghana since 2008 and no measles death since 2008.

The cholera outbreak which claimed 243 lives out of 28,975 cases and the Ebola virus disease (EVD) scare were challenging moments in 2014.

WHO is committed to working assiduously in partnership with the Government and other Development Partners to achieve its mission of the attainment by all peoples of the highest possible level of health in 2015 and beyond.

CHAPTER ONE

HISTORY OF WHO IN GHANA

1.1 General Information - The World Health Organization (WHO) is the agency of the United Nations system which has the constitutional mandate by the Member States to direct and coordinate international health work. The World Health Assembly, the annual meeting of the Health Ministers of the 194 member states is the highest decision-and policy-making organ in the Organization.

1.2 Mission of the WHO "… the attainment by all peoples of the highest possible level of health…."

1.3 WHO's core functions – As the UN Agency mandated to direct and coordinate international health, WHO performs a number of functions, notably among them are:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalyzing change, and building sustainable institutional capacity;
- monitoring the health situation and assessing health trends.

1.4 Strategic directions – WHO performs the core functions through four strategic directions listed below:

- reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes;
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands which are financially fair; and
- supporting framework on enabling policy and creating institutional environment for the sector, and promoting an effective health dimension to social, economic, environmental and developmental policy.

1.5 WHO Country Office for Ghana - Ghana joined the World Health Organization in 1958, a few months after its political independence. Since then the WHO Country Office in Ghana (WCO) has operated in collaboration with the Ministry of Health and other Government Ministries, Departments and Agencies (MDAs), and health partners including bilateral, multilaterals, UN system, civil societies, academia and the private sector to attain its core functions. The WHO Country Office in Ghana is responsible for delivering aid through the Government of Ghana's (GoG) agency – Ministry of Health (MoH).

Dr Magda Robalo is the WHO Representative (WR) to Ghana. She arrived on the shores of Ghana on 09 February, 2014 and presented her credentials to the Honorable Minister of Foreign Affairs, Miss Hannah Tetteh on Wednesday 12 March, 2014. (***Picture shows Dr Robalo, right, presenting her credentials to the Minister of Foreign Affairs***). Dr Robalo is the 11th WR to Ghana. The list is as below:

1. Dr Ward-Brew
2. Dr Mabel Ali
3. Dr Pascal Bulengo, 1986 – 1991
4. Dr Brian Dando, 1991 – 1996
5. Dr Martin Mandara, 1996 – 2001
6. Dr Melville George, 2001 – 2005
7. Dr. Joaquim Saweka, 2005 – 2008
8. Dr Daniel Kertesz, 2008 – 2012
9. Dr Idrissa Sow, 2012 - 2013
10. Dr Patrick Kabore, 2013 - 2013
11. Dr Magda Robalo, 2014 – till date

The staff position of the country office is presented in Annex – 1. The Organization's structure of the office is also in Annex – 2 for reference.

1.6 Programme support areas – WHO provides support to countries through 6 category priority areas listed below with a number of programmes under each category.

1. **Communicable Diseases –** This covers five programmes such as (i) HIV/AIDS (ii) Malaria (iii) Tuberculosis (iv)Neglected tropical diseases (yaws, schisto, buruli ulcer etc) and (v) Vaccine-preventable diseases (VPDs) such as polio, measles-rubella, yellow fever, MNT, Rotavirus, etc;

2. **Non-Communicable Diseases –** The Non-Communicable Diseases (NCD) category covers the following programmes (i) Non-communicable diseases (diabetes, cancer, hypertension etc) (ii) Mental health (iii) Violence and Injuries (iv) Disabilities and rehabilitation and (v) Nutrition;

3. **Promoting Health through the Life Course-** Programmes under this category are (i) Reproductive, maternal, newborn, child and adolescent health (ii) Healthy ageing (iii) Gender, equity and human rights mainstreaming (iv) Health and the environment and (v) Social determinants of health;

4. **Health Systems** – The Health Systems category programmes are (i) National health policies, strategies, and plans (ii) Integrated people-centred health services (iii) Access to medical products and strengthening regulatory capacity and (iv) Health system information and evidence;

5. **Preparedness, Surveillance and Response-** The following are the programmes under category five (i) Alert and response capacities (ii) Epidemic- and pandemic-prone diseases (iii) Emergency risk and crisis management (iv) Food safety (v) Polio eradication and (vi) Outbreak and crisis response;

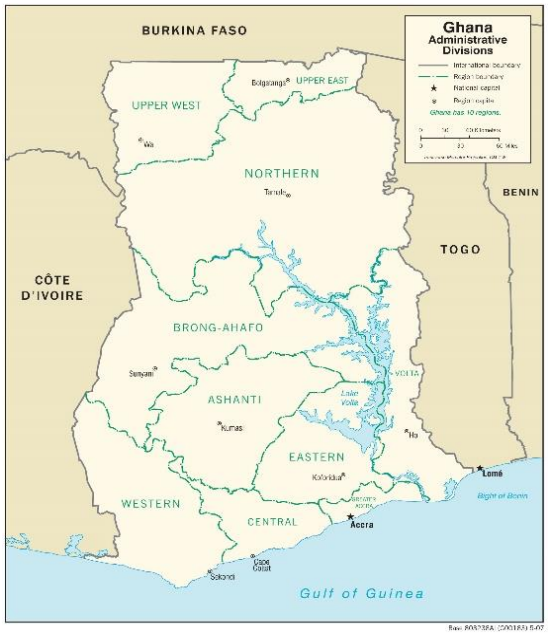
6. **Corporate services and enabling functions-** Finally the programme under corporate services are (i) Leadership and governance (ii) Strategic planning, resource coordination and reporting (iii) Strategic communications (iv) Transparency, accountability and risk management and (v) Management and administration

CHAPTER TWO

BACKGROUND AND GENERAL COUNTRY INFORMATION

2.1 GENERAL PROFILE AND DEMOGRAPHY - Ghana is located on the west coast of Africa, sharing borders with three French-speaking countries: Burkina Faso (548 km) to the north, Cote d'Ivoire (668 km) to the west and Togo (877 km) to the east. On the south are the Gulf of Guinea and the Atlantic Ocean, which form the coastline of Ghana (see Figure 1). The country is stratified into 3 vegetative zones. These are (i) coastal lands (ii) deciduous forest from the south towards the middle belt and (iii) savannah regions in the north towards Burkina Faso. Ghana has a tropical climate throughout the year with two major seasons – a dry (Harmattan) season and a wet (rainy) season.

Figure 1: Map of Ghana



Administratively, the country is divided into 10 regions and 216 decentralized districts, covering an estimated population of 24,658,823 (GSS, 2010) with varied population density among the regions. The National population density is estimated to have increased from 79 per square kilometer (km2) in 2000 to 102 in 2010 and 114 in 2014. The Ashanti and Greater Accra Regions are the most populated with 4,780, 280 and 4,010,054 of the country population, representing 19.4 % and 16.3% respectively. The Upper East and Upper West Regions to the north of Ghana are the least populated with 1,046,545 (4.2%) and 702,110 (2.8%), respectively.

Ghana has a youthful population consisting of a large proportion of children under-15 years (38.3%) and a small proportion of elderly persons (65 years and older 4.7.%). Life expectancy is estimated at 56 years for men and 57 years for women, while the adult literacy rate (age 15 and above) is an estimated 65 percent. An estimated 97.6% of the population are Ghanaians while 2.4 percent are non-Ghanaians. The country is gradually being urbanized with 50.9% located in urban areas in 2010 compared to 23.1% in 1960 and 43.8% in 2000.

Each district is headed by a politically appointed District Chief Executive (DCE), who is also the head of the District Assembly, the highest political and administrative authority in the district.

2.2 ECONOMY OF GHANA

Ghana gained a lower middle income status on November 5, 2010, after the country completed a rebasing of its national accounts that pushed its official GDP per capita to US$1,363 from the previously thought of under US$800. Ghana has also started production and exporting of crude oil in commercial quantities, aside the traditional exports of cocoa, timber, and minerals such as gold, bauxites, and manganese thereby making the country stand the chance of becoming aid independent in future.

Ghana's Human Development Index (HDI) value which measures a country's overall achievement in its social and economic dimensions has increased from 0.391 in 1980 to 0.573 in 2014, an increase of 47 percent or average annual increase of about 1.3 percent. Related to that, Ghana is ranked 138 out of 187 countries and territories, thereby making Ghana a medium human development country.

2.3 HEALTH STATUS

Ghana's health sector operates a decentralized system with established mechanisms that coordinate policy formulation, resource mobilization, policy implementation and monitoring and evaluation of activities. The health sector is split into policy-making and service delivery arms. The Ministry of Health (MoH) is the central decision-making body in health matters, and has the responsibility to recruit, train and manage staff postings as well as remunerate health workers on government payroll. The training of health professionals for the health sector is by both public and private health-training institutions that have been accredited.

The Ghana Health Service is the largest service delivery agency and operates through the government-owned facilities. The faith-based institutions and private sector provide about 40% of health care service.

Health service delivery is organized at three levels – national, regional and district with tertiary, regional and district hospitals. The district level is further divided into a number of sub-districts which incorporates community-level health delivery system. Public health services are delivered through a hierarchy of hospitals, health centres, maternity homes and clinics including a Community-based Health Planning and Services (CHPS) strategy. Civil Society Organizations (CSOs) also play a considerable role in delivering health services to communities. The table below is the summary of key health indicators from 2010-2014 in the country. There are also specialist care facilities and other service delivery agencies like NBA, NAS, and MHA. Other agencies include regulatory authorities like Food and Drugs Authority, NMC, MDC and AHC. NHIA is responsible for financing.

Table 1: Summary of Health Indicators, 2010-2014

Indicator	2010	2011	2012	2013	2014
Infant Mortality Rate	N/A	N/A	53	N/A	41
Institutional Neonatal Mortality Rate	-	-	5.5	5.9	4.29
Neonatal Mortality Rate	N/A	N/A	32	N/A	29
Under-5 Mortality Rate	-	N/A	82	N/A	60
Maternal Mortality Ratio	N/A	N/A	N/A	380	N/A
Number of functional CHPS zones	1,241	1,659	2,175	2,315	2,948
Per capita OPD attendance	0.91	1.05	1.17	1.16	1.15
Proportion of total MTEF allocation to health	7%	9%	8%	10%	11%
Per capita expenditure on health (USD)	28.60	35.00	50.70	47.1	32.8
Budget execution rate (Goods and Service as proxy)	94%	82%	87%	56%	61%
Proportion of population with active NHIS membership	33%	33%	33%	37%	38%
Doctor : Population ratio	1:11,698	1:10,402	1:11,515	1:10,170	1:9,043

Indicator	2010	2011	2012	2013	2014
Nurse : Population ratio including CHNs	1:1,516	1:1,599	1:1,362	1:1,084	1:959
Midwife : WIFA Population ratio	1:1,566	1:1,505	1:1,611	1:1,525	1:1,374
Couple Year Protection (CYP), incl. the private sector	1,424,585	1,988,893	2,012,807	2,070,630	2,608,352
Proportion of children fully immunized (proxy Penta 3 coverage)	86%	86%	88%	86%	90%
Non polio AFP rate (%)	1.8	2.2	1.6	2.7	2.9
Proportion of mothers making fourth ANC visit	43%	53%	72%	66%	67%
TB treatment success rate	85%	87%	85%	86%	87%
HIV prevalence rate	1.5%	1.7%	1.3%	1.2%	-

2.4 HEALTH SYSTEM IN GHANA

The Ministry of Health (MoH) provides oversight responsibility for all agencies within the health sector – Ghana Health Service, Teaching Hospitals, Faith-based institutions including Christian Health Association of Ghana (CHAG), Quasi-government health institutions and Private sector. The goal of the Ghana health sector is to ensure a healthy and productive population that reproduces itself safely. Ghana's National Health Policy (2007) was developed in line with the Primary Health Care Approach and Regional strategies. This provides direction on the national health strategic plans in order to harmonize and align the management and provision of comprehensive essential health services throughout Ghana. The critical driver for Ghana was to operationalize the Alma Ata goal of "Health for All".

Ghana recognizes the need for primary health care for all in order to expand promotive, preventive and rehabilitative as well as curative care. In response, the country adopted an evidence-based primary strategy to reach the unreached, essentially recognizing the role of households in achieving the national health goals. Thus, there was the need to bridge geographical access gaps in order to bring basic yet essential health services to communities, while making up for the gap in human resources for health and augmenting their capacities.

Ghana's community-based health planning and services (CHPS) approach is the national strategy for addressing these gaps in access to quality health services at the community level (2). CHPS is equity-focused and has an implementation modality that has strong support of the government and Development Partners in the health sector. Through the CHPS close-to-client approach, there have been significant reductions in immunization dropout rates and improvements in coverage, service accessibility, and quality of maternal and family planning care essentially bridging the access gap between communities and health facilities (2,3). The CHPS is thus recognized as the lowest level of health service delivery in the health sector. The sub-district level comprises of health centres, which serve as the next referral level after CHPS and provide oversight to CHPS.

The District Health Services (Management Teams) take full oversight responsibility to ensure that all public health initiatives are organized and synchronized in collaboration with other sectors particularly District Assemblies.

CHAPTER THREE
HEALTH SERVICES ADMINISTRATION

3.1 INTRODUCTION AND OVERVIEW OF HEALTH POLICY

The health sector of Ghana is driven by the National Health Policy (2007) and the Health Sector Medium Term Development Plan (HSMTDP) 2014-2017 which are annualised into Programme of Work (POW). The HSMTDP and the POW have been developed as the health sector's response to Government's medium term development policy framework - Ghana Shared Growth and Development Agenda (GSGDA). The GSGDA recognised the health sector as a key contributor to ensuring that Ghana has a healthy human capital to support national development. The Ministry of Health delivers its mandate of making quality health care accessible to all people living in Ghana through its twenty three agencies which fall within three broad categories of service providers, regulators and colleges. The implementation of the POW and other partnership arrangements are guided by the Common Management Arrangement which is jointly developed by the Ministry and its agencies in collaboration with Development Partners including bilateral, multilaterals and civil societies. The health sector identifies dialogues to be very critical for smooth implementation of programmes and projects hence the provision of a framework for dialogue for sector stakeholders. Prominent among the dialogue structures include:

i. The Inter-Agency Leadership Committee (IALC) which brings together the heads of the MOH and its agencies to improve communication and coordination within the framework of performance improvements, adherence to policies and accountability for better and more effective implementation of health sector activities;
ii. The Health Sector Working Group (HSWG) which meets monthly was instituted as a coordination mechanism that provides opportunity for all key stakeholders at managerial and senior levels in the sector include agencies, DPs and Civil societies to be engaged for effective engagement and information sharing;
iii. Inter-Agency Coordinating Committees (ICCs) is one of the decentralised sectoral dialogue platform that provides the forum to discuss technical issues on specific diseases/themes;
iv. The sector holds one annual summit during March-April of each year where sector performance for the previous year is reviewed and discussed using holistic assessment tool which is a sector performance appraisal;
v. Three Business Meetings are held immediately after the Summit, August and November/December with the participation of key sector partners at senior management and technical level and Ministry of Finance. The Business Meetings usually discuss stakeholders' (DPs) commitments to implementation of the sector programmes and projects.

In the implementation of its programmes and in line with the overall national public sector financial reforms, all closely related programmes and activities in the health sector are reorganised into budget programmes and sub-programmes. These budget programmes and sub-programmes are then linked to definite and measureable results framework or output. Each agency of the Ministry falls under one of the Budget Programmes and Sub-Programmes, for which the various agencies have their detailed specific plans based on their mandate to achieve the targets set out for each year as stipulated in the HSMTDP.

3.2 HEALTH CARE FINANCING

Total funding for the health sector has been growing nominally at 34% per annum between 2009 and 2014, with the highest growth of 53% experienced in 2012 over 2011 expenditure and with the minimal growth of 22% in 2014 over 2013 figure as depicted in Table 5. The health sector is financed mainly from four main sources; Government (GOG) National Health Insurance Fund (NHIF), Internal Generated Funds (IGF) and external financing. For the year under review GOG accounted for 28.2%, as against 21.1% for NHIF, 31.9% for IGF and 18.3% for external financing. This trend is similar to what has been happening since 2009. Considering that NHIF is a public fund, it can be concluded that government has become the main source of funding accounting for over 50% of the total funding followed by IGF and external financing.

Table 2: Trends in Budgeted Expenditure for Health Sector by Sources of Funding (Million Ghana Cedi)

Source of Funds	2009		2010		2011		2012		2013		2014		Annual Average by Sources
	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	%
GoG	355.8	32.6	408.5	28.8	411.6	22.8	513.3	22.4	555.8	15.9	1,208.8	28.2	25.1
NHIF Statutory Funding	391.8	35.9	480.9	34.0	477.7	26.5	682.1	29.8	917.9	26.2	926.6	21.6	29.0
IGF	108.3	9.9	208.0	14.7	507.5	28.1	468.0	20.5	1,831.4	52.3	1,363.6	31.9	26.2
Devt Partners	234.7	21.5	318.6	22.5	408.5	22.6	624.1	27.3	194.5	5.6	781.3	18.3	19.6
Total	1,091	100	1,416	100	1,806	100	2,286	100	3,500	100	4,280	100	100
Year on Year Growth of Available Resources			30%		27%		27%		53%		22%		34%

Source: Budget Statements (2009-2014), MOH POW (2009-2014)

3.3 INTERNALLY GENERATED FUNDS

Internally Generated Fund (IGF) is non-taxable revenue that is generated through the activities of public health facilities like hospitals and health centres as an additional source of funding. The aim of introducing IGF into public hospitals in 1985 is to help alleviate financial difficulties confronting the health sector in delivering quality health care. The generation, management, and utilisation of IGF are anchored in several pieces of legislation notably MDA (Retention) of Funds Acts, Act 753 0f 2007, Fees and Charges (Amendment) Instrument of 2011; LI 1986, Part III of the Financial Administration Act, Act 653 of 2003, Part II of the Financial Administration Regulation L.I. 1802 of 2004, and Non-tax Revenue Act. These legislative instruments mandate public health facilities to collect and retain all IGF for its operations. Since the mid-2000s, IGF has become the major source of finance to public health facilities constituting over 75% of their total receipts.

IGF which is composed largely of payments for service rendered by MOH agencies to their clients is very prominent as a source of financing for the health sector over the years. IGF as a source of funding the health sector has increased nominally from 108.3 million cedi or 9.9 percent in 2009 through 208 million cedis (14.7 percent) in 2010 to a high of 1,831.4 million cedis (52.3 percent) and falling to 1,363.6 million cedis (31.9 percent) in 2014. Within the six year period for which data is presented for in Table 2, IGF has become the third most important source of funding for the health sector of Ghana. Prior to the introduction of NHIS in 2003, IGF was mainly household expenditure or out of pocket payment (OOP) from patients. Contribution from NHIS has become a dominant source of IGF contributing about 60 percent with the remaining 40 percent coming from OOP. IGF is spent by health facilities mainly on service expenditure, administrative expenses and limited extent on personal emolument and investment expenditure. Practically health facilities would deem the increasing IGFs as a progress in their resource mobilisation effort; however this phenomenon needs to be examined within the context of its effect on catastrophic health expenditure which has the potential of pushing people into poverty and perpetuating poverty in the country as a whole.

3.4 GOG FINANCING OF PUBLIC HEALTH SECTOR

Financing in the health sector is expended in three broad areas; Employee Compensation, Goods and Service and Assets. As depicted in Table 3 Employee Compensation which is made up of salaries and salary-related allowances, social security, gratuities and others paid to workers in the health sector has been the cost driver for the expenditure till 2012 when it was overtaken by expenses on goods and services which is the amount of money that government pays for running its operations and for delivering services to the public. Assets which consume less than a third of all budgets include capital expenditure on major infrastructure projects such as health facilities, offices, health training institutions, transport, water systems, plant and machinery among others.

Table 3: Trends in Budgeted Expenditure for Health Sector by Expenditure Categories (Million Ghana Cedi)

Expenditure Categories	2009		2010		2011		2012		2013		2014	
	Amt	%	Amt	%	Amt	%	Amt	%	Amt	%	Amt	%
Compensation	427	39	741	40	704	39	824	36	630	18	1,412	33
Goods & Services	342	31	486	34	686	38	984	43	1,157	66	1,841	43
Assets	322	30	361	25	415	23	480	21	140	16	1,027	24
Total	1,091	100	1,416	100	1,805	100	2,288	100	3,499	100	4,280	100

Source: Budget Statements (2009-2014), MOH POW (2009-2014)

Ghana was among 53 African Union member states who signed the Abuja Declaration in April 2001 pledging to commit at least 15% of its annual budget to improve the health sector. As indicated in Table 4, since 2009 Ghana has not met the Abuja Declaration. The highest level of 13.5% was attained in 2014 with the least of 9.8% in 2009. This calls for a concerted effort and continuous reminder for government to meet its commitment to the health sector. Related is the

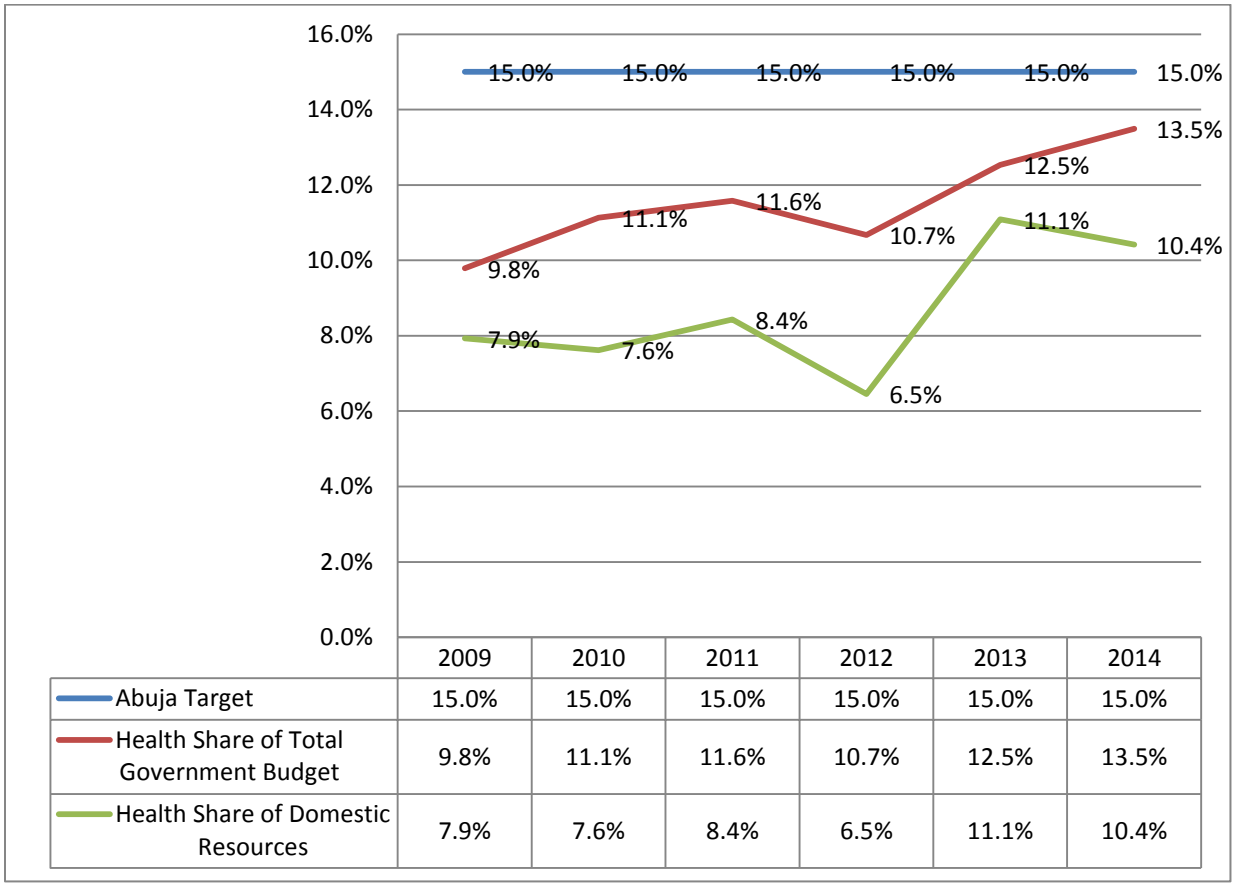
health share of domestic resources which is erratic with the highest of 11.1% attained in 2013 as against the lowest of 6.5% in 2012 as indicated in Table 4 and Fig 2.

Table 4: Progress towards Abuja Target (2009 – 2014)

	2009	2010	2011	2012	2013	2014
Abuja Target	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Health Share of Total Government Budget	9.8%	11.1%	11.6%	10.7%	12.5%	13.5%
Health Share of Domestic Resources	7.9%	7.6%	8.4%	6.5%	11.1%	10.4%

Source: Budget Statement Appendix Tables, (2009 – 2014)

Fig 2



3.5 EXTERNAL FINANCIAL SUPPORT

The health sector of Ghana benefits from the flow of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional in character with a grant element of at least 25 percent (using a fixed 10 percent rate of discount). By convention, official development assistance (ODA) flows comprise

contributions of DP government agencies, at all levels, to developing countries ("bilateral ODA") and to multilateral institutions. ODA receipts comprise disbursements by bilateral DPs and multilateral institutions. Financing of the health sector from external sources is very important to Ghana despite its gradual fall in relation to other sources of funding like government and IGF. External funding used to be the most prominent source for Ghana's health sector in the 1990s and early 2000s, but has fallen to the region of around 20% since 2009 as shown in Table 2**,** with the lowest value of 5.6% in 2013. Most of the DPs have indicated their intention of changing their financing portfolios as well as gradually reducing their support to the sector with Ghana becoming a middle income country in 2010. DPs' support to the health sector in recent times comes through four main mechanisms - Grants, Earmarked Funding, Sector Budget Support, and Loan/Mixed credits. Loans/Mixed Funds is provided mainly by commercial and financial institutions to finance capital investments like construction, rehabilitation, expansion and equipping of health facilities

3.6 SECTOR ALLOCATION BY PROGRAMME BASED BUDGET (PBB)

As part of national policy on public financial management reforms to improve service delivery and performance measurement, the MOH has adopted Programme Based Budget (PBB) instead of the previous Activity Based Budget (ABB) since 2010. The PBB is made up of five main programmes (1) Management and Administration; (2) Health Service Delivery; (3) Tertiary and Specialised Health Services; (4) Human Resource for Health Development and (5) Health Sector Regulation. As indicated in Table 5, in 2014, 73.1 percent of the sector's total resource envelope was allocated to Health Service Delivery which includes mainly annual budget for the main service delivery agencies of GHS and CHAG. Tertiary and Specialised Health Services including teaching and psychiatric hospitals as well some subvented organisations were allocated 14.1 percent of the total resource envelope making health service delivery the largest consumer of the total resource envelope to the tune of 87.2 percent. Management and Administration and Human Resource for Health Development and Management were each allocated 5.5 percent and 1.9 percent for health sector regulation.

Table 5 : Sector Allocation by Budget Programme and Source of Fund excluding NHIF for 2014 (in GH¢ '000							
Budget Programme	Government of Ghana		Development Partners			Total	Share (%)
	GOG	IGF	SBS	EARMARKED GRANTS	LOANS/MIXED CREDITS		
BP1: Management and Administration	100,136.94	9,860.04	37,932.57	1,818.00	49,410.14	199,157.68	5.5
BP2: Health Service Delivery	852,304.83	1,050,135.24	45,487.92	271,429.06	432,499.52	2,651,856.57	73.1
BP3: Tertiary and Specialised Services	175,319.45	137,753.86	2,235.00	-	194,514.27	509,822.58	14.1
BP4: Human Resource Development and Management	66,840.53	116,283.56	450.00	-	14,743.60	198,317.69	5.5
BP5: Health Sector Regulation	14,221.26	49,590.11	-	-	3,988.99	67,800.36	1.9
Total	1,208,823.01	1,363,622.80	86,105.49	273,247.06	695,156.51	3,626,954.87	100.0
Source: 2014 POW; MOH							

The total resource envelope allocation as per BPP and economic classification had compensation of employees having 31 percent, goods and services 44.9 percent and assets 24.1 percent as depicted in Table 6. Health Service Delivery has been allocated the highest of 75.1 percent for compensation, 79.2 percent for goods and services and 59.2 percent for assets. Tertiary and Specialised Services was also allocated 15 percent for compensation, 6.9 percent for goods and services and 26.1 percent for assets. The least allocation of 1.2 percent was made for compensation, 1.6 percent for goods and services and 3.2 percent for assets for Health Sector Regulation.

Table 6 : Sector Allocation by Budget Programme and Economic Classification excluding NHIF for 2014 (in GH¢ '000)							
Budget Programme	Compensation of Employees	%	Goods and Services	%	Assets	%	Total
BP1: Management and Administration	31,346.49	2.8	110,850.24	6.8	56,960.95	6.5	199,157.68
BP2: Health Service Delivery	843,772.60	75.1	1,289,912.03	79.2	518,171.94	59.2	2,651,856.57
BP3: Tertiary and Specialised Services	168,924.47	15.0	112,456.68	6.9	228,441.43	26.1	509,822.58
BP4: Human Resource Development and Management	65,147.22	5.8	89,111.91	5.5	44,058.55	5.0	198,317.69
BP5: Health Sector Regulation	13,601.99	1.2	25,925.88	1.6	28,272.48	3.2	67,800.36
Total	**1,122,792.78**	**100**	**1,628,256.75**	**100**	**875,905.35**	**100**	**3,626,954.87**
Share (%)	31.0		44.9		24.1		100.0
Source: 2014 POW; MOH							

3.7 DRUG FINANCING

In Ghana, financing for medicines has been supported largely by the National Health Insurance Scheme. The development and implementation of appropriate policies and strategies for regulating medicine prices and expanding coverage of essential medicines under health insurance schemes are given due emphasis. The benefit package covers about 95% of disease conditions seen at district health service level in Ghana. The NHIS Medicines List has about 548 items on the list (NHIA Medicines list 2013) based on the diagnosis within the benefit package and the Standard Treatment Guidelines issued by the Ministry of Health. Medicines costs under the NHIS have been over 50% of claims costs. Enforcing the link between diagnosis and treatment to improve rational use of medicines and implementing uniform prescription forms to promote rational prescribing are some of the cost containment measures identified by the NHIS. Challenges with the financing of medicines under the NHIS include delays in re-imbursement of claims by the NHIA to service providers leading to co-payment and out of pocket payments for medicines defeating the agenda for Universal Health Coverage. Also high medicines prices and proliferation of substandard medicines could affect sustainability of the insurance scheme. This calls for legislation to back the implementation of portions of the revised medicines policy.

3.8 HUMAN RESOURCES FOR HEALTH DEVELOPMENT AND MANAGEMENT

The Ministry developed Human Resource for Health Policy, Strategy and implementation plan for the sector and duly submitted to NDPC for their comments after which a Cabinet memorandum would be prepared for submission for approval. To improve staff deployment and

allocation of health workers in an efficient manner, the Ministry in conjunction with its agencies started the development of Sector Staffing Norms to replace the previous one which was developed in 1992. The norm which was based on WHO's Workload Indicator for Staffing Needs (WISN) covered all categories of health facilities; Teaching Hospitals, Regional Hospitals, Specialized hospitals, District Hospitals, Polyclinics, Health Centres, CHPS and District Health Management Teams using GHS and CHAG facilities. Sixty four types of clinical staff were covered as against fifty two non-clinical staff who were covered in the analysis for the development of the staffing norms. What remained outstanding to cover in the study for the development of the staffing norm was the staff at health training institutions, at regional and headquarters level of the Ministry and its agencies. The Ministry had piloted Human Resource Information System (iHRIS) in the Northern Region and has resumed the process of interfacing it with the Human Resource Management Information System (HRMIS) of the Public Services Commission. The Ministry had developed a plan for Ghana Community Health Worker Initiative for community health worker scale-up in the context of health systems strengthening.

The Ministry in conjunction with its partners established Ghana Health Worker Observatory (GHWO) and its website in 2006 with the mandate supporting the health sector's vision by producing "evidence for decision making and advise Government to set its direction for the country's health workforce in the areas of scaling up, distribution, production, and financing. The processes for the smooth implementation of GHWO have been revived.

3.9 DEVELOPMENT PARTNERSHIP AND HEALTH DEVELOPMENT IN GHANA

The health sector in 2014 has sixteen DPs who are mainly bilaterals and multilaterals. The bilaterals include Denmark International Development Agency (DANIDA, Department for International Development (DFID) of the United Kingdom, the European Union (EU), Japan International Cooperation Agency (JICA), the Korea International Cooperation Agency (KOICA), the Kingdom of the Netherlands, and United States Agency for International Development (USAID). The multilaterals include African Development Bank (AfDB), International Labour Organisation (ILO), UNAIDS, UNFPA, UNICEF, WFP, WHO, and the World Bank. Other multilaterals which are more of funding mechanism are GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) whose is represented by Country Coordination Mechanism (CCM). There are some DPs who do not have physical presence in the health sector of Ghana but do support at certain times depending upon the circumstances. This includes Norway which provided financial support in 2014 during the outbreak of Ebola Virus Disease. The DPs' supports are mainly in the form of finance which may be sector budget support, which is similar to general budget support, except that resources are directed to the budget of Ministry of Health, Project funding, which is directed towards a specific activity or investment, such as specifically for malaria, tuberculosis and Health System Strengthening which may or may not pass through government systems. DPs also provide technical assistance, which include the provision of training, expert consultancy advice, and support for particular activities. This assistance usually aims to improve the ability of staff in the health sector to carry out their roles more effectively. Other key stakeholders in health development in Ghana include civil societies which are represented by Ghana Coalition of NGOs in Health in

addition to the private sector which is represented by Private Health Sector Alliance of Ghana (PHSAG)

3.10 COOPERATION WITH THE UN SYSTEM IN GHANA

There are twenty six entities operating in Ghana under the United Nations with some of them also serving as regional or sub-regional offices and they are the FAO, IAEA, IFAD, IFC, ILO, IMF, IMO, IOM, UNAIDS, UNDP, UNDSS, UNEP, UNESCO, UNFPA, UN-Habitat, UNHCR, UNIC, UNICEF, UNIDO, UNODC, UNU-INRA, UN Volunteers, UN WOMEN, WFP, WHO and World Bank. The key objective of the United Nations system in Ghana is to support the country towards its vision of advancing equitable economic growth, reducing poverty and achieving human development in consonance with its mission statement which states that *"The United Nations Country Team works coherently and effectively to support Ghana in achieving the Millennium Development Goals, advancing equitable economic growth and reducing poverty, through capacity development, strengthening of accountability systems and the delivery of quality social services, with a focus on the most deprived and vulnerable populations"*. Health development features prominently in the attainment of the country's vision for which the UN system is supporting. In supporting the national development aspirations as captured in the GSGDA in conjunction with international development goals and global orientations, the UN system in Ghana, in recent times, has been focussing its development assistance on ensuring equitable economic growth, constructive social protection, equal political and social participation, and multifaceted human development of which health development is key. The UN system in Ghana supports the government through its United Nations Development Assistance Framework (UNDAF) 2012-2016 which has four thematic areas of Food Security and Nutrition; Sustainable Environment, Energy and Human Settlements; Human Development and Productive Capacity for Improved Social Services; and Transparent and Accountable Governance which are further into eleven outcome areas. Two of the outcome areas are directly health and five are health related. The remaining four have some connotation for health development. Five UN entities which are directly involved in the health sector of Ghana are UNAIDS, UNFPA, UNICEF, WFP, WHO, and the World Bank, though others may come in to support at certain times directly or through the UN Resident Coordinator's office.

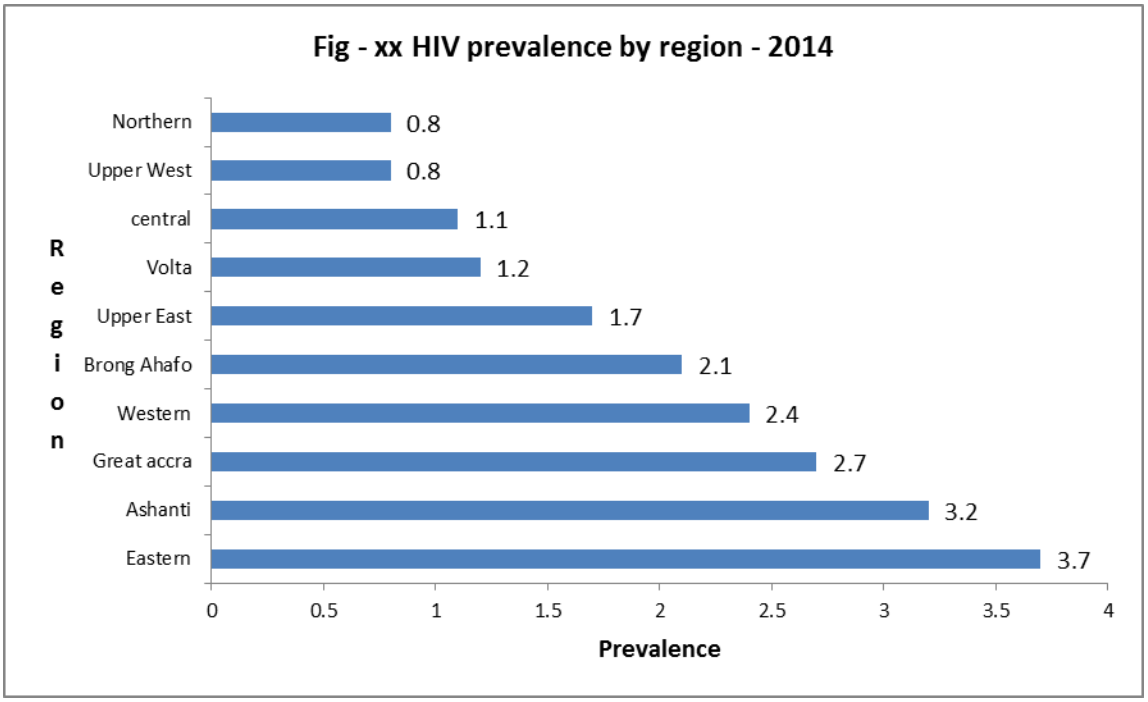
CHAPTER FOUR
COMMUNICABLE DISEASES CONTROL PROGRAMMES

4.1 HIV/AIDS

WHO supports the health sector with technical assistance to deliver integrated control strategies for TB, HIV and Malaria which fall under the Disease Prevention and Control Category. The goals of the control of these diseases are to reduce death and illness due to these diseases in line with the Millennium Development Goal 6 (MDG6).

The control of HIV, TB and Malaria has seen significant progress over the past years. With the first case seen in 1986, HIV prevalence has steadily dropped from about 1.8% in 2007 to 1.37% in 2012 and 1.3% in 2014. Annual AIDS-related deaths in adults has declined by more than 50% from a little under 16,000 in 2006 to about 7,800 in 2013. In 2014, based on CD4<350, only 60% of eligible clients received antiretrovirals (ARV), below the national target of 85%. Sixty-two percent (62%) of pregnant women attending antenatal care (ANC) were receiving ARV for prevention of mother to child transmission (PMTCT), below the national target of 95%. Early infant diagnosis (EID) is low at 17%. Antiretroviral treatment (ART) and adherence at 12 months is 72%.

Challenges still remain with access to quality services including diagnosis, issues of stigma for TB and HIV patients, quality data for decision making and funding gaps in universal coverage for HIV/AIDS. The median HIV prevalence for pregnant women dropped from 2.1% in 2013 to 1.9% in 2014. Prevalence of HIV is at 3.0% but with regional variation as shown in the graph below: fig 3



4.1.1 WHO support - WHO as member of Joint United Nations Team on AIDS (JUTA) supported the adaptation of the new ART and PMTCT guidelines in line with the new WHO recommendations. WHO again provided technical support mission made up of Dr Francoise Bigirimana and Dr Morkor Newman together with a local costing expert to conduct a needs assessment and costing of the adaptation of PMTCT Option B+.

Two consultants (a local and an international) were recruited to carry out a Mode of HIV Transmission survey to determine the main drivers of the epidemic. This survey showed casual heterosexual relation as the leading driver of the epidemic.

WHO has been part of the protocol development for HIV drug resistance monitoring and the development of a National HIV Drug Resistance Management Plan.

4.1.2 JUTA Activities - Assessment of Pediatric ART

Ghana is one of the countries in West Africa working towards the elimination of mother-to-child transmission of HIV (eMTCT). The Government of Ghana is committed to eliminating mother-to-child transmission of HIV by 2015. The National Strategic Plan (NSP) has adopted eMTCT as the preferred strategy to achieving overall reduction of new HIV infections in children with the view to attaining marked decline in MTCT of HIV from 30% in 2010 to less than 5% by 2015. Ghana is also in the process of transitioning to the more effective PMTCT Option B+. To this end, support for the PMTCT has been a major focus for the JUTA. Hence UNICEF and other JUTA members supported the National AIDS Control Program (NACP) to conduct a situation analysis of the early infant diagnosis and pediatric HIV response in September, 2014. Bottlenecks were identified and disparities analyzed. Recommendations for definitive actions for accelerating and improving access were shared at the technical working group session for action.

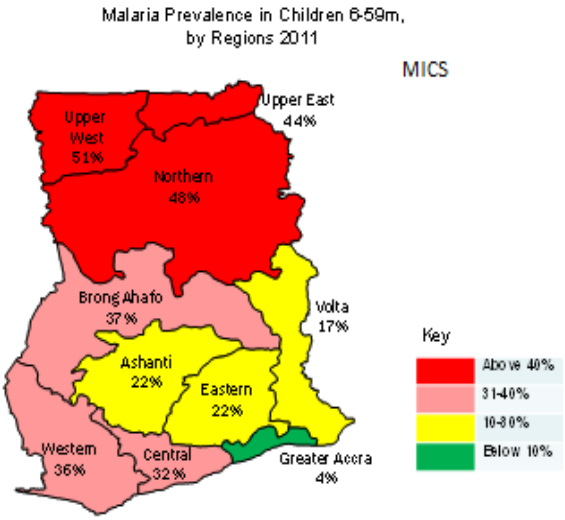
4.1.3 Retreat - WCO was part of the JUTA Work Planning and Review Retreat held at Akosombo Continental Hotel from 19-21 November 2014. The main objectives of the retreat were to review progress of the Joint UN Team on AIDS against the 2014 JUTA work plan and to develop the 2015 Work plan ensuring that it is aligned to national and global priorities. This three day retreat ended successfully with the objectives achieved and a draft 2015 work plan in place. WHO was selected as the convener for the PMTCT and Treatment cluster of the JUTA.

4.1.4 Capacity building - WHO AFRO supported the NPO-ATM and the HIV Program Manager to participate in the Annual Inter-Agency Task Team (IATT) on PMTCT meeting in Johannesburg in November, 2014 **(Picture- Participants at IATT annual meeting held in Johannesburg on 11-12 November 2014)**

4.2 MALARIA CONTROL PROGRAMME

Fig 4

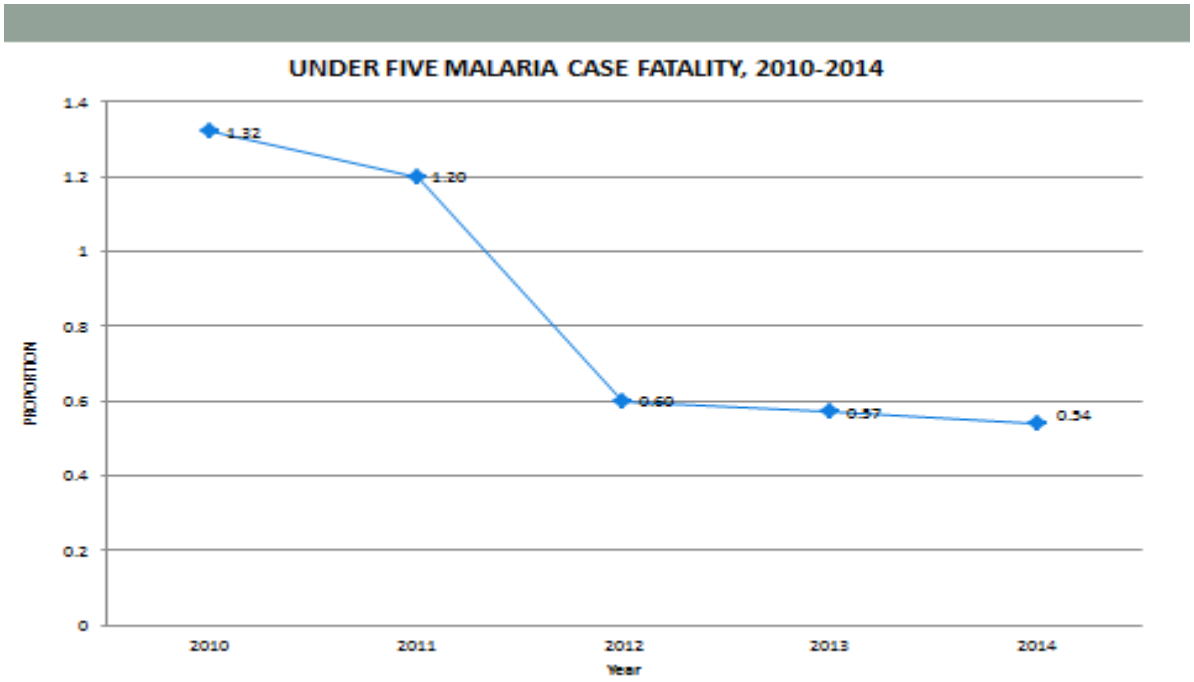
Between 2000 and 2012, a substantial scale-up of malaria interventions led to a reduction of parasite prevalence of more than 50% from 62.5% to current mesoendemic values of 27.5% (2011 MICS). Malaria Case Fatality Rate declined from 1.32% in 2010 to 0.54% in 2014. (NMCP Annual Report, 2014)



While malaria is a preventable and treatable disease, it continues to remain as the leading cause of OPD attendance in the country. The entire Ghanaian population of about 25 million is at risk of malaria with children less than five years more at risk as shown in the graph below.

There still remain challenges with access to quality services including diagnostics, behavioral change with regard to LLINs use and quality data for decision making and funding gaps in universal coverage for malaria. There are regional variations in the parasite prevalence as shown in the map:

Fig 5



Source: DHIMS

NMCP and partners including WHO are making a concerted effort to put in place mechanisms and strategies to achieve universal coverage of preventive malaria interventions as well as effective treatment interventions. The expansion of malaria interventions serves as an entry point for strengthening health systems, including maternal, child health and laboratory services.

4.2.1 WHO support - WHO supported the Joint Assessment of the National Strategy (JANS) as part of the finalization of the National Strategic Plan for the concept note development.

4.2.2 Dashboard reviews - WHO as a member of the technical oversight committee supported the regular dashboard review which assesses the principal recipients of Global Funds with respect to financial, managerial and programmatic performance.

4.2.3 Commemoration Of The World Malaria Day - World Malaria Day 2014 was celebrated under the two year theme. **"Invest in the future; Defeat Malaria".** The main objective was to energize the commitment to fight malaria. It was also to highlight the need for continued investment and sustained political commitment for malaria prevention and control. Progress made in malaria control in Ghana which include the universal distribution and hang up of 12.5 million LLINs over a two year period and the reduction in deaths attributable to malaria were highlighted during the celebration.

4.2.4 Malaria Vaccine Technical Working Group Stakeholders' Meeting For Central and West Africa 24 -26 June.

WHO/AFRO collaborated with PATH/MVI to organize Malaria Vaccine Technical Working Groups (TWGs) stakeholders' meeting for countries in Central and West Africa in Accra. The main objectives were to share the RTS,S 18-month follow up clinical trial results, planning around vaccine implementation communications and recent experience of new vaccine introduction. The meeting discussed plans for evidence-based decision making and also map policy decision making processes at country-level. The meeting also discussed needs and gaps in country level RTS,S decision making and identified priority activities and technical assistance required for malaria vaccine decision making in West and Central Africa.

4.3 TUBERCULOSIS

WHO in collaboration with other partners supported the National TB Program to finalize the National Strategic Plan. WHO also supported training of staff in programmatic management of MDR TB.

4.3.1 TB prevalence survey - WHO provided technical support for the National TB Program in the conduct of a state of the art electronic prevalence survey since 2013. Data was collected from 98 clusters, located in 98 eight communities in all 10 regions of Ghana.

The office also supported data cleaning, verification and analysis workshop for the Prevalence Survey Team in 2014**.**

4.3.2 Commemoration of the World Tuberculosis Day 2014 - Ghana joined the world to commemorate World TB Day 2014 on 24 March in Accra under the theme "REACHING THE MISSED TB CASES" and slogan "THE UNTOLD STORY OF THE GHANAIAN TB PATIENT"

(***Picture shows dignitaries at the commemoration of World TB Day)***

WHO supported the event to educate the public about the devastating health and economic consequences of TB and advocate for early treatment seeking and for continued investment in TB control with the threat of TB/HIV co-morbidity and MDR TB. Under the theme, the country intends to position itself to reach out to find the missed TB cases using modern diagnostic equipment such as the Digital imaging and Gene Xpert machines.

4.4 NEGLECTED TROPICAL DISEASES (NTDs)

WHO provides technical and policy support to the development and implementation of plans and strategies for the control of priority Neglected Tropical Diseases (NTDs). Two categories of NTDs are reported in Ghana. These are (i) Lymphatic Filariasis, Onchocerciasis, Trachoma, Schistosomiasis, Soil Transmitted Helminthiasis, together classified as Preventive Chemotherapy (PCT) diseases and (ii) Buruli ulcer, Yaws and Leprosy, Human African Trypanosomiasis (which constitute Case Management diseases).

Key areas for WHO support included NTD related research and surveys, surveillance and mapping, delivery of drugs for Mass Drug Administration and planning.

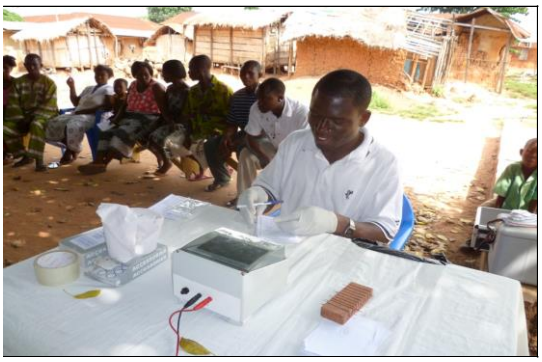
NTD Master Plan - Technical support was provided for the development of 5-year Strategic Ghana NTD Master Plan. The plan launched on 03 July 2014 outlines the integrated strategy for delivering interventions to prevent, control, and eliminate/eradicate the prevalent neglected tropical diseases in Ghana.

(*Picture - Launch of NTD Master Plan – Hon Minister of Health Ms Sherry Ayittey being supported by Ms Joyce Aryee, ex-Chief Executive Officer of Ghana Chamber of Mines*)

4.4.2 Buruli Ulcer - Buruli Ulcer (BU), mainly affects children from poor rural communities. In Ghana, an average of 1,000 cases is reported annually. Conventional treatment involves several weeks of antibiotics one of which is an injection. Various studies are ongoing to facilitate provision of safer and more patient-friendly medicines for administration under shorter treatment regiments. For the second year running, WHO with funding from American Leprosy Mission continued support for one such study in Ghana. The study comparing streptomycin (one of the conventional medicines given by injection) and clarithromycin (which is taken by mouth) for the treatment of BU in 3 sites in Ashanti Region (Agogo, Tepa and Nkawie) and 1 in Central Region (Upper Denkyira) is coordinated by physicians from Komfo Anokye Teaching Hospital. By the end of 2014, 132 out of expected 322 patients (41%) had been recruited. The results from the study will subsequently inform guidelines for the treatment of BU. ***(Picture - Presentation of public address system to Tepa Trial Site staff to augment early case detection in community outreach activities)***

Lymphatic Filariasis (LF) - In Ghana lymphatic Filariasis is endemic in 8 of the 10 regions and 98 out of the 216 districts in Ghana with an at-risk population of about 12 million. After several rounds of annual mass drug administration (MDA) for LF in affected districts, Transmission Assessment Surveys (TAS) were conducted to determine whether prevalence of lymphatic filariasis in defined populations is low enough to stop MDA among the people. WHO provided technical support for the conduct of LF Transmission Assessment Survey (TAS) in 2014. All the participating 64 districts assessed in 2014 passed the TAS and therefore qualify to stop mass drug administration. (***Picture - School children being tested in TAS being conducted in Prestea-Huni Valley District, Western Region)***

Human African Trypanosomiasis (HAT) - HAT commonly known as sleeping sickness is occasionally diagnosed in Ghana, the last time being in 2013. To achieve the NTD Road map target of achieving 100% elimination by 2020, surveillance for the disease and community screening activities in areas where cases are reported are key to facilitate identification of possible cases. **(*Picture - HAT case search in the community*** WHO is supporting HAT sentinel



surveillance in 3 health facilities in Takoradi, Western Region and 1 in Akuse, Eastern Region. In 2014, out of 107 suspected cases tested for HAT, none came back positive.

Leprosy -Leprosy is a chronic infectious disease of man caused by mycobacterium leprae affecting mainly the skin and the peripheral nerves. With a national prevalence of 0.13/10,000 population, Ghana has achieved the WHO target of elimination set at <1/10,000. However a few districts such as Akyemansa district in the Eastern Region with a prevalence of 1.5/10,000 are endemic for the disease. WHO supported Akyemansa District to implement leprosy awareness creation and case finding activities.

A total of 1,174 people comprising 457 males and 717 females were screened for leprosy out of which 107 people comprising 42 males and 65 females were identified suspected cases. Subsequently, thirteen cases of leprosy including 2 children were confirmed.

***(Picture - Demonstrations on Leprosy diagnosis during a session of the health workers training in Akyemansa District*)**

4.4.3 Schistosomiasis - It is estimated that about 7 million school-aged children in Ghana are at-risk of schistosomiasis, and therefore require annual or biannual treatment with Praziquantel. To facilitate targeted mass drug administration to communities affected by Schistosomiasis, there is a need for mapping of highly endemic communities. Building up on support in previous years in which similar exercises were conducted in other regions, in 2014, WHO supported the NTD program to undertake Schistosomiasis mapping exercise in 23 districts in Upper East and Upper West Regions. A total of 497 communities were identified to be highly endemic of schistosomiasis and have been earmarked for future mass treatment.

4.4.4 Support for MDA - The integrated NTD programme with the support of its partners and stakeholders undertake mass drug administration as one of the key strategies for the prevention, control and elimination of PCT NTDS. WHO's logistical support enables the delivery of procured and donated drugs for the MDA exercise. In 2014, this translated into more than $42 million worth of drugs being cleared and delivered. MDA was undertaken for LF, with coverages of 79.9% in 2014.

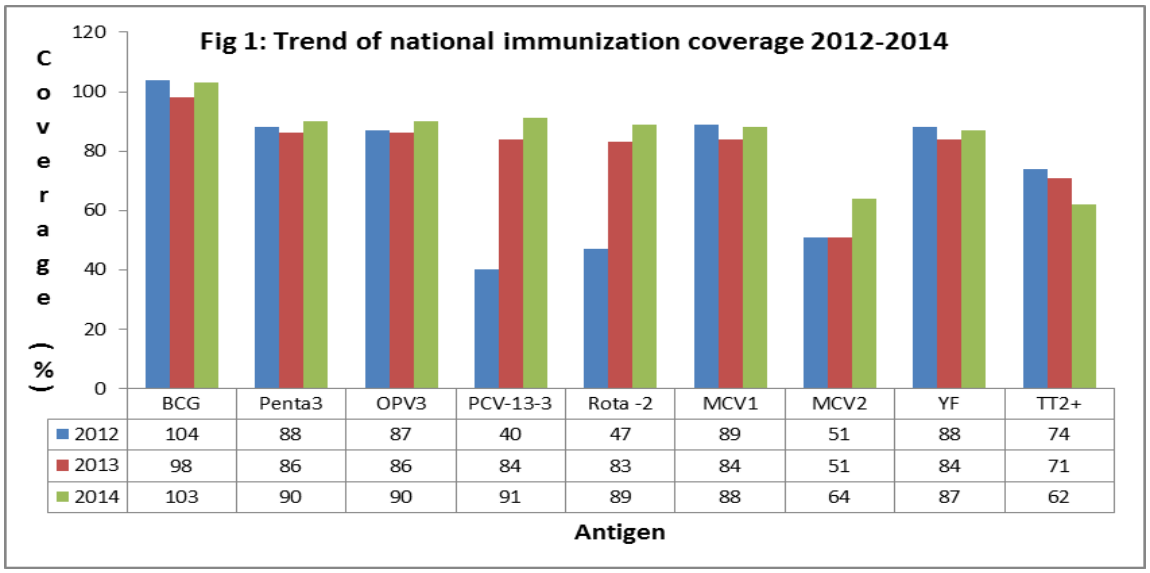
4.5 VACCINE PREVENTABLE DISEASES (VPDs)

WHO support for VPDs in Ghana is aimed at reducing morbidity, mortality and disability due to vaccine preventable childhood killer diseases. This support is provided through the (i) strengthening of the routine immunization activities which focuses on the reaching every child (REC) approach (ii) Accelerated Immunization Initiatives (AII) that comprises supplemental immunization activities such Polio NIDs and other vaccination campaigns and (iii) Vaccine Preventable Disease (VPD) surveillance. These are briefly described below:

4.5.1 Routine EPI - Strengthening of routine immunization activities continued throughout the year through the implementation of all components of the REC approach in all 216 districts. WHO provided support to strengthen integration of EPI with other child survival intervention programmes such as Child and Adolescent Health, Nutrition, Malaria Control through the African Vaccination and Child Health Promotion Week programmes.

Figure 6 illustrates the 3-year trend of immunization coverage performance since the introduction of MCV2, Rotavirus and PCV13 into the routine programme in 2012.

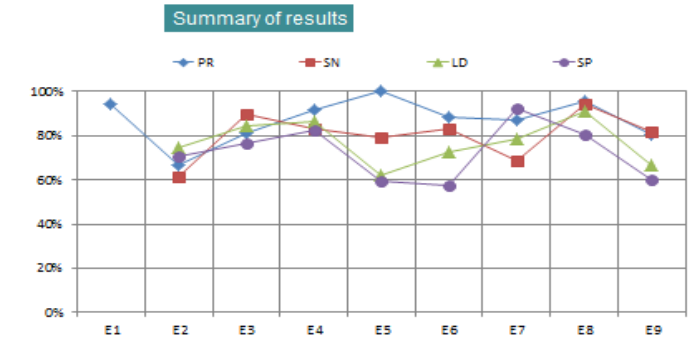
Fig 6



	BCG	Penta3	OPV3	PCV-13-3	Rota -2	MCV1	MCV2	YF	TT2+
2012	104	88	87	40	47	89	51	88	74
2013	98	86	86	84	83	84	51	84	71
2014	103	90	90	91	89	88	64	87	62

There has been an increase in all the antigens for the infant immunization. However, there is a continuous decline in the TT coverage over the past 3 years which is being investigated for root causes and possible solution. One hundred and fifty (150) districts out of the 216 representing 69.7% recorded penta3 coverage >= 80% whilst two districts recorded penta3 coverage of <50%. The estimated number of un-immunized children was 60,121 (representing 5.8%) of total annual EPI target. Vitamin A coverage for the year is 64%. The country has been able to sustain the gains achieved in the past and that include (i) break in transmission of wild polio virus since November 2008 (ii) no measles death since 2003 and (iii) MNTE validation since 2011.

4.5.2 Effective Vaccine Management (EVM) Assessment – WHO in collaboration with UNICEF provided support to conduct assessment of the vaccine management practices to identify gaps at the various levels and also develop plans to improve on vaccine management practices in the supply chain system at all levels. The WHO EVM site selection tool was used to randomly select a total of 69 facilities made up of national, regions, districts and service delivery points.



PR-National	94%	67%	81%	92%	100%	88%	87%	96%	81%	1
SN-Regional		61%	90%	83%	79%	83%	68%	94%	82%	10
LD- District		74%	84%	87%	62%	73%	79%	91%	67%	28
SP-Service Point		71%	77%	82%	59%	57%	92%	81%	60%	30

Fig 7

The assessment covered the following 9 criteria (i) E1: Vaccine arrival reports (at national vaccine store only), (ii) E2: Temperature monitoring (iii) E3: Storage capacity (iv) E4: Buildings, equipment and transport (v) E5: Maintenance (vi) E6: Stock control (vii) E7: Distribution (viii) E8: Vaccine management and (ix) E9: Supportive services.

The minimum score required for each criterion is 80%. From the results summary graph above, (i) temperature monitoring is the most ineffective at all levels including national (ii) Maintenance of equipment etc is also poorly managed from regional to the facility points. (iii) Stock control is ineffective at district and service delivery points whilst (iv) facilitative supervision is inadequate at the district and sub-district levels.

Key challenges identified affecting vaccine management from the assessment in the country are: (i) Inadequate training (ii) Lack of continuous temperature monitoring devices (iii) Knowledge gaps in vaccine management, (shake test, icepack conditioning, stock management) (iv) Irregular supportive supervision at all levels (v) Lack of sustainable maintenance system for building, equipment and transport. Major recommendations include – training at all levels, expansion of storage capacity and intensification of supportive supervision.

4.6 POLIO ERADICATION INITIATIVE - WHO provided support for two rounds of synchronized polio NIDs conducted in September and October respectively targeting 5, 715, 720 children (0-59 months) in each round. (***Picture-WR-Ghana, Dr Robalo administers polio vaccine whilst on rounds monitoring the Polio NID***)

The second round was integrated with Vitamin A supplementation, AFP case search, Guinea worm case search and education on Ebola virus disease prevention.

Table 7 below is the summary of the two rounds of polio NIDs and the vitamin A campaign conducted in 2014. A total of 5,994,505 children (representing 104.9%) were reached with the OPV in the first round in September and 6,030,248 (representing 106.2%) in the second round in October respectively. The Vitamin A supplementation recorded 96.8% coverage.

Table 7

Table 1: Summary of Polio NIDs and Vitamin A coverage in 2014								
Regions	Polio Target	Round 1:18-20 Sept		Round 2: 30 Oct-01 Nov		Vitamin A Supplementation		
		Total vaccinated	% Cov	Total Vaccinated	% Cov	Vitamin A Target	Total dosed	% Cov
Ashanti	1,078,732	1,141,607	105.8	1,141,599	105.8	970,859	895,655	92.3
Brong-Ahafo	521,941	540,075	103.5	542,379	103.9	469,747	449,700	95.7
Central	463,081	509,310	110	508,285	109.8	416,773	418,907	100.5
Eastern	590,648	604,243	102.3	610,818	103.4	531,583	518,417	97.5
Greater Accra	875,782	899,264	102.7	922,932	105.4	788,204	755,858	95.9
Northern	774,489	812,835	105	829,707	107.1	697,040	703,592	100.9
Upper East	273,990	292,266	106.7	292,167	106.6	246,591	239,917	97.3
Upper West	152,984	154,904	101.3	156,303	102.2	137,686	132,875	96.5
Volta	428,488	445,948	104.1	452,706	105.7	385,639	370,028	96
Western	555,585	596,065	107.3	611,109	110	500,027	497,144	99.4
National	5,715,720	5,996,517	104.9	6,068,005	106.2	5,144,148	4,982,093	96.8

WHO also provided support for the successful development and submission of application documents to GAVI to introduce Inactive Polio Vaccine (IPV) into the routine immunization programme in September 2015.

4.6.1 Monitoring protection at birth (PAB) – pilot project - The WHO supported the Western Region Health Directorate to undertake a six month pilot programme in two districts (Wassa East and Mpohor) from April to September 2014 to assess the TT vaccination status of women through the monitoring of children protected at birth (PAB).

Table 2: Summary of PAB project results				
Indicators		District		Summary
		Mpohor	Wassa East	
Mothers	Total interviewed	807	1648	2455
	Age Range (yrs)	14-48	14-51	14-51
	Maximum parity	11	10	11
TT vaccination	Maximum Dose	12	15	15
	Minimum Dose	1	1	1
Received TT in last pregnancy	Yes	728 (90.2%)	1287(78.1%)	2015(82.1%)
	No	79 (9.8%)	361 (21.9%)	440 (17.9%)
Source of Information	History	619 (76.7%)	1386 (84.1%)	2005 (81.7%)
	Records	188 (23.3%)	262 (15.9%)	450 (18.3%)
PAB status of child	Protected	712 (88.2%)	1315 (80%)	2027 (82.6%)
	Not Protected	95 (11.8%)	331 (20%)	426(17.4%)

The main objective is to document the process, challenges and cost implication of PAB scale up in the country. Specifically, the pilot

project is to determine whether the PAB concept can be implemented and strategies to adopt.
The process involved training of health staff in the two districts and assessing TT vaccination status of mothers attending child welfare clinic 6 weeks after delivery using a checklist.
Out of 2,455 mothers interviewed in the two districts during the six month period, 2015 (representing 82.1%) received TT vaccination in their last pregnancy. Children protected at birth totalled 2027 (82.6%). TT vaccination received ranged from 1-15 doses suggesting that some mothers received as many as 6-15 doses above the recommended 5 doses. History (81.7%) forms main source of information indicating that very few mothers (18.3%) had TT vaccination cards.

4.7 VPD SURVEILLANCE

Vaccine preventable disease surveillance covered activities that included – Acute flaccid paralysis (AFP) for polio, vaccine safety monitoring or surveillance for adverse effects following immunization (AEFI), surveillance for measles and yellow fever, maternal and neonatal tetanus, rotavirus, pediatrics bacterial meningitis (PBM) and pneumonia. WHO provided support for VPD surveillance in various forms in 2014 and among the support were the following:

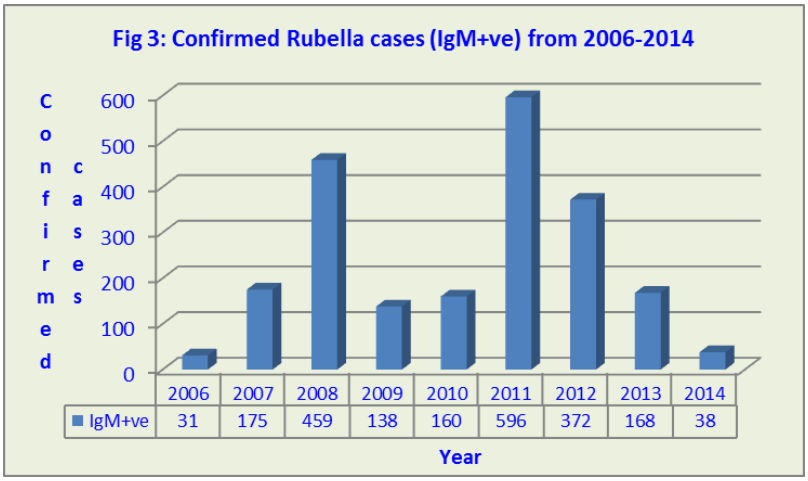
- support for the 4 sentinel sites for surveillance of diseases targeted by new vaccine introduction such as PMB, Rotavirus and Pneumonia in Korle Bu and Komfo Anokye Teaching hospitals;
- support for 2-weeks regional workshop at Noguchi Memorial Institute for Medical Research for Data Managers and Laboratory Technicians on Rotavirus surveillance for 6 countries in the West African sub-region;
- coordination of three-day vaccine safety and pharmacovigilance workshop for 8 Anglophone countries held in Accra from 28-30 April;
- technical support for Vaccine safety Training of Trainers (TOT) under the theme "Ensuring the safety of vaccines and vaccination in Ghana" from 18 – 20 November;
- support for activities implemented by the Polio Eradication Technical committee – such as national polio expert Committee (NPEC, National Certification Committee (NCC) and Task Force on poliovirus containment;
- technical support for the development and dissemination of national policy on viral hepatitis control in Ghana;
- support for publication of feedback surveillance bulletins, IE&C materials and posters (for enhanced Surveillance for VPDs and other Priority diseases);
- support for Social mobilization, community-based and cross-border activities (for enhanced Surveillance for VPDs and other Priority diseases);
- support for Noguchi Polio Lab and National Public Health and Reference Lab operational activities;
- support for Polio-related Technical Committees (NCC, NPEC & NTF on Containment);
- continuation of galvanizing support towards resource mobilization for Polio (AFP) Surveillance – by bringing on board other partners such as Ghana Rotary International Polio-plus;

- support for the development of measles-rubella elimination strategic plan; and
- financial support to selected regions to improve on routine immunization and VPD surveillance activities.

Table 9 below is the summary of AFP and measles rubella surveillance performance indicators for 2014. Table 9

Table 3: VPD surveillance summary table - AFP and Measles-rubella											
		AFP surveillance inticators					Measles-rubella surviellance indicators				
Region	Number of Districts	Pop <15 yrs	Expected AFP cases	AFP cases reported	Non polio AFP rate	% Adequate stool	Districts reporting	% districts reporting	Suspected measles cases	Measles IgM+ve	Rubella IgM+ve
Ashanti	30	2,233,539	45	34	1.29	82	25	79%	86	3	1
Brong Ahafo	27	1,063,037	21	97	8.76	95	26	95%	339	41	17
Central	20	1,044,899	21	33	2.67	85	17	85%	53	1	3
Eastern	26	1,201,790	24	23	1.75	83	23	83%	166	2	8
Greater Accra	16	1,902,980	38	32	1.47	78	11	75%	33	0	0
Northern	26	1,167,530	23	42	3.3	90	14	88%	43	21	0
Upper East	13	461,030	9	24	4.89	92	12	92%	65	24	0
Upper West	11	317,944	6	19	6.33	100	10	100%	59	15	0
Volta	25	982,025	20	25	2.3	88	20	88%	81	0	2
Western	22	1,080,190	22	47	3.45	79	21	74%	114	14	7
National	216	11,454,964	229	376	2.95	88	179	86%	1039	121	38

Measles-rubella vaccine (MR) was introduced in October 2013. The graph below illustrates significant decline in rubella cases after the introduction of the vaccine. Fig 8



4.5.6 Support for miscellaneous activities – WHO supported the national Immunization programme with the preparation of the comprehensive multi-year plan for EPI (cMYP) 2014-2019, GAVI graduation assessment and GAVI HPV demonstration project.

CHAPTER FIVE
NON-COMMUNICABLE DISEASES CONTROL

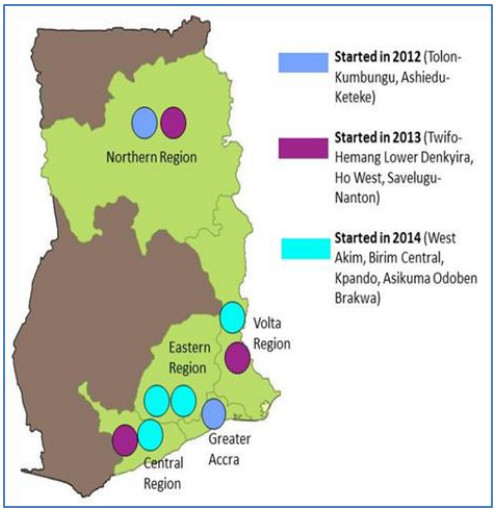
5.1 NON-COMMUNICABLE DISEASES

Non-communicable Diseases (NCD) is a growing health problem in Ghana and among the leading causes of reported institutional deaths in recent years. It is estimated that NCDs accounted for an estimated 34% deaths and 31% of disease burden in Ghana in 2008. Risk factors for NCDs include tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. Consequently there is a need for interventions to prevent and manage non-communicable diseases and their risk factors to reduce the disease burden. WHO is supporting the NCD Control Program (NCDCP) of Ghana Health Service to pilot a package of essential NCD (PEN) interventions in 3 districts. The objective is to enhance the capacity of health workers down to the primary care level to implement cost-effective and low technology interventions for the prevention, early detection, prompt management of NCDs and control of their risk factors. WHO provided support for an assessment of logistics gaps and training needs in 26 health facilities in the 3 districts and the subsequent training of 32 health workers from the facilities in protocols for early detection, prevention, treatment and care of NCD and risk management. The office further supported the procurement of essential diagnostic equipment to facilitate the implementation of the program.

(Picture - Basic equipment procured and distributed to PEN)

5.2 MENTAL HEALTH

5.2.1 Fight Against Epilepsy Initiative - The fight against epilepsy initiative which was started in 2012 has been ongoing and it is aimed at improving access to epilepsy care and services. It is currently being implemented in 5 regions (Greater Accra, Volta, Northern, Eastern and Central regions) and in nine districts. The objectives of the initiative are to:



- develop and engage in the strategy for delivering epilepsy care;
- promote training of all professional health care providers, making them competent in diagnosing and treating epilepsy;
- improve awareness of community groups to decrease stigma and increase demand for epilepsy care;
- integrate provision of care and services for epilepsy within the primary health care system;
- monitor and evaluate the project and disseminate new ideas and knowledge.

(***Map showing participating districts and year of enrolment)***

Activities undertaken during the year under review included supportive supervision to the districts implementing the initiative, training of health staff including staff from CHAG facilities, training of health volunteers to assist in referring clients to primary health facilities from the communities and from prayer camps, engagement of community leaders and sensitization of faith based healers and traditional healers to understand the disease condition and refer clients to health facilities. A national stakeholder meeting was held to disseminate information about the project and discuss sustainability of the project after the pilot phase.

5.3 VIOLENCE AND INJURIES

Status Report on Injury Prevention - WHO's work in injury and violence prevention is achieved by supporting national efforts to raise awareness about the magnitude and consequences of injuries, violence and disability. It is also to improve data collection, analysis and dissemination of information and policy formulation among others. WHO supported data collection for the Ghana component of the Global status report on violence prevention and convened a consensus building meeting of stakeholders from various agencies including the National Youth Authority, Ghana Police Service, Ghana Health Service, Ghana Education Service Headquarters, Ministry Of Justice & Attorney General for data validation. The report which provide a broad assessment of the state of interpersonal violence prevention including youth violence, gang violence, child maltreatment, intimate partner violence, sexual violence in countries around the world helps to evaluate the extent to which countries have been implementing the recommendations of the WHO's 2002 World report on violence and health.

Similar to other global reports on road safety and tobacco control, this snapshot of the state of interpersonal violence prevention in Ghana will serve as a baseline to track future progress in violence prevention and be a catalyst to stimulate action at the national level. It will also be a benchmark to assess Ghana's position in violence prevention relative to other countries. The report was launched on 11 December 2014 and can be accessed from ***http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/***

The Ghana report is available at ***http://www.who.int/violence_injury_prevention/violence/status_report/2014/coutry_profiles/GHANA.pdf***

5.4 NUTRITION

Building the capacity of health workers to provide nutrition services through strengthening nutrition pre-service training - A highly skilled and knowledgeable workforce to deliver quality nutrition services at the different levels of the health systems was one of the requirements identified for the implementation of the national nutrition policy. Due to the limited number of nutritionists and dieticians, nurses are currently playing a vital role in delivering nutrition services at the facility and community level. It is therefore essential that nurses and other support staff have adequate knowledge and skills to deliver quality nutrition services at the facility level and are abreast with the recent changes.

In 2013, Ghana with support from USAID, developed a competency-based approach to strengthen the current nursing and midwifery pre-service training on nutrition. This resulted in a curriculum review and the development of technical nutrition updates. It further facilitated the training of over one hundred tutors from nursing and midwifery schools across the country. WHO supported the development of the key competencies and the curriculum review. The next steps are to orient trainers on the technical reference materials, to conduct monitoring and feedback from the tutors trained on the application of the knowledge and skills obtained during the training.

In 2014, WHO supported the GHS for a two-day orientation of a core team of trainers. The orientation was conducted in collaboration with the GHS and partners; UNICEF and JHPIEGO to build the capacity of a core team which would provide continuous on –the- job support to the school and tutors to strengthen their nutrition competencies on the use of the technical update and reference materials. Twenty participants from 5 regions, Northern, Western, Eastern, Volta and Greater Accra were oriented on the teaching aids and reference materials for tutors of nursing and midwifery schools.

5.4.1 Commemoration of World Breastfeeding Week (WBW) 2014: Breastfeeding A Winning Goal - for Life - The MICS, 2011 showed a decline in exclusive breastfeeding rates from 63% (DHS 2008) to 43% in 2011. This decline raises a lot of concern and the need for strategies to revamp the advocacy and awareness on exclusive breastfeeding and its benefits. The WBW 2014 was therefore an opportunity for Government and Partners to rally around and call attention to the need to promote, protect and support breastfeeding. WHO supported the Ghana Infant Nutrition Action Network (GINAN) in collaboration with GHS to orient mother support group members. Twenty-two mother support group members were oriented on the current status of breastfeeding in Ghana and policies/key messages, importance of breastfeeding and benefits of breastfeeding to the mother, baby, family and the nation, lactation management (proper positioning and attachment, and addressing common breastfeeding difficulties).

5.4.2 Review and adaptation of the WHO evidence-based guidelines on the prevention and control of micronutrient deficiencies - In 2011 WHO released evidence-based micronutrient guidelines. WHO provided support to review and adapt the guidelines for Ghana. A multi-sectorial task team, made up of government (nutrition, child health, maternal health, health promotion, malaria programmes of the Ghana Health Service), research, academia, partners

WHO, UNICEF, WFP reviewed a total of 13 guidelines, and made recommendations on its impact in terms of adoption in Ghana. Although all 13 guidelines were of importance, the team focused on the guidelines on maternal post-partum Vitamin A supplementation and new provisions regarding iron supplementation of women in the reproductive age which were of particular interest to guide policy formulation.

CHAPTER SIX

PROMOTING HEALTH THROUGH THE LIFE COURSE

6.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

WHO provides technical support to the Ministry of Health/Ghana Health Service (GHS) for planning, implementation, monitoring and evaluation of Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes in the country. WHO is working to improve access to, coverage and quality of health services for pregnant women, newborns, children and adolescents along the continuum of care. Ghana's maternal mortality ratio is currently 380 per 100,000 live births and the Neonatal mortality rate is 32 per 1000 live births. Inadequate access to quality skilled delivery, emergency obstetric and newborn care and family planning have been identified as some contributory factors. WHO has supported an MDG Acceleration Framework (MAF)-Ghana Action Plan to redouble efforts to overcome bottlenecks in implementing interventions that have proven to have worked in reducing the maternal mortality ratio in Ghana. The MAF focuses on improving maternal health at the level of both community and health care facilities through the use of evidence-based, feasible and cost-effective interventions in order to achieve accelerated reduction in maternal and newborn deaths. The three key priority interventions identified are improving family planning, skilled delivery and emergency obstetric and newborn care.

6.1.1 Strengthening Maternal and Reproductive Health Indicators - WHO provided support to the Ghana Health Service to revise the existing Reproductive Health indicators with specific focus on family planning, prevention of unsafe abortion and post abortion contraception. Data management tools at the facility level were revised and are being tested in 4 districts after which the indicators will be incorporated nationally into the District Health Information Management System (DHIMS2).

6.2 CHILD HEALTH

6.2.1 African Vaccination and Child Health Promotion Week - African Vaccination Week (AVW) is a week set aside by the WHO in 2011 to create more awareness about (i) the importance of immunization, (ii) the immunization services available and (iii) to encourage all caregivers to patronize the services available. The goal is to increase immunization coverage, reduce the burden of vaccine preventable diseases and achieve the MDG 4.

Similarly the Child Health Promotion Week (CHPW) is also a week set aside by the Ghana Health Service since 2004 to create awareness and deliver integrated child survival interventions such as immunization, growth monitoring, birth registration, health promotion, insecticide treated bed nets etc. The 2 events are conducted together. There is a Press briefing in April and the service delivery is in second week of May every year.

The WHO Representative, Dr Magda Robalo made remarks on behalf of UN Agencies at the Press briefing in April in Accra whilst the UNICEF Representative Ms Susan Namondo Ngongi represented the UN Agencies at the national launch of the CHPW at Bolgatanga in the Upper East Region in May. WHO's support also included technical assistance from IST-West for the field implementation of the programme.

The Minister of Health, Ms Sherry Ayitey launched the two events on 02 May, 2014, at a colorful durbar of the chiefs and people at Bolgatanga in Upper East region. Development Partners (DPs) including WHO, UNICEF and USAID attended the function (***Picture- Minister for health launching the programme at Bolgatanga)***.

The table 10 below shows the number of children vaccinated during the AVW and CHPW period

Table xx Total number of children vaccinated during AVW by antigen								
Region	BCG	Penta 3	OPV3	MR	MCV2	Y Fever	Rota 2	PCV 3
Brong-Ahafo	1214	2296	2296	2572	2203	3627	2281	2295
Eastern	9504	6626	7704	7892	7525	7594	7596	7732
Greater Accra	5293	4166	4162	3502	1996	3464	4369	4168
Northern	2712	2344	1999	3313	3426	3296	2424	2347
Upper East	758	880	897	1137	1891	936	595	551
Upper West	419	408	475	560	298	466	478	424
Western	2676	1849	1869	1877	1444	1854	1883	1862
Total	22576	18569	19402	20853	18783	21237	19626	19379

6.2.2 Vehicle for Maternal and Child Health Services– WHO supported the Aowin-Suama district in the Western Region with a double-cabin Toyota Hilux pick-up for integrated maternal and child health - The WR on Tuesday 06 May 2014 handed over keys to the vehicle to the Deputy Minister of Health, Dr. Alfred Tia Sugri in Accra to help improve child healthcare services and maternal related complications in the district. The Aowin-Suaman district is one of hard-to-reach districts in Ghana due to bad roads that become very non-motorable during the rainy season. Disease control and surveillance activities will also be enhanced with the availability of the vehicle in the district. (***Picture-Dr Robalo, middle, handing over keys to Deputy-Minister whilst Dr Joseph Amankwa, Director of Public Health, right looks on***).

6.2.3 Support to Newborn Strategy and WHO Pocket Handbook for Children in Ghana

WHO, in collaboration with other Partners, supported the Ministry of Health (MOH) and the Ghana Health Service (GHS) to develop a five-year National Newborn Health Strategy and Action Plan from 2014-2018.

WHO further supported the Ministry with Pocket Hand Books which were distributed to all health facilities to enhance delivery of essential services to infants and children in the country. The Minister of Health, Honourable Kwaku Agyemang–Mensah launched the five-year strategy and action plan together with the WHO Pocket Handbook for Children at an Executive National Forum organized by the Ghana Health Service and other Partners (WHO, UNICEF, USAID, PATH etc) on July 30, 2014. The Hon Minister was assisted by the Country Representatives WHO, UNICEF, the Deputy Mission Director of USAID, Ghana and the Director-General of the Ghana Health Service. (***Picture – Honorable Minister for health launching Pocket book)***

6.3 ADOLESCENT REPRODUCTIVE HEALTH PROGRAMMES

WHO supported a survey on technical assistance needs for implementing the GAVI assisted demonstration project on HPV Vaccination which is being implemented by the GHS in 4 districts. The HPV demonstration Project is a 2-year project to learn HPV vaccine and the socio-economic implications for scale up nationwide. The survey was to assess the following:

- potential HPV vaccine delivery strategies for coverage, feasibility, acceptability, and cost;
- necessary tools (e.g. training materials for staff, national communication plan);
- feasibility of integrating selected adolescent health interventions with the delivery of HPV vaccine; and
- feasibility of integrating HPV vaccination in a national cervical cancer prevention and control strategy.

WHO is supporting the process to prioritize adolescent health interventions to be integrated with HPV vaccination to establish cost of integrating each intervention with HPV vaccine delivery.

6.4 CAPACITY BUILDING ON PRE-SERVICE TRAINING OF HEALTH WORKERS IN ADOLESCENT HEALTH

WHO provided support for site visits and field testing to sixteen Nursing and Midwifery schools in the three ecological zones of the country to:

- enquire about the quality and content of the document "LIST OF ESSENTIAL COMPETENCIES IN ADOLESCENT HEALTH" and the 'CHECKLIST" tool and to reflect on how the instruments may be improved: missing pieces, unclear questions, etc.
- reflect on the use of the instruments as an advocacy tool to improve the content and structure of training in adolescent health, and on a broader scale, to positively impact on the delivery of health care and prevention strategies to adolescents.

The Schools represent the six programs: Registered Nurses (RGN), Registered Midwifery (RM), Registered Mental Nursing (RMN), Registered Community Nursing (RCN), Community Health Nursing (CHN), and Health Assistants Clinical (HAC).

WHO is supporting the review of the curricula of Pre-service institutions and the in-service training manuals to harmonize the materials and tools used for training.

6.4.1Training on adolescent health and development - This was carried out in two districts in the Eastern Region; Lower Manya Krobo and Akwapim South Districts by Ghana Health Service to help the district level health staff to build their knowledge and understanding for adolescent reproductive and sexual health to facilitate training and quality service delivery at the grass root level. Participants were Public Health Nurses, Nutrition Officers, CHOs and CHNs.
The program facilitated the formation of Fifty (50) adolescent corners in health facilities in the two districts and twenty five (25) Adolescent School clubs.

6.5 HEALTHY AGEING

The Review of a national ageing policy was supported and both the first and second wave SAGE (Ghana Study on global aging and adult health) Reports were launched. Some of the findings from the first wave study were as follows:

- Women rate their health worse than men;
- Health related issues and old age were the main reasons for the discontinuation of work for both women and men.

- Health
  - 14% of older Ghanaian reported having been diagnosed with high blood pressure, while 55% were hypertensive when blood pressure was measured;
  - 14% of older Ghanaians reported having arthritis;
  - 76% of older adults are at high risk of anaemia;
  - Prevalence of HIV among adults aged 50+ years was 2.3%;

- Risk factors
  - 8% of older adults are currently daily smokers with a high percentage of former smokers;
  - 52% of men were non-heavy alcohol drinkers. 5% were considered heavy drinkers. Heavy drinking was low in women.
- Health spending - The average household out-of pocket spending on health services was Gh¢ 13.47 per month.

6.6 HEALTH AND THE ENVIRONMENT

6.6.1 UN Global Analysis of Drinking Water and Sanitation (UN- GLAAS) Financial Tracking in Ghana - Effective financing for drinking-water, sanitation and hygiene (WASH) is essential to deliver and sustain services. WHO is leading the "TrackFin" initiative under the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) umbrella to define and test a globally accepted methodology to track financing to WASH at national level.

In 2014, WHO globally supported Ghana, Morocco and Brazil to conduct a pilot of the UNGLAAS TrackFin. In Ghana the pilot was conducted by a team of both international and local Experts led by the Ministry of Local Government and Rural Development. Data was collected through desk review, interviews with key stakeholders in the WASH sector and stakeholder validation workshops. The financial track for Ghana was done for the period 2010 to 2012 and some key findings are as follows;

The WASH expenditure from 2010 to 2011 increased by 23% and by 32% from 2011 to 2012. From the table below however, in terms of the US dollar there was rather a decrease from 16% to

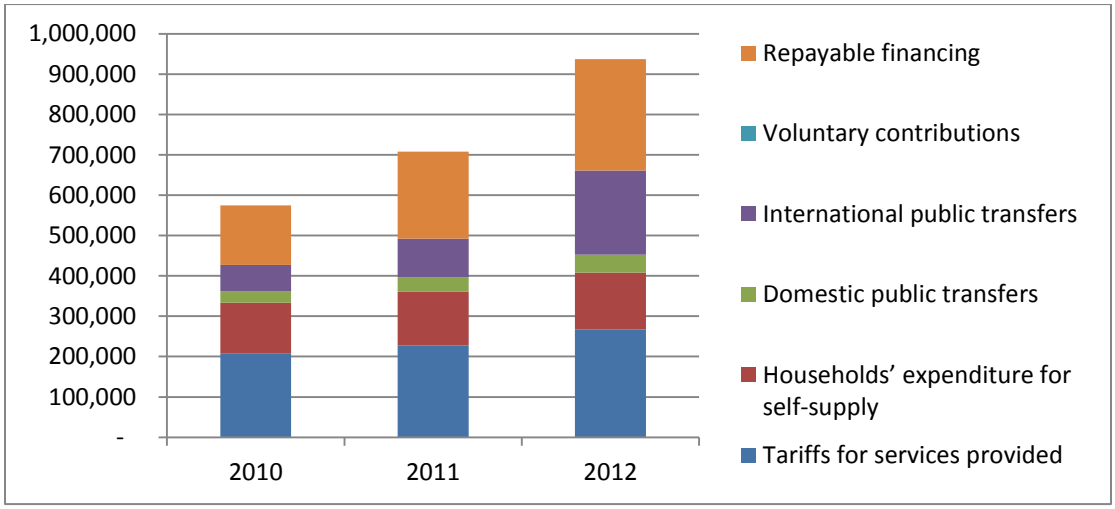
11% for the same period. This can be attributed to the changes in the value of the local currency and can be seen from table 11 below.

WASH-Accounts summary indicators on expenditure to WASH

	Unit	2010	2011	2012
Total expenditure to WASH	Local currency	575 m	708 m	937 m
	USD	402 m	468 m	521 m
Total expenditure to WASH per capita	Local currency	23.69	28.51	36.94
	USD	16.55	18.86	20.57
Total expenditure to WASH as a % of GDP		1.25%	1.26%	1.28%
Total expenditure to health as a % of GDP		5.29%	5.27%	5.17%
Total expenditure to education as a % of GDP		5.5%	8.1%	N/A
Total expenditure on urban WASH as a % of total WASH expenditure		68%	69%	69%
Total household expenditure as a % of WASH expenditure		21.78%	18.80%	15.07%
Total government domestic transfer expenditure and as a % of WASH expenditure		4.92%	4.99%	4.75%
Total international transfer expenditure and as a % of WASH expenditure		11.46	13.61	22.25%
Total operating and maintenance costs as a % of total WASH expenditure		NA	NA	NA
Official exchange rate (LCU per US$, period average) (source: World Data Bank)		1.431	1.512	1.796

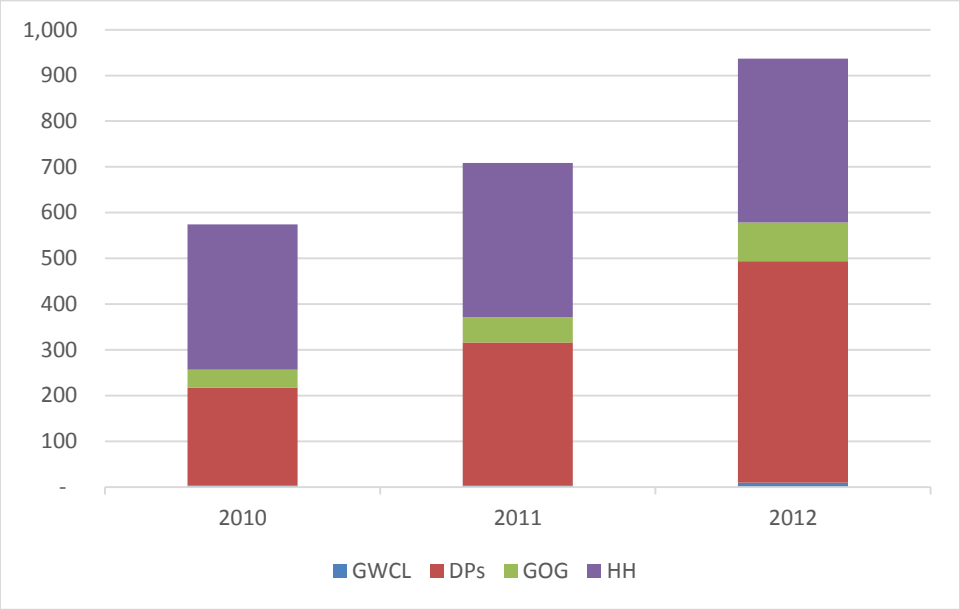
There is a gradual increase in WASH expenditure from domestic public transfers, households and voluntary contributions as seen from Table 1 above. Financing coming from international public transfers and repayable financing are at a marginally higher rate.

Figure 10: Total Financing to WASH



In terms of who pays for WASH, the major financing units for WASH expenditure are households and Development Partners. Expenditure by GWCL which comes from other sources other than tariff, Development Partners or the central government accounts for less than 1% of expenditure.

Figure 11: WASH Expenditure by Type of Financing Unit



There were a number of challenges faced during the data collection phase, however the experience was positive for Ghana and the key stakeholders found the exercise useful and willing to embark in developing WASH accounts in the future.

6.7 FINALIZATION OF NATIONAL HEALTH ADAPTATION PLAN FOR CLIMATE CHANGE:

In 2014 WHO provided support for the finalization of a National Plan of action for Health sector Adaptation to Climate Change in Ghana 2015-2019 which is to be harmonized and integrated into the national climate change strategy. Capacity building in the environmental health impact assessment, environmental and occupational health issues related to the use of mercury in small scale artisanal mining will be built in 2015.

6.8 SOCIAL DETERMINANTS OF HEALTH

6.8.1 Tobacco

In an effort to prevent chronic diseases and promote good health, WHO supported the Ministry of Health/GHS and other partners to raise public awareness of health issues and concerns and to motivate people to take positive action and responsibility for their health by adopting healthy lifestyles.

WHO also supported the strengthening of national capacity to plan, implement and evaluate setting-based health promotion programs for the reduction of the risks associated with leading causes of death, diseases and disability as well as advocacy for the creation of conducive environments and policies for promoting healthy lifestyles. This led to the following:

- finalization of the National Alcohol Policy;
- development of a five-year strategic plan for Diet and Physical Activity.

6.8.2 Articles 5, 12 and 13 of FCTC Implementation - During the year under review WHO provided support to Ghana Health Service for the implementation of the WHO Framework Convention Tobacco Control Article 5, 12 and 13. Key activities include: (i) Strengthening infrastructure for tobacco control (Article 5.0: General obligations) 5.2.1 Improve implementation of Tobacco Control interventions in line with the International Treaty, (ii) protect tobacco control policies from commercial and other vested interests of the tobacco industry in accordance with the Public Health Law to ensure that appropriate standards, protocols and guidelines are in place and (iii) Educate, communicate, train and create public awareness on harmful effect of tobacco use and TI interference.

6.9 WORLD HEALTH DAY CELEBRATIONS

Ghana celebrated the 2014 World Health Day (WHD) in Accra with the focus on Vector Borne Diseases (VBD) which includes Malaria, Lymphatic filariasis (which can cause Elephantiasis) and Yellow Fever. The occasion was used to highlight the serious and increasing threat these diseases pose to global health and the need for self-protection from the vectors such as the mosquitoes which play a key role in the transmission of VBD. The slogan for the celebration was "small bite, big threat". The function was graced by the Honorable Minister of Health, the Director-General of the Ghana Health Service (GHS), the WHO Representative to Ghana, health workers and people from all walks of life.

The formal ceremony was preceded by a clean-up exercise at the Tema Station, a popular transport hub for commuters heading for different parts of Accra and beyond.

CHAPTER SEVEN
HEALTH SYSTEMS

7.1 NATIONAL HEALTH POLICIES, STRATEGIES, AND PLANS

The Ministry of Health in conjunction with its Agencies and Development Partners develop health system specific policies, strategies and plans. In line with directive from NDPC, the sector developed its response to the GSGDA 2014-17 by developing its Health Sector Medium Term Development Plan (HSMTDP) 2014-2017 with its costing. WHO supported the development process by being part of the Technical working group commissioned to prepare the HSMTDP. Related to this is the annual Programme of Work which is prepared based on the HSMTDP. WHO supported the POW development process. To ensure that the POW is implemented effectively with the attainment of the desirable health objectives and outcomes, the Ministry, its Agencies and Development Partners hold annual health summit to review sector performance in relation to its POW using a number of mechanisms and tools including joint MOH-DPs monitoring visits and holistic assessment tool which gives scores to indicate the level of attainments by the sector. Activities culminating into annual health summit include district, regional and agencies' performance review, DPs' review and planning meetings. WHO participates actively in all the processes and lead some of them aside providing technical assistance for the process. The sector also holds three MOH-DPs business meetings in April/May, August and November/December to review performance as well as to set the priorities and agenda for the following year. WHO participated both in the business meetings and their preparations.

WHO supported the Ministry to develop its Health Financing Strategy and its implementation plan. The goal of the Ghana Health Financing Strategy (GHFS) is to contribute to achieving improved health outcomes, financial risk protection and consumer responsiveness through equitable, efficient, effective, transparent and sustainable heath financing mechanisms. The objectives of the Ghana Health Financing Strategy includes improving resource mobilization to ensure sufficient and predictable revenue and to promote equity in the distribution of health resources and use of health services and reduce financial barriers to access to health care. Others are to ensure efficient allocation and use of health sector resources, motivate and stimulate service delivery and quality improvement and increase population satisfaction and involvement in their own health, and to strengthen governance, transparency and accountability. The GHFS has six main strategies with each having its major activities; Health Financing Policy and Legal and Regulatory Framework; Revenue Collection and Resource Mobilization; Pooling of Funds; Health Purchasing (dealing with what to Purchase: Coverage and Benefits and How to Purchase: Provider Payment Systems); Public and Private Financing Relationship and Monitoring and Evaluation and Communication.

The Ghana HFS does not contain an explicit timeframe and is expected to continue to serve as the umbrella guiding health financing vision, policy, strategy, plans and implementation as long as it remains relevant. The GHFS implementation plan is phased into four cycles with detailed

activities and plans of work as follows: Initiation spanning 2014-2017, Expansion for 2018-2020, Deepening and Solidification phases 2021-2023 and 2024-2026 as the respectively. Phase I (Initiation) is to be used in expanding Primary Health Care (PHC) capitation payment system to include formation of Preferred PHC Provider Networks (PPPNs) through framing of problem; development of options, generation of analysis and evidence; stakeholder consultation and policy dialogue; make or refine policy decisions as necessary. Phase II (Expansion) is cover to expanding health purchasing improvement which started in Phase I by national roll-out of PHC capitation payment system and formation of PPPN including CHPS by addressing major policy issues by realizing policies and related mechanisms. Phase III (Deepen) is to adopt two prongs of implementation strategy which is to converge as well as the impact of having resolved major policy issues thereby deepening the implementation of HFS. Phase IV (Consolidation) will consolidate, solidify and institutionalize the new health financing system for sustainability. The two prongs of the overall HFS Implementation Strategy will have fully converged into one track with long-term revenue sources, clearer and health purchasing improvement driving efficiency gains moving towards UHC and service delivery realignment and improvement. Phase IV (Consolidation Phase) will continue indefinitely to solidify the new health financing system.

The Ministry of Health is gradually institutionalizing the development of Health Accounts (HA) with support from WHO. WHO participates actively in all processes and at all stages from stakeholders engagements through data collection and analysis to report writing and dissemination. Health Accounts which tracks the flow of funds through the health system from their sources to their end uses is an internationally accepted framework used to comprehensively track expenditures for a given year specifically details financial transactions between Financing Sources (Government of Ghana, households and DPs), Financing Agents (Ministry of Health, Insurance companies and Private enterprises), Providers (public and private hospitals and clinics) and associated functions (health services or products rendered, such as inpatient and outpatient curative care). The Ministry was supported by WHO to prepare the Health Accounts for 2012, apart from the earlier ones of 2002, 2005 and 2010. The emerging trend is that government and other public fund transfers like NHIF are becoming the main source of funding for health followed by household out of pocket expenditures, with DPs contributions decreasing comparatively. Over 60 percent of Total Health Expenditure (THE) is spent on curative care with less than 20 percent being spent on preventive. About 15 percent of THE is spent on governance, and health system and financing administration which includes staff compensations.

7.2 INTEGRATED PEOPLE-CENTRED HEALTH SERVICES

The Ministry of Health has been developing its Human Resources for Health Development (HRHD) Policies, Strategies and Plans since 2002 with the first edition being for 2002-2006 which was followed by a revised version for 2007-2011 which were all developed as aspects of POW II and III respectively. WHO supported the development process of all the HRHD policies, strategies and plans including the latest one which were in two different parts as National Policies for Human Resources for Health for Ghana (NPHRH) and HRHD Strategies and Plans

in order to effectively accommodate any emerging exigencies. The NPHRH which was submitted to NDPC for their review and comments before submission to cabinet has three broad focuses to strengthen the health workforce which are divided into four key thematic areas and four related policy thrusts. They are informed by and aligned with global, national and sector-specific policy frameworks, plans and programmes. These areas and policy thrusts are: Production which is to increase the production of HRH focusing on the quality of the health workforce produced; Distribution which intends to ensure equity in the distribution of HRH; Productivity aiming to improve health worker performance and Cross cutting issues which is to address issues of HRH financing; leadership; HRH information and research, gender mainstreaming, partnerships and monitoring and evaluation.

The Ministry of Health has been developing its staffing norm with WHO's support and participation at the various phases. WHO introduced its Workload Indicators for Staffing Needs (WISN) through a training of selected Human Resource Managers, Health Planners and Information Officers and other Health Managers in the application of WISN.

WHO facilitated the piloting of the WISN in eighteen (18) selected facilities of the various health delivery levels in five (5) regions for clinical staff only. The facilities covered were five (5) health centres, three (3) polyclinics, seven (7) district hospitals, one (1) regional hospital, one (1) specialized (psychiatric) hospital and one (1) teaching hospital. This process was followed by training and data collection from thirty-eight health facilities comprising of one specialist /psychiatry hospital, three tertiary hospitals in KATH, KBTH and Tamale Teaching Hospital were included in the study as well as four out of nine regional hospitals, fifteen district hospitals, (4 GHS and 11 CHAG owned facilities) and 15 health centres/polyclinics (10 GHS and 5 CHAG owned facilities). WHO supported CHAG to use the WISN as one of the working tools in updating their institutional human resource plans for all their 173 facilities covering all types of workers in their facilities. The data collected through the pilot study was used to develop activity and workload standards for clinical staff and these were validated by the results from CHAG's human resource planning exercise. WHO further supported the Ministry and its agencies to use the WISN tool again to collect data to develop activity and workload standards involving twenty one (21) public owned facilities consisting of 3 polyclinics, 7 health centres, 4 municipal hospitals, 4 regional hospitals, 2 teaching hospitals and 1 psychiatric hospital in six (6) Regions covering both clinical and non-clinical staff. The results from this process was used to revalidate the earlier data collected after which a draft staffing norm was developed for sixty four types of clinical staff and fifty two non-clinical staff.

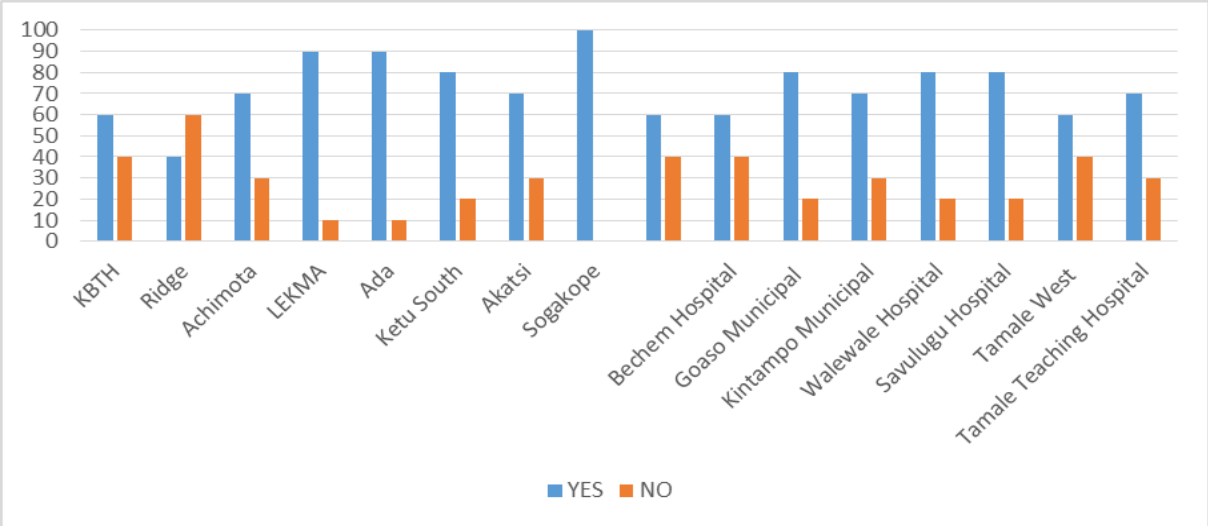
7.3 PATIENT SAFETY

Patient safety has been defined as the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care. These events include "errors," "deviations," and "accidents." Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. Patient safety

improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environments of care. The WHO African Region guidance for developing national patient safety policy and national patient safety strategic plan outlines a four-step approach for developing a patient safety policy and patient safety strategic plan; undertake a situation analysis, develop a patient safety policy, develop a patient safety strategic plan and monitor and evaluate the implementation of the patient safety policy.

WHO has supported the MOH/GHS to undertake a situation analysis in sixteen facilities purposefully selected across the country to guide the development of a patient safety policy. They included 2 Teaching Hospitals and 14 other facilities from 4 selected regions in the country. Data collection methods were mainly by the use of interviews, observation and the administration of an adapted questionnaire. Facilities assessed cumulatively had an average "Yes" score of 66% demonstrating a strong patient safety situation in Ghana. Health facilities assessed were generally weak in the action areas of National Policy, Patient Safety awareness raising, Patient Safety partnerships, Patient Safety funding and Patient Safety surveillance and research respectively.

Fig 12
Graph illustrating the responses of selected hospitals on Patient Safety Awareness



Source: PS Field Survey, 2014

7.4 ACCESS TO MEDICAL PRODUCTS AND STRENGTHENING REGULATORY CAPACITY

WHO provides support to the Ministry of Health and other key stakeholders in the health sector to develop, implement and monitor national policies to improve access to essential medical

products and technologies. Support is provided to the Medicine regulatory agency to build capacity to assure the quality and safety of medical products in use in the country. The main challenges experienced in the implementation of activities in the sector are as follows:

- time spent to develop common understanding of process and content;
- requests to the country office not submitted in adequate time to allow for timely processing and release of funds – minimum of 4 weeks required;
- backlog in submission of Technical and Financial Returns;
- delays in implementation of activities.

In the period under review the following activities were carried out:

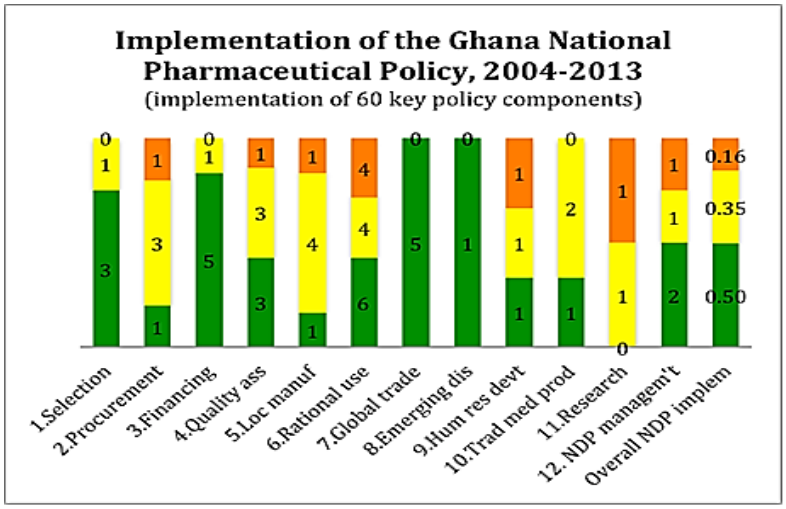
7.5 REVIEW OF STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINES LISTS

The Standard Treatment Guidelines (STG) and Essential Medicines List (EML) are tools that guide medicines prescribing, procurement and re-imbursement of providers by the NHIS in the country. They are also used for training of health workers to provide clinical and public health actions in the health sector. The development of the STG and EML involves a combination of evidence-synthesis, expert input and stakeholder consultative processes in order to arrive at a guideline which has a solid evidence-base and which is also implementable in the context of Ghana. The Minister of Health, Honourable Sherry Hanny Ayittey inaugurated a twenty-five member expert committee to start the review of the National Standard Treatment Guidelines and Essential Medicines List. The Committee includes experts in all the clinical areas of the health sector.

She tasked the committee to execute this task diligently in the time frame they had been given to help the National Health Insurance to effectively determine their re-imbursement list from the STG and EML that will be developed. The Expert Committee was then given a template to use for the review and this is to be collated for a peer review meeting of the experts which will then yield to a stakeholder discussion before the guidelines will be finalized. The major challenge for completing this activity was inadequate funding for carrying out all the components of the review. The activity will be completed next year.

7.6 REVIEW AND FINALIZATION OF THE NATIONAL MEDICINES POLICY

The National Medicines Policy represents decisions based on the best current evidence, the consensus opinion of all stakeholders as well as the general direction of governance on pharmaceuticals and other related health technologies. The second edition, July 2004, has contributed significantly to efforts at bringing standards in the pharmaceutical sector to global standards. However, factors affecting access to medicines keep evolving, at both the national and international level, and thus the need for regular review of the document. The aim of revising the policy is to actualize the commitment of the Government of Ghana towards the goal of ensuring universal access to affordable essential medicines of assured quality for all persons living in Ghana, as well as their responsible use by health professionals and consumers. The revision process was justified by an independent assessment of the implementation of the 2004 policy by WHO and through several stakeholder consultations. The assessment revealed that about half of 60 key policy components were on track and one third were at risk; in a small number of policy areas no action had been taken at all. Good structures have been created in many areas. The Minister of Health therefore inaugurated a Technical Working Group (TWG) to revise the policy. The TWG worked systematically based on the best evidence and in smaller groups on different topics, with co-opted members.



New additions to the revised policy include:

- Health Technology Assessments
- Transparency and Accountability
- Governance
- Pricing
- Disposal of Medicines

The draft policy was then submitted for stakeholder engagement and consensus building for their comments and also for advocacy for the document. The policy has been finalized, with an implementation plan, advocacy and communication plan, as well as an M & E framework for cabinet endorsement, printing, launching and implementation.

7.7 THE MEDICINES TRANSPARENCY ALLIANCE (META) INITIATIVE IN GHANA

The Medicines Transparency Alliance (MeTA) Initiative is an international initiative that aims to increase transparency in the registration, procurement, distribution and sales of essential medicines in developing countries. It was initiated from a global commitment to make progress towards the MDGs including MDG8 Target 17. The principal international partners are the UK Department for International Development (DFID), the World Health Organization (WHO) and Health Action International (HAI). (***Picture shows Minister for Health making a speech at one of the Fora)***

MeTA seeks to address issues about access to essential medicines considering factors such as medicine prices, availability and quality of pharmaceutical products and the need to focus on distribution from the port to the patient. The model is based on a multi-stakeholder approach to increase transparency, governance, efficiency and accountability, and encourage responsible business practices. It also promotes and encourages progressive disclosure of data on price, quality, availability and promotion of medicines and use of the evidence generated to improve policies and practices.

WHO supported activities on implementation of the work-plan for MeTA Phase 2. This included an assessment of civil society capacity on transparency, accountability and access to medicines issues; two stakeholder forums held on the "Quality of Pharmaceuticals in Ghana" and "Good Governance of Pharmaceuticals: The impact of medicine prices on the sustainability of Ghana's National Health Insurance Scheme". The project will be ending so a meeting of all the countries (Ghana, Uganda, Zambia, Jordan, Philippines, Kyrgyzstan and Peru) was called for a global avenue to share experiences across countries, discuss issues on implementation of the initiative and sustainability of the initiative after 2015 when MeTA Phase 2 ends. Integration of MeTA principles into the health system was thought to be one of the ways to sustain the initiative; however funding was considered as one of the main issues to affect sustainability of the programme.

7.8 HEALTH SYSTEM INFORMATION AND EVIDENCE

WHO supported the development of Monitoring and Evaluation (M&E) framework for the health sector during the year under review. The framework has the main goal of having a coordinated and effective M&E mechanism that will support evidence-based decision-making and accountability in the health sector. It has objectives to provide a comprehensive and objective basis for measuring health sector performance and to define roles and responsibilities of stakeholders. The framework was built upon five pillars: stakeholder collaboration and accountability (Who?); Timely, reliable and accurate data (How?); Comprehensive data repositories (What?); Timely analysis and use of information (Analysis) and Feedback, supportive monitoring and supervision (Reaction and Feedback).

CHAPTER EIGHT
PREPAREDNESS, SURVEILLANCE AND RESPONSE

8.1 EBOLA VIRUS DISEASE (EVD)

WHO's strategic agenda on preventing and controlling communicable disease has as one of its main focus areas support for national preparedness and response to epidemics and other complex health emergencies. Technical support and advocacy for implementing the International Health Regulations is also a priority. In the area of strengthening the integrated diseases surveillance and response system, priority is placed on supporting preparedness and response to epidemic prone diseases such as meningitis and cholera. The changing disease landscape and the re-emergence of new diseases such as occurred with unprecedented Ebola outbreak in the West African sub-region triggered a substantial WHO support for Ebola epidemic preparedness in 2014.

Since the declaration of the Ebola outbreak on 21 March 2014, WHO Ghana has played a key role in coordination of preparedness and response activities, interfacing between the national authorities, partners and the UN in the country. WHO's support to the national effort, have been along the lines of the following objectives:

1. effective coordination of preparedness and response activities;
2. strengthening capacity for active surveillance, early detection, investigation and reporting;
3. strengthening capacity for laboratory diagnosis;
4. building capacity for early diagnosis, case management, contact tracing and infection prevention and control;
5. effective risk communication, public information and education.

Resources to support implementation of the activities have come from the Norwegian Government, African Development Bank and WHO internal funds.
(***Picture - Norwegian Ambassador in a handshake with the WHO Representative witnessed by MOH Director of PPME).***

This was after the Norwegian Government channeled an equivalent of $1million to WHO to support Ebola activities.

Notable WHO achievements in Ebola Preparedness include:
Coordination - Technical support for coordination activities at the National Technical Coordinating Committee (NTCC) and the Inter-ministerial Coordinating Committee (IMCC) meetings on Ebola Preparedness***(Picture - Discussion during an NTCC meeting)***

Support for an assessment of Ghana's preparedness and response in the event of an outbreak by an international preparedness strengthening team (PST) led by WHO. By means of a checklist, the team assisted the country in identifying areas for strengthening to be implemented over 30 to 90 days so as to become as operationally prepared as possible to detect, investigate and report potential EVD cases effectively safely and to mount an effective response to prevent a larger outbreak. ***(Picture - A table top exercise during the PST mission)***

Surveillance - Adaption of case definitions, surveillance and contact tracing tools and training of 196 health workers from across the ten regions of Ghana. WHO supported training of 196 health personnel from all the ten regions of the country and the national level including staff from the Ghana Health Service, the four teaching hospitals, 37 Military and Police hospitals and Ambulance Service in the use of the surveillance tools. Categories of personnel trained were Regional Deputy Directors (Public Health), Disease Control Officers, Surveillance Officers, Biomedical Scientists, Public Health Nurses, District Directors of Health Services, Medical Directors and Superintendents, Public Health Specialists, Environmental health officers, and Paramedics.

Assessment of readiness of major Points of Entry (PoEs) to detect EVD cases entering the country was conducted by a team made up of WHO, Ghana Health Service (GHS), International Organization for Migration (IOM)) between 17 and 26 November 2014 using a checklist developed by WHO in collaboration with GHS. During the assessment areas that could benefit from capacity building for effective surveillance at these entry points in line with International Health Regulations were identified to facilitate the appropriate interventions. (***Picture - Hand washing at the border post Ghana-Cote D'Ivoire border at Elubo)***

Laboratory - The NMIMR has since its establishment, as part of its mandate, provided laboratory support to the Ministry of Health /Ghana Health Service (MOH /GHS) for disease control and outbreak investigations. Financial support and laboratory reagents and logistics was provided to the Institute to enable it provide reliable and prompt testing and confirmation for EVD in the country. ***(Picture - Laboratory in Noguchi Memorial Institute for Medical Research)***

Case Management - For effective case management of Ebola patients, it is imperative that case management teams are well trained and institute appropriate infection prevention and control (IPC) measures including having the requisite PPEs and practice universal IPC in order to reduce the spread of the disease to healthcare workers and hospital patients. WHO recruited an international consultant with EVD expertise to support capacity building in infection prevention and control and EVD case management (CM). By the end of the year, case management and IPC training had been conducted for 320 clinicians, nurses, pharmacy and laboratory staff, counsellors, environmental health officers, infection prevention and control officersand other categories of health workers from 10 regions. Financial and technical support was provided to support adaptation of EVD clinical management guidelines to facilitate training and as reference materials for clinicians in management of EVD cases.Two batches of personal protective equipment (PPE) were also donated to the MOH. ***(Picture - PPE donation to MOH)***

8.1.1 Ebola Advocacy & Social Mobilization Activities - Public Education and social mobilization on Ebola was a key element of Ghana's preparedness and prevention efforts. The Ministry of Health and Ghana Health Services with support from WHO and UNICEF and partners established a Social Mobilization and Risk Communications Strategy to help contain the outbreak.

8.1.2 Production of IE &C materials - WHO supported the development and production of various Ebola Information Education and Communication (IEC) materials for distribution to the general public and targeted groups.

(*Picture – Training of journalists*)

8.1.3 Training Journalists for Effective Ebola Media Reporting - The Media Foundation for West Africa (MFWA), in partnership with WHO, organized two-day training from 06 - 07 November 2014, for 60 journalists from radio stations nationwide on the Ebola Disease.

Sixty radio journalists were trained on Ebola to improve reporting which was organized by the Media Foundation for West Africa in partnership with GHS and WHO.

8.1.4 Engaging Parliamentarians, Queen mothers to sensitize Communities - Ghana Health Service with support from WHO on 17 December 2014 engaged Members of the Parliamentary Select Committee on Health, Education and Local Government in an advocacy meeting to support the Ebola Prevention and Preparedness programme. The meeting was one of the key activities identified as part of Ghana's Ebola Social Mobilization and Risk Communication National Plan. The involvement of MPs as advocates on Ebola is very critical considering their role as representatives in their communities and the relatively high influences they have on the people and also among their peers. Similar events were organized with Association of Queen mothers.

8.1.5 WHO and GHS meet with Traditional Healers on Ebola - Ghana Health Services and WHO met with Ghana's Federation of Traditional Medicine Practitioners Association in Kumasi on 13 January 2015 to sensitize them on Ebola. More than 70 traditional healers from all 10 regions were present at the meeting. This meeting was extremely important as 60 -70% of all patients seek primary health care from traditional healers as a first point of call for health care.

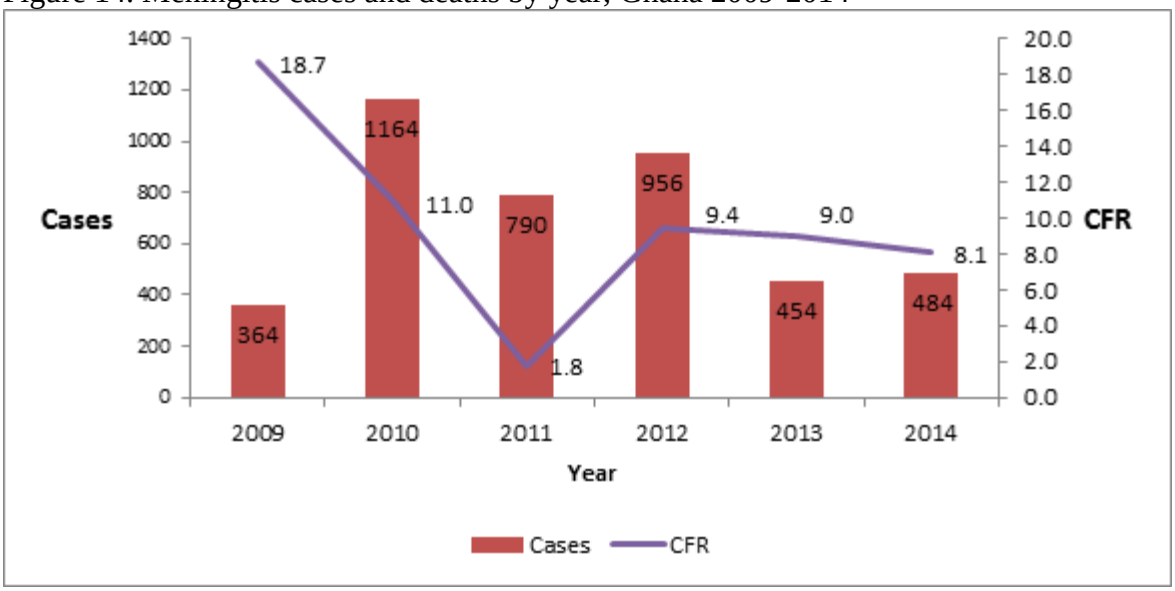
The Ashanti Regional Minister of Health, Hon. Samuel Sarpong spoke to more than 80 traditional healers to sensitize them on the important role they have towards Ebola preparedness and response.

8.2 MENINGITIS

The Upper East, Upper West, and Northern Regions of Ghana have historically been the hot bed for multiple meningitis outbreaks with most of the cases attributed to *Neisseria meningitidis* serogroup A (Nm A). Following the mass vaccination campaign of persons aged 1—29 years with the Nm A Vaccine MenAfriVac in the three regions in the north in 2012, surveillance has been ongoing for vaccine effectiveness. In 2014 a total of 484 cases of meningitis and 39 deaths case fatality rate of 8.1% were reported in Ghana. This was a slight increase over the previous year's figure but still much lower than the previous years before the vaccination campaign. As part of WHO's support to strengthen surveillance, WHO made available meningitis laboratory diagnostic supplies to the Public Health Reference Laboratory for distribution to the 3 northern regions to support laboratory capacity for diagnosis. Antibiotics were also supplied for treatment.

WHO provided support for the investigation of a reported meningitis outbreak in Jirapa in the Upper West Region in the first month of the year. The investigation ruled out a *Neisseria meningitidis* outbreak.

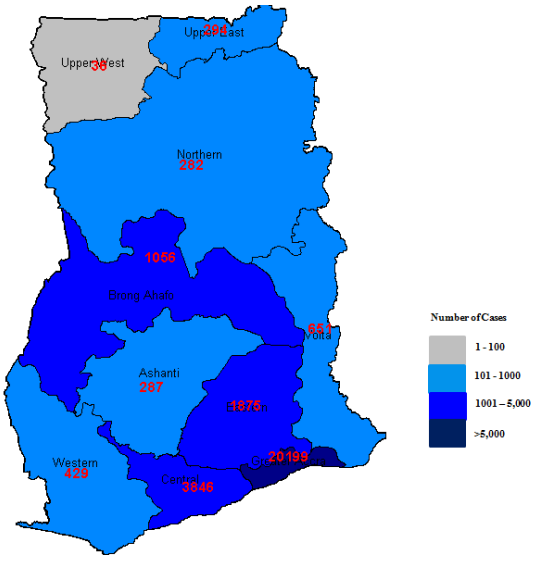
Figure 14. Meningitis cases and deaths by year, Ghana 2009-2014



CFR case fatality rate

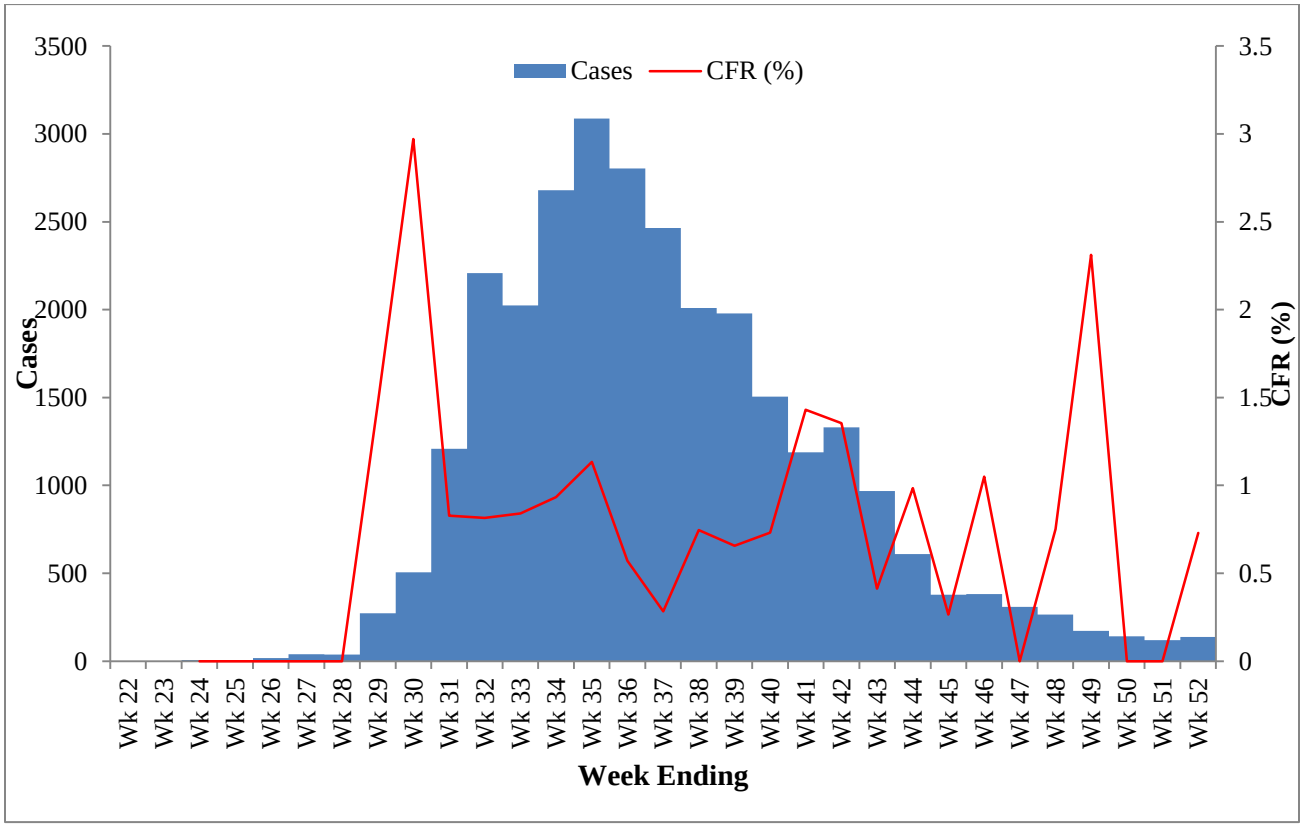
8.3 CHOLERA

Ghana experienced an unprecedented cholera outbreak in 2014 with an all-time record of 28,975 cases, 243 deaths and 0.8% case fatality rate. WHO support included provision of cholera rapid test kits and laboratory reagents for speedy diagnosis, technical expertise to support surveillance, data management and reporting, training of 196 surveillance officers on enhanced surveillance tools and reporting. A team of technical experts from WHO HQ and AFRO also came on mission in the country to assess the feasibility of carrying out mass vaccination with the Oral Cholera Vaccine (OCV). ***Map shows Regional Distribution of Cholera Cases in Ghana, Jan – December 2014***



The mission reported that the OCV would not be suitable in the 2014 outbreak but could be explored for the future as part of a targeted multi-sectoral intervention in selected cholera 'hot spots' involving environment (water and sanitation) improvement, food safety and patient care.
The 2014 outbreak started in Accra in June and spread to other parts of the country. Figure 15 shows the regional distribution of the cases whilst Figure 16 shows evolution of the outbreak from June to December 2014.

Fig 16: Cholera Cases and Case Fatality Rate (CFR) in Ghana by Week, June - December 2014



An outbreak investigation conducted in the Accra Metropolis, the epicentre of the outbreak showed that Cholera cases were six (6) times more likely to have drunk street-vended sachet water; and were also about six times more likely to have eaten food prepared outside home, especially street vended food. The key risk factors and challenges to the outbreak identified are as follows:

1. Street water and food vendors are a major factor for cholera spread;
2. Poor access to safe water for drinking and domestic use;
3. Floods leading to contamination of domestic water sources;
4. Poor environmental sanitation;
5. Poor personal and food hygiene practices;
6. Inadequate drugs and non-drug supplies for treating cholera patients;

7. Inadequate cholera beds at treatment centres compelling management of cases on benches
8. Inadequate cholera treatment centres.

The following response measures were instituted

- Case Management at cholera treatment centres
- Provision for adequate case management logistics to treatment centres
- Awareness creation on prevention and control of cholera
- Public education on sanitation, garbage collection and disposal in Accra and Kumasi.
- Enforcement of laws on sanitation.
- Provision of water purification tabs to households in affected communities

8.4 YELLOW FEVER

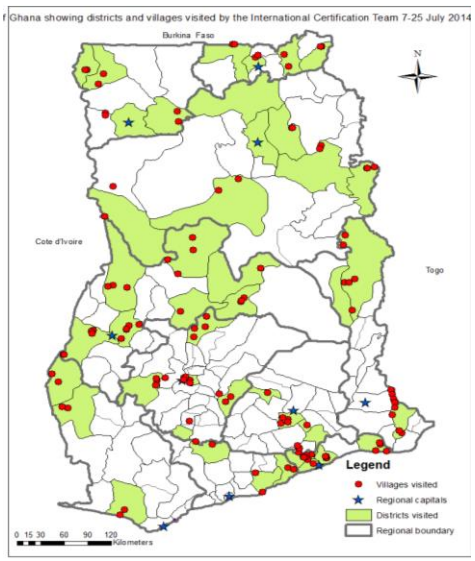
Ghana lies in the yellow fever endemic zone and vaccination is an effective preventive tool. In addition to routine yellow fever vaccination in the Expanded Program on Immunization, the country has also benefitted from mass vaccination in 58 high risk districts. Sporadic cases are however reported and in the past, reactive vaccination campaigns have been carried out in districts where they occur. Surveillance for yellow fever is key for early detection and diagnosis for the necessary action. To strengthen surveillance, WHO supported the country with diagnostic reagents for yellow fever and also facilitated quality assurance of testing by WHO Collaborating Centers.

8.5 GUINEA WORM PROGRAME

The Guinea Worm (GW) Programme in completing the 3 year mandatory pre certification phase after interrupting indigenous transmission in May 2010 was poised to attain criteria for certification in 2014.

WHO provided support for many activities during the year and key among them are:

- National Certification Committee meetings and advocacy sessions with stakeholders
- Supervisory visits to nine out of the ten regions.
- Nationwide case search during the Polio NIDs.
- Launching of Guinea Worm Week by Director-General collaboration with WHO, UNICEF, JICA
- Technical mission from WHO IST/West Africa to support Ghana's administrative and technical preparedness for ICT visit (May/June 2014)
- Water inventory conducted in 805 formerly endemic communities
- International Certification Team (ICT) visit to Ghana in July 2014. ***(fig 17 shows places visited by the ICT)***



- GWEP Programme review in December 2014

Major Achievements

- No case of guinea worm reported in Ghana since May 2010; 179 GW rumours were investigated in 2014 and almost 95 per cent were within 24 hours.
- Final country report endorsed by NCC and submitted by the Minister of Health to WHO requesting to be evaluated as Guinea worm free
- Intensive preparations in the area of surveillance and all administrative issues for ICT evaluation
- Ghana certified as Guinea Worm free and ushered into Post-certification Phase

CHAPTER NINE
CORPORATE SERVICES AND ENABLING FUNCTIONS

9.1 LEADERSHIP AND GOVERNANCE

WHO assumed the leadership of Development Partners group in the health sector in mid-2014 and as part of the steward process, WHO organises and superintends over the group's monthly meetings which are usually held a week before the HSWG's meeting which are usually held on the first Thursday of every month. To ensure that there is careful and responsible management of the MOH-DPs' partnership, WHO in its capacity as the DPs' Lead ensures that the relationship between the two parties is cordial for effective engagement. This is done through leading DPs in discussions in monthly HSWG meetings, quarterly MOH-DPs business meetings and annual health summits. Also as the DPs' Lead WHO co-chairs some of the sectoral engagements and meetings as well as leading discussions pertaining to critical health issues which need government's attention, (another role WHO plays in its stewardship).

To ensure the effective running of the WHO Country office, the various programmes and work portfolios have been organized around three cluster areas of Policies and Systems; Programme Support and WCO Presence. Each of the clusters has a lead and supported by secretarial staff. One of the main tenets of leadership and governance is to ensure that people are organized into manageable groups and influencing them to a specific direction for the purposes of harnessing available resources for the general good of the organization and the individual members. As a result of that under the leadership of WR, periodic professional staff meetings are held to discuss implementation of workplan, as well as sharing best practices and challenges and what is done or can be done to ameliorate the challenges. To ensure accountability, each NPO is expected to generate weekly and monthly activity reports and quarterly report which are collated and submitted to the Regional Office.

All professional staff participate in at least one of the eleven outcome groups of the UNDAF to plan, implement and review the process and outcome. Some of the professional staff act as chairpersons and conveners of the outcome groups.

9.2 STRATEGIC PLANNING, RESOURCE COORDINATION AND REPORTING

Strategic planning in WCO activities is done in conjunction with directives from Regional office. The year under review is the first year of the biennial of 2014-2015 whose workplan was concluded and approved in 2013. With the introduction of GSM, each NPO who is identified as a project team member or project user is expected to process the implementing of planned activities within the GSM following specific rules and regulations which are same and common to all. The statutory planning activities conducted in the GSM include two semi-annual monitoring after June in the first and second year respectively, mid-term review held in December of the first year and biennial reports at the end of the biennium.

9.3 STRATEGIC COMMUNICATIONS

During the year under review, a facebook page: **www.facebook.com/WHOGhana** was created and regularly updated. A twitter handle **@WHOGhana** was also created. The WCO/Ghana website which was already in use, was regularly updated.

WCO/Ghana produced monthly newsletters in addition to press releases on sanitation days, polio NIDs and during the Ebola campaign.

9.4 TRANSPARENCY, ACCOUNTABILITY AND RISK MANAGEMENT

Transparency, accountability and risk management have been high on the WHO Reform Agenda and WCO Ghana has not been left out of this. Over the last couple of years, the Office has had an Internal Review conducted by the IST West Africa Office, an External Audit and recently, a visit by the AFRO Compliance Team in October 2014. Reports on these assessments highlighting the gaps identified in the office operations and procedures were received and shared with all staff members.

Some of the areas strengthened and being strengthened in order to enhance the Office's compliance with the Organization's rules and regulations are institution of a Local Procurement Committee, information-sharing, improvement in supporting documents provided for accessing funds and the segregation of duties in the finance and procurement units of the office.

One major gap identified in all the reports is the outstanding DFC reports. The office has engaged the Ministry of Health and its Agencies in this area to ensure the backlog is cleared and also to avoid this situation in future.

9.5 MANAGEMENT AND ADMINISTRATION

The general management and administration of the Office included implementing control framework and ensuring compliance, ensuring an efficient and effective computing infrastructure; provision of operational and logistics support and complying with MOSS.

9.5.1 Implement Control framework and ensure compliance -The office operations have been in line with the rules and regulations of the Organization. Internal controls are being further strengthened following recent internal reviews and audit recommendations. These include actions being taken to fully implement the CSU model to address segregation of duties issues in the areas of finance and procurement.

9.5.2 Managing Expenditure Tracking and Reporting-In order to properly monitor the financial transactions of the Office and overall awards status of the budget centre, a detailed awards' status monthly report was issued and shared with all programmes at the end of every month. Summary of Projects and Awards details in respect of 2014 are as below:-

Table 12 - Summary of Projects and Awards details in 2014

No. Awards received in 2014	Thirty-four (34)		
No. of projects managed	Six (6)		
Projects	**Total amount received per project**	**Total amount disbursed per project**	**Overall Implementation rate**
Programme Support	US$2,316,547	US$1,610,409	70%
Policies & Systems	US$562,839	US$201,441	36%
Polio Eradication	US$3,507,840	US$3,359,178	96%
PIP PC Ghana Activities	US$277,500	Nil	0%
WHO Presence	US$402,000	US$265,369	66%
Salaries	US$2,058,800	US$1,130,371	55%
Total	**US$9,125,526**	**US$6,566,768**	**72%**

Purchase Orders

PO schedules were sent monthly to programmes for review and expired POs were closed accordingly after review to release unspent balances back unto the Awards. The break-down are as follows:

Type of PO	**Number Issued**	**Number Closed**	**Number Open**
eImprest	32	27	5
GES	199	163	36
Goods	35	21	14
APWs, SSA, TSA	29	19	10
DFC	66	23	43
Total	**361**	**253**	**108**

Direct Financial Cooperation

Monthly status of DFC reports were also issued and shared with IST/WA and also with all Technical Officers for their follow-up actions with their national counterparts. WCO Office engaged in a number of Direct Implementation of activities for and on behalf of the government

so as to minimize the number of outstanding DFCs during the period. DFC details at the end of the year was as follows:

Total number of DFCs issued in 2014	Total amount of DFCs issued in 2014	Total amount of DFC reports received in 2014	Total amount of outstanding DFCs
Sixty-five (65)	GHS14,840,411.10	GHS12,057,470.50 (23 DFCs)	GHS2,782,908.60 (42 DFCs)

E-Imprest

The e-imprest system was well managed during the period and end-month closure reports were prepared and submitted to IST and AFRO monthly within the deadline dates. There were no outstanding unreconciled items at the end of the year.

9.6 IT INFRASTRUCTURE

WCO Ghana enjoyed an efficient and effective computing infrastructure during the period. In order to enhance efficiency and minimize costs, the office procured three network printers to replace existing 20 printers assigned individually to staff members.

Back-up service

Document files were backed up daily and monthly during the year. A copy of the monthly backup is kept off site at one of the UN Sister Agencies.

The office has a second Internet connectivity from a local Service Provider. This Internet connection is operational 24/7 and also serves as backup for the primary Internet.

Migration to Cisco Telephony system

WHO initiated a project to deploy Cisco Unified Communication Manager (CUCM) solution and it is mandatory for all WCOs to migrate.

This project is intended to modernize WHO IT infrastructure and Services, improve efficiency of work processes and procedures, reduce cost and eliminate duplication of services. Business Sunrise together with the IT focal point will implement this migration between 18 and 25 April 2015. Although all the infrastructure required are not in place due to possible relocation of the office soon, all the necessary equipment needed for the successful migration have been delivered.

Challenges
One of the major challenges is the inadequate power supply when on the national grid. This has had serious effects on the IT equipment rendering most UPS non-functional as they absorb the surges.

9.7 OPERATIONAL AND LOGISTICS SUPPORT

Office Accommodation
The WCO Ghana office has been at its present location since August 1997. As the current premises is in a deplorable state and can no longer accommodate the increasing number of staff members, there have been serious efforts to relocate the office within the shortest possible period. The relocation is expected to have some serious financial implications on the office's already over-stretched budget.

Generator Set
A new generator set was procured during the year to replace two very old ones received over 16 years ago. There was an urgent need to have a new generator set so as to ensure business continuity as a result of power rationing that has been going on in the country for over three (3) years.

Office fleet of vehicles
As of December 2014, the Office had fourteen (14) vehicles; eight (8) over-aged with average mileage of over 200,000kms each. Four (4) over-aged and packed vehicles were processed and disposed of and five (5) more are in the pipeline to go.

In 2014, two new vehicles were procured; one with support from AFRO. There are plans to procure another two in 2015, depending on the Office's financial standing, so as to replace the old fleet of vehicles.

Procurement of Goods and Services
WCO Ghana enhanced its procurement processes by instituting a Local Procurement Committee in 2014. This was commended in the report of the Compliance Team.

Some challenges in the local procurement of goods and services are in the areas of quality, timely delivery of goods and services and fluctuations in price quotes due to frequent exchange rate changes. The office has therefore, as much as possible, resorted to procurement through the e-catalogue system.

MOSS

SOPs in respect of office security have been enforced during the period in compliance with MOSS. A security assessment is yet to be carried out to ascertain the current status of the office.

APPRECIATION AND CONCLUSION

On behalf of the Ghana Country Office staff, the Regional Director of the African Region, the Director General of the World Health Organization, I express our heartfelt appreciation and gratitude to the Government and the people of Ghana for the convenient working environment that made the year 2014 a successful one.

We also owe a debt of gratitude to the Ministry of Health, the Ghana Health service, the UN family and other stake holders for their team work and collaboration towards achieving better health for the people of Ghana.

My final thanks go to the staff of the organization at the country level, the regional office in Brazzaville (Congo) and Headquarters in Geneva for the Teamwork and support to make achievements of 2014 a reality.

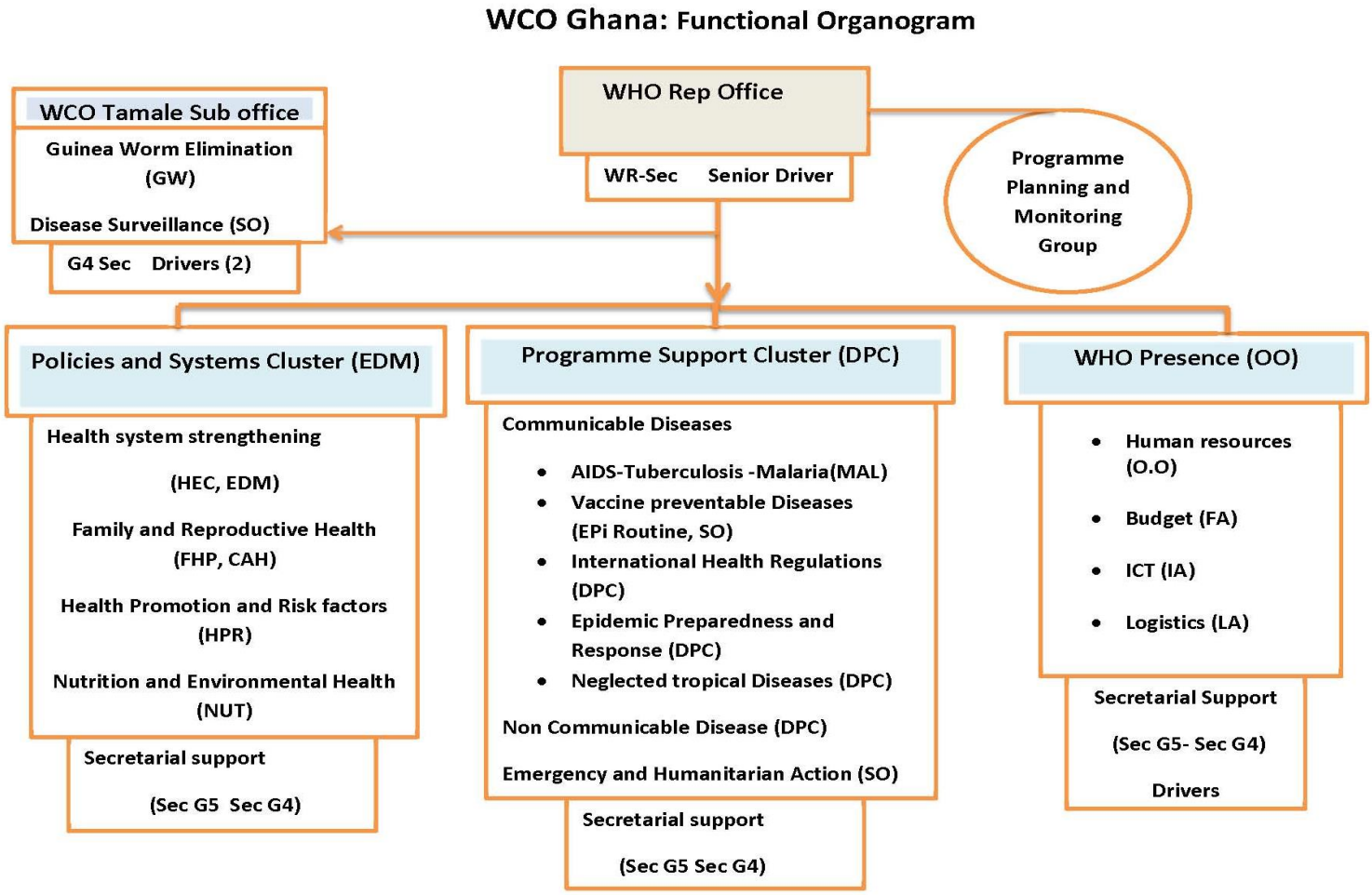
WHO in general and the Ghana Country Office in particular is committed to working in harmony with the Government of Ghana and the health sector in 2015 and beyond to achieve the health agenda of the country.

Dr Magda Robalo
WHO Representative, Ghana
May 2015

ANNEX – 1
STAFF POSITION

ANNEX ONE - STAFF POSITION		
NO.	**NAME**	**POSITION**
1	Dr Magda Robalo	WHO Representative
2	Dr Sally-Ann Ohene	Disease Prevention and Control Officer/DPC
3	Mr Stanley Diamenu	EPI Routine Immunization/EPI-RI
4	Dr Vincent Ahove	EPI Surveillance/EPI-SURV
5	Mrs Edith Andrews Annan	Essential Drugs and Medicines/EDM
6	Dr Felicia Owusu-Antwi	AIDS, TB and Malaria/ATM
7	Mr Selassi Amah d'Almeida	Health Economist/HEC
8	Mr Edward Gyepi-Garbrah	Guinea Worm Eradication/GWE
9	Mrs Akosua Takyiwa Kwakye	Nutrition/NUT
10	Dr Roseline Doe	Maternal and Child Health (MCH)
11	Mrs Joana Ansong	Health Promotion
12	Mrs Sakyibea Akuffo-Parry	Operations Officer/OO
13	Mr Samuel Hagan	Logistics/LOG
14	Mrs Akosua Spitta-Ansah	Finance Assistant/FA
15	Mrs Priscilla Eshun	Information, Communication Technology/ICT
16	Mrs Cynthia Hagan	Senior Secretary/SS-WR
17	Mrs Agnes Badger	Secretary
18	Ms Marian Laryea	Secretary
19	Mrs Cindy Braimah-Dorkenoo	Secretary
20	Mrs Gladys Obuobie	Secretary
21	Mrs Matilda Issah-Amipare	Secretary
22	Mrs Rosemary Kisseh	Secretary
23	Mr Daniel Yeboah	Senior Driver
24	Mr David Andoh	Driver
25	Mr Alex Afful-Turkson	Driver
26	Mr Thomas Danquah	Driver
27	Mr Dominic Owusu	Driver
28	Mr Opoku Kusi-Appiah	Driver
29	Mr Charles Mensah	Driver
30	Mr Reynolds Adu-Darko	Driver
31	Mr Stephen Frimpong	Janitor
32	Mr Michael Chibor	Janitor

ANNEX -2
WCO GHANA FUNCTIONAL ORGANOGRAM



ANNEX - 3
TOTAL FINANCIAL SUPPORT

NO	NAME OF PROGRAM	TOTAL AMOUNT DISBURSED (GHS)	% OF DISBURSEMENT
1	AIDS, Tuberculosis, Malaria (ATM)	140,840.00	0.95
2	Vaccine Preventable Diseases/EPI	11,633,460	78.39
3	Health Economist	123,525.00	0.82
4	Disease Prevention and Control	1,244,528.50	8.4
5	Guinea Worm Eradication	636,135.00	4.3
6	Essential Drugs and Medicines	341,638.00	2.30
7	Nutrition	91,850.00	0.62
8	Health Promotion	445,613.80	3.00
9	Family Health Population/Essential Medicines & Drugs	182,820.00	1.22
	TOTAL AMOUNT	14,840,411.30	100.0

ANNEX FOUR (a) INTERNATIONAL WORKSHOPS SUPPORTED FOR NATIONAL PARTICIPATION (2014) PROGRAMME SUPPORT CLUSTER				
NO.	**NAME OF PARTICIPANT**	**ORGANIZATION**	**MEETING/WORKSHOP**	**PERIOD**
1	Mr Peter Arhin	Ministry of Health	WHO/CIDA Regional Stakeholders Workshop on Traditional Medicine and Malaria, Ouagadougou, Burkina Faso	26 - 28 February
2	Mr James Frimpong	National Malaria Control Programme	WHO/CIDA Regional Stakeholders Workshop on Traditional Medicine and Malaria, Ouagadougou, Burkina Faso	26 - 28 February
3	Dr Jacob Barnor	Noguchi Memorial Institute for Medical Research	Annual EPI Managers Meeting	03 - 06 March
4	Dr Franklin Asiedu-Bekoe	Guinea Worm Eradication Programme	18th Review Meeting of National Dracunculiasis Eradication Programme, Addis Ababa, Ethiopia	19 - 22 March
5	Dr Constance Bart-Plange	National Malaria Control Programme	Malaria GTS Regional Consultation, Harare, Zimbabwe,	07 - 11 April
6	Dr George Bonsu	Ghana Health Service	Workshop on capacity building on the process of filling in the WHO-UNICEF joint reporting form & Peer Review Meeting Workshop on Annual Progress Report	15 - 18 April
7	Ms Adela Ashie	Food & Drugs Authority	Workshop on Vaccine Safety and Pharmacovigilance for English speaking countries, Accra	28 - 30 April
8	Dr Kwame Amponsah-Achiano	Ghana Health Service		
9	Ms Ethel Atanley	WHO Collaborating Centre		
10	Dr David Agyapong Opare,	Public Reference Laboratory	Inter-country training workshop on quality management of malaria diagnostics and therapeutic efficacy testing of antimalarial medicines, Ouagadougou, Burkina Faso.	09 - 13 June
11	Dr Benjamin Abuaku	Noguchi Memorial Institute for Medical Research		
12	Dr Keziah L. Malm	National Malaria Control Prog	RBM Harmonization Working Group Global Fund Concept Note Mock TRP Workshop, Uganda	19 - 21 June
13	Mr David Norgbedzie	CCM Secretariat		
14	Dr George Amofah	Local Consultant		
15	Mr Sylvester Segbaya	Global Fund Focal Point		
16	Dr Kwame Amponsah Achiano	Ghana Health Service	Orientation Workshop on new guidelines for developing and updating cMYP 2014, Lome, Togo,	23 - 27 June

17	Dr Frank Adae Bonsu	National TB Control Programme	TB Prevalence Data Analysis Workshop, Geneva, Switzerland	24 - 27 June
18	Jane Amponsah			
19	Raymond Gockah			
20	Dr Bernard Dornoo	National AIDS Control Programme	Meeting of National HIV/AIDS Programme Managers on scaling up Health Sector Response toward Universal Access in the African Region, Congo, Brazzaville	24 - 27 June
21	Dr Baba Ibrahim Mahama	Tamale Teaching Hospital	Special Ministerial Meeting on Ebola Virus Disease Outbreak in West Africa, Accra,	01 - 04 July
22	Dr Dennis Odai Laryea	Komfo Anokye Teaching Hospital		
23	Dr David Opare	Public Health Reference Laboratory	Emergency Surge Training for Anglophone countries, Accra, Ghana	07 - 11 July
24	Dr Emmanuel Dzotsi	Disease Surveillance Department		
25	Dr Jack Galley	Municipal Health Directorate, Tarkwa		
26	Dr Joseph K. Larbi Opare	District Health Directorate, GHS, Upper East Region		
27	Mr Michael Adjabeng	Disease Surveillance Department, GHS	Orientation Meeting of National Polio Committees of 5 English speaking countries, Ouagadougou	09 - 11 July
28	Dr Lorna Renner	Department of Child Health, UGMS (represented NCC Chairman)	Orientation Meeting of National Polio Committees of 5 English speaking countries, Ouagadougou	09 - 11 July
29	Prof Julius A.A. Mingle	UGMS, College of Health Sciences, Department of Microbiology	Orientation Meeting of National Polio Committees of 5 English speaking countries, Ouagadougou, Burkina Faso	09 - 11 July
30	Dr Nana K. Biritwum	Ghana Health Service	Regional NTD Master Plan Review Workshop and TIPAC Training, Lusaka, Zambia	19 - 27 July
31	Mr Asiedu Odame	Ghana Health Service	Regional NTD Master Plan Review Workshop and TIPAC Training, Lusaka, Zambia	19 - 27 July
33	Dr Kwame Amponsa-Achiano	Ministry of Health	Strengthen Monitoring Reporting, Investigation and Causality Assessment of Adverse Events following Immunization, Dar Es Salaam, Tanzania	09 - 15 August

34	Dr George Bonsu	Ghana Health Service	Participation to the consultative meeting for the implementation of monitoring measles elimination method in WA from 15 to 16 August and Peer Review meeting of the new vaccine country proposals, 18 to 20 Aug., Ouagadougou, Burkina Faso	13 - 21 August
35	Ms Gifty Mawuli	Noguchi Memorial Institute for Medical Research	Training Workshop in the African Region on Safe Shipment of Infectious substances, Brazzaville, Congo	19 - 23 August
36	Dr Badu Sarkodie	Ghana Health Service	Training of Trainers and Preparedness and response assessment workshop to the Ebola Outbreak, Brazzaville, Congo	24 - 30 August
37	Dr Joseph Oliver Commey	Korle Bu Teaching Hospital		
38	Prof Margaret Lartey	Korle Bu Teaching Hospital		
39	Mr Aboubakar Safyan	Ministry of Health		
40	Ms Afia Asante Ntim	Noguchi Memorial Institute for Medical Research	Regional Training on Laboratory Diagnosis of Ebola, Entebbe, Uganda	16 - 20 September
41	Mr Eric Karikari-Boateng	Food and Drugs Authority	9th Annual meeting of AVAREF, Johannesburg, South Africa,	03 - 07 November
42	Dr Cynthia Bannerman	Ghana Health Service	9th annual meeting of AVAREF, Johannesburg, South Africa	03 - 07 November
43	Dr Stephen Ayisi-Addo	NACP	Annual Elimination of Mother to Child Transmission Interagency Task Team Meeting, South Africa	11 - 14 November

ANNEX FOUR
INTERNATIONAL WORKSHOPS SUPPORTED FOR NATIONAL PARTICIPATION (2014)
POLICIES CLUSTER

NO.	NAME OF PARTICIPANT	ORGANIZATION	MEETING/WORKSHOP	PERIOD
1	Dr Sylvia Deganus	Ministry of Health	Reproductive, Maternal, Newborn and Child Health Task Force meeting, Brazzaville Congo	01-05 April
2.	Dr Edith Tetteh	School of Public Health	Capacity Building for Improving Planning, Implementation and Monitoring and Evaluation for Adolescent Health Interventions in the WHO African Region, Brazzaville, Congo	06 - 12 April
3	Dr Albert Akpalu	Ministry of Health	2nd African Epilepsy Congress of the International League Against Epilepsy Initiative in Cape Town, South Africa	22 - 24 May
4	Dr Foster Osei-Poku	Ministry of Health	2nd African Epilepsy Congress of the International League Against Epilepsy Initiative in Cape Town, South Africa	22 - 24 May
5	Dr Sammy Ohene	Ministry of Health	2nd African Epilepsy Congress of the International League Against Epilepsy Initiative in Cape Town, South Africa	22 - 24 May
6	Mrs Edith Gavor	Ministry of Health	Participate in EU/ACP/WHO Renewed Partnership 2nd Year Meeting, Harare, Zimbabwe	24-26 June
7	Mr Isaac Adom	Food and Drugs Authority	Participate in the Training Course on Good Practice in Pharmaceutical Quality Control Lab Potcheftstroom, South Africa	7-10 July
8	Mr Ernest D. Afesey	Food and Drugs Authority	Participate in the Training Course on Good Practice in Pharmaceutical Quality Control Lab Potcheftstroom, South Africa	7-10 July
9	Mr Thomas Amedzro	Food and Drugs Authority	Participate in the Regional Working Group Meeting on SSFFC Medical Products in the WHO African Region, Brazzaville	23 - 25 July
10	Dr Samuel Akoriyea Kaba	Ministry of Health	Meeting on implementation of the ICD in African countries, Dar-Es-Salaam, Tanzania	25 -27 August
11	Dr Hodgson Araham	Ghana Health Service	Meeting on implementation of the ICD in African countries, Dar-Es-Salaam, Tanzania	25 -27 August
12	Mr Kingsley Asare Addo	Births and Deaths Registry	Meeting on implementation of the ICD in African countries, Dar-Es-Salaam, Tanzania	25 -27 August

13	Ms Christie Akoto-Bamfo	Ghana Revenue Authority, Customs	Study tour on regulating tobacco products, Nairobi, Kenya	01 – 02 October
14	Mr Nelson Bright Atsu	Ghana Revenue Authority, Customs	Study tour on regulating tobacco products, Nairobi, Kenya	01 – 02 October
15	Mr Benjamin Ayesu-Kwafo	Ministry of Finance	Study tour on regulating tobacco products, Nairobi, Kenya	01 – 02 October
16	Mr Hendrick Dwommoh-Mensah	Ministry of Finance	Study tour on regulating tobacco products, Nairobi, Kenya	01 – 02 October
17	Dr Sylvia Deganus	Ministry of Health	participate in the Consultation on Improving Quality of Newborn Care in the Context of Every Newborn Action Plan (ENAP),	13 - 14 November
18	Dr Alfred Ampomah Appiah	Centre for Scientific Research into Plant Medicine, Mampong Akwapim	participate in the Regional Workshop on Development of Country Work plans for Implementation of the WHO Strategy on Traditional Medicine	11-14 November
19	Mr Peter Arhin	Ministry of Health	participate in the Regional Workshop on Development of Country Work plans for Implementation of the WHO Strategy on Traditional Medicine	
20	Mr Emmanuel Kofi Nti	Consultant	Tobacco tax mission to Angola, Angola	17-19 November
21	Mr Benjamin Botwe	Medicines Regulatory & Quality Assurance	1st Meeting of the task team for the establishment of the African Medicines Agency (AMA), AUC, Addis Ababa	25 - 26 November
22	Mrs Kate Quarshie	Ministry of health	Second International Conference on Nutrition,	19 - 21 November
23	Mr Benjamin Botwe	Medicines Regulatory & Quality Assurance	1st Meeting of the task team for the establishment of the African Medicines Agency (AMA), AUC, Addis Ababa	25 - 26 November

ANNEX FIVE MISSIONS TO GHANA (2014) PROGRAMME SUPPORT CLUSTER					
NO.	**NAME OF CONSULTANT/ STAFF**	**ORIGINATING ORG**	**UNIT/ PROGRAM**	**MISSION/ PURPOSE**	**PERIOD/ DATE**
1	Dr Josephine Nambozi	Staff/IST/ESA	ATM	Technical Assistance for Malaria Control Strategic Plan Review and Finalization	28 April - 02 May
2	Dr Marina Tadolini (Consultant)	HQ	ATM	To review the Ghana National TB Prevalence Survey	02 - 06 June
3	Dr Irwin Law (WHO/HQ)	HQ	ATM	To review the Ghana National TB Prevalence Survey	02 - 07 June
4	Dr Francoise Bigirimana – IST/WA Dr Morkor Newman – IST/ESA	Staff, IST/WA and IST/ESA	ATM	Technical assistance for needs assessment and cost of Option B+	07 - 17 July
5	Dr Donna F. Stroup (Consultant)	Non staff/IST/WA	ATM	Mode of Transmission (MOT) survey mission	05 - 11 October
6	Dr Andrew Seidu Korkor (IST/WA)	Staff, IST/WA	GWE	Technical Support to Ghana Guinea Worm Eradication Programme	08 - 14 June
7	Dr Andrew Seidu Korkor (IST/WA)	Staff, IST/WA	GWE	Technical Support to Ghana Guinea Worm Eradication Programme	02 - 10 July
8a	Consultants for GW ICT – 1) Dr Abdulhakim Al-Kuhlani 2) Dr Robert Reid 3) Prof Oka Martin Obono 4) Dr Joel Breman 5) Dr Honore A. Meda 6) Dr Vinod Kumar Raina	Non Staff/HQ	GWE	GW International Certification Team (ICT) mission to Ghana	06 - 26 July
8b	Dr Gautam Biswas (WHO/HQ)	Staff/HQ	GWE	GW International Certification Team (ICT) mission to Ghana	06 - 26 July
9	Dr Andrew Seidu Korkor – IST/WA	Staff/IST/WA	GWE	Technical support to Ghana Guinea Worm Eradication programme, Accra, Ghana,	20 - 25 July

10A 10B	Dr Domique Legros (WHO/HQ) Dr Mamoudou H. Djingarey D. Alexandria Hill	Staff/HQ & IST Staff/HQ	SURV SURV	Cholera Outbreak in Ghana – Risk assessment Preparing Request Documents for OCV to ICG	04 - 11 September 17 – 21 November
11	Mr Hilaire Dadjo (IST/WA)	Staff/IST/WA	EPI	Technical Assistance for Launching Child Health Promotion Week activities	26 April - 14 May
12	Mr Peter Wangombe (Consultant)	Non staff/IST/WA	EPI	Technical Support for preparation of Polio National Immunization Days in Ghana	10 - 27 September
13	Mrs Victoria Kehinde Akinbobola (Consultant)	Non staff/IST/WA	EPI	Effective Vaccine Management (EVM) Assessment	05 - 27 October
14	Dr Abdou Diop (Consultant)	Non staff/HQ	EPI	Technical support for costing analysis of HPV vaccination program in Ghana	15 - 30 October
15	Mr Peter Wangombe Ndirangu (Consultant)	Non staff/IST/WA	EPI	Technical Support for the preparation of Polio National Immunization Days in Ghana, October 2014	24 October – 08 November
16	Mr Jim Ting (IST/WA)	Staff/IST/WA	EPI	Technical Support for the preparation of Polio National Immunization Days in Ghana, October 2014	24 October – 08 November
17	Alireza Khadem Broojerdi (HQ) Juliette Puret (HQ) Dr Youssou Ndao (Temp Adviser) Dorina Pirgari (Temp Adviser) Razied Ostad (Consultant) Karan Sagar (GAVI) Maryse Dugue (GAVI) Thomas O'Connell (UNICEF) Amrita Palriwala (Gates) Angela Micah (World Bank)		EPI	Global Alliance for Vaccination and Immunizations (GAVI) Assessment Mission to Ghana	24 November - 04 December

18	Professor Tjip van der Werf Mr Raymond Omollo Mr Michael Otien		DPC	Buruli Ulcer Trial Visit	04 - 11 November
19	Dr Kingsley Asiedu	Staff/HQ	DPC	Buruli Ulcer Trial Visit & Yaws Clinical trial visit and discussions	04 - 16 November
20	Paul M. Cox Dr Daniel J. Eibach (con) Freya L. Jephcott Ian Clarke		DPC	Ghana's Preparedness Meeting on EVD, Accra	10 - 14 November
21	Dr Kingsley Asiedu (HQ) Dr Ron Ballard (CDC)	Staff/HQ	DPC	Support the One-year Assessment of Mass Treatment of Yaws in West Akyem District & Laboratory work on Yaws at Noguchi	23 November – 08 December

POLICIES AND SYSTEMS CLUSTER

NO.	NAME OF CONSULTANT/ STAFF	ORIGINATING ORG	UNIT/ PROGRAM	MISSION/ PURPOSE	PERIOD/ DATE
1	Dr Anne Meynard	HQ	NUT	Pre-service Assessment of Adolescent Health in Ghana,	03 – 07 February
2	ALLÉLY-FERMÉ, Didier Philippa Ross Marie Alix Prat	HQ Non-staff, HQ	NUT	Inception meeting of TrackFin in Ghana	03 – 05 March
3	Ms Philippa Ross	Non- staff, HQ	NUT	TrackFin mid-term meetings in Accra	26 - 29 May
4	Dr Hana Bekele	AFRO	NUT	Global Nutritional Surveillance in Africa-A joint IARC-WHO Initiative	21 – 25 Jul
5	ALLÉLY-FERMÉ, Didier Philippa Ross	HQ Non-staff, HQ	NUT	final TrackFin country workshop in Ghana	11 – 15 Aug
6	Mr Darwin Young	HQ	HEC	National Health Account mission	08 – 15 February
7	Dr Sam Omar	AFRO	HEC	Joint WHO-GAVI mission to support implementation of new HSS Grant in Ghana	05 - 09 May
8	Sheila O'Dougherty	HQ	HEC	Health Financing Implementation Plan	19 - 23 May

9	Sheila O'Dougherty	Non, staff, HQ	HEC	Health Financing Strategy Implementation Plan and NHIS Sustainability Roadmap in Accra, Ghana	16 to 27 June
10	Dr Sheila O'Dougherty Dr Dirk Mueller	HQ Non- staff, HQ	HEC	Health Financing Strategy	14 – 17 October
11	Nigar Nargis Noureiny Tcha-Kondor	AFRO	EDM	Ghana Tobacco Taxation mission	21 – 24 May
12	Alexandra Jane Wright	HQ	EDM	Ghana Fight Against Epilepsy Initiative	8 – 12 September
13	Prof. Hans V. Hogerzeil	HQ	EDM	Technical assistance to MOH to Develop and finalize National Medicines Policy	22 – 26 September
14	Dr Joyce Hightower	AFRO	EDM	support country level activities on patient safety	20-24th October
15	Dr Moses Chisale Dr Anne Paschke Ms Deidre Dimancesco	HQ	EDM	Medicines Transparency Alliance and Good Governance for Medicines	27-31 October
16	Dr Tarun Dua	HQ	EDM	Fight Against Epilepsy Initiative	9-13 November 2014
17	Dr Joyce Hightower	AFRO	EDM	support country level activities on patient safety	22 – 29 November
18	Dr Blerta Maliqi	HQ	CAH	Joint WHO/UNICEF mission to launch the BMGF/UNICEF project on Maternal and Newborn Health and Nutrition Initiative	02 – 06 November
19	Dr Michelle Hindin Dr Maria Rodriguez	HQ Non-staff, HQ	CAH	Reproductive Health	10 – 12 November 2014
20	Mr Hugson Kubwalo	AFRO	HPR	Consultative meeting to finalize the draft Alcohol Policy	13 – 17 October