EXTERNAL SUPPORT FOR POVERTY ALLEVIATION IN GHANA SINCE 1997 (A CASE STUDY OF THE HEALTH SECTOR)

BY

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LEGON
AUGUST 2001
This dissertation was written by me under the guidance and supervision of Dr. Yaw Asante. Where references were made they are fully acknowledged. I hereby certify that this is my original work and has not been submitted for any degree work in this University or any other University.

DR. YAW ASANTE  
SUPERVISOR

LINDA AUDREY DARKWA  
STUDENT
DEDICATION

This work is dedicated to my family and all those who supported me.

God bless you all.
ACKNOWLEDGEMENTS.

To God be all the glory.

First and foremost I would like to thank my parents, my brothers, my Aunt Paulina and cousins who supported me in various forms throughout the academic year.

I would also like to thank Mr. Eric Odoi-Anim who encouraged me to take this course and was supportive throughout the year.

My thanks also go to my supervisor Dr. Yaw Asante whose dedication and guidance enabled me complete the work and all my lecturers.

Many thanks also to the staff of the Ministry of Health and the staff of the Technical Committee on Poverty at the Flagstaff House. To all my friends and roommate who were there for me through out the beginning of the course “ayekoo.”
ABSTRACT

In the 1970s when Ghana faced a debt crisis due to high inflation rates, falling prices of its exports to mention a few, it sought assistance from the Bretton Woods Institutions, namely the World Bank and the International Monetary Fund, who implemented certain economic policies in a bid to help Ghana ease some of her debt burden. Some of these policies were the liberalisation of trade, divestiture, and sector reforms. Institutions which were initially subsidized by government had the subsidies removed. The health sector was not left out and the cash-and-carry system, whereby patients now paid for health care, was introduced to replace the subsidies.

An economic growth of 5% of GDP was achieved during this period but this could not be sustained. Thus, a Vision 2020 strategy paper was drawn up in the hope that it would help Ghana in its bid to alleviate poverty. Under this paper the Medium Term Health Strategy was drawn up in 1995. In 1996 this was translated into the Five Year Programme of Work.

The study tried to find out how external support has helped in the alleviation of poverty in the health sector. It takes a look at the health sector reforms, that is the 5YPOW, looks at its aims and objectives, the restructuring of the sector and its financing. The effect it has had on the sector is looked at and recommendations are made to help solve the problems the sector is still facing.
LIST OF ABBREVIATIONS

1. 5YPOW - Five Year Programme of Work
2. AIDS - Acquired Immune Deficiency Syndrome
3. BMCs - Budget Management Centres
4. CEDEP - Centre for the Development of People
5. CHPS - Community Based Health Planning Services
6. DANIDA - Danish International Development Agency
7. DFID - Department for International Development
8. EDL - Essential Drug List
9. ENT - Ear, Nose
10. EPI - Expanded Programme on Immunisation
11. ERP - Economic Recovery Programme
12. GDHS - Ghana Demographic Health Survey
13. GDP - Gross Domestic Product
14. HDI - Human Development Index
15. IGF - Internally Generated Funds
16. IMF - International Monetary Fund
17. IMR - Infant Mortality Rate
18. MMR - Maternal Mortality Rate
19. MTEF - Medium Term Expenditure Framework
20. MTHS - Medium Term Health Strategy
21. NPC - National Population Council
22. NPRP - National Poverty Reduction Programme
23. OPD - Out Patients Department
24. PAMSCAD - Programme of Action to Mitigate the Social Cost of Adjustment
25. PHC - Primary Health Care
26. PRONET - Professional Network
27. PURFMARP - Public Financial Management Reform Programme
28. SAP - Structural Adjustment Programme
29. SRN - State Registered Nurses
30. STGs - Standard Treatment Guidelines
31. TB - Tuberculosis
32. TCOP - Technical Committee on Poverty
33. TFR - Total Fertility Rate
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<tr>
<td>34.</td>
<td>U5MR</td>
<td>Under Five Mortality Rate</td>
</tr>
<tr>
<td>35.</td>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>36.</td>
<td>UNECA</td>
<td>United Nations Economic Committee for Africa</td>
</tr>
<tr>
<td>37.</td>
<td>UNICEF</td>
<td>United Nations International Children's Education Fund</td>
</tr>
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<td>38.</td>
<td>USAID</td>
<td>United States Agency for International Development</td>
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CHAPTER ONE

EXTERNAL SUPPORT FOR POVERTY ALLEVIATION IN GHANA
SINCE 1997 (A CASE STUDY OF THE HEALTH SECTOR).

1.1 Background

The concept of poverty alleviation pre-supposes the existence of poverty. The persistence of this phenomenon creates human deprivations that cause misery and suffering of human beings all over the world. The UNDP Human Development Report of 1998 notes that one third of people in developing countries continue to live in income poverty, earning less than US$ 1 per day. It also emphasizes looking beyond income to education, health and food. According to the UNDP report, 30% of all children under five are malnourished and 38% of all adult women in developing countries are illiterate.

In Africa poverty exists in the midst of plenty. Countries like Senegal, Ghana and Benin, which have peace prevailing, as well as countries which are conflict stricken like Liberia, Sierra Leone and Democratic Republic of Congo are all submerged in the scourge of poverty. Africa has about 700 million people living below the poverty
Out of the 48 poorest countries in the world, 34 of them come from Africa. To show the extent to which poverty prevails in Africa, the 1999 Human Development Report shows that the current income of Ethiopians is equivalent to 17% of what the British had in 1820. Even with this information one wonders why countries like the USA and South Africa, countries which are rich, technologically advanced and have strong industrial bases have people living below the poverty line.

In a global economy of US$25 trillion, poverty is not only shameful but reflects a catalogue of inequalities and inexcusable failures of international and national policies.

At the World Summit for Social Development at Copenhagen in 1995, 117 Heads of State and Government and representatives of 186 countries identified poverty eradication as "an ethical, social, political and economic imperative of humankind". At this summit countries pledged to halve the present poverty level by the year 2015. According to the report, a survey made to gauge the extent to which governments have gone in their commitment towards this exercise showed that out of 130 countries, 43 have national poverty
plans in place, 35 address poverty explicitly within their national planning framework and 38 have set targets for eradication of extreme poverty. In line with this Ghana has also drawn up a Poverty Reduction Strategy Paper for the alleviation of poverty by the year 2020.

1.2 STATEMENT OF THE PROBLEM

In the 1980s as a result of the debt crisis, the Structural Adjustment Programme (SAP) was mooted as a means of stabilizing the economies of developing countries, including Ghana.

In 1983, an Economic Recovery Programme (ERP), supported by the World Bank, the International Monetary Fund (IMF) and other bilateral and multi-lateral agencies, was launched to achieve three main objectives of stabilization, liberalization and rehabilitation of the economy, for sustained economic growth and therefore poverty reduction on a sustainable basis.

Significant results were achieved, leading to a moderate growth averaging about 5% per annum. Poverty in Ghana was reduced from about 36.9% in 1987/88 to about 32% in 1991/92. In 1991/92, this
32% were classified as poor with 75% living in rural areas. The 1997 Ghana Human Development Report points out that 30% of the Ghanaian population is poor and 15% of the population is extremely poor in income terms.

Following the failure of the SAP to achieve sustained growth, the Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD) was introduced to help prop up the adjustment programme. Among the PAMSCAD targets was Basic Needs which had the health sector being under it. The components of the Basic Needs project which targeted vulnerable groups comprised safe and reliable water supply to rural inhabitants, supplementary feeding to severely malnourished children, de-worming of children in primary schools throughout the country and provision of essential drugs to health posts and urban polyclinics in low income areas. This programme however, offered temporary relief till the government engaged the services of both non-governmental organisations and international government agencies from various countries on donor-specific projects in the alleviation of poverty, especially in the health sector.
Poverty alleviation initiatives in Ghana have been influenced by political and socio-economic factors since independence. Dr. Kwame Nkrumah drew up a Seven-Year Development Plan. Dr. Busia drew up a One-Year Development Plan and finally the Five-Year Development Plan by the NRC/SMC were all attempts to alleviate poverty in Ghana. The relationship between good health and poverty reduction is direct and has been explicitly stated by the various governments. As the Technical Committee On Poverty (TCOP) stressed in 1996 "national well being is a pre-requisite for achieving the highest level of social, mental and physical potential of the population".

Despite the efforts of past governments and donor assistance poverty still seems to be a problem hampering Ghana’s economic growth. It is against this background that the health sector underwent some reforms. After the World Health Summit in 1995, the Medium Term Health Strategy was developed and it set out to achieve the objectives of this summit which targeted children. The Medium Term Health Strategy poverty-focused activities include reduction of population growth rates and levels of malnutrition,
increasing access to water and sanitation and strengthening support systems for human resources logistics and supplies, financial management and health information. In 1996 this was translated into the Five-Year Programme of Work (5YPOW) 1997-2001. In that same year the Ghana Health Service bill was passed to institute the service. The 5YPOW has achieved some successes but the sector is still faced with a lot of problems. Under the 5YPOW the inequality rate is still high, HIV/AIDS has increased and infant and maternal mortality rates continue to be high in the northern and rural areas.

The question is what is hampering the 5YPOW from achieving its objectives? Is the funding from donors inadequate?

1.3 OBJECTIVES.

Ghana receives a lot of external support for its poverty alleviation programmes. This support is either through local non-governmental organisations like the Centre for the Development of People (CEDEP), Professional Network (PRONET) or international non-governmental organisations like ACTIONAID, Plan International as well as international voluntary agencies.
The study seeks to

1. Look at the health sector reforms under the 5YPOW
2. Assess the achievements of the health sector before and after the 5YPOW and some of the challenges it still faces
3. Make conclusions from the findings and give recommendations from the conclusions.

1.4 THEORETICAL FRAMEWORK

Adam Smith's theory used in this work is quite controversial. This theory states that

"following the specialisation of labour and the expansion of trade, growth in productivity meant an increase, on the one hand, in the demand for industrial labour and wages (and thus in aggregate demand) and, on the other hand, in the availability of agricultural and industrial products (aggregate supply)." \(^8\)

Smith argued that poverty could be absorbed by a society adopting appropriate economic policies which would in turn promote economic growth. For example, better healthcare for workers would
increase their capacity to work which will in turn lead to an increase in wages.

This argument of Smith's is buttressed by an article which appeared in the Ghanaian Times dated Saturday February 17th, 2001. In the article the author, Dani Rodrik, states that economic reform strategies should focus on poverty for at least three reasons. First, in considering social welfare governments should give more weight to the well-being of the poor than to that of the rich. Second, interventions aimed at helping the poor may still be an effective way to raise average incomes. Third, focusing on poverty is also warranted from the perspective of a broader, capabilities-oriented approach to development.

1.5 LITERATURE REVIEW

Batse Z.K.M et al in their paper "Integrating capacity building within the context of social policies for poverty reduction in Ghana" describe poverty on three levels, that is the national, community and personal levels. At the national level, they describe poverty as a "composite of personal and community life situation. On the
community level it is manifested by the absence of basic community services such as health, education, water supplies and sanitation. On the personal level it is a situation where basic needs to sustain daily livelihood are not sufficiently satisfied." It summarizes previous policy focus before the ERP and its impact on the education and health sectors.

The Government of Ghana's "Interim poverty reduction strategy paper 2000-2002" touches on the government's efforts since 1995 towards the reduction of poverty. This paper looks at poverty by region and economic activity, the measuring and monitoring instruments used by the government, Ghana's Vision 2020 and strategies already in place to reduce poverty.

Dr. Kwadwo Tutu in his paper "Structural adjustment programmes and their effects on Ghanaian workers" throws light on the effect the SAP policies have had on formal workers, agriculture, industry, the balance of payments and the social services sector. He however fails to show it's effects on the social sector the way he does with the other sectors.
United Nations Economic Community of Africa (UNECA) in its paper "African Alternative Framework to Structural Adjustment Programmes for Socio-economic recovery and transformation" outlines the impact of the SAPs on African countries. It states that:

"The Structural Adjustment Programme were addressing the symptoms rather than the fundamental factors responsible for Africa's persistent socio-economic crisis. The SAPs failed to address the need for improved social and technological infrastructure and postponed development programmes under its policies."

The Bretton Woods Institutions encouraged African countries to draw up an alternative framework and a new one was drawn, taking into consideration the inequality in economies, viable concepts instead of textbook theories and long-term objectives. Some of the alternatives proposed were the strengthening and diversification of Africa's production capacity, the improvement and the pattern of distribution of incomes and the provision of institutional support for adjustment with transformation, to mention a few.
1.6 **DATA COLLECTION.**

The research will be basically dependent on library material and articles on workshops, conferences and seminars attended by people who are directly involved in poverty reduction strategy programmes in the health sector. Where necessary resource persons were contacted for help, especially in areas where current figures or statistics were needed.

1.7 **LIMITATION**

The research is limited to the period 1997-2001 because the health sector reforms were made based on the Vision 2020 strategy paper which was drawn up in 1996. The overall objective of the Vision 2020 health policy was to improve the health status of all Ghanaians.

1.8 **DEFINITION OF POVERTY**

What is poverty? There is no general consensus on the definition of poverty. Ravillion defines poverty as follows:

"Poverty can be said to exist in a given society when one or more persons do not attain a level of economic well-being
deemed to constitute a reasonable minimum by the standards of that society.”

The 1997 UNDP Global Human Report defines poverty beyond low income levels to include denial of choices and opportunities for living a tolerable life. Apart from low income, it also reflects poor health and education, deprivation in knowledge and communication, inability to exercise human and political rights and the absence of dignity, confidence and self-respect.

Poverty in Ghana can be described as a composite of personal and community life situation. On the personal level it is the situation where basic needs to sustain daily livelihood are not sufficiently satisfied. On the community level it is manifested by the absence of basic community services like health, education, water supplies and sanitation.

1.9.1 IDENTIFICATION OF THE POOR

Household survey

The traditional method of gathering data for the identification of the poor is through household surveys, collection of information
from household expenditures and incomes to educational attainment. Based on this method, the poor are mainly found in rural areas because they are mainly engaged in agriculture or primary based activities. They have very low levels of educational attainment, limited access to basic services, tend to live in large households and have lower health status than the non-poor.

**The Participatory Approach- The Voices of the Poor**

The approach to the collection of data is a means of filling in some of the gaps in household surveys. The poor are given the chance to speak for themselves.

"Poverty is hunger, loneliness, nowhere to go when the day is over, deprivation, discrimination, abuse and illiteracy." (Single mother from Guyana).

This confirms the broad dimensions of being poor. A recent survey by Korboe on sixteen (16) communities in Ghana showed that the main distinguishing features of poverty included "hunger, food insecurity, weak capacity to educate children and access to basic services, inability to honour social obligations, powerlessness and isolation."
Findings from the two approaches seem to contradict each other. The difference may be explained partly by the fact that household surveys do not explicitly take into consideration the values and norms whereas the participatory approach does. Though the two approaches are different they could be used to complement each other.

1.9.2 Measurement of poverty

When determining the type and extent of poverty three measures are of particular importance. These are poverty lines separating the poor from the non-poor, poverty profiles giving a more detailed picture of the characteristics of the poor and poverty indicators intended to provide an overall impression of the living standard, income and social conditions of the poor.

1.9.3 Absolute and Relative poverty

Poverty lines vary between social and economic environments. The poverty line in the United States will be higher than that in Ghana. Absolute poverty refers to a situation where a person or household
consumption, income or well-being falls below a critical "minimum" selected to reflect what is needed to sustain life. Relative poverty is poverty that results from comparing a level of living with that of a reference group with higher incomes.

1.9.4 Primary and secondary poverty

Rowntree defines primary poverty as "the inability to command enough income to buy the bare necessities of life. Secondary poverty is "a situation in which real incomes are adequate to buy the minimum requirements but for a reason the poor do not spend their money on satisfying those needs.

1.9.5 The Human Development Index (HDI) of the UNDP

This indicator combines subsistence and income criteria in order to make statements about relative the relative poverty of countries. Three options are available to people and they are 1) a long and healthy life: 2) knowledge and access to opportunities for the acquisition of knowledge: 3) access to financial resources especially employment and income.
ARRANGEMENT OF CHAPTERS

CHAPTER ONE - This chapter looks at the research design.

CHAPTER TWO - This chapter looks at the health sector under the Structural Adjustment period and the 5YPOW.

CHAPTER THREE - This chapter looks at the trend of external support and the achievements of the 5YPOW are looked at.

CHAPTER FOUR - Contains the conclusions and recommendations
ENDNOTES

2 ibid. p.1
3 ibid. p. 2.
5 ibid. p.5
9 Batse et al, "Integrating capacity building within the context of social policies for poverty reduction in Ghana", SPR/WCA, Senegal, March 1999.
13 Asante, Yaw Dr., "Poverty Analysis" (unpublished) p. 1
14 ibid. p. 3
15 quoted from the above ibid. p. 7
CHAPTER TWO

2.1 The Health Sector under the Structural Adjustment Program

This chapter looks at the health sector under the SAP and the reforms which took place after the World Health Summit in 1995.

The 1970s oil price hikes and Africa’s dependence on primary products as a source of foreign exchange had African governments petitioning the IMF and World Bank to come to their aid to help in the stabilization of their economies. These institutions upon this request introduced the SAP. The SAP brought along with it reforms in all sectors of the economy. Some of these were the non-interference of government in the economy and it giving way to the private sector, public and social reforms as well as the withdrawal of subsidies on the part of the government.

Under the SAP, the health sector received funding from both multilateral and bilateral agencies. Some of these agencies are United Nations International Children Education Fund (UNICEF), Department for International Development (DFID), Danish International
Development Agency (DANIDA) and the United States Agency for International Development (USAID). Funding from these agencies accounted for the withdrawal of government subsidies.

For example, government expenditure on health care fell from 6.45% of the budget and 0.95% of gross domestic product in 1980 to 4.38% and 0.35% respectively in 1983.¹ The public sector reforms affected it with a lot of employees being deployed to increase efficiency. In the late 1970s the Government of Ghana adopted the Primary Health Care system (PHC) as a means of achieving health for all by the year 2000.² This system was intended to introduce a culture of efficiency and ensure that those in the rural areas had access to health. It aimed at empowering the local people to combine their efforts with trained personnel to provide their own health care.

Under the SAP the Health sector reforms were to strengthen, expand and increase access to the facilities. Existing facilities were rehabilitated and expanded with the involvement of the private sector and other donors. The cash-and-carry system was introduced. Patients now had to pay for the drugs themselves. They received no subsidies from the government, and money got from the cash-and-
carry system was used to run the health facilities and build more in the rural areas.

Tables 2.1 and 2.2 show the trend of patient consultation in both the urban and rural areas. Both tables show that there was an increase in the percentage of patients consulting spiritualists and traditional healers between 1987 and 1992. In Table 2.1 the number of patients consulting doctors fell from 80.25% in 1987 to 74.85% in 1992 while that of nurses and medical assistants increased from 14.45% in 1987 to 20.90% in 1988 and fell again in 1992 to 12.3%.

On the contrary those consulting other sources and pharmacists kept increasing from 5.25% in 1987 to 12.90% in 1992. This was probably because of the cash and carry system. In Table 2.2 the numbers consulting doctors were small compared to the urban areas and kept falling, those consulting medical assistants increased from 29.63% in 1987 to 32.8% in 1988 and fell again in 1992 to 19.16%, while those consulting pharmacists, other sources and nurses kept rising.
Table 2.1 Percentage of health personnel consulted: Accra and other urban areas

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<tr>
<td>Doctor</td>
<td>80.25</td>
<td>73.65</td>
<td>74.85</td>
</tr>
<tr>
<td>Nurse/midwife</td>
<td>5.75</td>
<td>8.95</td>
<td>5.3</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>8.7</td>
<td>11.95</td>
<td>7</td>
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<tr>
<td>Other</td>
<td>3.2</td>
<td>3.2</td>
<td>7.75</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2.05</td>
<td>2.25</td>
<td>5.15</td>
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<tr>
<td>All</td>
<td>100</td>
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Table 2.2 Percentage of health personnel consulted: the rural coastal, forest and savanna areas.

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<tr>
<td>Doctor</td>
<td>39.93</td>
<td>34.96</td>
<td>38.7</td>
</tr>
<tr>
<td>Nurse/midwife</td>
<td>14.96</td>
<td>19.53</td>
<td>19.23</td>
</tr>
<tr>
<td>Medical assistant</td>
<td>29.63</td>
<td>32.8</td>
<td>19.16</td>
</tr>
<tr>
<td>Other</td>
<td>11.36</td>
<td>10.5</td>
<td>15.2</td>
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<tr>
<td>Pharmacist</td>
<td>4.13</td>
<td>2.56</td>
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<tr>
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<td>100</td>
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Social indicators of health show that specific areas under the SAP showed some progress. Immunization coverage increased. In 1989, 67% of children below the age of one were immunized compared to the previous years in which only 13% were immunized\(^4\). In the late 1960s the death rate was 17 per 1000, in the late 1980s it was an estimated 13 per 1000 and in 1994 it had reached a level of 12.5 per 1000.\(^5\) Life expectancy in 1983 was 53 but by 1990 it was 55 and has been improving since.\(^6\) Infant mortality rate in 1988 was 154 but fell to 110 per 1000 live births in 1999.\(^7\)
Between 1985 and 1995 government allocation to the Ministry of Health fell from approximately $10 per capita per year in 1978 to $6 per capita.\textsuperscript{8} Donor funding to the sector increased from 25\% of the total public health budget before 1992 to 30\% in 1994. In 1994 it was $28m but increased to $35m in 1996.\textsuperscript{9} These donor funds were not coordinated. They were tied to specific programmes and capital inputs, which do not reach operational levels.

2.2 Health Sectors Reforms

In 1995 after the World Health Summit, the health sector in Ghana underwent some reforms. These reforms took cue from the government’s Vision 2020. The national health policy in this document was to improve the health status of all Ghanaians. The objectives were:\textsuperscript{10}

- Significant reduction in the rates of infant, child and maternal mortality rates
- Effective control of risk factors that expose individuals to major communicable diseases
Increased access to health services especially in the rural areas

Establishment of a health system effectively re-oriented towards delivery of public health services

Effective and efficient management of the health system

It was based on this that the Ministry of Health developed and published a Medium Term Health Strategy (MTHS) and a Five Year Programme of Work 1997-2001 (5YPOW) to guide health development in Ghana over a five year period.

The objectives were:\footnote{11}

- Increased geographical and financial access to basic services
- Better quality of care in all health facilities and during outreach programmes
- Improved efficiency in the health sector
- Closer collaboration and partnership between the health sector and communities, other sectors and private providers
 Increased overall resources in the health sector, equitably and efficiently distributed.

The Programme of Work tried to capture the health sector objective in Vision 2020 in a mission statement that says that:

“As one of the critical sectors in the growth and development of the Ghanaian economy, the mission of the health ministries, departments and agencies is to improve the health status of all people living in Ghana through the development and promotion of proactive policies for good health and longevity; the provision of universal access to basic health service and provision of quality health services which are affordable and accessible. These services will be delivered in a humane, efficient and effective manner by well trained friendly, highly motivated and client oriented personnel.”

Defined targets to be attained over the five-year period are summarized in the table below:

- Immunization through EPI (Expanded Programme on Immunisation)
Reproductive Health Programme – Family planning services, essentials and emergency obstetrics care

Prevention and control of infections with epidemic potential – cholera, cerebro-spinal meningitis, yellow fever

Health protection and promotion – bed net use, nutrition and diet, alcohol, drugs and tobacco, STDs/HIV hygiene and sanitation

Prevention and control of micro-nutrient deficiencies – vitamin A, iron, iodine

Management of selected endemic diseases – malaria, tuberculosis, leprosy, respiratory tract infections, sexually transmitted diseases, diarrhea diseases, guinea worm, onchocerciasis, yaws, buruli ulcer, schistosomiasis, hypertension.

2.3 The Five Year Programme Of Work (5YPOW)

The 5YPOW was designed to guide health development in Ghana. Increasing financial access was a central strategy of the MTHS and the 5YPOW. It provided public funding for immunizations,
treatment of leprosy and other epidemic prone diseases. Clients did not pay for these services. An exemption budget which included paupers, antenatal care, care of the under fives and the elderly was established. Potential insurance systems have also been proposed and exploratory work has already taken place to find out how viable it will be.

Below in Table 2.3 is a table of the amount of money put into the exemptions fund in 1997 and 1998.

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<tr>
<th>Exemptions</th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paupers</td>
<td>N/A</td>
<td>390m</td>
</tr>
<tr>
<td>Antenatal services</td>
<td>2.6bn</td>
<td>1,515m</td>
</tr>
<tr>
<td>Aged over 70</td>
<td>0.76bn</td>
<td>429m</td>
</tr>
<tr>
<td>Children U5</td>
<td>-</td>
<td>54m</td>
</tr>
<tr>
<td>Psychiatry/leprosy</td>
<td>2.8bn</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency cases</td>
<td></td>
<td>153</td>
</tr>
<tr>
<td>Others</td>
<td>0.4bn</td>
<td>191m</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Health Sector 5YPOW 1997-2001, April 1999, pg 29

From the table it can be seen that the amount reduced in 1998. This could probably be due to the fact that the Internally Generated Funds (IGF) brought in more money so the donors shifted to other areas.

Substantial progress has been made in integrating service delivery. Vertical programmes like TB and Leprosy control
programmes have been successfully integrated into existing institutional arrangements for service delivery.\textsuperscript{14} Other changes were the integration of support systems like planning, procurement, and transport to mention a few within a decentralized district health system.

Quality assurance initiatives have also been undertaken though only in the public health sector. Quality assurance teams have been established in a number of health facilities. Standards and treatment protocols to improve quality have been developed and found to be useful.\textsuperscript{15} These protocols place emphasis on the technical aspects of service delivery. The Food and Drugs Board was established for the registration and monitoring of the quality of drugs in the country.

Clinical practice is now regulated. The various professional associations have been established to regulate the practice of its members. For example, the Medical and Dental Council, Nurses and Midwives Council and the Pharmacy council are responsible for the registration and maintenance of up-to-date register of doctors, nurses and pharmacists respectively. The Private Hospitals and
Maternity Homes Board is also responsible for the registration and maintenance of private hospitals and maternity homes.

2.4 Health related interventions and inter-sectoral collaboration

The 5YPOW recognized the importance of inter-sectoral collaboration as a means of involvement in health related interventions. It identified five areas where developments could be monitored and joint work would take place. The five areas are poverty alleviation, limited access to water and sanitation, high population growth, poor nutrition and low female literacy.

Poverty has been recognized as the major barrier to health. To contribute towards poverty alleviation, the Ministry of Health reviewed its inter-regional financial resource allocation, implemented a fee exemption for the poor and increased geographical accessibility to health. It is also actively involved in the design of the National Poverty Reduction Programme (NPRP), which is aimed at improving the living standards of the poor in Ghana.
The Ministry of Health has played a minor role in the accessibility of piped water to the people. Health inspectors were transferred to the Ministry of Local Government as part of the decentralization process and strengthening of capacity.

In the area of nutrition, the 5YPOW identified four areas for action to improve food and nutrition. They are public education on healthy foods and feeding practices, salt iodation, Vitamin A supplementation and other micro-nutrient supplements to population at risk, training of health and agricultural field workers on better nutrition and promotion of basic nutrition as an integral part of the school health programme through the training and regulation of school based vendors and the promotion of nutrition education. Food supplementation has largely been implemented by the World Food Programme and incorporated in foods distributed through the Ministry of Health, but there is still no linkage with the Ministry of Agriculture Extension Services to ensure the local component for sustainability is implemented. Together with the Ministry of Agriculture, Universities and other experts, the Ministry of Health led the process to develop a National Nutrition Policy.
An area that has seen some collaborative action in education is the School Health Programme. Under this programme the Ministry of Health shared some donor resources with the Ministry of Education.

The Ministry of Health has played a major role in the activities of the National Population Council (NPC). It has concentrated on service provision for family planning and safe motherhood. It has also been involved in the conduct of health research and the formulation of health and population policies.

2.5 Support Services.

A national transport policy was in place before the start of the 5YPOW. Progress has been made in strengthening the transport management system under the 5YPOW and currently there is a zero breakdown of the fleet of motorcycles and 80% availability of vehicles for service and prohibitive budget of $20million has been produced for transforming the fleet to an ideal one. Improved availability of affordable drugs and other medical supplies and their rational use were seen as strategies for improving quality.
A Procurement Unit has been established to help in the development of procurement capacity. In a bid to promote rational use of drugs key instruments in the form of the Standard Treatment Guidelines (STGs), Essential Drugs List (EDL) and Rational Drug Use Training Manual have been published and distributed to health staff with long-term Technical Assistance being secured to support the Ministry of Health to enhance the operational effectiveness and transformation of the medical stores.20

2.6 Restructuring of the sector

The Ministry of Health underwent some restructuring under the 5YPOW and agencies were brought in to provide health services. Some of these were the Teaching Hospitals, the Ghana Health Service, the private sector, the traditional medical practitioners and statutory bodies.

The institutional re-organization was through the separation of the Ghana Health Services and Teaching Hospitals as autonomous agencies of service provision, thus leaving the Ministry to focus on the purchasing, regulation and co-ordination of service delivery.
The private sector is made up of NGOs, mission institutions like the Catholic Church and Muslim communities and the private for profit providers made up of privately owned hospitals and clinics. Those in this sector provide public health services like family planning services that are mainly the domain of the NGOs with the mission institutions providing curative services.

Traditional and herbal remedies are the common source of treatment for most Ghanaians. As a result of this the objective of the MTHS was to promote the safe integration of traditional medicine into the health system. The Traditional Practice Act, 2000 (ACT 575) was passed and the Traditional Medicine Practice Council and Traditional Medicine Directorate were established.

Statutory bodies were established to regulate the ethics and standards practice and premises. The statutory bodies include the Medical and Dental Council, the Nurses and Midwives Council, the Foods and Drugs Board, the Pharmacy Council and the Private Hospital and Maternity Homes Board. Below are the various levels under the health sector:21

**Teaching Hospitals** - Korle Bu Teaching Hospital, Komfo Anokye Teaching Hospital


**Psychiatric Hospital** - Accra Mental Hospital, Pantang Hospital, Ankaful Hospital.

**Regional Health Services** - Regional Health Directorate, Regional Hospitals, Training Institutions, District Health Services, District Health Administration, District Hospitals, Sub-districts (health posts, clinics), Subvented (CHAG)
2.7 Management of the sector

At the onset of the 5YPOW, planning and budgeting of the sector was weak. Budgets were not linked with plans and did not incorporate donor funds. In the four years of implementation, substantial progress has been made through improvement of the overall capacity for planning and budgeting within the sector.

The Government of Ghana Public Sector Reform further enhanced this. The Ministry of Health was selected to benefit from the Public Financial Management Reform Programme (PUFMARP) in 1996 and the Medium Term Expenditure Framework (MTEF).

The introduction of the Budget Management Centres (BMCs) concept and full decentralization to BMCs of decision-making in relation to a proportion of donor funding has led to a more operational link between plans and budgets. BMC specific indicators were developed to monitor progress. Annual reviews with the active participation of health partners have become strategic and sector wide through the examination of performance and revision of the vision of the health sector. These reviews are conducted at the district, regional and national levels and discuss achievements and
problems. Co-ordination of development partners has also increased donor contribution into the Health Fund. Technical assistance however still remains donor driven.

2.8 Funding

At the beginning of the MTHS, there was no uniform financial management system in operation. There were several accounting systems, unreliable financial returns, no standardized accounting procedures and internal control system. Before the 5YPOWER donors basically financed projects and informed the Ministry of those projects. As a result of this there is no compilation of financial and technical support given the health sector.

The 5YPOWER emphasized the standardization of internal controls and procedures, accounting procedures, channels of disbursement and reporting, the development of formats as well as the management of all funds. As a result of this the Ministry of Health has from 1997 to date produced regular quarterly financial statements and annual audit reports for each year. Certified BMCs are allowed to hold and manage their funds.
Under the health sector reforms, the sector has four sources of funding. They are the Government of Ghana, Internally Generated Funds, Donors and Credits. Some donors contribute into a common basket from which the Ministry finances its projects and improves the health sector. In 1998 for example, with the exclusion of capital expenditures, the Government of Ghana and the Internally Generated Fund (IGF) financed about 80% of total recurrent health expenditures with the remaining 20% financed by donor-pooled funds which is lower than the 28% received in 1992. The decrease has been replaced by an increase in user charges.

Table 2.4 below shows the projected and actual contribution to financing the health sector.

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>PROJECTIONS (US$M)</th>
<th>ACTUALS (US$M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOG</td>
<td>81</td>
<td>93</td>
</tr>
<tr>
<td>IGF</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>DONORS</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>CREDITS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>127</td>
<td>140</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Health of the Nation, May 2001

From the table it can be seen that the actual contributions from donors and the Government of Ghana fell below the projected
amounts while internally generated funds exceeded the projected amounts. The total budget for the 5YPOW is US$ 773.4 million but at the end of 1999 the estimated actual expenditure stood at US$ 443 million against a 3-year target of US$ 422 million.24
ENDNOTES

1 Avle S K et al., "Exemption and access to health care services by selected by vulnerable groups: the community perspective." SAPRI. Accra, April 2001
2 Batse et al., "Integrating capacity building into within the context of social policies for the reduction of poverty in Ghana", SPR/WCA, Senegal, March 1999, p. 2.

5 ibid. p. 40
6 ibid. p. 40
7 Health of the nation.(Draft). op. cit. p. 6
8 ibid. p. 49
9 ibid. p. 49
10 ibid. p. 6
11 ibid. p. 6
12 ibid. p.7
13 ibid. p.9
14 ibid. p.20
15 ibid. p.21
16 ibid. p.28
17 ibid. p. 28
18 ibid. p. 28
19 ibid. p.38
20 ibid. p.41
21 ibid. p.31
22 ibid. p.53
23 ibid. p.31
24 ibid. p.50
CHAPTER THREE

3.1 EFFECTS OF EXTERNAL SUPPORT ON THE HEALTH SECTOR.

Under the 5YPOW, a lot has been achieved. Health services have been improved both in quality and quantity. Divisions will be taken individually and assessed and conclusions made as to whether donors have contributed more or if the government is to take the credit. Information used in this chapter was taken from the Ministry of Health’s publication *Health of the nation* (Draft).

3.2 Human Resources

Before 1997, there was an estimated shortfall of 15% against facility-based staffing norms.¹ This shortfall was made up of medical doctors - 233 with 195 for specialist positions, nurses – 259, dental – 51, pharmacists – 141, and all others – 4275.² To make up for this shortfall the 5YPOW made it a priority to increase the production of health workers through an increased intake in training institutions.
For the State Registered Nurses (SRN), this strategy has been successful as it has now doubled its intake and is now five times more than it was in 1995 which had a total intake of 249 students.\textsuperscript{3}

See Table 3.1. The intake indicates the number of students who were taken in all categories.

Table 3.1 Average annual intake and output from the basic health training programme 1997-2000.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Average Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRN</td>
<td>633</td>
</tr>
<tr>
<td>Post-SRN Midwifery</td>
<td>126</td>
</tr>
<tr>
<td>EN/CHN Midwifery</td>
<td>236</td>
</tr>
<tr>
<td>Community Hlth Nurses</td>
<td>233</td>
</tr>
<tr>
<td>Environ. Hlth Asst.</td>
<td>70</td>
</tr>
<tr>
<td><strong>Total intake</strong></td>
<td><strong>1299</strong></td>
</tr>
</tbody>
</table>


The two medical schools now produce about 120 doctors a year, School of Pharmacy 80 per year, the University of Ghana from its Bachelor of Nursing programme 30 students, all of whom work to full capacity.\textsuperscript{4} The number of doctors coming out now compared to the 200 which came out between 1975 - 1985 from the Komfo Anokye Teaching hospital shows that there has been a vast improvement.\textsuperscript{5}
Fellowship programmes in the form of internal and external long and short courses are available, but the numbers however nominated do not differ much from the previous years. This has been due to the fact that there is only one school for each of the specialized training schools and, due to the small budgetary allocations only small numbers can be taken in at a time.

Table 3.2 Regional distribution of training fellowships in 1998 and 2000 respectively.

<table>
<thead>
<tr>
<th></th>
<th>HQ</th>
<th>GA</th>
<th>ER</th>
<th>VR</th>
<th>CR</th>
<th>WR</th>
<th>BAR</th>
<th>NR</th>
<th>UW</th>
<th>UER</th>
<th>AR</th>
<th>KAT</th>
<th>KBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Ministry of Health, Health Sector SYPOW 1997-2001, April 1999
Source: Ministry of Health, Health of the Nation, (Draft) May 2001

Compared to the situation at the beginning of the SYPOW, staff distribution which was 29,645 has increased to 30,612 which is an improvement.\(^6\) In terms of staff distribution in the regions there was marked disparity. Korle Bu Teaching Hospital had 285 doctors (25.6%) and Komfo Anokye Teaching Hospital had 184 doctors (16.5%) compared to 6.8% of medical doctors available in the three northern regions.\(^7\) Before the SYPOW, the number of doctors...
amounted to 1057 but by 1999 it had increased to 1143, the number of nurses before the 5YPOW amounted to 9310 but has increased to 12,864.8 

The proportion of doctors and nurses in the total health staff is 49.8% with the doctor population being less than 5% and the distribution across 7 of the 10 regions being less than 2%.9 Below in Table 3.3 is a table showing the distribution of doctors according to gender and by region in 1999.

<table>
<thead>
<tr>
<th>Category (Gender)</th>
<th>GAR</th>
<th>VR</th>
<th>ER</th>
<th>CR</th>
<th>WR</th>
<th>AR</th>
<th>BAR</th>
<th>NR</th>
<th>UER</th>
<th>UWR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
<td>M/F</td>
</tr>
<tr>
<td></td>
<td>101/49</td>
<td>55/2</td>
<td>73/11</td>
<td>45/2</td>
<td>62/7</td>
<td>61/11</td>
<td>54/5</td>
<td>29/0</td>
<td>25/0</td>
<td>14/0</td>
</tr>
</tbody>
</table>


Of the 2,037 staff recruited in 1999, 50 (2.5%) of them refused their first posting to the northern regions on grounds of financial, social and family issues, accommodation and lack of opportunity for self-development.10 To encourage medical staff to accept postings to rural areas a comprehensive package was drawn up. This included provision of accommodation, an allowance of 30%
of salary for staff in these areas to mention a few are some of the incentives contained in the package which at the time was costed at about US$4m per annum.\textsuperscript{11}

3.3 Health and Disease

The mortality rate statistics for Ghana under the 5YPOW has decreased. The under five mortality rate (U5MR) is generally regarded as a good overall indicator of the health of the nation. Even though children under five years of age constitute less than 20% of the population, they account for more than 50% of the estimated 192,200 deaths in Ghana each year, using a crude death rate of 12 per 1000.\textsuperscript{12} Between 1988 and 1998 the U5MR declined from 154 per 1000 to 110 per 1000 whiles the infant mortality rate has fallen from 133 in 1957 to 57 per 1000.\textsuperscript{13} According to the Ghana Demographic Health Survey (GDHS), regional U5MR ranges from 62 per 1000 live births in the Greater Accra Region to 171 per 1000 in the Northern Region.\textsuperscript{14} Some of the causes of high U5MR are teenage motherhood, birth order and lack of education. The Northern regions have under U5MR levels that are 1.4 to 1.5 times higher than the
national average and 2.5 to 2.7 times higher than that of the Greater Accra Region.\textsuperscript{15} Between 1988 and 1998 this rate declined by 41\% in the urban areas compared to 25\% in the rural areas.\textsuperscript{16} Table 3.4 below shows the regional trends for Infant Mortality Rates (IMR) and U5MR from 1988 to 1998 and Table 3.5 shows how the level of education among mothers affects the pattern of maternal deaths.

**Fig. 3.4 Trends in IMR and U5MR from 1988 to 1998**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>WR</td>
<td>151</td>
<td>132</td>
<td>110</td>
<td>77</td>
<td>76</td>
<td>68</td>
</tr>
<tr>
<td>CR</td>
<td>209</td>
<td>128</td>
<td>142</td>
<td>138</td>
<td>72</td>
<td>84</td>
</tr>
<tr>
<td>GAR</td>
<td>104</td>
<td>100</td>
<td>62</td>
<td>58</td>
<td>58</td>
<td>41</td>
</tr>
<tr>
<td>ER</td>
<td>138</td>
<td>93</td>
<td>89</td>
<td>70</td>
<td>56</td>
<td>50</td>
</tr>
<tr>
<td>VR</td>
<td>133</td>
<td>116</td>
<td>98</td>
<td>74</td>
<td>78</td>
<td>54</td>
</tr>
<tr>
<td>AR</td>
<td>144</td>
<td>98</td>
<td>78</td>
<td>70</td>
<td>65</td>
<td>42</td>
</tr>
<tr>
<td>BAR</td>
<td>123</td>
<td>95</td>
<td>129</td>
<td>65</td>
<td>49</td>
<td>77</td>
</tr>
<tr>
<td>NR</td>
<td>222</td>
<td>237</td>
<td>171</td>
<td>103</td>
<td>114</td>
<td>70</td>
</tr>
<tr>
<td>UWR</td>
<td>-</td>
<td>188</td>
<td>156</td>
<td>-</td>
<td>85</td>
<td>71</td>
</tr>
<tr>
<td>UER</td>
<td>-</td>
<td>180</td>
<td>155</td>
<td>-</td>
<td>105</td>
<td>82</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Health of the Nation, May 2001

**Table 3.5 Mother’s education and mortality rates.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>175</td>
<td>166</td>
<td>131</td>
<td>88</td>
<td>87</td>
<td>66</td>
</tr>
<tr>
<td>Primary</td>
<td>148</td>
<td>141</td>
<td>113</td>
<td>85</td>
<td>86</td>
<td>70</td>
</tr>
<tr>
<td>JSS</td>
<td>129</td>
<td>89</td>
<td>91</td>
<td>70</td>
<td>55</td>
<td>54</td>
</tr>
<tr>
<td>Sec. +</td>
<td>100</td>
<td>41</td>
<td>60</td>
<td>79</td>
<td>28</td>
<td>37</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Health of the Nation, May 2001
From table 3.4 it can be seen that apart from Central Region and Brong Ahafo Region the U5MR declined in all the other regions between 1993 and 1998. It however increased in the Northern Region in 1993 but fell in 1998. Mortality rates are high on the U5MR side in all levels and most especially in women with low levels of education.

About 70% of the economic cost of health problems in Ghana has been attributed to environmentally related diseases. In 1997 the proportion of the rural population with access to sanitation ranged from 3% in the UWR to 95% in the ER.

Various institutional data reveal malaria, anemia, stroke, pneumonia and tuberculosis as leading causes of death in Ghana, with malaria and anemia accounting for about 40% of deaths in children up to the age of fifteen. Injury and liver disease cause high deaths among adults with HIV accounting for a higher proportion among women. Reported annual cases of AIDS increased from 42 in 1996 to 6289 in 1999 but in 2000 it was 34 per 100,000 population. Currently it is estimated that 125 persons are developing AIDS
everyday with 90% aged between 15-49 years and 70% of them being females.\textsuperscript{21}

Whereas HIV numbers seem to be increasing, TB cases of all types have stabilized at between 10,000 and 11,000 since 1995. The case finding rate in 1995 was 41\% made up of 7800 cases, the cure rate in1996 being 36\%, 1997 between 29\% and 66\% and in 1999 it ranged between 0\% to 70\%.\textsuperscript{22}

Incidence of measles outbreak has declined due to successful childhood immunization from 1.1\% in 1990 to 0.5\% in 1998 and malaria from 44\% in 1989 to 41\% in 1998.\textsuperscript{23} In 1994 the number of reported measles cases was 35,000, in 1996 it was 32,000 and in 1998 it had dropped to 22,000.\textsuperscript{24}

Guinea worm declined by 96\% from 179,556 in 1989 to 7402 in 2000 and by 17\% between 1997 and 2000.\textsuperscript{25} In 1997, a survey done on 781 communities recorded 8,921 cases and in 1998, a survey on 606 communities recorded 5,473 cases, which was a decrease of 38.6\%.\textsuperscript{26} This has been attributed to the breakdown of health service delivery but eradication efforts are now recovering.
Condom use under family planning has increased from 480,170 in 1997 to 613,806 in 2000.\textsuperscript{27} The Expanded Programme on Immunization (EPI) coverage increased as measured by DPT3 injection which rose from 51\% in 1996 to 71 \% in 1999 and in 2000 rose to 80\%.\textsuperscript{28} Under the 5YPOW the Ministry of Health made some projections. Below in Table 3.6 is a table showing the trend for EPI coverage from 1994-1998.

### Table 3.6 EPI coverage among children 0-11 months in Ghana 1994-1998

<table>
<thead>
<tr>
<th>Year</th>
<th>BCG</th>
<th>Measles</th>
<th>DPT3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>60.6%</td>
<td>49.5%</td>
<td>48%</td>
</tr>
<tr>
<td>1995</td>
<td>67.1%</td>
<td>55.1%</td>
<td>52.2%</td>
</tr>
<tr>
<td>1996</td>
<td>65.2%</td>
<td>53.2%</td>
<td>51.4%</td>
</tr>
<tr>
<td>1997</td>
<td>70.8%</td>
<td>58.5%</td>
<td>59.6%</td>
</tr>
<tr>
<td>1998</td>
<td>76.7%</td>
<td>66.7%</td>
<td>67.5%</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Health Sector 5YPOW, April 1999, pg 35

From the table it can be seen that BCG coverage fell between 1995 and 1996 but picked up again in 1997. The same trend can be seen in Measles and DPT3 between 1995 and 1996. This may have been due to lack of co-ordination during the onset of the period when changes were being made.
The Ministry of Health defined targets to be achieved under the 5YPOW. Some of the surveys are still being done. Information used in this paragraph was taken from the Health sector 5YPOW 1998 review. Per capita Out Patient Department (OPD) attendance at public facilities has not changed. In 1996 it was 0.36, 1997 it was 0.3 and in 1998 0.35. The percentage of supervised delivery has also not changed much: in 1996 it was 37.7%, 1997 it was 40% and in 1998 it was 40%. DPT3/OPV3 coverage has increased. In 1996 it was 51% and 53% respectively, 1997 it decreased to 49% and increased to 68% in 1998. TT2 increased from 38% in 1996 to 64% in 1997 but fell in 1998 to 58.3%. Infants exclusively breastfed for four months increased from 19% in 1997 to 36% in 1998. Total Fertility Rate (TFR) fell from 5.5% in 1997 to 4.5% in 1998. Maternal Mortality Rate (MMR) in 1996 was 214/100,000 and still remained at that rate in 1997. Infant Mortality Rate (IMR) increased from 66/1000 in 1997 to 77/1000 in 1998.
3.4 Health interventions and service delivery.

In 1977 it was estimated that 70% of the population lived more than 30 minutes away from a health facility though this proportion had declined by 1997 to about 35% and 40%. In a bid to increase geographical access to static health facilities, one hundred and twenty-six (126) new health centers as well as three (3) regional hospitals have been built with 11 health centers being upgraded to district hospitals.

A considerable number of hospitals at the national, regional and district levels have been rehabilitated and re-equipped. Opening hours have also been extended to 24 hours with specialist outreach programmes being introduced to facilitate the use of available specialists in fields like ENT. Outreach site per health facility has increased from 7 in 1996 to 8.3 in 1999. Outreach sites in 1996 numbered 6,677, in 1997 it was 7,436 and in 1998 it increased to 10,249. This outreach service was a major service strategy for child welfare services. They are in recognition of the fact that it is important to take services to the people rather than expecting them to come to where the services are.
The Community Based Health Planning and Services (CHPS) involves stationing a community health nurse in a community to work with a community health committee and a health worker.

3.5 Challenges

The 5YPOW has had its fair share of problems. Emerging major non-communicable diseases of public health concern are cardiovascular diseases, hypertension, diabetes mellitus, cancers, asthma and sickle cell disease. Data on these diseases are limited, however, reported cases of hypertension at health facilities have increased by 67% from 58,677 in 1989 to 97,980 in 1998. Another major public health problem is injuries from road accidents. Between 1992 and 1998 Ghana recorded 6517 deaths and 51,877 injuries from road accidents. Leading causes of maternal deaths are hemorrhage, hypertensive disease in pregnancy, abortions, sickle cell disease, genital tract infections, anemia and obstructed labour. Ghana experiences major epidemics of cholera, cerebrospinal meningitis, yellow fever, and rabies. In the last cholera epidemic in
1999, 9,463 cases with 259 deaths were recorded and 18,703 cases and 1356 deaths were recorded for cerebrospinal meningitis between November 1996 and May 1997. More than 90,000 Ghanaians have already died of AIDS and it is currently estimated that 600,000 people including about 40,000 children are HIV infected and 230 people being infected everyday. This number is projected to reach 1.36 million by the year 2014. The prevalence of HIV among facility based sex workers is higher than the national average, that is 75% in Accra-Tema and 82% in Kumasi. An average of 10-15 HIV infections are encountered in 200 donors monthly at Korle-Bu Teaching Hospital.

Although geographical access to health facilities has improved this has not generated increased utilisation. Another argument is that the perception of the people on quality of care in terms of poor staff attitudes to clients and long waiting periods could be a contributory factor.

The Human Resources Department has encountered some problems with staff. There is a major problem of staff recruitment, distribution and retention within the health service. This has been
attributed to over-centralisation of the recruitment process, low remuneration package and weak incentive. During training, the dropout rates and attrition rates following graduation appear to be high coupled with shortage of tutors, infrastructural limitations, and lack of equipment and Health Learning Materials. There is one school for each of the specialized training programmes and each has a small intake at a time. The training of laboratory assistants and enrolled nurses training ceased in 1982, thus leaving only a few institutions to train them. At the post-basic level, the numbers trained are not enough to meet the health sector requirements for specialized staff.

At the inter-sectoral level there is lack of co-ordination and communication between the sectors. Health Inspectors were transferred to the Ministry of Local Government as part of the decentralization process and strengthening of capacity for managing public health issues. No strategic discussions have been made towards achieving a common objective on access to water and sanitation.
From the foregoing, it cannot be overemphasized that there is still the need for health education on diseases like HIV/AIDS which has a high prevalence among the youth and is adversely affecting the labour force and leading causes of maternal deaths.

Improvement in the working conditions of health personnel to motivate them to render efficient service and curb their exodus to other countries for greener pastures must be looked at with all the seriousness it deserves.

Roads, both trunk and feeder, must be improved to reduce deaths and injuries through accidents and also facilitate access to health facilities by the rural communities.
ENDNOTES

1 Ministry of Health, The health of the Nation, (Draft) Ministry of Health, Accra, May 2001, p. 43
2 ibid. p. 43
4 Ministry of Health, Health of the Nation, (Draft), Ministry of Health, Accra, May 2001, p. 44
5 Batse et al, "Integrating capacity building within the context of social policies in the reduction of poverty in Ghana," SPR/WCA, Senegal, March 1999,
6 Health of the Nation, (Draft), op. cit., pp. 43 and 46
7 ibid. p. 45
8 ibid. p. 45
9 ibid. p. 46
10 ibid. p. 45
11 ibid. p. 46
12 ibid. p. 11
13 ibid. p. 1
14 ibid. p. 1
15 ibid. p. 1
16 ibid. p. 1
17 ibid. p. 15
18 ibid. p. 15
19 ibid. p. 13
20 ibid. p. 16
21 ibid. p. 16
22 ibid. p. 16
23 ibid. p. 14
24 Health Sector Five Year Programme Of Work 1997-2001, op. cit., p. 86
25 Health of the Nation, (Draft), op. cit., p. 16
26 Health Sector Five Year Programme Of Work 1997-2001, op. cit., p. 91
27 Health of the Nation, (Draft), op. cit., p. 22
28 ibid. p. 22
29 ibid. p 19
30 ibid. p. 19
31 ibid. p. 20
32 Health Sector Five Year Programme Of Work 1997-2001, op. cit., p. 29
33 Health of the Nation, (Draft),op. cit. , p. 16
34 ibid. p. 16
35 ibid. p. 16
36 ibid. p. 15
37 ibid. p. 16
ibid. p. 16
ibid. p. 16
ibid. p.16
4.1 Health and disease

Under the 5YPOW, important health gains were made. There have been improvements in the health indicators like infant and child mortality rates. These improvements have not however seen evenly distributed as can be seen in the differences in the regional statistics and socio-economic status shown in the level of maternal education.

Despite these gains, the sector is still faced with some challenges, and these include the high maternal mortality rates, persistent communicable diseases like malaria, TB, guinea worm and malnutrition, HIV/AIDS which now poses a major threat to health and development and the newly emerging diseases such as stroke, hypertension and the high levels of death and injury from road traffic accidents.

To bridge the inequality gap, an approach, which will take into consideration the development of health care should be taken. This approach should address issues like poverty, gender and the major
disease problems like HIV/AIDS as well as the emerging communicable and non-communicable diseases like cardiovascular diseases and cancer.

Health systems need to be strengthened and human resources re-oriented to deal with these diseases. Communities have to be mobilized to play an active role in the prevention of the major diseases. This could be incorporated into the Non-Formal education programme.

4.2 Health Service Delivery.

Under the 5YPOW a lot of providers in the public, private and informal sector have become involved in health service delivery. The availability of these providers vary from place to place. For example the informal and community based providers are mostly found in the rural areas and the northern part of the country. The use of these facilities are influenced by factors like cost and gender issues.

Even though progress has been made in public health services like immunization and family planning, there has been little progress in clinical services, though a lot of money has been invested in health
infrastructure. The health sector focused more on improving the geographical access, while little attention has been given to needs of the poor as well as issues like quality and responsiveness to clients needs.

To overcome the problem of financial barriers becoming more important than geographical barriers, health-financing policies have to be developed in order for the poor to make use of health facilities. The further development of the sector will be shaped by the policies of the new government which places emphasis on reducing the financial barriers. It intends to do away with the cash-and-carry system.

To increase the use of clinical services, community based approaches should be used concurrently with facility-based services. To buttress this the new government places more emphasis on community-based care. The public sector’s regulatory capacity should be strengthened and efforts focused on improving quality and responsiveness of services like staff attitudes and waiting times to client needs and expectations.
4.3 Human Resource Development.

Under the 5YPOW, staff increment has been impressive. However, the waste is almost equal to the rate of production. Using the staffing norms as adopted by the initial analysis for staff projections 1997 – 2001, the conclusion is that the sector is grossly overstaffed and not understaffed and that the basic problem is one of distribution. The distribution favours more or less those in the urban areas and the skill mix does not reflect health sector needs. Secondly, staff is ill-motivated and remuneration is low.

To ensure that the human resource department becomes efficient, strategies need to be put in place to respond to the needs of the sector. Staff distribution should be made with the objective of making services more equitable.

Innovative incentives to retain staff should be put in place. Staff remuneration should be put in the context of local and international labour markets in order to prevent the exodus of staff for greener pastures outside the country. Staff and skill needs should be made to match with the service needs for the different levels.
4.4 **Inter-sectoral Collaboration.**

The health sector has not exploited the potential of non-governmental and inter-sectoral action on key determinants of health such as poverty, educational status (particularly of females), access to water and sanitation, development of access roads and prevention of road traffic accidents. There is poor communication and coordination between sectors as seen in the transfer of Health inspectors to the Ministry of Local Government. There have been no discussions on achieving a common objective on access to water and sanitation. The inability of the sector to identify common needs, goals and objectives is also a problem.

This shortfall can be addressed if a new approach, which will influence the determinants of health, is taken. The Ministry of Health needs to re-define what its core business is and plan and budget concrete inter-sectoral activities to achieve its objectives. The Ministry must also take the initiative to develop its own plans for inter-sectoral collaboration since there is no Ministry with the mandate outside Cabinet to bring sectors together. These plans must
operate at all levels, which are the national, regional and district levels. Impact and monitoring assessments should be carried out to find out how effective the strategies are and address those with shortfalls.

4.5 **Organisation and Management of the Health Sector.**

The re-structuring of the Health sector created new sectoral arrangements in terms of the Ministry of Health as purchaser, Ghana Health Service and the autonomous Teaching Hospitals as providers and the statutory bodies for regulation. However, the roles and responsibilities arising from this split are still not clarified.

Progress has however been made in strengthening management support systems and improving budget management. The Budget Management Concept (BMC) concept is now established within the health sector. Investments in capacity building have been made in areas of planning and budgeting, financial management, procurement, monitoring and evaluation. The links between the individual systems are however weak.
To overcome the problems in this sector, the purchase-provider roles and relationships between the sectors should be clarified and strengthened. The linkage between the management support systems should be improved as well as that between sector investments and service delivery requirements strengthened.

The pluralistic nature of health services now requires that the regulatory environment be developed and strengthened. Both public and private providers should be regulated to ensure quality of services to clients.

4.6 Health Financing

Under the 5YPOW the flow of resources increased but fell below targets. While the Government of Ghana and donors did not meet the projected targets Internally Generated Funds (IGF) outrun its projections. The increases in user fees have the potential of widening inequalities in access to health services.

Progress in the development of alternative financing schemes like the health insurance and pre-payment schemes have been limited and the implementation of the exemption policy fraught with
difficulties. Resource allocation to the district level has increased. The resource allocation criteria did not have an explicit poverty focus and it was difficult to discern its linkage with service providers.

The commitment of both the Government of Ghana and donors should be secured and this should be used for developing a business plan. There should be better co-ordination and understanding between Ministry of Health and Partners in bringing in incentives for joining the pool funds to stop the donor direct transfers to Budget Management Centres.

The resource allocation criteria should be reviewed and the links between the health strategy priorities, resource allocation and service output strengthened. Health financing mechanisms should be completely thought out again to remove barriers to health care. Strategies should be put in place to address the low utilisation capacity of BMCs.
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