AN ASSESSMENT OF SECTOR WIDE APPROACH (SWAp) IN THE ATTAINMENT OF HEALTH SECTOR GOALS IN GHANA

By

Samuel Kwofie

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CERTIFICATION

I hereby declare that this submission is my own work towards the MSc in Development Policy and Planning and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

Samuel Kwofie (20045527) 27/04/09

(Student Name and ID) Signature Date

Certified by:

Mrs Dina Adei 27/04/09

Supervisor Signature Date

Certified by:

Dr Yaw Nsiah-Peprah 26-05-09

Head of Department Signature Date

ABSTRACT

According to the 2003 GDHS and APR 2006, the achievements of poverty targeted health interventions have so far been mixed. Indicators like malaria, infant and child mortality and child malnutrition showed worrying changes. While access to water and sanitation among the rural folks are improving, the number of guinea worm infections cases only decreased slightly in 2006 (from 8,290 in 2003 to 4136 in 2006).

These prompted the researcher to assess the SWAp in Ghana which aimed at bridging the inequalities gap in the health sector. The specific objectives of the study include the following: assess the current level of health status of Ghanaians; assess health related interventions and intersectoral collaborations; identify the various development partners that have relationship with the health sector; assess the current situation of the organization and management of the health sector; identify the prospects and challenges of the SWAp Initiative in Ghana and make recommendations that will enhance the attainment of health sector goal. The purposive sampling technique was mainly used for the research and a sample size of 15 institutions out of 18 institutions identified to be the major stakeholders in the health sector.

From the analysis it was realized that HIV/AIDS is still a major challenge to health and development which invariably is a threat to the attainment of health sector goals. Also malaria is the single most important cause of mortality and morbidity especially among children under five years and pregnant women. This is partly due to poor water and sanitation practices among people in the country more especially in the rural areas. M ore so, the health sector has not adequately exploited the potential for non-government and intersectoral action on the key determinant of health such as poverty, educational status (particularly of women and girls),.access to water and sanitation, development of access roads and prevention of road traffic accidents, as well as community development. There is an increasing accountability and annual hearing sessions on performance of partners. This makes the programme transparent to the development partners making it sustainable. Progress in the Under Five mortality has been very slow with the reduction rate of 119 per 1000 births in 1993 to 111 per 1000 in 2006 it is worst when one disaggregates the figure to spatial dimensions (northern and the southern part of the

country).The under five mortality is 60 per cent higher in rural areas, 7 per cent higher among male children, and 2. 2 times as much in children of women with no education as in those of women with secondary or higher education.

In order to bridge the inequality gap there is the need for the government to institute a comprehensive approach to health care development which addresses issues like poverty, gender as well as tackling major diseases problems such as HIV/AIDS, other communicable diseases and emerging non-communicable diseases.There is also the need by MoH to formulate explicit strategies and output for advocacy by the health sector to achieve careful targeted investment in health-related sectors such as water, sanitation, education, food and agriculture, social welfare, road transport and economic development.

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ABREVIATIONS

AAVP	African AIDS Vaccine Programme
APR	Annual Progress Report
AIDS	Acquired Immune Deficiency Syndrome
BMC	Budget Management Centres
CCM	Country Coordinating Mechanism
CDF	Comprehensive Development Framework
CIDA	Canadian International Development Agency
CP	Co-operating Partner
CSO	Community Service Organisation
CSPG	Cross Sectoral Planning Groups
DAC	Development Assistance Committee
DFID	UK Department for International Development
EDP	External Development Partner
EU	European Union
DA	District Assembly
DHD	Ghana Health Directoriate
DP	Development Partner
DPCU	District Planning Coordinating Unit
DEPP	Development Policy and Planning
GAC	Ghana AIDS Commission
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GDHS	Ghana Demographic and Health Survey
GoB	Government of Bangladesh
GF	Global Fund to Fight AIDS, TB and Malaria
GHS	Ghana Health Service
GoG	Government of Ghana
GPRS I	Ghana Poverty Reduction Strategy (2000-2003)
GPRS II	Growth and Poverty Reduction Strategy (2006-2009)
GSS	Ghana Statistical Services

HMIS	Health Management Information System
HIV	Human Immune Virus
HPSO	Health and Population Support Office
HIPC	Heavily Indebted Poor Countries Initiative
HSR	Health Sector Reform
IDT	International Development Target
IMF	International Monetary Fund
IAG	Inter-Agency Group
LGR	Local Government Reform
M&E	Monitoring and Evaluation
MDA's	Ministries, Departments and Government Agencies
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTDP	Medium Term Development Plan
NDPC	National Development Planning Commission
NACP	National AIDS/STI Control Programme
NGO	Non Governmental Organisation
NHIS	National Health Insurance Scheme
NSF I	National HIV/AIDS Strategic Framework I (2001-2005)
NSF II	National HIV/AIDS Strategic Framework II (2006-2010)
PHC	Population and Housing Census
POW	Programme of Work
PLWHAS	People living with HIV/AIDS
SIP	Sector Investment Programme
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
UNAIDS	United Nations AIDS Commission
SBS	Sector Budget Support
SPA	Strategic Partnership with Africa

SWAps	Sector Wide Approaches
TA	Technical Assistance
TH	Teaching Hospital
TC	Technical Cooperation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

CHAPTER ONE
GENERAL INTRODUCTION

1.1 Introduction

The Sector Wide approach (SWAp) for health was developed on principles of partnership and collaboration and the goal of achieving sustained improvements in health. In 1997, Cassels set out the concept and described how the process of health development might lead to greater efficiency and effectiveness through a coordinated and negotiated programme of work, rather than fragmented project approaches usually employed in health sectors. (Cassels,1997).

There is compelling evidence that improved health system performance is key to improved health, and hence to meeting health-related international development targets such as the Millennium Development Goals. In contrast, the strategies on how this is achieved are still open to debate. The Ghana Health Service (2002) cited in the Annual Progress Report 2004, acknowledges that the health status of Ghanaians has been improving since independence. However, the rate of change has been slow and current health indicators are still far from desirable. Maternal mortality Ratios, Child mortality and morbidity rates remain high; malaria and other communicable diseases including HIV/AIDS are still persistent. So, despite substantial investments in expanding and upgrading the network of government health facilities, evidence for increased uptake of health services is mixed (MoH/, 1977).

Since the mid-1990s, a new approach to health sector development has taken hold in a number of developing countries of which Ghana is a key subscriber to this: the Sector-Side Approach (UNFPA 2002)

There are persuasive arguments for supporting a sector-wide approach (SWAp) as opposed to the traditional project approach: increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems. These are variously claimed to reduce duplication, lower transaction

costs, increase equity and sustainability, and improve aid effectiveness and health sector efficiency.

Furthermore, the SWAp has become an integral part of poverty reduction strategies, and its ideology has enjoyed a growing acceptance from donor agencies as well as aid recipients (UNFPA 2002)

The SWAp concept followed an earlier structure, the Sector Investment Programme (SIP) introduced by the World Bank to manage, on a sector basis, its specific investment lending. Although the principles of SIPs are common to SWAp, it is important to distinguish that the SWAp describes the programme itself and is based upon nationally-led sector development, and is not merely an instrument of financing. SWAp defines methods of working between government and donors. It brings together all financial and technical support to a sector within a common planning and management framework, around a government expenditure programme (Addai, 2001).

1.2 Statement of Problem

The Sector Investment Programme (SIP) which was introduced by the World Bank in the mid 1980's had some challenges which include the mis-management of the funds, lack of serious commitment on the part of the implementers who were not involved in the programme formulation, poor monitoring and evaluation strategy, the programme being seen as an imposition of activity by foreigners are just but a few of the many challenges faced.

The above problems culminated the introduction of SWAp in 1997 which seeks to avert the situation by improving health status of Ghanaians. But the 2003 Ghana Demographic and Health Survey (GDHS) indicated that major health indicators such as maternal mortality, infant mortality and under-five mortality are still unacceptably high. These stand at 214 deaths per 100 000 live births, 64 deaths per 1000 live births and 111 deaths per 1000 births respectively. It is also estimated that 'less than three fifths of the population have access to some form of modern health services'. This has prompted the

need to study the Sector Wide Approach to health in order to ascertain its impact on health status in Ghana since its inception in 1997.

The Sector Wide Approach (SWAp) which was to attain the national health goals in Ghana has been implemented since 1997 with the aim of improving the health situation in Ghana but the health problems are still emanating and even those that are reducing are not all that significant. For instance, malaria accounts for 40 per cent of outpatient attendance and it is still the major cause of death. Malaria accounted for 21 per cent, 34 per cent and 47 per cent of deaths in 2004, 2005 and 2006 respectively (*GHS*, 2006).

Mortality rate in rural West Africa is very high, if not the highest in the world. The Ghana Poverty Reduction Strategy document placed critical importance to the individual in the intrinsic value of health and beyond this, health is also central to the overall human development and poverty reduction.

The SWAp which was intended to improve the health status of the people has not been totally fruitful since there are continuing problems with some major areas like HIV/AIDS, malaria, TB and guinea worm. Therefore there is the need to review the programme in order to see if this programme will really help improve the health situation of Ghanaians.

Demographic projections of the HIV/AIDS epidemic show that the number of persons infected with HIV in Ghana has risen steadily since the start of the epidemic in 1986. The HIV prevalence rate has decreased from 3.6 per cent in 2003 to 3.2 per cent in 2006 (Sentinel Report, 2006). Over the last five years (2001 to 2004), the median HIV prevalence rate increased steadily from 2.3 per cent in 2001, 3.4 per cent in 2002 and to 3.6 per cent in 2003, implying that, the 3.5 per cent recorded in 2004 represents the first observed reduction in the last four years. By 1994, an estimated 118,000 Ghanaians were living with HIV and the number more than tripled to about 400,000 in 2004.

This concept of Sector Wide Approach (SWAp) recognizes the complex connection and inter-linkages between the existing human settings and health risks, and places emphasis

on the home, neighborhood, place of health, and schools. The concept also recognizes that effective and sustainable solution can only be achieved if actions are coordinated at all levels.

The research questions to be considered are:

1. What is the current level of the health status of Ghanaians
2. What are the concepts of SWAp and what has been the status of implementation of SWAp in Ghana?
3. Who are the development partners within the health sector and what has been the level of contributions and management?
4. What is the current situation of the organization and management of the health sector?
5. What are the prospects and challenges of SWAp?

1.3 Objectives of Research

The specific objectives of this research are:

1. To assess the current level of health status of Ghanaians;
2. To assess health related interventions and intersectoral collaborations since the introduction of SWAp in Ghana;
3. To identify the various development partners that have relationship with the health sector;
4. To assess the current situation of the organization and management of the health sector;
5. To identify the prospects and challenges of the SWAp Initiative in Ghana; and
6. To make recommendations that will enhance the attainment of national health goal.

1.4 Research Scope

The study concentrated on ways of improving the health service delivery using SWAp approach which allows the government, development partners and other stakeholders in the health sector to coordinate and harmonize their activities for the purposes of ensuring efficiency in the heath delivery system in the country. The idea of SWAp was introduced in the health sector in the 1997. Therefore, this study would look at data from the period

1997 to 2007. Geographically, the whole country was considered as a single unit because the SWAp was implemented nationwide.

1.4 Justification of the Study

Health is seen as one of the basic necessities of life and as such much emphasis is being placed on this need so as to ensure that every individual has access to health care which is also a basic right and a required responsibility of the state. In order to improve the health status of Ghanaians, there is the need to adapt a multi sectoral approach which leads to efficient and effective application of scarce resources.

The national health goals have a link with the millennium development goals in addressing issues pertaining to women and children and ultimately improving the health status of all Ghanaians. Goals 4 and 5 which is reducing under-five mortality by two thirds by 2015 and reducing maternal mortality ratio by three quarters by 2015 respectively, might not be achieved if the current health indicators like maternal mortality rate, infant mortality rates and under 5 mortality rate still stand at 214 per 100,000 live birth, 64 per 1,000 live birth and 111 per 1,000 live birth respectively. Therefore, the need to assess SWAp to ascertain, whether it is achieving its intended purposes is the focus of this study.

Fragmentation of a health sector along geographic, programme, and disease lines is largely a result of governments' response to priorities set goals by external donors. Control of development resources has tended to be almost entirely through donor-led institutional arrangements that bypass government channels and reduce government involvement and control. Performance and impact of health services outside individual projects, is largely unknown. The considerable number of financiers and NGOs negotiate and contract separately, leading to an untenable volume of transactions that the Ministry of Health has to service. SWAp addresses these complexities, inefficiencies, and high transaction costs. It requires a commitment to change – towards unified strategy, programme and investment plan, and harmonization of procedures.

This study would also contribute a lot in terms of learning and the improvement and management of the health status in Ghana, particularly in the areas of policy direction.

1.6 Limitations

The major limitation to this exercise was the time to answer the questionnaire by the schedule officers who had other responsibilities to attend to. However, this limitation was compensated with the quality and insight information the reseacher eventually received from the respondents.

1.7 Organization of the Report

The report of this study has been put into five chapters. Chapter one, the general overview, contains the introduction, problem statement, objectives, scope, justification and limitations of the study. Chapter two which is the literature review concentrates on the review of relevant literature on health issues, while chapter three is on the research methodology for the exercise. Chapter four focuses on the results and discussions of the data collected. The final chapter, five, contains the findings, prospects and challenges of the SWAp initiative in Ghana, recommendations for the improvement of the SWAp initiative and conclusions drawn from the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

Based on the definition of the research problems, the study objectives and the identified research issues and questions, it is necessary to understand the concepts and importance of the Sector Wide Approach (SWAp) of the health sector. This second chapter is essential because it deepens and broadens ones knowledge about the Sector Wide Approach being used in Bangladesh and some selected African countries like Uganda. The first part of this chapter deals with the concept of Sector Wide Approach; the various definitions and forms available, and its characteristics stating its strengths and weaknesses.

2.2 WHAT IS SWAp

There is the need to seek agreement on the definition of SWAp, and identify how SWAp can be evaluated in order to know whether it is yielding the required results or not. The background to this was the recognition that there is not a single agreed definition of what a SWAp is, and also to establish some level of clarity to avoid some constraints to discussions. There are cases where there is a debate over whether or not a country has a SWAp, as well as controversy over whether there can be 'sub-sector SWAp'.

The need for a definition of SWAp is greater at the international level than at the country level. Countries adapt the approach and the terminology to suit their situation For example, it is referred to as "Sector Wide Management" in Bangladesh and Cambodia; in the case of Cambodia this currently excludes a Government managed pool funding or sector budget support arrangement, while there is this type of funding in Bangladesh.

But in the international debate, it would be helpful to have some clarity about whether a particular country has SWAp. For example, in the last Inter-Agency Group on SWAp and Development Cooperation (IAG), meeting there were inconsistent views on whether

Mozambique has a health SWAp or not. It was agreed to classify it as amateur SWAp although some consider that the SWAp is only just starting (Foster 2006).

There are various types of sector level working and coordination mechanisms that are available and in use in different countries, for example: sector policy dialogue; sectoral expenditure plans within a medium term expenditure framework (MTEF); sector donor coordination; and sector budget support. These can be used in isolation or in combination.

The original concept of a SWAp combines some of these and other characteristics. If a SWAp is to mean more than 'any sector level mechanism' then it is necessary to identify what is classified as SWAp and what is not.

For purposes of this research, the following definition is used:

The sector wide approach defines a method of working between government and development partners, a mechanism for coordinating support to public expenditure programmes, and for improving the efficiency and effectiveness with which resources are used in the sector.

The defining characteristics are that:

- All significant funding for the sector supports a single policy and expenditure programme,
- Government provides leadership for the programme,
- Common implementation and management approaches are applied across the sector by all partners,
- Over time, the programme progresses towards relying on government procedures to disburse and account for all funds.
- The SWAP is an approach rather than a blueprint, flexible and adaptable to a changing environment. Most programmes, even well established ones, are in the process of moving towards broadening support to all sources of funding, making the coverage of the sector more comprehensive, bringing ongoing projects into line with the SWAp, and developing common procedures and increased reliance on government. The working definition thus focuses on the intended direction of change.

• The process of a SWAp brings together development partners in dialogue on sector policy issues. The "implicit bargain" is that the external development partner agree to give up their explicit role in running projects (or small fragments of the sector), in return for a voice in the overall direction of sector policy and its management.

2.3 When does the SWAp start?

SWAp is a process and it is clear that countries will not have all the elements in place from the start. Typically there is a decision between Government and development partners to move into a SWAp. Then there tends to be a development stage often lasting two years or more, when there are preparatory activities such as development of the sector strategy and programme; design of shared monitoring and reporting processes or strengthening financial systems. Then the shared sector programme starts to be implemented. In practice there is variation in use of the term SWAp – in some cases this preparatory stage is seen as part of the SWAp, in others it is seen as 'preparation for' or 'moving towards' the SWAp (IHSD, 2001).

If there is to be a common definition then there is the needs to be a clear point when the country has reached a stage that is classified as a SWAp. This implies a minimum threshold. The start of the SWAp could either be the decision to move into a SWAp (this is the most inclusive approach) or it could be the stage when one or more of the elements are in place for example, when the sector wide policy and corresponding expenditure programme are approved and start to be implemented (i.e. elements 1 and 2 in place). This sets a clearer boundary and is perhaps more commonly accepted as the start of a SWAp.

2.4 Stages of SWAp development

In addition it may be helpful to identify different stages of SWAp development. There are two aspects to this, which can be characterised as breadth and depth: Breadth refers to whether the country has all or only some of the five elements: Depth refers to how effectively the elements are implemented. For example, how genuine is Government

leadership and ownership? How realistic is the sector plan? How many of the development agencies share the common reporting systems and do not have their own systems too? Is any external funding in a pool funding mechanism? Is the pooled funding only for drugs or sector wide? (IHSD, 2001).

If the SWAp has limited breadth, that is, only some of the five elements, then should it count as a SWAp at all (for purposes of international debate and lesson learning)? It could be referred to as 'having some SWAp elements' but not count as a SWAp. The discussion in IAG suggested that members feel this should still be classified as a SWAp.

In many cases depth is limited that is, some of the elements are implemented to a very limited extent; this could still be considered as being in a SWAp. The distinction that could be made is where a country has all five elements and these are well implemented, then it would be classified as a full (or 'extensive' or 'comprehensive') SWAp.

When this idea was discussed by the Inter-Agency Group on SWAp and Development cooperation(IAG), most members agreed that it was useful to distinguish a full SWAp from one that only had some elements, or where elements were only implemented to a limited extent, although the suggestion of calling this a 'partial SWAp' was not accepted, as it sounds too negative.

A second issue to consider is whether an assessment of 'depth' should include judgments on content. For example, whether the sector plans addresses the private health sector well, and whether the budget framework will contribute to poverty reduction. Here it is important to emphasize that there should be content-neutral. This does not exclude considering the 'depth' of the SWAp in terms of the quality of the processes for example, the extent of support channeled through Government managed systems.

2.5 The Use of SWAp to Address Health Inequalities and Inequities

There is an obvious inequality in the distribution of health facilities among countries, regions and even within regions. In Ghana for instance, Greater Accra region has the

largest percent of all health facilities in the country. The SWAp has the great potential to address the problem of inequalities and inequities in the health care delivery system in Sub-Saharan Africa of which Ghana is not an exception because the funding for health intervention would be regulated by a central pool under SWAp.

Inequalities and inequities in health have long been central to the concerns of public health. Governments in several countries have recently shown renewed interest in tackling these issues (Acheson, 1998). Concerted attempts have also been made to push them up the global health policy agenda, (Leon and Gilson, 2001 and WHO, 2000) and at the same time international agencies and donors are giving priority to efforts to reduce poverty.

Inequalities and inequities in health are not only about the plight of the most deprived in each society. In many low income countries, over half of the population may be living in poverty and those who are not will still be living in circumstances that contribute to the poor health of the country as a whole. Even in high income countries, where there is little absolute poverty, there are fine and graduated inequalities in health status that span the full socioeconomic spectrum. For example, in a study of 300, 000 men in the United States, mortality declined progressively across 12 categories of household incomes from less than $7500 (£5000) to more than $32 499 (Smith et. al, 1996).

Health inequalities and inequities within countries are not understood in the same way throughout the world. In countries such as the United Kingdom, Sweden, and the Netherlands, much of the research on inequalities in health has focused on the mechanisms that generate socioeconomic gradients in ill health and mortality. From this perspective, the policy solutions that arise are around primary prevention. In low and middle income countries, by contrast, people working on inequalities in health tend to see the problem as one of devising policies to ensure more equitable provision of health care.

There are some exceptions to this. For example, in the United States, concern about equity of access to adequate health care runs alongside an active research base on the determinants of inequalities in incidence of disease. Nevertheless, in many high income

countries, as in Western Europe, access to health services is relatively universal and not strongly dependent on socioeconomic circumstances or geography. In developing countries, however, the issue of organising and funding the health sector has been more central to inequalities in health (Scott, 1999).

Focusing on equity of provision of health care in the developing world therefore has a compelling logic. Nevertheless, the forces producing inequalities in health status in developing countries need to be given more attention than they are at present. Much healthcare reform the world over has been driven by a set of principles that emphasise efficiency and effectiveness and give little consideration to equity (Gilson, 1999).

Although not all governments perceive inequalities in wealth and health to be something the public sector can or should address, all governments are interested in improving economic growth. The World Health Organization (WHO) now argues forcibly that health is key to reducing poverty and development. If improving health can have a positive effect on economic growth, then health should become a central priority of every government: "Because ill-health traps people in poverty, sustained investment in the health of the poor could provide a policy lever for alleviating persistent poverty" (WHO, 1999). This emphasis on the potential causal link running from ill health to poverty, rather than vice versa, is contentious (Ruger et. al, 2001).

Gakidou et al (2000) advocate that, rather than looking at the way in which health or disease rates vary between socioeconomic groups, we should measure the distribution of health across all individuals in a population. This approach is analogous to measuring inequality in income and would estimate the spread of health (at an individual or household level) across the population.

The issues highlighted reflect the complexity of the scientific, conceptual, and policy issues inherent in addressing the issues of poverty, inequality, and health. The way that the problem is perceived, the priority given to it, and the solutions advanced vary widely according to ideology, country, and region. To be effective, action must be rooted in better understanding of the full scope of current knowledge (Walford, 2007).

2.6 The Sector Wide Approach, a case study in the Bangladesh

2.6.1 Background

Sector wide approaches (SWAp) were introduced in the early 1990s with the aim to rationalize and simplify what was considered at the time an overly complex aid architecture, where many projects, vertical interventions and donor-driven initiatives were fragmenting national health systems and undermining the role of governments.

In Bangladesh the SWAp is known as the Health, Nutrition and Population Sector Programme (HNPSP). to be precise, the HNPSP is the composite five-year programme and financing framework around which SWAp arrangements work. The HNPSP was formulated to ensure that government action and resources made a cost-effective contribution to the priority health needs of the poor, particularly women and children. The first Health and Population Sector Programme started on 1st July 1998 (the Nutrition component was added in 2003), and the current HNPSP is expected to be completed by 2010.

Since then SWAp have achieved much, and particularly in the early years. But after those initial successes, some of the more mature health SWAp soon began to change their efforts in terms of contributions. In some cases it was because the think tanks of SWAp had moved on and joined certain leadership positions, but more often it was because of pressure from the external health policy and financing environment. This includes new global health initiatives or large disease-specific interventions do not fit in easily with Codes of Conduct and other similar SWAp arrangements. For example, there are reports of fatigue, and of difficulties in coping with change in the increasingly complex international aid architecture among some of the older SWAp in Africa (Walford, 2007).

The continued existence of stand-alone projects and the new global health initiatives, combined with weak leadership and loss of momentum have delivered a serious blow to the implementation of the Bangladesh Health, Nutrition and Population Sector Programme (HNPSP).

2.6.2 The health SWAp goal of the Bangladesh

The ultimate goal of the Bangladeshi Health SWAp was to ensure that there was an integration of health services.

2.6.3 Implementation

The broad, ambitious scope of the HNPSP has negatively affected programme implementation and monitoring, as well as the relationship between the government and its development partners. Problems arise from the difficulty to visualise (and agree on) the priority interventions of the HNPSP, and from the fact that, given such a broad framework, the MOHFW (as implementing agency) can be easily found to be underperforming. The impression that the HNPSP is performing poorly in many areas (though not always true) has had a detrimental effect on MOHFW staff morale. Things would be easier if the HNPSP had fewer operational priorities that can be used for monitoring purposes (Martinez, 2006).

Another issue linked to the weak planning framework is the lack of leadership among the senior level cadres of the MOHFW responsible for HNPSP implementation. In fact, this is just the visible tip of a larger iceberg – poor governance and entrenched corruption within the government of Bangladesh. (Moore, 2007).

Many of the problems identified boiled down to lack of implementation capacity, but others appeared to affect the very foundations of the HNPSP. On the government side, lack of leadership and programme ownership, weak financial management practices, inadequate planning instruments, limited expenditure of pool fund resources.

2.6.4 Impact of SWAp in the Bangladesh

In Bangladesh the health SWAp has made highly significant contributions to the process of rationalizing the aid architecture.

A pool fund was created to better support the MOHFW budgeting and accounting processes. Under the current HNPSP the pool fund totals an estimated $750 million over five years. This represents about half of total funds committed to HNPSP by development partners, or 18.7 per cent of the total HNPSP budget of $4 billion. The government's share of the HNPSP budget represents about 66 percent of the total. Development partners provided an estimated $659 million through what is known as "parallel funds", that is, bilateral, direct support to national programmes and specific initiatives. It is worth noting that parallel support relates to project type interventions which use off budget financing arrangements channelled through separate accounts, even if these funds are "on plan" that is reflected in the HNPSP accounts.

Budget preparation, forecasting and reporting on expenditure within the MOHFW have improved in recent years, but not to a sufficient extent, and financial management practices remain extremely weak. However, instruments such as Public Expenditure Reviews, National Health Accounts, Medium Term Budget Frameworks and Benefit Incidence studies have allowed greater transparency on how resources are allocated and spent, and on who actually benefits from public subsidies.

The HNSP's teething problems, combined with weak leadership and implementation capacity in the MOHFW, have resulted in low expenditure in the HNPSP pool fund in 2006 and 2007. This has sent signals to development partners who contributed to the common fund, perhaps to reconsider earlier commitments to pool funding in favour of larger amounts of project aid.

The pooling of funds does not guarantee increased disbursement rates, but it would be a serious mistake to undermine pool funding on the basis of two consecutive "bad years". Hesitating development partners should perhaps be reminded that pool funding is the

government's choice for sector financing and that its potential for improving government health systems and for building sustainable capacity is incomparably greater than project aid. (HSSP II)

2.6.5 Lessons Learnt

In spite of undeniable improvements and contributions achieved over the years, the Bangladesh SWAp was found to be in poor shape. These point to a poorly managed health sector, where absorptive capacity of external and domestic resources was seriously compromised. They point to a poorly performing MOHFW, unable to exercise leadership and plagued with organisational, governance and functional limitations. Thus HNPSP objectives were not being achieved and the intended focus on the poorest and more vulnerable remains unclear or have been lost.

It is observed that these problems and limitations have prooved that the Bangladesh SWAp, or SWAp more generally, are failing to deliver on their planning, alignment and harmonisation objectives, and have called for a different approach to better cope with the complexities of the present day aid architecture.

This review of the Bangladeshi experience has shown that the problems do not lie in the SWAp model, but in its *application*. In other words, whether or not a SWAp is in place, health sectors cannot deliver more and better services on the basis of poorly conceived health plans, just as they cannot resolve emerging problems through inadequate monitoring arrangements or through weak mechanisms for dialogue.

The main lesson is that "mature" SWAp need to look critically at themselves and ensure that the focus remains on a set of *core principles and values*, such as a realistic health plan implemented through government leadership and based on effective monitoring and productive policy dialogue. The responsibility for maintaining such focus is not, however, limited to government: development partners should place equal emphasis on increasing health financing as on ensuring that this is delivered according to

harmonisation and alignment principles, in ways that strengthen (rather than weaken) sector capacity.

When faced with difficulties, SWAp partners should focus on helping the Ministry of Health re-take control of the sector. To achieve this, capacity building in selected parts of the Ministry of Health should become once again the centre piece of the sector programme. In the specific case of Bangladesh, additional efforts should be made, and specifically: focus the health sector plan on a narrower (and clearer) set of sector objectives and priorities, particularly as sector governance and planning systems remain weak. A few essential, long overdue reforms may need to be put in place, but through more fluent policy dialogue, not pressure or imposition.

As a partnership, the Bangladesh SWAp needs to strengthen its structures for dialogue and mutual accountability. In fact, it is suggested that these have been already strengthened and that working arrangements have substantially improved.

The Bangladesh health SWAp should revisit and clarify its sector financing architecture, making every effort to accommodate the needs of global health partnerships and the expectations of individual donors, but recognising as well that a realistic financing scenario cannot be based on the principle that "anything goes". Thus, there is a limit to how much additional parallel funding a sector can accommodate – more than that will have a deteriorating impact on sector performance and governance. There is also a need to ensure that the pool fund truly supports sector priorities and people with greater health needs in a more transparent manner. The problem is not one of "pool" versus "non-pool" funds but one of ensuring that all funds and all donors support the government and its programme with equal commitment.

2.7 The Sector Wide Approach, a case study of Uganda

2.7.1 Introduction

In the early 1970s to the mid-1980s Uganda experienced a period of intermittent civil war. The country emerged from conflict with a vastly deteriorated public health situation, and a health sector in shambles. This aggravated the already poverty state of the people in

Uganda coupled with lack of trained staff, poor infrastructure and poor literacy levels. Nonetheless, Uganda subsequently managed a rapid and remarkable recovery, which is often quoted as a success story in economic growth and poverty reduction (Moore, 2007).

In the early years of the Uganda's health SWAp was highly considered a success mainly because it was on the verge of achieving the objectives that were set aside for the programme. However, its performance has subsequently declined. The lessons from the Uganda experience with the health SWAp also have wider relevance especially to Ghana since they give a lot of clue to the successes as well as the failures of the programme. They point to the need for a more balanced architecture of development assistance for health, a broader form of cooperation among government and all partners (including non-SWAp partners), as well as the crucial importance of leadership capacity level.

In the 1990s Uganda's pioneering Poverty Eradication Action Plan (PEAP), which received strong support from the World Bank, became a model for what was to become a global movement for poverty reduction policy and strategy. The PEAP is the overarching policy, with sector specific strategies contributing to the overall plan. The current National Health Policy (NHP) was developed in the late 1990s as a result of the PEAP planning process, and benefited from improved co-operation between government and development partners.

Through the help of the World Health Organization (WHO), and with strong political leadership from the Ministry of Health, development partners and government agreed on a health SWAp arrangement in 1999. The improved cooperation between government and development partners was also instrumental in the translation of the NHP into an operational plan – the Health Sector Strategic Plan I 2000-2005 (HSSP I) –which was launched in 2000, and followed by the HSSP II (Uganda Health SWAp (2007) .

The ultimate health goal of the Uganda government is to improve access and equity of access to essential health care, and ensure that the health sector plays an essential role in the Uganda poverty reduction.

2.7.2 The successes of Uganda SWAp

The first three years of the Uganda health SWAp were very successful. The Memorandum of understanding that guided the SWAp process included two particularly important features. These are;

1) An obligation from the government to steadily increase the budget for health; and,

2) A commitment from development partners to increasingly use general or sector budget support as the principal aid modality. (HSSP I)

Both the government and development partners strove to implement and deliver upon their commitments. The resource flow to the health sector improved considerably; more staff were hired and new infrastructure (predominantly in the primary health care domain) was developed.

Progress in achieving the targets outlined in the HSSP I was visible a few years after the launch of the SWAp. New outpatient attendance rose from 0.4 visits per capita a year in 2000 to 0.9 in 2004/05, and child immunization showed similar sharp improvements. Inputs into the health system improved so much that it is reasonable to expect that the National Demographic and Health Survey, when published in 2007, will also show improvements in health outcomes. (HSSP II)

Such was the success of the Uganda health SWAp that other African countries sent delegations to study it as part of their own efforts to build strong health sectors.

2.7.3 The challenges of the SWAp in the Uganda

The situation of the health SWAp today in Uganda is quite different based on the commitment both by the government and the development partners and this is attributed the following factors;.

i. Reduction in government health spending

The increase in real term government spending for health has come to an end, and at present there is no evidence that this policy will be reversed. In 2004/05 government spending on health as a percentage of government budget rose to 9.7 per cent but it has since declined to a projected level of 8.3 per cent for 2007/08.

Consequently, adherence to the HSSP II is weaker because the plan is far from fully financed from the government budget. The underlying causes of the lowered priority accorded to health are not completely clear. The President of Uganda commented on the health sector during the 2005 Mid Term Review, pointing to a need to improve preventive care over curative care for cost efficiency and also a representative from the , Ministry of Finance, Planning and Economic Development(MoFPED) in 2005 made it clear that there is the high time they take other sectors like the energy sector on board in terms of government financial support this and other problems has led to the reduction of the government financial contribution to the health sector (Foster, 2006)

ii. Reduction of contribution by development partners

Budget support as a share of total health financing has rapidly declined. This is the result of stagnating budget support funding and a dramatic increase in project funding from development partners. In 2003/04 government made a greater contribution to health than the sum of development partners' project support. In 2004/05 government spent 219 billion Ugandan shillings (Ush) on health (partly financed with general and sector budget support from donors) – compared to almost Ush 255 billion on project/programme support from development partners. In 2005/06 the figures were respectively Ush 230 billion from government and Ush 507 billion to project oriented development partner contributions. It is important to note that the sums of donor project financing are uncertain. Figures from Ministry of Health and Ministry of Finance tend to differ considerably in the budget discussions. The figures do not answer a fundamental question: have the increases in donor support led to decreases in government funding, or have decreases in government funding led to higher donor contributions? Probably both

are true, but the dominant force is most likely that of dramatic increases in donor project funding through global health partnerships (GHPs)(The Uganda Health SWAp 2005

iii. Weak government leadership

There has been a considerable weak government leadership, and the mutual respect shown by development partners and government in the early days of the SWAp process is now less evident. During the 2006/07 budget process there were at times confrontations, and donor statements in the Joint Reviews have become more outspoken and critical.

iv. Weak governance

There is also evidence of poor governance in the health sector, with increased corruption, poor coordination between ministries, and decreasing transparency. Notable examples are the Global Fund to Fight AIDS TB and Malaria fraud scandal exposed in 2005 and the embezzlement of funds from Global Alliance for Vaccines and Immunisation (GAVI) which led to the arrest of three former ministers of health.

2.7.4 Hypothetical Decline Causes of SWAp in Uganda

Based on the afore mentioned causes of the decline of SWAp in Uganda, one cannot attribute the failures to only the afore mentioned but there is the need to look at some other hypotheses of the causes of the failure and the following are some few of them;

1. The leadership decline hypothesis

The change in SWAp efficiency coincided with a change in political leadership in the Ministry of Health (MoH). The recently replaced leadership has been accused of involvement in major corruption scandals.

When an experienced MoH director general left, there was a vacuum until a qualified successor was appointed on a permanent basis. After the General Elections in 2006 the political leadership in the MoH was replaced by a team with little experience of central government. Leadership effectiveness and efficiency has been affected by these recent changes, and by other governance issues.

2. The aid instrument hypothesis

Major new funding initiatives, including two major global health partnerships (GHPs) have played an increasing role in Uganda over the last couple of years:

The GAVI Alliance, which might rightly claim success in view of the rapid increases in immunization coverage, has underlined the challenge of sustainability posed by the advent of such external initiatives. A certain lack of clarity around financing measles vaccination campaigns has illustrated the need for long term financial planning involving all parties – government, development partners and GHPs.

The Global Fund to Fight AIDS, TB and Malaria (GFATM) has a more mixed record. On the one hand it has rapidly improved financing for antiretroviral and anti-malaria drugs. On the other hand, it has been at the centre of a damaging scandal, which had paralysing effects on policy makers, implementing agencies and on relations between the Ministry of Health, national stakeholders and development partners for more than a year.

The President's Emergency Plan for AIDS Relief (PEPFAR) has broadened the involvement of civil society in the AIDS response and increased the availability of antiretroviral drugs and of resources for prevention. However, PEPFAR's strong emphasis on the abstinence component of the Abstain, Befaithful, and Use Condoms (ABC) approach has created difficulties for other development partners who have been more supportive of the "B" and "C" elements, leading to fragmentation in Uganda's HIV prevention policy.

Equally, the President's Malaria Initiative is an important source of finance, but in terms of policy development and implementation it functions separately from the country's established systems for malaria control. The approach clearly has sustainability implications, and poses a major challenge to the overall financial planning for the health sector, which will have to accommodate the cost to the sector when funding by the initiative expires. At present there is no room in the government budget for initiatives on this scale. For this, a marked increase in general budget support earmarked to the health

sector would be required, but none of the budget support development partners have so far indicated that such an increase is viable or probable.

These major funding initiatives are usually implemented through project support, which clashes with comprehensive policy implementation and planning frameworks such as the HSSP I and HSSP II. Duplication of ministerial efforts and an increased administrative burden for districts with weak district managerial capacity is an unavoidable consequence In turn, the demand for strong coordination and leadership from government increases.

Furthermore, GHPs have very substantial resources in comparison with SWAp-financed government activities, and compete very successfully for key staff and other scarce resources. This creates not only imbalances to health sector funding in general, but also displacement of activities with less generous financing.

3. The national economic imbalance hypothesis

The Ministry of Finance has expressed concerns (both privately and in public) about the high level of development partner dependency and the influence that health spending from development partner sources might have on the short, medium and long term macroeconomic stability of the Ugandan economy. Among the risks are: appreciation of the Ugandan shilling, causing difficulties for exports; increased interest rates (and decreased volume) for private investments caused by the need to neutralise the inflow of foreign exchange; a resulting long term deceleration in GDP growth; and inflationary tendencies due to demand on key staff and key materials in the economy.

4. The flag-fading hypothesis

Development partners (both bilateral and multilateral) have the need to "show their flag" to their home countries in order to justify their presence and attract resources. But the SWAp approach tends to make the origin of financial resources less visible. SWAp may also cause concern among policy conscious Head Quarters (HQ) representatives because the health policy direction is influenced by a large group of development partners, and the profile of their particular country or organisation can be lost.

At the receiving country level this might hinder efforts to secure compromise agreements and positions. If important development partners push in the direction of a more "flag-showing" approach, other development partners will feel they have sacrificed their individual positions for the sake of solidarity and common interest. It is worth noting that in Uganda donors have generally managed to discipline themselves when under pressure from home to show a sharper national identity. The "flag-fading problem" may be a specific Headquarter'sQ problem.

2.7.5 Lessons from Uganda SWAp

The 'balance' agreements between government and the whole group of development partners, and non-SWAp partners should be included in this effort. Such agreements were adopted on a long-term time perspective to satisfy the needs of the Ministry of Finance in securing budgetary and allocative efficiency and macroeconomic stability. This is a precondition for balanced growth in health sector spending reflected both in the medium and long term macroeconomic frameworks. This balance also applies to non-financial resources, particularly with regard to trained health staff. Without such co-ordination, any imbalance will result in crowding out of essential activities, risking major harm to the realisation of common strategies and goals.

The leadership weakness observed in Uganda is partly related to the high transaction costs caused by several independent planning and implementation mechanisms beside the SWAp process. Thus SWAp structures and processes may need to be revised and reformed to allow for broader cooperation between development partners and government, where GHPs and other separate bilateral initiatives are also given a voice and an obligation to act under a common umbrella.

2.7.6 Conclusion

The Uganda health SWAp, with its early successes and later problems, offers valuable insights into the present realities and the immediate future of development for health. Its experience suggests that a balanced architecture of aid for health is needed which:

1. Promotes active participation from global financing partnerships and other donors acting within the framework of common co-ordination structures and supports systems development;
2. Supports long term macroeconomic balance and allocative efficiency, together with increased predictability both for project mode financing and budget support;
3. Enables effective use of non-financial resources – particularly staff; and
4. Is informed by financial planning frameworks (for the medium and longer term) with dependable data on donor finance, that integrate project funding in line with sector priorities. The leadership capacity of the country is fundamental to the success of improved SWAp processes. Further studies into how the leadership factor is affected by, and also affects the effectiveness of development assistance for health, would be of great interest.

2.8 The health Status of Ghanaians before SWAp

In general, the health of Ghanaians is improving. Since independence in 1957 more infants and children have been surviving and people are living longer, the infant mortality rate has dropped from 133 in 1957 to 66 in 1993; life expectancy has increased from 45 to 55 years. However, there still exist wide variations between region, between urban and rural population, and between different cultural and religious group. Factors beyond the remit of the health care system which contribute significantly to the relatively slow improvement in the health status of Ghanaians include: poverty; poor nutrition of vulnerable groups; low illiteracy rate especially among women; a high population growth rate; and limited access to safe water and sanitation. (GSS, 1999).

The mortality pattern has not changed significantly over the years, with the population suffering from the same disease such as malaria, tuberculosis, respiratory and gastro-intestinal infections, as well as nutritional deficiencies. However, non -communicable diseases like diabetes and cardio-vascular diseases are beginning to assume significance. The emergence of new infectious agents such as HIV adds to this growing public health burden. (GSS, 1999).

Malaria continues to be the disease most commonly reported. It is the leading course of mortality in children under five years, a significant cause of adult mortality, and the leading cause of work-days lost to illness. The number of reported cases of tuberculosis had continued to rise from a low point in 1984 and there is an increasing risk of tuberculosis combined with HIV infection, gastro-intestinal diseases due to infections including typhoid, dysenteries, parasites and helminthes continue to cause high morbidity and mortality in both children and adults. Cholera has become endemic but still appears in epidemic form periodically. Other epidemic infections including, yellow fever and meningococcal meningitis, Onchocerciasis, schistosomiasis, dracunculiasis, fillariasis and yaws are endemic in certain region,(GSS, 1999).

Ghana is facing a number of serious reproductive health problems. Many adult women die from complication of pregnancy, childbirth or unsafe abortion and the rate of HIV infection is increasing rapidly. Female genital mutilation and birth injuries especially vesico-vaginal fistulae are serious problems in some areas. The maternal mortality rate remains high at 214 per 100,000 live births in 2003 (GSS, 2003).

Awareness of family planning is relatively high and the transition to smaller family has begun. The TFR declined from 6.5 to 5.5 between 1988 and 1992 respectively. The uptake of modern methods of family planning was 10 per cent in 1992 but there are indications that the practice of modern family planning is continuing to rise. The 1993 DHS estimated that 38 per cent of women have an unmet need for family planning.

In 1991, seninel surveillance of women attending 22 antennal clinics and of attendees at STD clinics in various parts of the country found less than 1 per cent of those tested were HIV positive. In the 1994, the average figure is between 2 and 4 per cent.

2.9 Challenges of the Ghanaian health system before SWAp

2.9.1 Geographical Access

Population growth in Ghana has outstripped the provision of social infrastructure including health services. About 40 per cent of the population lives more than 15

kilometres from a health facility. Rural communities are particularly affected since facilities are predominantly located in towns and villages along main road and very few sub- district teams make routine, regular trips to out-of- the –way villages. Although people in the urban areas (about 32 per cent of the population) are better served with facilities, the provision of health care has not kept pace with the growth of polylingual, multi-ethnic, peri-urban slum settlements (GoG, 2002).

2.9.2 Access to basic services

Many health care services were unavailable at most health facilities, due to staff shortages and skill separation between different professional staff. At the same time, first level referral hospitals were neither accessible nor appropriate for certain cases. This is true for certain illnesses such as sexually transmitted diseases, but also for some particular cohorts of the population like the elderly and male adults whose health needs are not a priority (GoG, 2002).

2.9.3 Financial access

Two key factors influencing access to health services were its high cost and how user charges were managed. Fees were inflated by extra legal charges, multiple fee centres and inappropriate prescribing. The poor were less inclined to report illness and seek medical treatment than the rich. In part, this was influenced by the perceptions service quality, but it was also related to the impact of high cost on household expenditure relative to income. According to GLSS3, the purest quintile in 1992 spent 12 per cent of their income on health, compared to a national average of 9 per cent.

As far as gender differences were concerned, although slightly more women than men seek medical care, this trend was distorted by the fact that present service provisions targeted maternal and child care. It does not reflect women's ability to pay. This was affected by the overall wealth of her household and her ability to access funds within it. Indeed, there was a sharp distinction between income earning roles of men and women which made women bear a disproportionate share of the burden of poverty. In 1995, only

6 per cent of the poorest quintile received pre-natal care, compared with 78 per cent of the richest. (MOH, 2001)

2.9.4 Service Quality

Many people perceived that the quality of health services was poor and therefore chose alternative treatment sources. Confidence was undermined by frequent shortages of drugs and medical supplies, long queues, absence of emergency services and poor staff behaviour which was often perceived as uncaring, demoralizing, and financially motivated.. In addition, patients had difficulty reaching facilities during working hours because these often accorded with staff rather than client convenience.

2.9.5 Funding of health services

In real terms, resources available to the health sector had been shrinking over the years. Government's allocation to the Ministry of Health has been $6 per capita in 2001, compared with $10 in 1978.This has had a direct impact on the ability of the Ministry to run an efficient and effective system. Insufficient amount were spent on non-wage recurrent costs, leading to shortage of drugs and other essential supplies and the persistence of weak logistical support system.(MoH, (2002-2006)

2.9.6 Community, intersectoral and private sector linkages

Households were at the centre of health decision but lack basic information on health enhancing behaviour. They did not know what services should be available and at what cost, and did not know where to access this information. In addition, they had little opportunities to express their own perceived health needs. Health care planning and delivery had been a top-down process in which client satisfaction had been of low quality. In the past there had been attempts to involve communities in the health care delivery system but for the most part these had become moribund. Many community-based volunteer health workers became disillusioned because logistical support system failed, while the Ministry of Health found that the supervision and regulation of unpaid semi-skilled workers were actually more costly than had been anticipated. At the same

time, Village Health Committees set up to improve service responsiveness to client needs played little role in the planning and evaluation of the health system,(GSS, 1999).

Finally, it is important to recognize that many health status determinants fall outside the mandate of the Ministry of Health. For example, clean water and sanitation facilities have a critical role to play in improving people's health status, but their provisions rest with other Government departments. Similarly, there is a close correlation between female literacy, fertility and the health of the whole family, (GSS, 1999).

2.10 HIV/AIDS as a Challenge to Attaining National Health Sector Goals

2.10.1 Global and the Sub-Regional Incidence and Distribution

On a global scale, AIDS continues a frightful expansion and continues to be a unique developmental challenge. In just a quarter of a century, HIV has spread relentlessly to virtually every country in the world. Still growing, the epidemic is reversing development gains, robbing millions of their health and lives, widening the gap between rich and poor, and undermining social and economic security. By the end of 2005, an estimated 25 million people had died and 40.3 million people were infected with HIV, up from an estimate of 37.5 million in 2003 (Ghana AIDS Commission, 2005).

There are over 7 million infected individuals living in South and South East Asia, and 1.8 million in Latin America. Infection rates are currently rising fastest in Eastern Europe and Central Asia, where over one fifth of the estimated 1.6 million HIV-positive people acquired the virus during 2005 alone due to increases in injecting drug use and a breakdown in the health care system especially in the Soviet Republic (UNAIDS, 2002).

Whereas men were most affected at the beginning of the epidemic, women rates of new infection now surpass those of men, especially in countries where women live in poverty and have relatively low status. Over 17.5 million people with HIV are women. For instance in Sub-Saharan Africa women make up 57 per cent of adults living with HIV. In South Africa more than one in five pregnant women are HIV- infected, and in a few

urban settings southern Africa antenatal sero prevalence reaches over 40 per cent (UNAIDS, 2002)

Approximately, 95 per cent of those living with HIV are in low and middle income countries and Sub Saharan Africa is the hardest hit region in the world. More Africans die of AIDS related illness than of any other cause. By the end of 2005, 25.8 million people were estimated to be living with HIV in the region. The region bears over 60 per cent of the world's people living with HIV; over 90 per cent of all children living with HIV and about 80 per cent of the children orphaned by AIDS. In several countries in Southern Africa including Botswana, Swaziland, Zimbabwe, Lesotho, Zambia, South Africa and Namibia, at least one in five adults is HIV-positive. For instance in Swaziland more than 38 per cent of adults are infected with HIV (UNAIDS/WHO, 2006).

2.10.2 Epidemiology of HIV/AIDS in Ghana

In Ghana, HIV/AIDS was first reported in 1986 at Agomenya in the Eastern Region among women who had migrated to Ivory Coast as sex workers. Interestingly, this town (Agomenya) has the highest prevalence rate (8.6) in the country. During that first year, 42 cases were identified. Recent trends of the demography of the disease, however, show an increasing number of people infected who have never had any history of travel. The main avenues of HIV infection in the country are as follows: heterosexual sex (80 per cent), mother to child transmission (MTCT, 15 per cent) and contaminated blood (5 per cent) (GHS , 2005).

With a total population of 21 million, Ghana had a median HIV prevalence rate of 3.6 per cent in 2003 (National AIDS/STI Control Programme/ GHS & GAC, September, 2005). HIV/AIDS prevalence in Ghana currently stands at 3.2 per cent in 2006 (UNAIDS, 2006 and GAC, 2007). This indicates a low prevalence rate than that of most Sub-Saharan African countries, which is attributable to increased public awareness about the disease. The low prevalence rate notwithstanding, the rate is of much concern because according to UNAIDS and the WHO, any country with infection rates above 1 per cent is still considered as having a generalized epidemic (UNAIDS as cited in National AIDS/STI

Control Programme/ GHS & GAC, -2004). Already, an estimated number of 29,000 people already lost their lives to AIDS in Ghana and this does not include those whose death are not reported (UNAIDS, 2006).

Despite the country's stable prevalence rate, considerable variations are found by geographic region, gender, age, occupation and to a lesser degree, urban–rural residence. On the basis of gender, HIV and AIDS affects women and men differently in terms of vulnerability and impact and so it is imperative that every policy, more especially the National Workplace HIV/AIDS policy takes this into account. There are biological reasons which make women more vulnerable to infections than men, structural inequalities in the status of women that make it harder for them to take measures to prevent infections, which in turn also intensifies the impact of the pandemic on them (GAC, 2005). For instance, the power imbalance in the workplace exposes women to the threat of sexual harassment, where in most cases, they are unable to negotiate for safe sex or refuse unsafe sex. Also the work that women carry out, paid or unrecognized is more easily disrupted by AIDS; an example is that women dominate the informal sector where jobs are mostly not covered by social security nor by any occupational health benefits.

With the level of infection and very limited gains in behaviour change, a renewed focus on HIV/AIDS prevention is key to achieving sustainable poverty reduction, given the low costs relative to treatment. Resources will nevertheless be provided for care and support for those living with the disease and their families, to reduce exclusion and further enhance prevention.

Priority interventions were focused on three areas as follows:

1. Preventing new infections of HIV, promotion of safer sex, prevention of mother to child transmission, ensuring safe blood and blood products and improved STI management
2. Providing a continuum of care for people living with HIV/AIDS (PLWHA) and their families, continuous supportive counselling and palliative care in the household & community and the management of opportunistic infections,
3. Laying an effective institutional foundation.

2.11 Fertility

2.11.1 Fertility levels and Trends before SWAp

Evidence from both the GDHS (1993) and 1988 suggest a declining trend in fertility. The 1993's total fertility rate (TFR) of 5.5 represents a drop in fertility in almost 1 child per woman from the 1988 level of 6.4.There are striking differences of fertility by place of residence and education. Rural women have a TFR of 6.4 children compared to 4 children for urban women, a difference of more than 2 children. Also women with no education have a TFR of 6.7 children compared to only 2.9 for women with at least secondary education a difference of nearly 4 children. Northern Region has the highest TFR (7.4 children per woman) and Greater Accra has the lowest of 3.6 (GSS, 1999).

2.11.2 Infant and Child Mortality before SWAp

In Ghana mortality is relatively lower during the childhood (age 1 to 4) than infancy, although the current levels of both are unacceptably high. Of every 1000 babies born in the five years before 1993, 66 died during their fist year of life. This is a drop of about 14 per cent below the corresponding estimate for the 1988 GDHS (77 per 1000 live birth). The level of under five mortality also improved. The rate for the 1988 is 119 per 1000 live births a reduction of 23 percent over the 1988 GDHS estimate of 155 per 1000 live births.(GSS, 1999)

Under five mortality in the rural areas is higher (149 per 1000) than in the urban areas (90 per 1000). The highest value (237 per 1000) is recorded in the Northern Region. Children of the uneducated mothers are twice as likely to die before their fifth birthday as compared to those of mothers with middle or junior secondary education, and are four times as likely to die as children born to mothers with at least secondary education. The overall evidence suggests a declining trend in both infant and under five mortality. (GSS, 1999)

2.11.3 CHPS: A step of attaining health goal in Ghana

Introduction

Primary Health care is the basis of all healthcare programmes. The overall goal of the Community-based Health Planning and Services (CHPS) concept is to reduce healthcare inequalities and promote equity of health outcomes by removing geographic barriers to healthcare. SWAp which has an epitome of bridging the inequality gap starts from the community level which promotes efficiency in the use of local human and financial resources to promote and manage health at the local level.

CHPS is a component of other government policy agenda, such as the Ghana Poverty Reduction Strategy (GPRS), which identifies it as a key element in pro-poor health services. In addition, various health sector performance reviews since 2002 commended CHPS as an appropriate way to deliver health care to communities in undeveloped and deprived areas distant from health facilities.

The specific elements of the CHPS service delivery model were based on the Navrongo research results demonstrating that placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader and volunteer involvement builds male participation in family planning and improves health service system accountability. Recent results, based on rigorous experimental research, shows that the Navrongo experiment reduced total fertility by one birth and childhood mortality by 38 percent in the first three years of project operation (Debpuur et. al, 2002) It must be emphasised that the key component of CHPS is community-based service delivery point that focuses on improved partnership with households and community leaders and social groups, addressing the demand side of service provision and recognising the fact that households are the primary producers of health (GHS, 2005).

Within the context of Ghana's Poverty Reduction Strategy (GPRS II), community-based health service delivery using the CHPS approach, provides a unique opportunity for achieving critical intermediate performance measures of the health sector. Also, to be

able to achieve the goal and reach the vision for 2015, the objectives of the CHPS initiative must be met. There are three important objectives and these are:

- improve access to services;
- improve efficiency and responsiveness to client needs; and
- develop effective inter-sectoral collaboration.

2.11.4 Prospects and Challenges of CHPS

The positive gains of the CHPS initiative in the rural areas of Ghana where it has been implemented are based on the positive factors that exist within and without the communities and promote the initiative. These prospects as well as the challenges that could cripple the success of the initiative were discussed by the Centre for Community Programmes (2005) are highlighted in this section.

2.11.5 Prospects

- The ideals of the CHPS initiative have it that beneficiary communities have a sense of ownership in the programme, which they see as their own. This is because the people are a part of the process, from the planning through the implementation stages. The needed structures are also provided with the help and support of the community so that they feel a sense of ownership and pride in the programmes of the initiative.
- Smaller numbers - the rural communities are not largely populated. The burden and pressure on the CHPS compounds and the CHO(s) is therefore reduced. The smaller numbers also help the medical staff to relate well with and get to know their clientele better and on a more personal basis so as to treat their cases as uniquely as they are.
- National Health Insurance Scheme (NHIS) - The introduction and acceptance of the National Health Insurance Scheme in the rural areas will impact positively on the health seeking behaviour of the rural folk. More people are now willing to access health since by registering and paying their premiums, their health needs are readily met and they do not have to pay out of pocket when they visit the CHPS compound for care.

- Government acceptance and support - CHPS has been identified by the government as a strategy for reducing health inequalities and increasing access to health services. CHPS therefore enjoys government support for its successful implementation. The initiative is also in line with the Government's manifesto of locating 'nurses in every hamlet' in Ghana.
- Support by Government of Ghana and community resources - Political leaders at all levels are committed to health sector reform. In 1996 an act of Parliament created the Ghana Health Service (GHS) as an extra-ministerial agency that is outside the civil service, freeing the health sector to change, innovate, and reform health care operations in Ghana. This flexibility enables the GHS to utilise research for guiding innovation with research activities.

- Decentralisation is a key element of health care reform in Ghana. The CHPS programme has demonstrated feasible ways of developing community health care in this new era of flexibility and dynamism. Decentralisation permits adaptation of service approaches to local needs and cultural circumstances, a critical component of effective community health care in a multi-ethnic African society.

2.11.6 Challenges

- Brain drain and staff attrition - The major challenge of the health sector as a whole is the issue of brain drain. The CHPS initiative is also affected by this phenomenon. Community health nurses who otherwise could be trained as CHOs are also leaving to seek greener pastures in other countries.
- In communities where the volunteers are very active, community members tended to see them as doctors and this if not checked, could lead to a situation where the volunteers start taking up tasks that are outside their prerogative.
- Most of the CHOs are ladies who may not wish to take up postings in very remote areas. The Acting District Director of Health Services attributes this situation to the conditions of the remote areas as well as the fear of not getting marriage partners of their choice. She further stated that they also face the risk of falling prey to unscrupulous persons who may want to attack or rape them. This is not far fetched, since some districts have reported cases of sexual harassment of CHOs.

The desires of CHOs to get married or join spouses in other communities also contribute to staff attrition.

- CHPS remains a nascent/novel initiative - CHPS is still new and some people are a bit sceptical about the initiative. This forms a draw back to the successful implementation of CHPS, in that support for the initiative will not be as expected. Thus desired impacts will not be made.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Approach/Design

The choice of a research approach/design depends on factors such as the control the researcher has on the phenomenon being studied, the focus of the study (whether contemporary, historical etc.), the purpose of the study, the time available for the study and the type of data involved. Having considered the foregoing, the case study and exploratory approaches were chosen.

The case study approach was used in this study, since it is best used in the study of contemporary issues. The choice of this approach is based on the fact that the study required multiple sources of evidence and the issue being investigated, is a contemporary phenomenon which is ongoing and over which the researcher had little control. According to Kumekpor (2002), the case study method involves procedures and techniques of investigation, usually, but not exclusively or always based on intensive interviewing. This is aimed at enabling the investigator to grasp and understand an individual, a group, a community, a social situation or an issue in order to take decisions that take into consideration the special and peculiar circumstances surrounding the case investigated, or practical solutions relating to the case in question. The approach is also one of careful and critical inquiry or investigation and examination, seeking to analyse the factors involved in a given case, problem, community and issue, among other things, before making any suggestions or recommendations. In using the case study approach, the peculiarity of the circumstances and conditions of each case was respected.

The study also took the form of an exploratory study, as it sought to fish out facts and reasons to explain the phenomenon. Exploratory research designs are best used when the researcher is examining a new area of interest or when the subject of study is itself relatively new or not over studied. Thus, this method was appropriate for the study, since the SWAp initiative is a nascent phenomenon and has not been over researched.

3.2 Units of Analysis, Key Data Categories and Variables

Definition of a problem to be investigated is not enough. The investigation helps to identify or isolate the problem, but does not necessarily imply how the problem should be measured or analyzed. It is still necessary to specify in what form the problem is to be measured.

The unit of analysis is the most elementary part of the phenomenon being studied or the most elementary or smallest unit of the phenomenon around which data is gathered. The unit of analysis according to Kumekpor (2002) refers to the actual empirical units, objects, occurrences etc., which must be observed or measured in order to study a particular phenomenon. Thus, the units of analysis were the following institutions Ministry of Health which is the Government agency with the responsibility of providing overall health policy direction for all players in the country's health sector. Ministry of Finance; Ghana Statistical Service; and some development partners in the country who are comtributing towards the attainment of the national health goal and the Millennium Development Goals. They are the Danish Development Agency, (DANIDA) Japanese Agency for International Cooperation (JICA), United Nations Development Programme (UNDP); World Health Organisation (WHO), United Nations Children Fund (UNICEF), Global Fund;United State Agency for International Development and Global Alliance for Vaccines and Immunisation (GAVI)

3.3 Data Sources and Collection Instruments

The study was based on data gathered and collected from secondary or documented sources and primary data from the field. Secondary data are type of observation and recording of data that does not involve original first hand observation. On the other hand, it makes intensive use of results of previous investigations and documents on the problem being investigated. In this way the researcher relies on what has been documented relating to the problem. The use of such recorded information is subject to all specifications and observations made earlier in relation to the exploration of existing literature under the definition of the problem to be investigated.

With regards to this research, the researcher found it useful to undertake study of trends, seasonal variations and fluctuations, growth rates, comparison of different areas where the same survey is being studied and their impact and explanation of variations. It is assumed that the same event has been recorded at the various times.

With regard to this research, secondary data was gathered from sources such as health reports and policy documents, newspaper clippings and journals, unpublished BSc and MSc theses, as well as other publications sourced from libraries, institutions and the Internet.

Primary/field data was collected through the administration of questionnaires to the various institutions currently implementing the SWAp programme; interview guides for discussions held with some key informants who were involved in the drafting and implementation of the various phases of the SWAp in Ghana.

3.4 Sampling Methods

In sampling, the main objective is to select a portion of a universe that the result may or could be, extended to the whole population. It is in this respect that the representativeness of the universe of which a sample forms a part becomes fundamental to sampling. However, certain characteristic of the universe of which a sample forms a part becomes fundamental to sampling.

The purposive sampling technique was mainly used which is a non-probability sampling technique. The units of the sample were selected not by a random procedure, but they are intentionally picked for study because of their characteristics or because they satisfy certain qualities which are not randomly distributed in the universe but are typical or exhibit most of the characteristics of interest to the study.

It is based on this that the various institutions were selected for the study, thus in purposive sampling, judgment and knowledge of the characteristics of the unit of the universe as to the object of the study is important. Where it is known that certain

individual units, by their very characteristics, will provide more and better information on a particular than a randomly -selected unit, then such units are purposefully picked up for study.

The formula $n = \frac{N}{1 + N(\alpha)^2}$ was used in determining the sample size for the study; where n = sample size, N = total institutions of 18 and α is the confidence level (which is 90 per cent) a sample size .From the interpolation a sample size of 14 was obtained for the study out of 18 institutions identified to be the major stakeholders in the health sector .They were: The Ministry of Health; Ghana Health Service; Ministry of Finance; Ghana Statistical Service. The aforementioned are the Government institutions. The others were: DANIDA, JICA, UNICEF, USAID, WHO, GAVI and Global Fund. The researcher administered one questionnaire to each of the institutions apart from MoH where two questionnaires were administered.

However, the researcher was directed to those who were directly involved in the SWAp implementation even though they were in different institutions, manning different schedules.

3.5 Data Processing, Editing and Analysis

In terms of data processing, a number of techniques were used. Data obtained were edited, coded and then tabulated. Editing was done with the aim of detecting and eliminating error to ensue clean and reliable data. In editing, the following three things were checked; completeness; accuracy and uniformity.

Completeness here has to do with ensuring that every question was answered on the questionnaire.

With regard to accuracy, there was the need to find out whether the answers were reliable or accurate. One major way is to check for consistency or inconsistency. Uniformity of questionnaires was also taken a closer looked at by checking whether institutions really understood the questions reposed to be answered and were answered correctly.

Coding was also done by classifying questions into meaningful categories in order to bring out essential patterns to inform research questions posed. Data were then presented in the forms of tables among others to facilitate the analysis.

CHAPTER FOUR

ANALYSIS AND DISCUSSION OF DATA

4.1 Introduction

Having assessed the prospects and operational problems faced by the health sector to attain the national health goals in chapter two, it becomes imperative to assess whether the introduction of SWAp has helped to obtain national health goals. This chapter analyzes the data that was gathered through the survey and tries to draw linkages with the research questions and objectives of the study. Issues such as the current levels of health status of Ghanaians, access to health care, health related interventions and intersectoral collaboration, organization and management of health sector and prospects and challenges of SWAp initiative in Ghana are assessed.

4.2 Background

The health of Ghanaians has been improving since independence. Infant mortality rate (IMR) amongst Ghanaian children has fallen from 133 in 1957 to 57 per 1,000 live births in 1988 and under five mortality rate (U5MR) from 154 in 1988 to 110 per 1,000 live births (GSS/MI, 1999).

However, the rate of change has been slow and current rates are still far from the desirable. Moreover the aggregate rate masks wide within country differentials that raise cause for concern. Infant mortality rate, for example, vary from less than 57 out of 1000 live births in the southern part of the country to over one hundred out of 1000 live births in the northern part of the country.

In 1996, Ghana developed a long term vision for growth and development that will move it from a low income to middle income country by the year 2020 known as 'vision 2020' In the vision 2020 document the overall objective of national health policy was seen as to 'improve the health status of all Ghanaians'

The specific health objectives of vision 2020 were:

1. Significant reduction in the rate of infant and child and maternal mortality ratios
2. Effective control of risk factors that expose individuals to major communicable diseases
3. Increase access to health services especially in the rural areas
4. Establishment of a health system effectively reoriented towards delivery of public health services
5. Effective and efficient management of the health system strengthened.

4.3 Objectives of SWAp in Ghana

Given the clue from the vision 2020, the Ministry of Health developed a Medium Term Health Strategy (MTHS) which was a five year programme of work that would guide the health development in Ghana over a five year period 1997-2001.

The objectives for the programme of work were to achieve:

- Increased geographical and financial access to basic services
- Better quality of care in all health facilities and during outreaches
- Improved efficiency in the health sector
- Closer collaboration and partnership between the health sector and communities, other sector and private providers both allopathic and traditional
- Increased overall resources in the health sector, equitably and efficiently distributed (GoG, 2001).

4.4 Health Status of Ghanaians

In 1997, the common perception was that government, mission and other donor-financed Non-Governmental Organizations dominated health service provision. The government had for some years, identified primary and preventive care as the major instrument of reducing morbidity and lengthening life. Although there has been substantial progress in developing a district –based package of primary services during the 1990s, this was still delivered unevenly and was substantially dependent on vertical programmes.

Moreover there were important differences in approach to health service priorities being adopted by mission and other NGO providers.

Earlier investment of health infrastructure by the government, mission and other NGO providers had resulted in an inefficient and inequitable distribution of facilities reflecting historical preferences, rather than current health needs. The overall result was great variation in the accessibility that Ghanaians had to access both preventive and curative care. In 1997 it was estimated that 70 per cent of the population lived more than 30 minutes away from a health facility. Although this proportion had declined by 2006, between 35 and 40 per cent, mostly in the rural areas, still did not have access to some health facility.

Overall, government health expenditure remained largely focused on curative services delivered by regional and tertiary hospitals. The linkages between hospital-based care and primary services delivered at the health clinic level were weak. Primary facility staffing was inadequate, poorly supervised and not well distributed in relation to either the infrastructure or health needs. Investment in the infrastructure and its maintenance had been inadequate resulting in the deteriorating of the sector's physical assets (GHS,2000).

4.4.1 Mortality Rates in Ghana after SWAp

The under five mortality rate (U5MR) is generally regarded as a good overall indicator of the health of a population. Overall, the U5MR declined from 119 per 1,000 live births to 111 per 1,000 live births in 1993 to 2006 respectively. These figures indicate that there is a slow pace in terms of reduction in the under five mortality rate. In relative terms Ghana's U5MR is much lower than that of her neighboring countries like Nigeria and Kenya having 143 and 124 per 1000 live births respectively (Addai, 2001). Inequalities in terms of the level of mortality and the trends of mortality were also looked at. Regional U5MR ranges from 62 per 1,000 live births in the Greater Accra Region to 171 in the northern region of Ghana. The Northern Regions have 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. Children in the rural areas are 1.6 times likely to die before their fifth birthday compared with those in the urban areas (GHS,2006).

Table 4.1 Trends in infant and under five mortality rates,Ghana 1993-2003

Region	IMR' 93	IMR '98	IMR '2003	U5MR '93	U5MR '98	U5MR '2003
Western	77	76	68	151	132	110
Central	138	72	84	209	128	142
Greater Accra	58	58	41	104	100	62
Eastern	70	56	50	138	93	89
Volta	74	78	54	133	116	98
Ashanti	70	65	42	144	98	78
Brong Ahafo	65	49	77	123	95	129
Northern	103	114	70	222	237	171
Upper West	-	85	71	-	188	156
Upper East	-	105	82	-	180	155

SOURCE: GoG 2003

Table 4.1 shows that the infant mortality rates (IMRs) of the northern region from 1993 to 2003 is higher than the rate in the Greater Accra Region. Even though, the trend shows a reduction pace from 144 in 1998 to 70 in 2003 yet the figure is unacceptably high as compared to the Greater Accra and the Ashanti Regions having 41 and 42 respectively. This therefore, presupposes that policies of increasing the number of traditional birth attendants and the outreach programmes during the period must be intensified.

Table 4.1 shows that in Greater Accra and Ashanti regions under five mortality rates are reducing, there is the need to intensify the policies that have contributed to these results

and the lessons learnt should be used in the other regions that are performing poorly in these directions. In effect apart from the two regions afore mentioned and the other two (Eastern and Volta regions), the rest are performing badly.

Table 4.1 shows that the U5MR and IMR in 2003 were very high due to the flood in the region which cut some districts like Asunafo and Sene from accessing health care services for four months.

Progress in the reduction of under-five mortality has been very slow with a reduction rate of 119 per 1000 births in 1993 to 111 per 1000 in 2006.This may reflect time lags between interventions and outcomes and/or improve levels of reporting as a result of increased sensitization of women health issues. Given the current trends it is unlikely that the MDG target of reducing under five mortality by two-thirds can be met without significant effort to strengthen the supportive environment.

4.4.2 Maternal Mortality Rate

Various interventions have been initiated to improve maternal health and reduce the high level of maternal mortality. Maternal mortality remains high and appears to have declined by only a quarter from 1993-1998. With this slow of performance it appears that the MDG of improving the maternal health by reducing maternal mortality rate by three-quarters by 2015 may not be achieved.

It should however, be noted that there were a number of policies that were meant to improve the maternal health like bridging the equity gap in access of quality health and nutrition services, ensuring financial arrangement that protects the poor and enhancing efficiency in health service delivery among others.

The problem to this abysmal performance may largely be due to the problem of implementation of these programmes and projects and lack of proper coordination between the MoH and other sectors whose activities have impact on the health of the people.

The following are some selected indicators within the sector

Table 4.2 Basic health indicators 1993-2006

Indicator	1993 DHS	1998 DHS	2003 DHS	2006 MICS	2006 Target
IMR/1000	66	57	64	71	50
U5MR/1000	119	108	111	111	95
U5 who are malnourished	27%	25%	22.0%	18%	20%
Maternal mortality ratio	214	214	Na	Na	Na

Source: GPRS, APR 2006

Table 4.2 shows that the IMR/1000 has been increasing since the introduction of SWAp. It is also seen that IMR/1000 could not achieve the target of 50 as it has been stated in the development framework in Ghana.

Table 4.2 shows that the U5MR has been reducing but at a marginal level of 108,111,111 respectively which could not achieve its target of 95. Here, there is the need to intensify the strategies of curbing this menace or other strategies should be brought on-board.

Table 4.2 also shows that the under five who are malnourished have been reducing therefore achieving the target of 20 per cent. However, the strategies of controlling this situation should be intensified to meet a single digit of 5 per cent target of the United Nations.

4.4.3 Incidence of HIV/AIDS

The reported annual cases of AIDS increased from 42 in 1986 to 6289 in 1999. The incidence of AIDS in 2000 was 34 per 100,000 population. By the end of December 2000, the cumulative number of reported AIDS cases was 43,587(GHS,2002) is recognized that there is a serious threat posed by HIV/AIDS to the socioeconomic

development of the country through its potential impact on human capital development, productivity, and social service delivery

4.4.4 Efforts at Handling the Epidemic

A number of policies have been put in place by both the government, the development partners, NGO's and CSOs, all aimed at ensuring that HIV/AIDS infections would be minimized while mitigating the social, economic, cultural and political effects and impacts of the disease. The following are some of the specific preventive strategies for HIV/AIDS:

i. Direct Service Delivery

Improved direct service delivery, which included strengthening the management of STDs, expanding facilities to prevent mother-to-child transmission, increasing the number and coverage of voluntary testing and counselling centres, ensuring safe blood transfusion, radically expanding access to female and male condoms, and ensuring provision of drugs to HIV positive mothers and children.

ii. Behaviour Change Communication

Programmes on behaviour change communication on HIV/AIDS in educational institutions both formal and informal, at work places and for out of school youth were intensified. Resources were also provided to support peer counselling programmes, school health education programmes was integrated

iii. HIV/AIDS and STI prevention and education on human sexuality.

HIV/AIDS/STI prevention was integrated in the curriculum of Teacher Training Colleges. Work place programmes involving employers and trade unions were also promoted.

iv. Special programmes for high-risk groups

Special programmes to support high-risk groups were undertaken, including re-integration schemes for street children, porters and commercial sex workers.

v. HIV infection rate

Prevention was used as the key strategy for curbing the HIV/AIDS epidemic. Preventing new HIV infection, particularly among the youth (aged 15-29) was crucial for managing the menace. Table 4.3 shows increases in HIV prevalence rate among age group 25-29 from 3.6 per cent in 2005 to 4.2 per cent in 2006, showing an increase of 16.7 per cent Also, table 4.3 shows that there is no percentage increase in 2005 and 2006 among age group 20-24. This shows that the strategies used to curb the menace have saturated and population among this year group have also increased to thwart the efforts of the institutions controlling the disease. Although the prevalence rate is reducing, it should be noted that the energetic people who would help achieve the national goal of attaining the middle income level by the year 2015 are mostly affected as indicated earlier and therefore development policies should be geared towards this age group.

Table 4.3 HIV Prevalence by age group, 2005 and 2006

Age group	2005 (%)	2006(%)	Percentage increase
National	2.7	3.2	0.5
15-19	0.8	1.4	0.6
20-24	2.4	2.4	0.0
25-29	3.6	4.2	0.6

Source: GPRS ANNUAL PROGRESS REPORT 2006

4.5 Access to Health Care

i. Geographical Access

During the SWAp programme, 56 new health centres have been built and eleven upgraded programme of existing health facilities were also instituted. Complimentary efforts including the extension of opening hours of facilities through the provision of 24 hour services and improving the packages of intervention available by providing an appropriate mix of human resources and equipment.

ii. Financial Access

With regard to financial accessibility, the national health insurance was initiated to address the problem of financial barrier to health care posed by the 'cash and Carry' system which requires out of pocket payment for health care at the point of service delivery. The National Health Insurance Act (2004) Act 650, has been enacted and a legislative instrument, LI 809, has been passed to provide operational and administrative guidelines for its implementation. To strengthen the operation of the health insurance body Act 650 has been amended to change council to an authority thereby making it autonomous in their operation.

District Mutual Health Insurance Scheme (DMHIS) serves as the vehicles for delivering pro-poor policy to the under privileged segment in society. All Districts have been provided with an average of GHć 25,000 as a start –up capital for the establishment of DMHIS. So far 123 district schemes have been set up out of a total of 170 Districts and personnel to serve as district Scheme Managers have been recruited.

Currently a minimum benefit package covers about 95 per cent of diseases in Ghana. Available data indicate that the proportion of the population registered under the scheme increased from 22 per cent in 2005 to 38 per cent in 2006 (National Health Insurance Secretariat cited in the APR 2006).

Not withstanding the above gains of the financial access, there are also some problems of pressures mounted on the health facilities and the staff of the various hospitals. The cash flow too has a problem of timely disbursement by the scheme.

iii. Doctor-Population Ratio

The doctor-population ratio in the country is improving steadily. Currently, there is one doctor to 10,641 of the population (APR 2006). This represents a significant improvement over the 2004 performance of 1:17,773. This improvement could be attributed to the implementation of the retention policies including the enhancement of

salaries for Doctors and the establishment of Ghana College of Physicians and Surgeons, which provides post graduate training for doctors.

At the regional levels the three most deprived regions namely Northern, Upper East and Upper West have the worst doctor-population ratio of 1:63,614; 1:28,670 and 1:44,317 respectively.

Table 4.4 Doctor-population ratio by region, 2004- 2006

Region	Doctor-population ratio (2004)	Doctor-population ratio (2006)
Ashanti	1:10,000	1:7,169
Brong Ahafo	1:25, 000	1:24,337
Eastern	1:20,000	1:19,125
Central	1:25,000	1:24,178
Greater Accra	1:3,333	1:3,706
Northern	1:100,000	1:63,614
Upper East	1:25,000	1:28,670
Upper West	1:50,000	1:44,317
Volta	1:25,000	1:20,720
Western	1:20,000	1:22,413
National	1:17,773	1:10,641

Source: GPRS (APR) 2006

From table 4.4, it is clear that there is a steady improvement in the doctor-population ratio from one Doctor to 17,773 to one doctor to 10,641 from 2004 to 2006. This is basically the results of the policies stated above and others like the tax rebate for doctors, logistical support provided them, short term engagement from those doctors on holidays from other countries among others. Despite the above improvement, it is also seen from table 4.4 that the ratio for the northern region is very large with the ratio of 1:63,614 and therefore more attention should be given in the form of posting more doctors to the region.

iv. Nurse-Population Ratio

The nurse-population ratio in 2006 was 1: 1,636 population, which is an improvement of the ratio of 1: 1,800 population in the previous year

The regional distribution of nurses indicate marked regional disparity, with the indicator ranging from a low level in the Greater Accra region to a very high level in the Brong Ahafo Region.

Table 4.5 Nurse-Population Ratio by Region,2004 and 2006

Region	Nurse-population ratio(2004)	Nurse-population ratio(2006
Ashanti	1:2,439	1:2,579
Brong Ahafo	1:2,941	1:3,007
Eastern	1:1,515	1:1,707
Central	1:1,694	1:1,729
Greater Accra	1:833	1:727
Northern	1:2,941	1:2,684
Upper East	1:1,408	1:2,092
Upper west	1:1,785	1:1,458
Volta	1:1,587	1:1,620
Western	1:2,272	1:2,199
National	1:1,800	1:1,636

Source: GPRS (APR) 2006

From table 4.5, it is seen that there is a general increase in the nurse-population ratios. Apart from the Greater Accra , Northern, Upper West and Western Regions of Ghana, which have small reductions in the nurse-population ratios, the rest of the regions are increasing more than the afore mentioned four regions. This presupposes that the rate of population growth in the country in general outstrips that of the nurses that join the profession. Therefore, there is the need to control the population and also train more nurses to take care of the ever increasing population.

It is also seen that apart from the Greater Accra Region, that has a ratio of less than 1000 (1:833 and 1:727) in both years, the rest of the region are above 1000, therefore there

should be a policy to attract more nurses to the other regions of the country. For instance, a policy like incentives for those nurses who accept postings to the other deprived areas of the region should be instituted.

v. Malaria control

Malaria is the single most important causes of mortality and morbidity especially among children under five years and pregnant women. It accounts for about 44.5 per cent of all outpatient illness, 36.9 per cent of all admissions and 19 per cent of all deaths in health institutions in Ghana. The disease is responsible for a substantial number of miscarriages and low birth weight babies among pregnant women. Among the pregnant women, malaria accounts for 13.8 per cent of Out Patient Department (OPD) attendance, 10.6 per cent of admissions and 9.4 per cent of deaths. About 800,000 children under the age of five died from malaria every year. (The health of the nation, 2001). Progress made towards malaria control in 2006 is summarized as follows:

Malaria Prevention Measures

Two key multiple malaria prevention interventions were implemented under the malaria control programme to reduce the incidence of the disease. These were:

1. ***Scaling up the distribution of Insecticides Treated Net (ITN)***

The use of ITN has been shown to be effective against malaria. There has been an increase in the use of ITNs over the period between 2004 and 2006 as depicted by table 4.6. The table also shows the increase in ITN use from 2004 to 2006 by known high risk groups for malaria (children under 5 years and Pregnant women)

Table 4.6 ITN Use by High Risk Category, 2004-2006 (percentage)

	2004	**2005**	**2006**
Children under 5years	9.1	26	32.3
Pregnant women	7.8	26.8	46.3

Source:GPRS (APR) 2006

As poor environmental sanitation also contributes to the high incidence of malaria, closer collaboration between the Ministry of Health and agencies responsible for environmental sanitation in the fight against the disease needs to be strengthened. Currently, through the Cross Sectoral Planning Groups (CSPG) under the National Development Planning Commission, the various Ministries, Department and Agencies (MDAs) have recognized the need to collaborate to improve the health needs of the population which would ultimately help achieve the middle income status by the year 2015, through this collaboration at the CSPG level the various institutions that have their quota in improving the health status of Ghanaians have realized the need to collaborate but the problem is the implementation of the programme since the various institutions have their mandate to accomplish.

2. Implementing intermittent preventive treatment (IPT)

According to the monitoring and evaluation reports, from 1992-1996, malaria accounts for miscarriages and low birth weights among pregnant women. To prevent these poor health outcomes, IPT prescribes chemoprophylaxis for all women during pregnancy. In 2006, all district health facilities implemented IPT policy.

vi. Community-based Health Planning and Services

The CHPS was an initiative aimed at bridging the equity gaps in access to quality health care and removing non-financial constraints to health care delivery through a 'close to client' approach to health service delivery. The CHPS was designed to deliver a specific basic package of services or essential interventions at the sub-district level. Eighteen (18) CHPS compounds were completed in four (4) deprived regions at a cost of 10 billion Cedis from HIPC funds in 2004. This represents improvement on the 15 such compounds constructed in 2003 in two deprived regions.(APR, 2004) Also, the 2003 APR survey reveals that 20 per cent has been achieved and additional 83 zones had been completed of which 26 were in deprived areas.

4.6 Health Related Intervention and Intersectoral Collaboration

The health of the nation requires much more than the delivery of health services. There are many other known determinants of health, which if put together, are probably more

important to health of the nation than just health services: Female education, water and sanitation and poverty reduction. However, the MoH has not invested much time and effort into developing cross-sectoral activities to address these multi -sectoral effort. Sanitary officers that provided services on environmental sanitation have been transferred to the Ministry of Local Government and Environment. No formal arrangement existed for the MoH to actively engage other sectors in health care delivery.

4.6.1 Access to Water and Sanitation

According to GLSS 5, there has been no increase in the period 1996-2000 in the percentage of households with access to piped water or in the percentage of the population (48 per cent in the rural areas) which relies on water from the natural sources and in 2006, 57 per cent of the population have access to piped water. This remains a health related issue to be discussed.(GHS, 2006).

Health inspectors were transferred to the MoLGS in 1995 as part of the decentralization process and strengthening of capacity of managing public health issues. However there is no comprehensive approach to working together for common objectives on access to water and sanitation

Regarding potable water provision, MoH has had very little input if any. However the rural water programmes generally have an education component involving operations and maintenance and health and sanitation. In 2000, a multi –sectoral guinea worm committee has been in operation. The Ministry of Works and Housing and the then Local Government and Rural Development jointly chaired this committee. The committee had made guinea worm 'endemicity' a major criteria for water provision. This committee provides clear lesson that for effective inter sectoral collaboration, it is necessary to identify a clear and definite objective around which the stakeholders can work.

4.6.2 Education

The programme identified female education as the main object for Inter-Sectoral Collaboration (ISC), but not much has been done in this direction. No meeting or

advocacy activities have been organized. An area that has seen some collaborative actions is the School Health Programme (SHEP). Under SHEP, collaborative institutional arrangements were made. A steering committee comprising representatives of various Ministries and agencies was established.

The MoH shared some donor resources with the Ministry of Education (MoE) to run the SHEP. In spite of these, SHEP faced many problems and has not functioned as planned. First, many Ministries and Agencies did not send senior persons to serve on the steering committee, so the steering committee did not have the influence it was expected to have SHEP relied mainly on MoH sources of fund activities .the MoE acted as if it was a problem and programme of MOH .This was compounded by some confusion over whether the MoE or the Ghana Education Service was responsible for supporting SHEP

4.7 Intersectoral Collaboration and Community Participation

Working with District Assemblies was seen as a mechanism for effecting intersectoral collaboration and community participation at the district level. It was noted that many District Directors of Health were active in the social services sub committee of the assemblies and in many cases were secretaries to the sub committee. The District Assemblies also provided assistance in the implementation of programmes such as Expanded Programme on Immunisation (EPI) and Guinea worm Eradication programme.

However, MoH needs to redefine its role in providing health interventions and to re-examine many of the health related issues that impact on health. Such issues may include health impact assessment, providing rural water, wearing seat belts and many others. Many of such issues lie outside the MoH domain. The MoH should consider how its resource allocation can be re-organized to work in partnership towards the achievement of the goal of improving health.

Table 4.7 Government's efforts in involving institutions in policy formulation

Policy formulation	Institutions	Percentage
Good	13	86
Fair	2	14
Bad	0	0
	15	100.0

Source: Author's Field Survey, March, 2008

Table 3.3 indicates that 86 per cent of the institutions surveyed see the Government's efforts as being good. Good in this study implies that, institutions are involved in all areas of policy formulation. This presupposes that the levels of involvements of the various institutions are very recommendable. None of the institutions proposed or rated the government bad in terms of their level of involvement with regard to policy formulation.

4.8 Organisation and Management of the Health Sector

Although, considerable progress had been made in developing district level management capacities and decentralizing health budget management since the inception of the SWAp programme in the 1997, it is however judged that improving the organizational arrangements could still further generate significant efficiency gains.

4.8.1 Ministry of Health

The MoH is the government agency charged with the responsibility of providing overall health policy directions for all players in the country's health sector. Prior to 1997, the MoH in addition to playing its functions was also involved in direct provision of services as well as in the regulation of those services. It was also responsible for the training of staff (Pre –service, post-basic and service training) as well as resource mobilization and disbursement within the sector (The health of the Nation 2006)

The Ministry was unable to perform all of these functions effectively and efficiently. There is the need to reassign them to different agencies with the Ministry of Health retaining the overall responsibility for policy, resource mobilization and monitoring of

outcome of health care interventions. What is envisaged ultimately is that there is a purchaser-provider split with the Ministry of Health as the purchaser and regulator of service provision.

During the SWAp period, a team was formed by the office of the head of civil service to examine critically functions of the MoH and their new role that they to play under the reorganization of the sector. Subsequently, the Director of Traditional medicines was added to the four divisions proposed by the team.

Generally, the Ministry is grouped into five agencies, namely the government sector, the quasi governmental, private and traditional system and other health related sectors. The government agencies consist of the Teaching Hospitals and the Ghana Health Service set up under Act 525 and quasi governmental organizations.

With regard to the Ghana Health Service, it has a Governing Council, a Director-General and a Deputy Director General. The service has the process of appointing Headquarters and regional directors. It also has a legislative instrument to implement Act 525.
The outstanding organizational challenge of the GHS is to develop its corporate identity as a provider of service especially primary and secondary service. At the national level because the MoH is not fully established and appointment of its directors is not as quick as it is supposed to be, the GHS has found itself managing the MoH. The directors at the national level have been performing the work of the Ministry in ways that compromise their own work as an agency charged with service provision. (GoG, 2006).

4.8.2 Private Sector.
Private providers are made up of NGOs that provide essential public health services such as family planning services, the mission institutions that are essentially curative service providers but also provide public health services, and the private for profit organizations that are predominantly curative based.

4.8.3 Traditional Medical Providers

Traditional and herbal remedies constitute the first line and commonly the only source of treatment for most Ghanaians. Consequently, the objective of the strategy was to promote traditional medicine, make them safe and integrate the service into the allopathic health system.

The Traditional Practice Act, 2000 (Act 575) was passed and the Traditional Medicine Practice Council and Traditional Medicine Directorate have been established. The center for Scientific Research into Plant Medicine (CSRPM) increased its testing and manufacturing activities. The result is that several herbal trials have been conducted on herbal preparations claimed to be effective against HIV/AIDS. The test are not yet not totally conclusive. However, overall progress towards mobilizing the potential of private providers to contribute to the government's policy objectives in a coherent way has been slow. The commissioning arrangements developed are poorly specified and inadequately managed (GoG,-2006).

4.8.4 Managing Planning and Budgeting

At the onset of the SWAp programme, overall capacity for planning and budgeting was thought to be weak (The health of the Nation 2001). Other outstanding issues identified included the fact that budget ceiling did not incorporate donor funds. There was still over-centralization particularly in the use of donor funds. Also plans were insufficiently linked with budgets.

The SWAp identified planning and budget as a key component of the common Management Agreements and stressed the need for capacity building in this area. It also emphasized linking planning and budget to policy development, performance monitoring and evaluation.

In the years of implementation of SWAp substantial progress has been made in the overall capacity for planning and budgeting within the sector. The introduction of the Budget and Management Centre (BMC) concept and full decentralization to BMCs of

decision-making in relation to a proportion of donor funding (i.e. funding channeled through the pooled fund) has led to a more operational linkages between plans and budgets.

Health sector planning and budgeting capacity has been further enhanced by a wider Government of Ghana (GoG) public sector reform. Specifically, the GoG introduced a Public Financial Management Reform Programme (PUFMARP) in 1996 and the Medium Term Expenditure Framework (MTEF) programme was launched 1997. MoH was selected as one of the pilot ministries and benefited from several training programmes. Other still outstanding issues include weak output-budget management allocating or linking budget to sector priorities, and improving budget predictabilities. (GoG, 2001).

4.9 Co-ordination of Development Partners

In 1997, the health development partners agreed on a new common funding mechanism of the health sector through a pooled funding system placed under government management. To facilitate and support the effective implementation of the first five- year programe of work, the government of Ghana and co-operating partners jointly decided that the collaboration, withdrawal and use of fund for the programme would be guided by the provisions in a memorandum of understanding and a Common Management Arrangements. Results of this arrangement indicate an improved flow of information, management cost and financial management of both government and donor funds.

Achievement of the partnership can be found in a strengthened planning and budgeting and further decentralization of management. There were unified and a standardized disbursement procedure that reduces transaction cost. Procurement capacity was strengthened and procedures standardized. Uniform financial accounting procedures were introduced and implemented. Performance of the programme was jointly monitored and improved co-ordination through MOH/partner activities.

A second five-year programme of work 2002-2006 was developed and it was a continuation of efforts at re-engineering the health sector and build upon the Sector wide

Approach (SWAp) as initiated in the first programme of work 1997-2002. By these arrangements all development partners and technical agencies of the MOH supported a single policy, common sector programme and agreed expenditure under the leadership of the Government of Ghana.

The relationship between the MoH and development partners has evolved from the development of the health strategies. The arrangements for sustaining this relationship were articulated in the management arrangement for implementation of the SWAp programme, the memorandum of understanding, and the code of practice for Ministry of Health and development partners. A strong arrangement for policy dialogue has been achieved, manifested by summits, meetings between the MOH and development partners. The proportion of donor allocation into the health fund continues to increase and donor reporting has also improved. Substantial progress had been made to establish joint management arrangement including joint reviews and monitoring and joint auditing.

A substantial proportion of fund for health sector activities is still outside the Health Fund. The management of technical assistance still remains donor driven. Lessons have been learnt about building partnerships with development partners, but less has been learnt about building partnerships with local Non-Governmental Organizations (NGOs), civil society and other sectors. The emphasis needs to change.

Table 4.8 Areas of Government's efforts in improving health

Policy implementations	Institutions	Percentage
Good	14	93
Fair	1	7
Bad	0	0
Total	15	100.0

Source: Author's Field Survey, March, 2008

With regard to Government efforts in involving the various institutions in policy implementations, 93 per cent responded 'good'. Good in terms of this study represents

the situation where all institutions are adequately involved in the all areas of policy implementation right from the beginning to the end. This shows that the quarterly hearing of the stage of the SWAp is very effective because for 93 per cent to respond good it means that their contributions during the hearing are imbibed in the implementation process.

However in the case where 7 percent responded "fair" representing some level of communication with institutions but basically are involved after policy has been formulated. It is however a relief to note that at least all institutions are informed one way or the other in policy formulation.

It must however be stated here that even though 7 percent are not fully involved is does not do augur well for the full development of the SWAp. There is the need to make sure that all related institutions are well informed and involved in the whole process of policy formulation and implementation especially so as to ensure the overall achievement of health goals.

4.9.1 Financing the Health Sector

Prior to 1997, the decline in the national economy meant that, overall resources available to the health sector from government were shrinking in real terms. For 10 years (between 1985 and 1995), government allocation to the Ministry of Health was approximately $6 per capita per year compared to $10 per capita in 1978. (GoG, 2006) Donor funding to the sector had increased substantially from 25 per cent of the total public health budget prior to 1992 to 30 per cent in 1994. However, donor funds were uncoordinated and tied to specific programmes and capital inputs, which do not reach operational levels. The chanelling of the funds also created parallel management systems and disrupted overall systems development.

In order to increase the government financial support to the Ministry of Health, the GPRS I committed the Ministry of Health, and re-allocated the resources within the Ministry in favour of the deprived regions. A plan was developed to respond to this initiative. Based

on this the government was committed to removing financial barrier to treatment due to out of pocket payments at point of service. Prepayment mechanisms were developed to replace fee for service. The exemption scheme to take care of the vulnerable was reviewed to make it more accessible.

Resource allocation to the health sector has increased over the years, with increasing shift from the center to the district level. However, a number of issues have emerged as a result of the changing environment. The following were some of those issues:

1. Although the expenditure target during the SWAp implementation had been met, it was through unanticipated sources-that is, Internal Generation Fund (IGF) and commercial loans, and not as intended through an increase in sector –wide fund expenditures over the years.
2. Ghana has accepted the HIPC status but initial reviews do not indicate any substantial additional resource to the sector.
3. The MoH is yet to design more rigorous resources allocation formulae that will address health inequalities, gender, deprived areas, and poverty issues.

In improving the efficiency of financial management, a management accounting system for internal use and a financial statement analysis for external purposes were developed and quarterly and annual financial statements which on strategic analysis of key trends were also developed.

Also, in enhancing capacity for financial management and utilization of resources, a mechanism was developed to retain existing staff; review the requirements of stakeholders and agree on the redesign of the financial statements (taking into account the on-going design of the sectors management information system).

However, accounting personnel were subject to periodic transfers made by the Controller and Accounting General, affecting the willingness of MoH to train accounting staff for fear of losing them, and also delay in government of Ghana's cash flow to BMCs have hampered the implementation of planned activities.

Table 4.9 Specific health financing by sources 1997-2006 (US$ million)

Year/ Source	1997	1998	1999	2000	2002	2003	2004	2005	2006
GOG	68	85	65	69	63	71	80	91	103
IGF	13	14	15	14	14	16	17	19	20
DONORS	28	24	31	N/A	60	60	60	60	60
CREDITS	50	32	10	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL	159	155	129	114	137	147	158	170	183

Source: GoG 2002 - 2006

Table 4.7 shows that the financial contributions made by the donors from the 1997 to 2000 have been increasing but at inconsistent levels.This could be attributed to the fact that the donors were not very sure about the outcomes of the initial SWAp approach in the country and therefore they were very careful in committing their resources to a venture that they were not very sure of the outcomes.

The table also shows that, the contribution of the government from 1997 to 2006 has been higher than the donors. This shows how the government is committed to improving the health care of her people. It is also indicated from the table that the financial support by borrowing has also been stopped which may be attributed to the fact that there is quite enough financial resources for the health sector .

The table also indicates the plateau level of the contribution of the donors from 2002 to 2006. This is because the donor community support to the health sector of $300 million for the 2002 to 2006 was released in tranches of the five year period. The government of Ghana's contributions has also increased considerably from the 1997 to 2006, and because the government sees the importance of the health sector to the achievement of the middle income target by the year 2015.

Table 4.7 indicates that the IGF proportion of the health sector is not encouraging. This means that insignificant efforts are being made by the GHS to improve the IGF. It was also found out that some personnel divert the proposed funds to unidentified areas. With the inception of NHIS this practice must be looked at seriously.

Table 4.10 Areas of Contributions by the Development Partners

Areas of contributions	Institutions	Percentage (%)
Technical Support	16	35
Financial Support	20	44
Material Support	10	21
	46	100.0

Source: **Author's Field Survey, March, 2008**

Table 3.5 shows that all the development partners contribute more than one in terms of the areas of contribution. The dominating areas of contributions are mostly found in technical (expertise) and financial support. Amongst the two areas, financial support is the area where majority of the support emanates from.

4.10 Prospects and Challenges of SWAp Initiatives in Ghana

The positive gains of the SWAp initiative in Ghana which has been implemented from 1997-2007 are based on the positive factors that exist both within and outside the country that has promoted the initiative. These prospects as well as the challenges that could cripple the success of the initiative are discussed in this section.

4.10.1 Prospects

1. The ideals of the SWAp initiative indicated that the country has a sense of ownership in the programme, which they see as their own. This is because the outcomes of the programme are strongly felt in the country which are exhibited in the current health status in the country. The needed structures are also provided with the help and support of the government

2. The existence of a well structured Ministry of Health can sustain the expansion of the programme if the need be. The qualified and competent staff that helped in the implementation of the programme still sees it as a laudable move by the initiators.

3. All the development partners are still willing to contribute to the programme and are fully prepared to increase their contributions if their resources would permit them to do so. The effects of the programme have been stretched to other sectors especially the Ministry of Food and Agriculture.

4. National Health Insurance Scheme (NHIS) - The introduction and acceptance of the National Health Insurance Scheme in the country will impact positively on the health seeking behaviour of the people in the country which has a long term effect of bridging the health inequality gaps in the country. More people are now willing to access health since by registering and paying their premiums, their health needs are readily met and they do not have to pay out of pocket when they seek medical attention.

5. Government acceptance and support - SWAp has been identified by the government as a strategy for reducing health inequalities and increasing access to health services. SWAp therefore enjoys government support for its successful implementation. The initiative is also in line with the Government's manifesto of improving the health status of Ghanaians.

6. Support by Government of Ghana - Political leaders at all levels are committed to health sector reform. In 1996 an act of Parliament created the Ghana Health Service (GHS) as an extra-ministerial agency that is outside the civil service, freeing the health sector to change, innovate, and reform health care operations in Ghana. This flexibility enables the GHS to utilize research for guiding innovation with research activities.

4.10.2 Challenges

1. Malaria is one of the leading causes of death in Ghana. This is largely due to the inadequate education on effect of bad water and sanitation practices.

2. There is a challenge of high maternal mortality ratios in the country .This problem is more acute when one categories the maternal mortality ratio on regional basis.

3. There is the issue of HIV/AIDS pandemic which now poses a major threat to health and development even though its prevalence rate has reduced from 3.6 per cent to 3.2 per cent in Ghana. (Ghana Aids Commission, 2008)

4. Many of the activities that would help improve health status of Ghanaians lies outside the domain of the Ministry of Health. A typical example is the issue of provision of water and sanitation.

5. The plateau level of contributions by the development partners are mostly due to the commitment to other areas and the changed focus of the new government. This was a contributing factor to the problems of the Uganda SWAp challenge.

6. The high level of development partners' influence on health spending might have macroeconomic instability of the Ghanaian economy. Among the risks are: appreciation of the cedi, causing difficulties for exports; increased interest rates (and decreased volume) for private investments caused by the need to neutralise the inflow of foreign exchange; a resulting long term deceleration in GDP growth; and inflationary tendencies due to demand on key staff and key materials in the economy. This was among of the challenges faced by the Ugandans during their implementation of the SWAp programme.

Table 4.11 Challenges of SWAp

Areas	Institutions	Percentage (%)
HIV/AIDS Pandemic	30	35
Malaria	30	35
IMR/MMR/U5MR	14	16
Other commitments by the development partners	12	14

Source: Author's Field Survey, March, 2008

Table 3.6 shows that HIV/AIDS and Malaria are the major threat to SWAp. Therefore, more efforts are needed to be made by the Government to curb this anomaly. These therefore pose serious threat to the achievement of the SWAp. Also, it is clear that the major development partners have other commitments. This is reflected in their financial support from 2002-2006 being in the plateau level.

For these reasons there is the need to ensure that these challenges are addressed to the latter so as to ensure a successful implementation of the SWAp with no or very little challenges. A conscious effort must be made therefore to ensure that all related issues that matter in the establishment of the SWAp to its full capacity is achieved.

FINDINGS, RECOMMEDATIONS AND CONCLUSION

5.1 Introduction

This chapter builds up from the previous one by looking at the findings obtained from the analysis of the field data in the light of the research questions as well as the objectives of the study. This chapter brings out the key findings of the study and appropriate recommendations to address these findings as well as conclusion. The recommendations when addressed will help improve the health status of Ghanaians which will ultimately lead to the attainment of goals of the government that is stated in the Growth and Poverty Reduction Strategy document (2006-2009). The research findings and recommendations have been presented according to the objectives outlined in the research.

5.2 Research Findings

Current Health status of Ghanaians

- HIV/AIDS is still a major challenge to health and development which invariably is a threat to the attainment of health sector goals.

- In Ghana, malaria is the single most important cause of mortality and morbidity especially among children under five years and pregnant women. It is indicated that only 55 per cent of the population have access to adequate sanitation with marked regional variations.
- Although progress in the under five mortality has been very slow with the reduction rate of 119 per 1000 live births in 1993 to 111 per 1000 live in 2006 it is worst when one disaggregates the figure to spatial dimensions (northern and the southern part of the country), the under five mortality is 60 per cent higher in rural areas, 7 per cent higher among male children, and 2. 2 times as much in children of women with no education as in those of women with secondary or higher education.
- The education on HIV/AIDS has been thoroughly done but still the infection rate is quite unacceptable especially among the young adults (25-29 years) which poses threat to the achievement of the Millennium Development Goal of combating HIV/AIDS, malaria and other diseases by 2015.

Intersectoral collaboration

- The health sector has not adequately exploited the potential for non-government and intersectoral action on the key determinants of health such as the poverty, educational status (particularly of women and girls), access to water and sanitation, development of access roads and prevention of road traffic accidents, as well as community development. This should be identified by the NDPC during the CSPG meetings so as to coordinate the activities of these stakeholders.

Organisation and management of the health sector

- The passage of Act 525 provided for the creation of a Ghana Health Service and Teaching Hospitals. This created the building blocks for the new sectoral arrangement in terms of the MoH (as purchaser), GHS and the autonomous teaching hospitals (providers) and the statutory bodies (for regulation). The relative roles, responsibilities and relationships arising from this split are not clear.

- Substantial progress has been made in strengthening management support systems and improving budget management within the sector. The BMC concept has become firmly established within the health sector and there has been strategic investment in capacity building in the areas of planning and budgeting, financial management, procurement and monitoring and evaluation. The linkage between the individual systems (that is, between planning, procurement and financial management) is weak.

Relationship of the various Development Partners and the Health Sector

- Since there is a strong policy dialogue between the MoH and its agencies and other development Partners
- There is an increasing accountability and annual hearing sessions on performance of partners. This makes the programme transparent to all the development partners. There is no wonder the development partners contribute to the health needs every year since the inception SWAp (1997-2007)

- Development partners bring on board the various help to the MoH in the form of both technical and financial support to sustain the programme and this has yielded the positive results of the programme.

Prospects and Challenges of SWAp

- The strong ownership by the government of Ghana and the development partners support of the programme makes it highly sustainable
- MoH is appreciating the existence of traditional and herbal health medicine more than before. This is more manifested in the passing of Traditional Practice Act, 2000 (Act, 575) and also adding them into the activities of the Ministry.
- Since the National Health Insurance Act (2004) Act 650, has been enacted and a legislative instrument LI 809, has been passed, the national health insurance authority would be more independent and the necessary efforts would be made for its sustainability.
- Malaria and HIV/AIDS are still the problems in the health sector even though there are still some on-going efforts of reducing the menace, they still need to be looked at again.

5.3 Recommendations

Health gains (the state of the health status)

1. In order to bridge the inequality gap there is the need for the government to institute a comprehensive approach to health care development which addresses issues like poverty, gender as well as tackling major diseases such as HIV/AIDS, other communicable diseases and emerging non-communicable diseases in the drawing up of the next development framework
2. More efforts are needed to be made by MoH (GHS) to reduce the maternal mortality ratio in the country. More gynecologists need to be trained and refresher courses should be organized for those who are already in the profession before 2015.
3. The hands-washing campaign needs to be intensified and sustained by the various Districts to educate more people, together with health education to reduce the

incidences of malaria, diarrhoea and intestinal worm infestation diseases to the barest minimum, if not completely eradicated by 2010.

Intersectoral collaboration

To address the shortfall in the intersectoral collaboration problems stated in the findings, a new approach to influencing the determinants of health by working with other sectors is required. The NDPC and MoF need to:

1. Broaden the core business of the health sector to include intersectoral advocacy and action;
2. The government must develop new mechanisms and strategies to achieve effective intersectoral collaboration at the national, regional, district and local level and building of alliance around common concern in the drawing up of the next development framework;
3. Formulate explicit strategies and output for advocacy by the health sector to achieve carefully targeted investment in health-related sectors such as water, sanitation, education, food and agriculture, social welfare, road transport and economic development (in the context of national development strategy).
4. Intensify impact assessment and monitoring of other sector policies and activities on health needs.

Organisation and management of the health sector

1. The Government should clarify and strengthen the purchaser-provider roles and relationships between the MoH, GHS and Teaching Hospitals and further develop capabilities in service commissioning, regulation and monitoring and evaluation.
2. The Ministry of Health should improve the linkage between the management support systems and strengthen the linkage between sector investment and service delivery requirements
3. Ghana Health Service should strengthened investment analysis within the health sector by assessing the recurrent cost implication of all future infrastructure, human resource and service investment

4. Sustain the experience gained under the SWAp and expand participation to include other stakeholders in other sectors of the economy.

Relationship of the various Development Partners and the Health Sector

- The government should sustain the strong policy dialogue between the MoH and its agencies and other development Partners in order to improve the health of Ghanaians
- More efforts should be made by the MoH to improve the increasing accountability and annual hearing sessions on performance of partners so as to continue increase their contribution to the sector.
- Technical supports should be encouraged more from the development partners so that the Ghanaian health professional would learn from them in order to improve on the health status of Ghanaians.

5.4 Conclusion

SWAp is a participatory process of a sector-wide health system change and development that aims to provide accessible health care to all communities in Ghana, through the promotion of health interventions and actions designed to make people healthy and stay healthy; and to bridge the inequality gap between urban and rural areas.

The implementation of SWAp in the country, though some prospects exist, is plagued by some challenges. The benefits of the National Health Insurance Scheme coupled with close-to-client service provision has helped to reduce 'downtime syndrome' (delaying patients at home) and encouraged patronage of health services.

Also, SWAp enjoys government and other development partners' support as a strategy for reducing health inequalities and increasing access to health services. Some of the challenges facing the successful implementation of SWAp are the causes of apparent surge prevalence rate of HIV/AIDS from 2.7 per cent in2005 to 3.2 per cent in 2006 which is needed to be investigated and measures developed to reverse this trend on a sustainable basis.

Some of the challenges facing the successful implementation of SWAp are the brain drain and staff attrition even though this is not an objective of this research; it is a phenomenon that runs through all the issue.

The most enthusiastic promoters of SWAp are strong government supports, development partners' support and the workers in the health sector who have experienced its approach and have developed a new found pride in their capacity to serve the sector. In order to accelerate access to quality health services, the health sector will have to continue deepening efforts and focus on the three broad policy objectives of bridging the equity gap in access to quality health and nutritional services; ensuring sustainable financing arrangements that protect the poor; and enhancing efficiency and coverage in service delivery.

In promoting health and preventing diseases and injury, it is clear that the health sector cannot do it alone. It is also evident that the activities of some sectors impact directly or indirectly on the health sector and if these activities are not well coordinated the impact on health would not be felt. This therefore presupposes that there is the need to synchronize the entire Ministry, Department and Agencies and other institutions to involve themselves into the activities of health SWAp in order to improve the health status of Ghanaians.

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KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TE CHNOLOGY

COLLEGE OF ARCHITECTURE AND PLANNING

DEPARTMENT OF PLANNING

RESEARCH TOPIC: AN ASSESSMENT OF SECTOR WIDE APPROACH (SWAP) IN ATTAINMENT OF HEALTH SECTOR GOALS IN GHANA

I am an MSc. Student from the Kwame Nkrumah University of Science and Technology, carrying out a research on an assessment of Sector Wide Approach (SWAp) in attainment of Health Sector Goals in Ghana. The information is purely for Academic purposes in partial fulfillment for the award of MSc. Development Policy and Planning.

QUESTIONNAIRE FOR MINISTRY OF HEALTH

1. Name of respondent .....
2. Position of respondent.....
3. What is the vision of the Ministry .....

.....

.....

4. What is the mission of the ministry

.....

.....

5. What are the goals/objectives of the ministry

.....

.....

.....

6 What is the level of achievements of the Ministry's goals/objectives?

.....

.....

.....

.....

6. How is the health sector organized?

.....

.....

.....

7. What have been the trend of the health status of Ghanaians since the inception of SAWp with regards to:

Infant mortality .....

.....

Maternal mortality rate .....

.....

Malaria infection .....

.....

HIV/AIDS prevalence rate.....

.....

Doctor patient ratio.....

.....

Nurse-Patient ratio .....

.....

Waiting time.....

.....

.....

Average travel time to access health facility.....

.....

8. What have been the efforts of the government in improving health delivery since the inception of Health SWAp with regards to:

Policy formulation .....

.....

Policy implementation .....

.....

Health financing .....

.....

9. What are the reasons behind the inter sectoral collaboration for SWAp?.....

.....

10. What are the goals/objectives for the SWAp?.....

.....

11. What have been the levels of achievements of these goals?

.....

.....

.....

12. Who are the stakeholders of the SWAp.....

.....

13. What are the criteria for joining the SWAp?.....

.....

14. How has the SWAp helped in the achievement of the health sector goals with regard to?

Technical support (expertise).....

.....

Financial support.....

.....

Material support.....

.....

12. How has the approach helped in bridging the inequality gap in access to health services?

.....

.....

.....

13. What has been the trend in the contribution level?

.....

.....

.....

.....

14. What accounts for the trend?

.....

.....

.....

15. What institution(s) manages the fund?

.....

.....

16. What are the criteria for accessing the fund .....

.....

.....

17. What role does your institution play in the management of the fund?

.....

.....

.....

18. What are the management problems?

.....

.....

.....

.....

19. What are the possible solutions to the above (12) problem(s)?

.....

.....

.....

.....

20. What have been the successes so far?

.....

.....

.....

21. What have been the challenges of the SWAp so far?

.....

.....

.....

22. What do you think should be done to improve on this approach (SWAp)?

.....

.....

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QUESTIONNAIRE FOR DEVELOPMENT PARTNERS

1 Name of institution.....

2 Name of respondent .....

3 Position of respondent.....

4 What is the vision of your institution? .....

.....

.....

5 What is the mission of your institution?

.....

.....

6 What are the goals/objective of the institution?

.....

.....

.....

7. What sector(s) do your institution focus (es) on?.....

.....

8. What are the reasons for joining the SWAp?.....

.....

9. How do you contribute to the SWAp?

a) Financial

b) Technical

c) Both

10 What is the level of contribution from your institution?.....

.....

11 What have been the trend of your contribution?.....

.....

12 What account for this trend?.....

.....

13 How is your institution involved in the annual drawing of SWAp plans?

.....

14 What has(have) been your role(s)in the management of the fund.....

.....

15. What have been the management problems that the fund has encountered....

.....

16. What are the possible solutions to the above problems?

.....

.....

17 How has the SWAp helped in the achievement of your institution's goal?

.....

.....

18 How has SWAp helped in the achievement of national health sector goals?

.....

.....

19. How do your institution see the leadership strategies/approach in sustaining the programme.....

.....

20 What is the level of involvement with regard to the monitoring of SWAp projects and programmes?

.....

.....

21. What are the set (draw) backs in the institution's efforts in monitoring SWAp Projects and programmes?

.....

.....

22. What is the level of involvement with regards to the evaluation of SWAp projects

.....

.....

23. What are the set backs in the institution's efforts in evaluating the SWAp projects

24. What have been the successes of the implementation of SWAp projects?

.....

.....

25. What are the prospects of SWAp.....

.....

26. What are the challenges of SWAp?.....

.....

27 What new ideas do your institution think will help improve the SWAp?.....

.....

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QUESTIONNAIRE FOR MINISTRY OF FINANCE AND ECONOMIC PLANNING

1 Name of respondent .....

2 Position of respondent .....

3 Who are the various stakeholders for the health sector SWAp?

.....

.....

.....

4 What have been the trend of financial contribution of SWAp from:

The government .....

.....

The NGO's .....

.....

The Development Partners .....

.....

5 What account for this trend?

.....

.....

.....

7. What is the system of ensuring accountability?.....

.....

.....

8. What are the common reporting systems used for the health sector SWAp?

.....

.....

11. How is your institution involved in the annual drawing of SWAp plans?

.....

12 .What has been your role in the management of the fund.....

.....

13. What have been the management problems that the fund has encountered....

.....

14. What are the possible solutions to the above problems?

.....

.....

15. How has SWAp helped in the achievement of national health sector goals?

.....

.....

16. How has the change in the ministerial appointment affected the implementation of SWAp plans?.

.....

.....

17 What is the level of involvement with regards to the monitoring of SWAp projects

.....

.....

18. What are the set backs in the institution's efforts in monitoring SWAp projects

.....

.....

19. What is the level of involvement with regards to the evaluation of SWAp projects

.....

.....

23. What are the set backs in the institution's efforts in evaluating the SWAp projects

.....

.....

24. What have been the successes of the implementation of SWAp projects?

.....

.....

25. What are the prospects of SWAp.....

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26. What are the challenges of SWAp?.....

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27 What new ideas do your institution think will help improve the SWAp?.....

.....