



MINISTRY OF HEALTH
REPUBLIC OF GHANA

HEALTH SECTOR ANNUAL PROGRAMME OF WORK

2022 HOLISTIC ASSESSMENT REPORT

MAY 2023

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ACRONYMS AND ABBREVIATIONS

ABFA	Annual Budget Funding Account
AFP	Non-polio acute flaccid paralysis
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
BCC	Behaviour Change Communication
BMCs	Budget and Management Centres
CAGD	Controller and Accountant General's Department
CAPEX	Capital Expenditure
CDR	Case Detection Rate
CFR	Case Fatality Rate
CHPS	Community Health Based Planning and Services
CYP	Couple Year Protection
DHIMS 2	District Health Information Management System
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunisation
EPRP	Emergency Preparedness and Response Plan
FDA	Food and Drugs Authority
FP/RH	Family Planning and Reproductive Health
GES	Ghana Education Service
GHS	Ghana Health Service
GoG	Government of Ghana
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
HSMTDP	Health Sector Medium-Term Development Plan
HSWG	Health Sector Workers Group
IALC	Inter-Agency Leadership Committee
IGF	Internally Generated Fund
IPEP	Poverty Eradication Programme
MHA	Mental Health Authority
MoF	Ministry of Finance
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NCD	Non-Communicable Diseases
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OPD	Outpatient Department

PLHIV	People Living with Human Immune Virus
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
POW	Programme of Work
RDTs	Rapid Diagnostic Tests
SDGs	Sustainable Development Goals
UHC	Universal Health Care
WHO	World Health Organisation
WIFA	Midwife to Women in Fertility Age

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EXECUTIVE SUMMARY



The 2022 Holistic Assessment marks the beginning of performance tracking of the 2022-2025 Health Sector Medium-Term Development Plan (HSMTDP). The HSMTDP has three main policy objectives to help speed up implementation of the Ghana Universal Health Coverage (UHC) Roadmap and progress towards attainment of the related SDG3 targets. A new Holistic Assessment Tool has been developed in line with the new 4-year HSMTDP and was used to conduct this year's performance assessment. Key findings of the 2022 Holistic Assessment are summarised and presented under each of the three policy objectives below:

Policy objective one: universal access to better, efficiently managed high quality primary health system

- Outpatients visit decreased from 34.8 million to 33.4 million (4%). Consequently, the OPD per capita decreased from 1.13 to 1.06 over the same period. There was much variation (3.6 times) between the region with the highest OPD per capita (Western North) and the one with the lowest OPD per capita (Northern).
- Government budget allocation to the sector increased from 8.53 billion to GHS10.75 billion (26%). As of September 2022, 73.2 % of the approved budget had been released to the Ministry.
- Per capita spending increased from GHS275.68 (\$47.38¹) to 341.58 (\$40.44²) between 2021 and 2022.
- NHIS population coverage increased marginally from 54.4% to 54.5%, mainly caused by coverage increases in five regions (Upper West, Bono, Ahafo, Bono East, and Upper East), which recorded more than 70%.
- Proportion of revenue used to settle health care provider claims declined marginally from 60.5% to 60%.
- Doctor-to-population density declined from 0.18 to 0.17 doctors per 1,000 population (or 1.8 to 1.7 doctors per 10,000 population) between 2021 and 2022. There are more doctors concentrated in the two most urbanised regions, Greater Accra, Volta, and Ashanti recorded higher doctor-to-population ratio (≥ 0.16).
- Nurse to population ratio increased from 1.89 to 1.99 nurses per 1,000 population. Half of the regions recorded higher nurse-to-population density than the national density of 1.99 per 10,000 population.

¹ Average exchange rate in 2021 was USD1.00=GHS5.82

² Average exchange rate in 2022 was USD1.00=GHS8.45

Policy objective two: reduce avoidable maternal, adolescent and child deaths and disabilities

- Proportions of pregnant mothers making at least 1+ and 4+ antenatal care visits; receiving skilled delivery; and accessing postnatal care have assumed a downward trend.
- Proportion of births attended by skilled health personnel decreased from 65.7% to 65%. Nonetheless, the proportion of births attended to by skilled personnel in the northern part of the country (Upper East, Northern, North East, and Upper West) is higher (>70%) than in the other regions.
- Maternal deaths reported at the various healthcare facilities declined from 109.2 to 102.6 deaths per 100,000 live births in the year under review, representing 14.14%. However, the more urbanised regions (Greater Accra and Ashanti) recorded higher maternal deaths than the other regions.
- Under-five mortality rate declined from 10.7 to 9.8 deaths per 1,000 live births. However, the regions in the northern sector of the country, particularly North East, Northern, Bono East, Upper West, and Bono recorded higher under-five mortality rates (>11 deaths per 1,000 live births).
- Neonatal deaths declined from 7.6 to 6.5 lives per 1,000 live births in the year under assessment. However, five regions (Greater Accra, Eastern, Ashanti, Bono East, and Volta), recorded more than 7 deaths per 1,000 live births in the year under review.
- There was a general improvement in Midwife-to-WIFA population rate (per 1000 women) from 1.46 to 3.09, and this is seen across all the regions.
- Prevalence of underweight among the under-five year group declined by 8.12% whilst stunting increased by 7.14% in the assessment year.
- Adolescent pregnancy rate (per 1,000 women) among the 10-19 years declined marginally from 15.9 to 14.6 in the year under review. It was lower among the 10-14 years group (<1.0 per 1,000) than the 15-19 years group.

Policy objective three: increase access to responsive clinical and public health emergency services

- Number of emergency cases responded to decreased whilst the case response time improved from 22.43 to 20.27 minutes in the year under review. The Bono region recorded the best emergency case response times of 14:28 whilst the Western region posted the worst emergency case response time of 24.26 minutes.
- Number of beds available for admission in the hospitals increased from 31,775 to 33,249 (4.6%) between 2021 and 2022. This translates into 1.1 beds per 1,000 population. There were more hospital beds in Upper West region (1.4 per 10,000 population) than in the Oti region (0.7 per 10,000 population).
- Percentage of beds occupied by patients increased from 56.1% to 59.0% (2.9 percentage points difference), indicating that a little over 50% of available beds were utilised.
- Average length of stay in emergency wards showed an improvement; it decreased from 3.3 to 2.3 days in an emergency ward.

- Number of persons accepting to use modern family planning methods increased from 2.5 to 2.7 million (8.8%) between 2021 and 2022, bringing the family planning acceptor rate to 36.1%. The acceptor rate is highest in the Ahafo region (50.2%) and lowest in the North East region (21%).
- New malaria infections per 1,000 population declined from 341 to 178 (52%) over the last five years (2018-2022). The year under review saw decline of 1.13%. The Upper East region recorded the worse malaria incidence of 349.2 per 1,000 population whilst the Greater Accra region posted the best of 38.2 per 1,000 population.
- The HIV incidence rate (new infections) declined marginally from 0.67 to 0.53% whilst the prevalence rate (new and old infections) increased slightly to 1.66% in the year under review.
- There was an improvement in the percentage of HIV positive individuals who knew their status (from 72% to 77.5%) in the year under review. However, the percentage of those who were on treatment decreased from 99% to 80.9% and those who had their viral dose suppressed went down from 95% to 68%.
- New TB infection per 100,000 population (incidence rate) went up by 9.1 percentage points difference over the last five years and 9.5 in the year under review.
- TB detection rate increased from 33% to 36.7% (3.7 percentage points difference) in the year under review after a consistent decline between 2019 and 2021. TB treatment success rate, however, did not improve in the year under review. it stagnated at 87%.
- The number of blood donation per 1,000 population increased marginally from 5.7 to 5.8 donations per 1,000 population. The Upper West region recorded the highest rate of 10.7 donations per 1,000 population whilst the Bono region posted the lowest of 2.8 donations per 1,000 population.

These findings translate into an overall health sector performance score of 0 on a scale of -3 to +3, indicating a “**fairly good**” performance. Clearly, there is a lot of work to be done to accelerate progress towards attainment of UHC by 2030. In addition to the sector-wide supportive monitoring and joint monitoring with development partners, we plan to have regular Health Sector Workers Group (HSWG) and Inter-Agency Leadership Committee (IALC) meetings to track progress of implementation of the health sector plan, Aid Memoire, and other ongoing interventions to help achieve set targets and objectives. Therefore, we implore Heads of Agencies and Development Partners to continue to collaborate and double their efforts for improved sector performance in subsequent years.



KWAKU AGYEMAN-MANU (MP)
MINISTER FOR HEALTH

1.0 INTRODUCTION

This report presents performance assessment of the health sector for the year 2022 with respect to implementation of programme of work. It represents the final stage of an intensive bottom-up review process for the Agencies of the Ministry of Health (MoH). The report was prepared by a Holistic Assessment Team, comprised of technical staff from selected Agencies of the MoH. The team assessed performance of the health sector using a set of indicators and a Holistic Assessment Tool, a scientific tool developed by the MoH together with its stakeholders.

This report is organised into five sections. Section one provides a background to the report. Section two discusses performance of the sector by objectives of the 2018-2022 HSMTDP; Section three presents the financial performance of the health sector; Section four provides updates on implementation of the 2021 Aide memoire; and Section five provides progress report on COVID-19 pandemic.

1.2 Performance Review Process

The MoH performance review employs a bottom-up approach to assess performance of the sector. It starts from the districts through to the regions and then to the national level, where strategic policy directives are discussed and reviewed. The overarching aim of the performance assessment is to measure and report on progress of the health sector using agreed set of core indicators and standardised tools. The review process forms part of the accountability agenda, and it starts from the Budget Management Centres (BMCs) through to the national level. The detailed process is elaborated below:

BMC performance reviews

This is the first step of the review process which is undertaken between January and February. At this stage, all Agencies of the Ministry ensure that all Budget and Management Centres (BMCs) under their supervision review their performance against targets set for the year using routine data generated from the health delivery system, as well as relevant research studies. The BMC reviews provide input into a district review and subsequent regional reviews.

Inter-Agency and Partners' reviews

The Inter agency and partners review is organised by the MoH for Agencies and Development Partners to share their experiences and assess performance of the sector. Prior to this meeting, all Agencies hold technical review meetings as part of preparations for the meeting. The inter- agency and partners review meeting provides opportunity for Heads of Agencies to answer for their stewardship. It also provides opportunity for Development Partners to review their financial and technical contributions to the health sector and present their reports to the Minister of Health.

Holistic assessment of the health sector

At the end of the year under review, a holistic assessment of the sector is carried out by either key personnel of the Ministry or an independent assessor who will provide an independent opinion on the extent of achievement of the health sector programmes of work. Several tools are used to conduct this performance assessment of the sector. The algorithm for scoring the various indicators under each of the four policy objectives is shown in the Appendix.

The annual operational plan or Programme of Work (POW), derived from the Health Sector Medium-Term Development Plan (HSMTDP) forms the basis for this assessment. All these review processes and assessment culminate in a Health Summit, where stakeholders review and validate the assessment report. Recommendations for improvement are then made for consideration in subsequent years. Thus, the holistic assessment report is finalised after the Summit when stakeholders' inputs are considered to fine-tune it.

2.0 PERFORMANCE OF THE HEALTH SECTOR BY OBJECTIVES

2.1 Overall sector performance

In the year under review, a total of 50 out of 60 selected indicators from the 2022-2025 Health Sector Medium-Term Development Plan were used to assess the performance of the sector in relation to the 2022 annual programme of work. There were no readily available data for the 10 indicators that were not used for the assessment. The overall sector score was 0 on a scale of -3 to +3, indicating a “fairly good” performance. Policy objective two and three also scored 0 (fairly good) whilst objective 1 score -2, interpreted as “below average” performance.

2.2 Policy objective one: Universal access to a better, efficiently managed high quality primary health system

This objective seeks to measure access to healthcare services. It considered the extent of health services coverage and utilisation through availability of medicines, availability of critical human resource and healthcare facilities and National Health Insurance Scheme. In all, fourteen (14) out of eighteen (18) indicators were tracked to assess the performance of this objective. The remaining four (4) were survey indicators, which data was not available for analysis.

The policy objective recorded a score of -2 overall on a scale of -3 to +3, representing a “below average” performance (Table 1). Three indicators had the maximum score of +3; another three indicators obtained a score of 0 each, eight indicators attained a -2 score and four indicators recorded -3.

Table 1 Performance score for policy objective one

Indicator	Performance score	Interpretation	Colour code
Average number of medicines per prescription	3	Excellent	
Nurses to population ratio	3	Excellent	
Percentage of samples analysed	3	Excellent	
Percentage of the population with active NHIS coverage	0	Fairly Good	
Percentage of facilities in good standing with HeFRA	0	Fairly Good	
Nurse Population equity index (Geographical)	-1	Average	
Government health expenditure as % of total government expenditure	-2	Below Average	
Doctor to population ratio	-2	Below Average	

Indicator	Performance score	Interpretation	Colour code
Doctor population equity index (Geographical)	-2	Below Average	
OPD per capita attendance	-2	Below Average	
Proportion of facilities offering Traditional & Alternative Medicine	-2	Below Average	
Percentage of FDA regulated facilities licensed	-2	Below Average	
Percentage of market outlets inspected	-2	Below Average	
Proportion of encounters with antibiotics prescribed	-2	Below Average	
Out-of-pocket expenditure as % of current health expenditure (CHE)	-3	Poor	
Proportion of population with large household expenditures on health as a share of total household expenditure or income (Catastrophic Health Expenditure)	-3	Poor	
Average percentage of clients satisfied with OPD/IPD services	-3	Poor	
Availability of essential medicines (Tracer Drug Availability)	-3	Poor	
Overall score	-2	Below Average	

Trend analysis of key indicators under policy objective one

Outpatient department utilisation (OPD) per capita

Several factors account for outpatient's service utilisation in Ghana. Predominantly among them on the supply side are the establishment of the National Health Insurance Scheme (NHIS), implementation of CHPS, availability of human resource, and investment in health infrastructure.

Interestingly, outpatient visit to health facilities, mainly the public health facilities did not see improvement in the year under review despite the ease of the COVID-19 restrictions. A total number of 33.4 million visits were made to the various health care facilities in the country (Table 2). As expected more than 80% of these visits occurred at the primary health care level (community level facilities to district hospitals). About 45% of the visits happened at the district hospitals. Visits by managing authority (or ownership of the facility) showed that close to 60% of them were made to the government health care facilities.

Table 2 Number of OPD visits by facility type and managing authority, 2022

Variable	Number	% share
Facility type		
CHPS	3,460,608	10.36
Health Centre	5,547,395	16.60
Polyclinic	4,756,897	14.24
District Hospitals*	15,005,338	44.91
Regional Hospital	1,297,114	3.88
Teaching Hospital	1,717,451	5.14
Others (Psychiatric, University, Mines, etc)	1,628,288	4.87
Managing Authority		
CHAG	5,546,385	16.60
Government	19,966,570	59.76
Mines	245,243	0.73
Other Faith-Based	120,415	0.36
Private	5,985,596	17.91
Quasi-Government	1,548,882	4.64
Total	33,413,091	100.00

*Including other designated private or faith-based district hospitals

The trend analysis revealed that the number of outpatient visit decreased from 34.8 million to 33.4 million (4%) between 2021 and 2022. Nonetheless, the females made more visits than the males, representing 21 million (64%). Consequently, the number of outpatient visits per person per year decreased marginally from 1.13 in 2021 to 1.06 in 2022 as shown in Figure 1. A trend over the last five years (2017-2021); however, showed a general improvement, from 1.05 in 2018 to 1.06 in 2022.

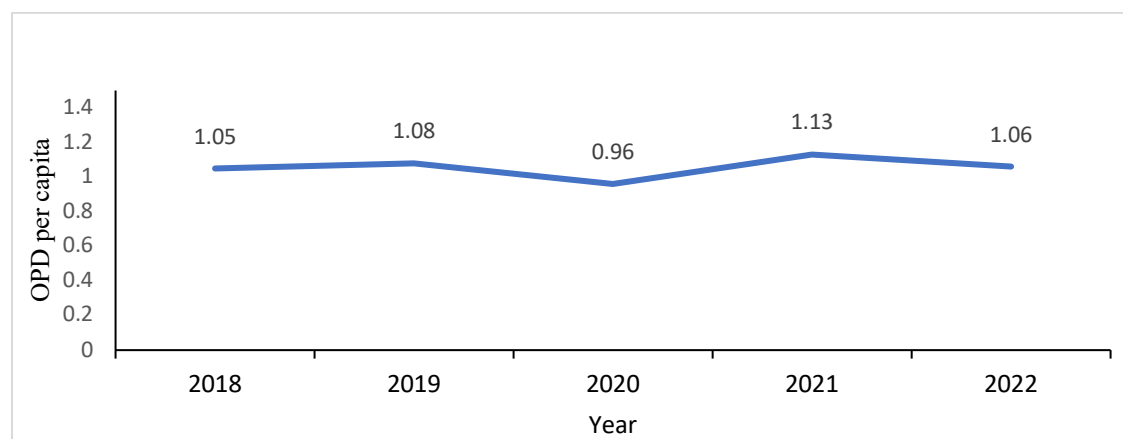


Figure 1 Trend in OPD per capita, 2018-2022

Regional decomposition of OPD per capita for the year under review showed high variation among the regions. The Western North region recorded the highest OPD visits per person per year (1.97) whilst the Northern region had the lowest of 0.55 (Table 3). That is, the OPD attendance per person per year in the Western North region was 3.6 times higher than that in the Northern region.

Half of the regions recorded higher OPD visits per person per year than the national average of 1.06. In addition, the Western North, Bono East, and Savannah regions recorded higher OPD visits per person per year, compared to the previous year. Persons living in or close to regions where there are mining activities happening (Western North, Bono, Bono East and Ahafo) had more OPD attendance per person per year compared to those in areas where there are less or no mining activities going on.

Table 3 OPD per capita by regions, 2018 -2022

Region	2018	2019	2020	2021	2022
Ahafo	1.41	1.55	1.34	1.57	1.44
Ashanti	0.99	1.05	0.96	1.19	1.07
Bono	1.65	1.85	1.65	1.74	1.67
Bono East	1.33	1.47	1.25	1.36	1.37
Central	1.14	1.16	0.96	1.03	0.94
Eastern	1.13	1.16	1.00	1.51	1.26
Greater Accra	0.80	0.86	0.88	1.02	0.95
North East	0.66	0.76	0.73	0.76	0.76
Northern	0.64	0.64	0.60	0.55	0.55
Oti	0.66	0.73	0.65	0.76	0.74
Savannah	0.82	0.72	0.64	0.63	0.65
Upper East	1.42	1.48	1.19	1.34	1.17
Upper West	1.09	1.24	1.05	1.08	0.99
Volta	1.11	1.02	0.84	1.12	1.07
Western	1.08	1.18	1.01	1.21	1.13
Western North	1.06	1.14	1.03	1.13	1.97

Analysis of the health services delivery data also showed that Malaria remained the number one cause of health facility visit in the country in 2022 (Table 4). It constituted more than 20% of all diseases diagnosed at the OPD each year over the last five years (2018-2022). This suggests that the interventions to eliminate malaria in the country need to be relooked at to achieve the desired results.

Table 4 Trend in top 10 OPD cause of morbidity, 2018-2022

No	2018	%	2019	%	2020	%	2021	%	2022	%
1	Malaria	23.5	Malaria	23.8	Malaria	20.3	Malaria	21.0	Malaria	20.3
2	Upper Respiratory Tract Infections	13.8	Upper Respiratory Tract Infections	13.5	Upper Respiratory Tract Infections	10.1	Upper Respiratory Tract Infections	12.2	Upper Respiratory Tract Infections	11.3
3	Rheumatism / Other Joint Pains / Arthritis	6.2	Rheumatism / Other Joint Pains / Arthritis	6.2	Rheumatism / Other Joint Pains / Arthritis	6.6	Rheumatism / Other Joint Pains / Arthritis	6.1	Rheumatism / Other Joint Pains / Arthritis	5.6
4	Diarrhoea Diseases	5.3	Diarrhoea Diseases	5	Diarrhoea Diseases	4.9	Diarrhoea Diseases	4.7	Diarrhoea Diseases	4.5
5	Anaemia	4.1	Anaemia	4.2	Anaemia	4.4	Anaemia	4.6	Anaemia	4.4
6	Skin Diseases	3.5	Skin Diseases	3.8	Acute Urinary Tract Infection	3.7	Acute Urinary Tract Infection	3.8	Acute Urinary Tract Infection	3.8
7	Intestinal Worms	3.1	Acute Urinary Tract Infection	3.3	Skin Diseases	3.6	Skin Diseases	3.4	Skin Diseases	3.4
8	Acute Urinary Tract Infection	3	Intestinal Worms	2.9	Intestinal Worms	3.2	Intestinal Worms	3.1	Intestinal Worms	3.3
9	Hypertension	2.2	Hypertension	2.2	Hypertension	2.3	Typhoid Fever	2.1	Typhoid Fever	2.4
10	Prostate Cancer	2.1	Acute Eye Infection	1.8	Typhoid Fever	2.1	Hypertension	2.1	Hypertension	2.3
11	All other diseases	33.2	All other diseases	31.7	All other diseases	38.8	All other diseases	37.1	All Other Diseases	38.9
Total		100.0		100		100		100		100.0

Government budget allocation to the health sector

Government of Ghana is the main financier of health services in the country. It is therefore important that there is increased and consistent allocation of the share of general government expenditure to the health sector to improve the lives and wellbeing of the population towards attainment of UHC. There has been improvement in this direction in the past especially in the pre-COVID-19 era, from GHS4.42 billion to 6.59 billion between 2018 and 2020.

The post-pandemic period, however, has seen a decline in government allocation to the sector due to economic constraints and other exogenous factors. For instance, there has been a significant drop in allocation to the sector in the last two years, compared to 2020. Nonetheless, there was a marginal increase in allocation in the year under review from 6.6% to 7.4% (0.8 percentage point difference) between 2021 and 2022, as shown in Figure 2.

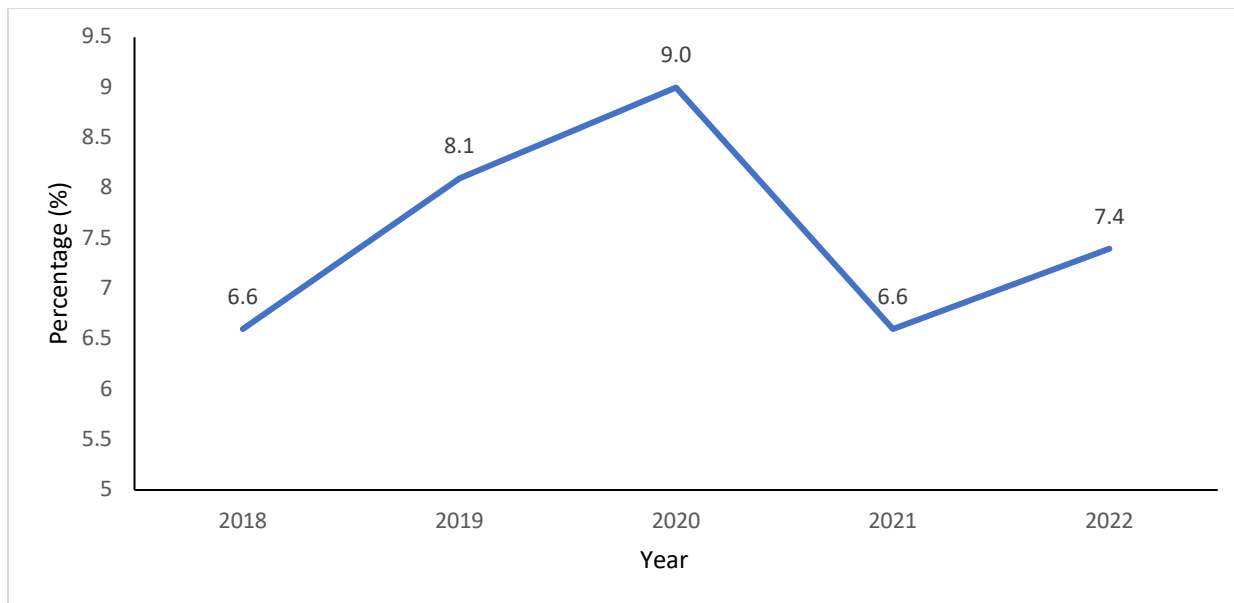


Figure 2 Trend of GoG allocation to the health sector, 2018-2022

In absolute terms, the Ministry received GHS7.86 billion (73.2%) out of the approved budget of GHS10.75 billion in 2022, which excludes allocations to other Ministries, e.g., Ministry of Defence, etc.

Total health budget per capita

The total approved budget of GHS10.75 billion for the Ministry in 2022 translates to an average per capita health budget of GHS341.58 (\$40.44). This is an increase of GHS7.49 (23.9%) from the base year (2021) health budget per person per year of GHS275.68 (\$47.38), as shown in Figure 3. over the last four years (2019-2020), the trend of health spending per person per year had increased by 62.3%. Although health spending per person increased in the year under assessment, it is far less than the reported sub-Saharan African average of \$73.79³ in 2020 and an African average of \$83.00 in the same year. This indicates that government ought to spend more and in an efficient manner to guarantee attainment of the related SDGs by 2030.

³ World bank Group (2023). <https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=ZG>

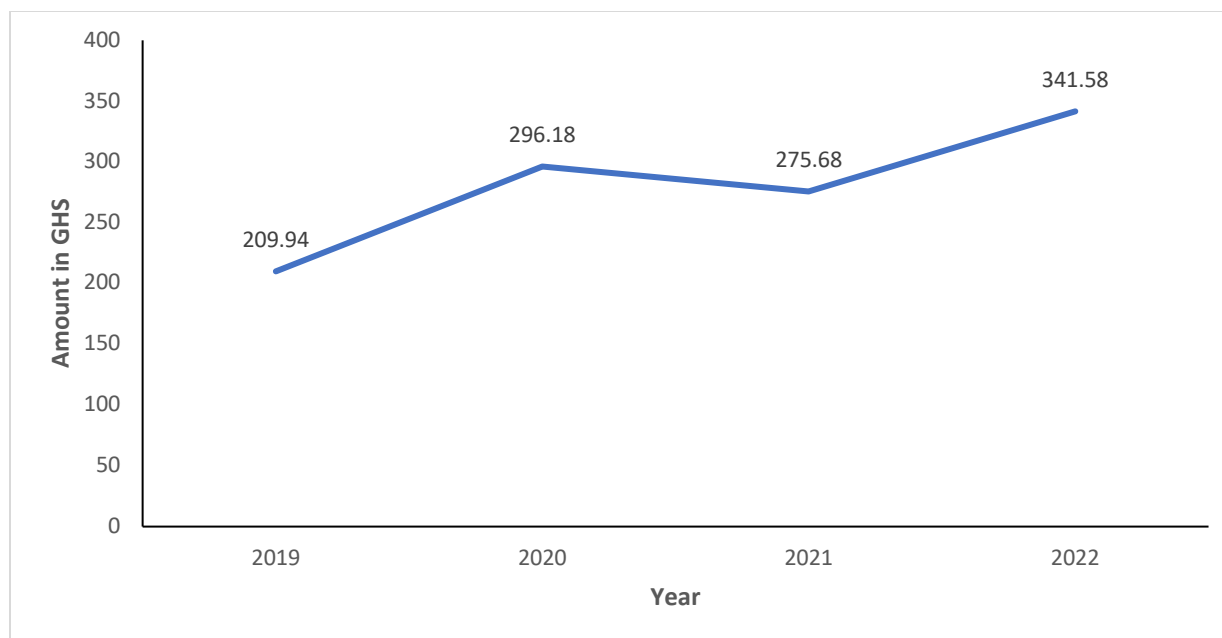


Figure 3 Trend in health expenditure per capita, 2019-2022

Note

Data was not readily available for the year 2018

National Health Insurance Scheme (NHIS) population coverage

The NHIS is the main purchaser of health services in the country. Reports and anecdotal evidence showed that the scheme has provided financial access to health services to majority of the population; improved financial situation of healthcare facilities; and contributed to expanding health infrastructure in the country.

Over the last five years, the number of people enrolling in the NHIS has seen a consistent improvement (Figure 3). The proportion of the population with active NHIS membership increased from 10.6 million to 17.2 million (62.2%) between 2018 and 2022. This remarkable increase over the last five years could be attributed to the introduction of the mobile renewal system in 2018, and its modification and re-introduction as “MyNHIS” in 2022. This mobile phone application allows non-members and members of the scheme to enrol as new members and renew their membership at the comfort of their homes.

In the year under review, 17.2 million people were active members of the scheme, representing 54.5% of the population. A total number of 402,041 people joined the scheme, representing 2.4% increase over the previous year (Figure 4).

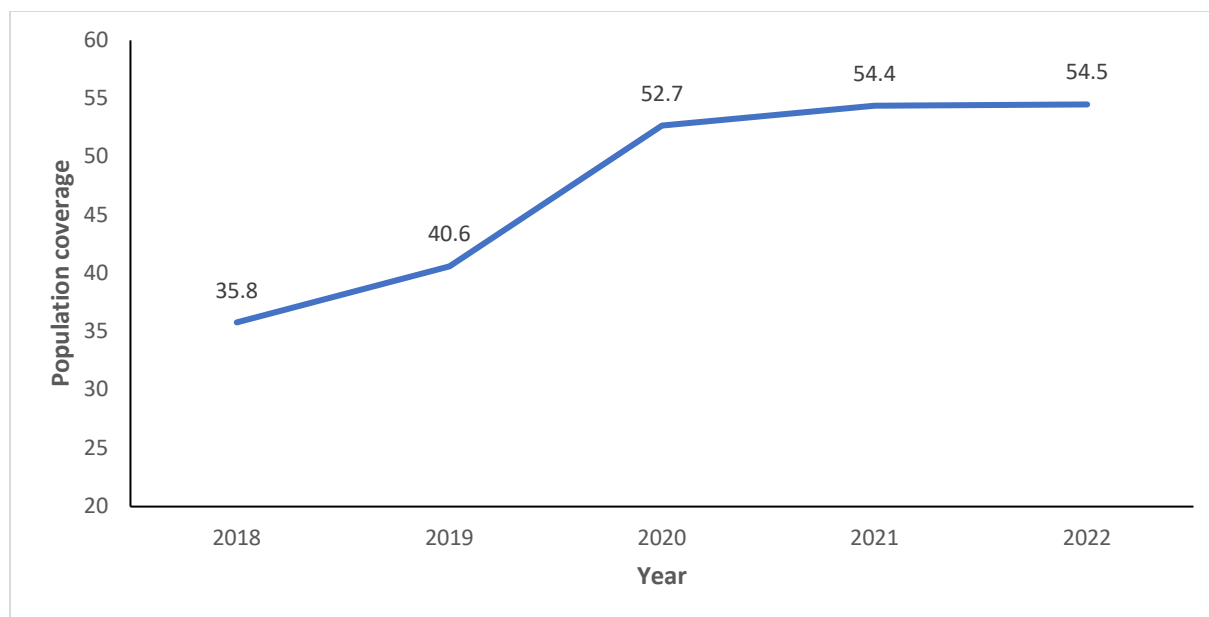


Figure 4 Trend of NHIS population coverage, 2018-2022

Analysis of data by region showed that the Upper West and Bono regions recorded the highest population coverage of 80.8% whilst the Greater Accra region posted the lowest coverage of 40.6%, followed by the Oti region, 41.9%. Half of the regions recorded population coverages higher than the national coverage of 54.5% (Table 5). Whilst majority of the regions had increases in population coverage between 2021 and 2022, five regions (Ashanti, Greater Accra, Savannah, Volta and Eastern), recorded declines. The increasing unauthorised co-payment at the facilities particularly those in the urban centres and revised population figures from the last census (2020) contributed to the low NHIS coverage in the Greater Accra region. Regarding the Oti region, limited access to health services (personnel, infrastructure, long distance to healthcare facilities) accounted for the low population coverage in the region.

Table 5 NHIS population coverage, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	39.59	44.75	64.86	72.7	74.4
Ashanti	35.78	38.74	49.01	54.1	53.7
Bono	51.3	58.82	83.21	80.5	80.8
Bono East	45.81	50.54	70.01	68.5	71.0
Central	30.94	35.03	45.54	44.2	46.1
Eastern	38.66	41.74	56.03	63.2	61.8
Greater Accra	29.7	34.76	42.35	42.7	40.6
North East	35.55	42.72	59.19	54	55.3

Region	2018	2019	2020	2021	2022
Northern	32.23	38.06	48.77	40.7	45.5
Oti	22.75	28.32	35.44	38.8	41.9
Savannah	36.94	41	50.03	50.4	45.2
Upper East	54.47	57.93	74.88	73.4	70.5
Upper West	55.31	57.94	78.34	79.7	80.8
Volta	37.04	41.75	52.33	64.1	62.7
Western	29.5	35.25	44.56	48.5	49.8
Western North	34.41	40.94	56.31	57.4	58.9

Disaggregation of active members in the scheme showed that the females are enrolling in the scheme more than the males (Figure 5). Enrolment of the females in the scheme has remained close to 60% over the last five years (2018-2022). This finding also explains the higher outpatient per capita health services utilisation for the females over the years. It also supports the long-standing empirical evidence that females have more healthcare needs than the males; therefore, they tend to seek financial risk protection against their health care cost more than their male counterpart.

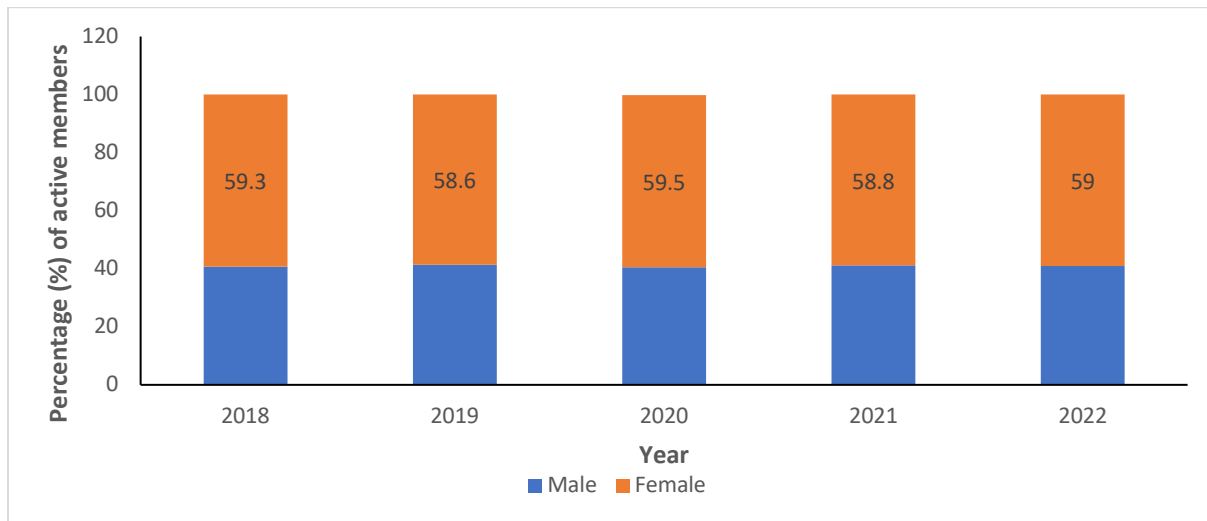


Figure 5 Proportion of active members by sex, 2018-2022

Further disaggregation of the enrolment data by member category showed that persons under the age of 18 years remains the largest category of active members (41.1%) in the scheme, followed by the informal sector workers (34.1%), who pay direct premiums (Figure 6). Trend analysis over the last five years (2018-2022) showed that the proportion of indigents increased from 3.8% to 12.1%. However, there was a decline in membership of the other categories over the same period. Enrolment of the aged (70 years or older) has proportionally remained at less than 1% over the same period, reflecting their share of the total population in the country.

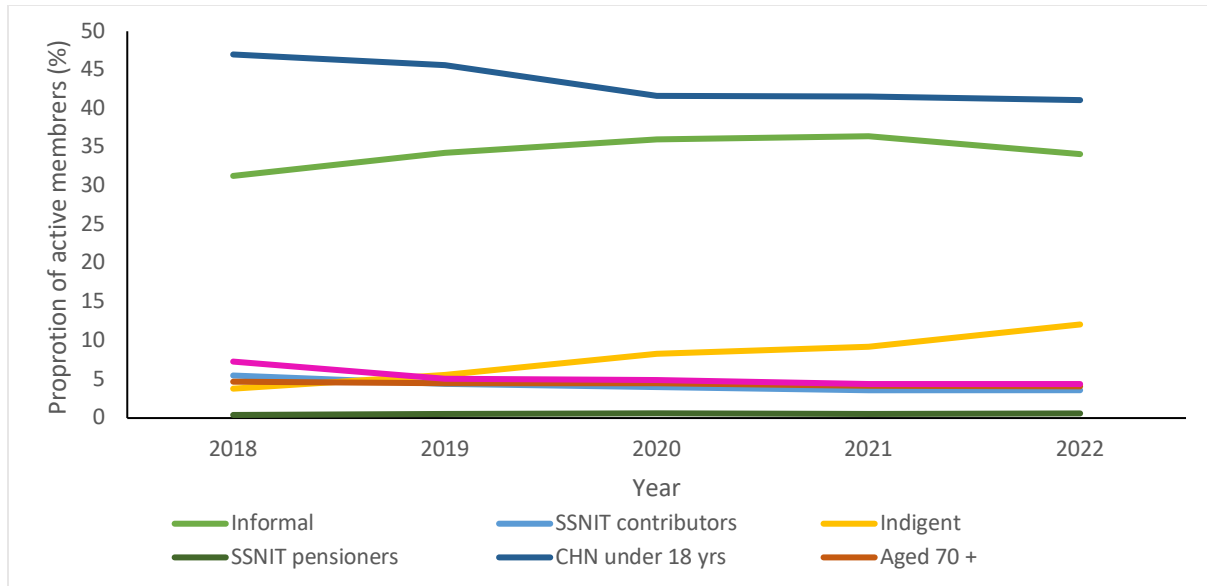


Figure 6 Trends in NHIS active members by category, 2018-2022

National Health Insurance Authority (NHIA) receivable funds

In the year under review, 2.7 billion was approved for the NHIA from the Ministry of Finance (MoF). The Authority, however, received a total amount of GHS2.0 billion in 2022, all of which related to 2021 revenue collection (arears). Compared to the previous year, the total approved budget increased from 1.903 to 2.694 billion (41.5%) between 2021 and 2022 (Figure 7). However, there was less improvement in the approved budget over the last five years, from GHS2.2 billion to GHS2.69 billion (20.6%).

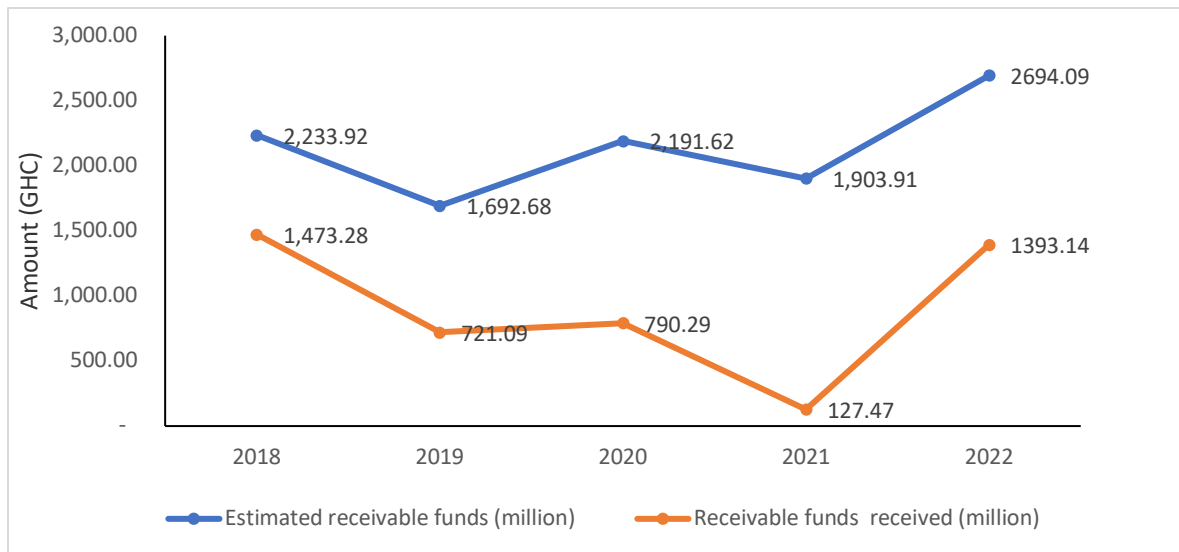


Figure 7 Trends in estimated funds and receivable funds, 2017-2021

Releases from MoH to the NHIA in year also showed similar pattern over the last five years (2018-2022). The last two years (2021-2022) saw a remarkable increase from 127.47 million to 1.39 billion (9.9%).

Claims expenditure

There has been a consistent decline in the proportion of revenues allocated to purchase healthcare services for members of the scheme over the last five years (Figure 8). In the year under review, GHS1.6 billion, representing 60% of total NHIA expenditure (GHS 2.67 billion) was used to pay for claims covering services rendered from July 2021 to May 2022. The analysis further shows that 52% of the total medical claims’ expenditure was used to settle public healthcare providers whilst 27% was paid to the private providers.

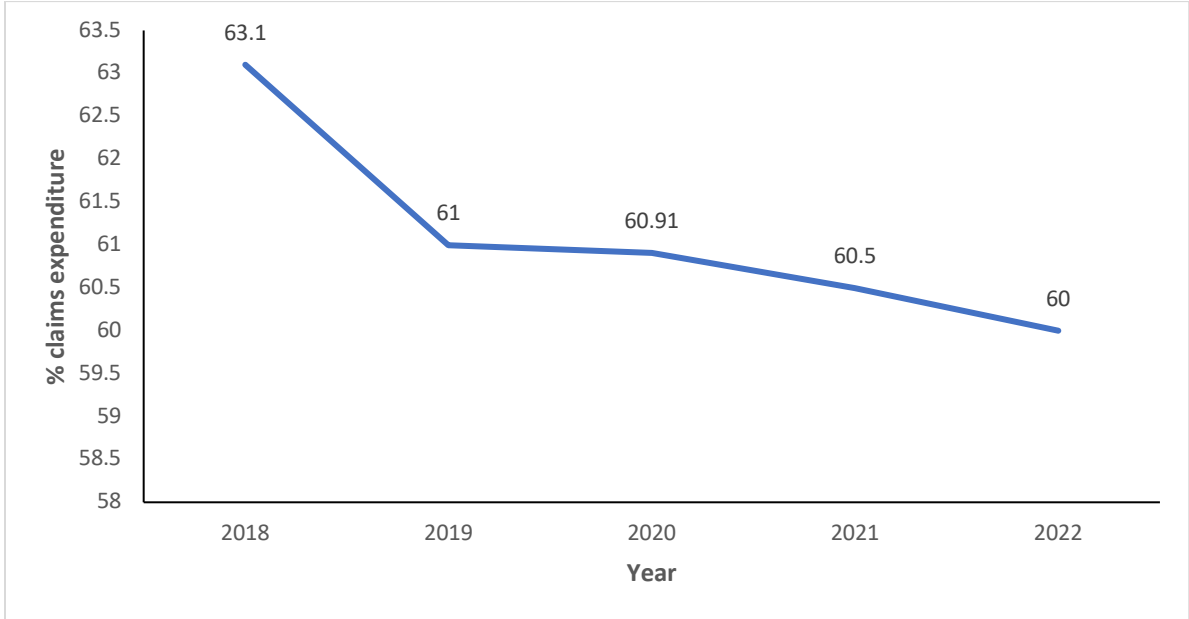


Figure 8 Trend in share of claims expenditure, 2018-2022

Average time of claims settlement

The average claims settlement time of 4 months in 2021 remained the same in 2022. (Figure 9). The law provides for NHIA to pay claims to service providers within 12 weeks upon receipt of the claims. However, performance of this indicator has not been met since its introduction. Despite the seemingly lengthy period for provider claims reimbursement, there has been steady improvement since over the last five years, as shown in Figure 36.

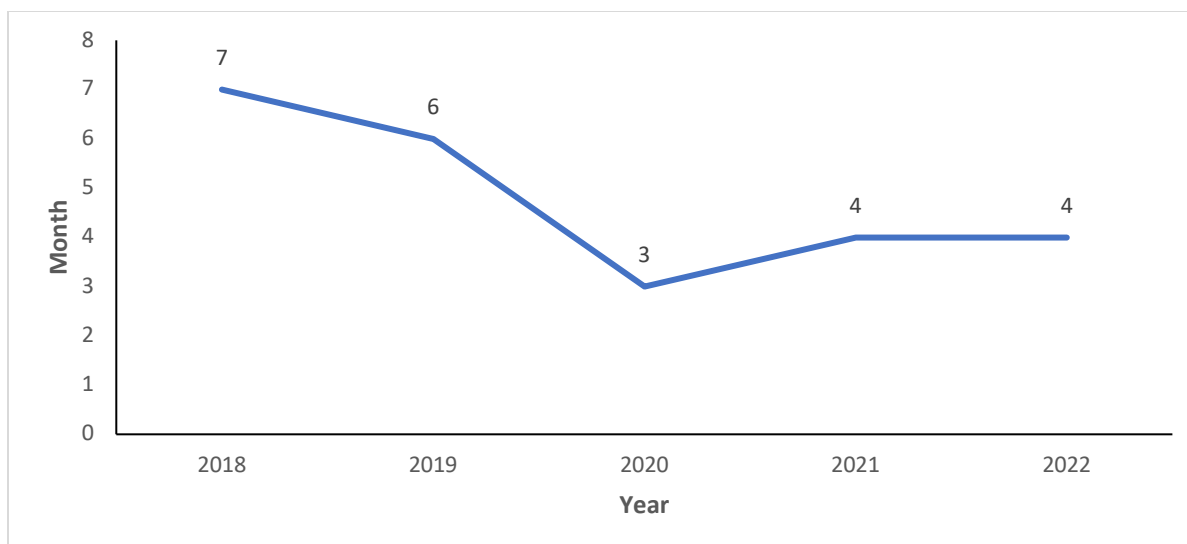


Figure 9 Trend in NHIS claims reimbursement time, 2018-2022

Human resource development for health

In 2021, the Ministry initiated steps to implement a recommendation that was raised at the 2021 Health Summit to attract and retain health professionals in the rural areas for improved inequity in the distribution. In that regard, a draft incentive package document for health professionals was developed and it is undergoing stakeholder engagement. The number of doctors on the GoG payroll decreased from 5,404 to 5,350 (1.0%) between 2021 and 2022. At the regional level, the number of doctors in the Greater Accra region had the highest increase from 2,110 to 2,344 over the same period whilst the Northern region recorded the lowest drop, from 995 to 884 (11.2%).

The density of health professionals (doctors, pharmacists, nurses, and midwives) relative to the population has seen remarkable improvement over the years. However, there is a surge in exodus of these professionals particularly the nurses in recent years, which has culminated in decision taken by the ministry to halt the sale of clearance form to enable them to leave the shores of the country for greener pastures in high-income countries.

Doctor to population ratio

The number of doctors serving a population in a defined geographic area has improved consistently over the last four years. However, the number of doctors per 1,000 population decreased to 0.17 in the year under review, compared to the previous year, which was 0.18 (Figure 10). The doctor to population density had fallen short of the WHO standard of 1 doctor to 1,000 population over the years, indicating the policy makers need to produce adequate number of doctors and ensure that they stay in the country to serve, as the country gets close to the 2030 deadline.

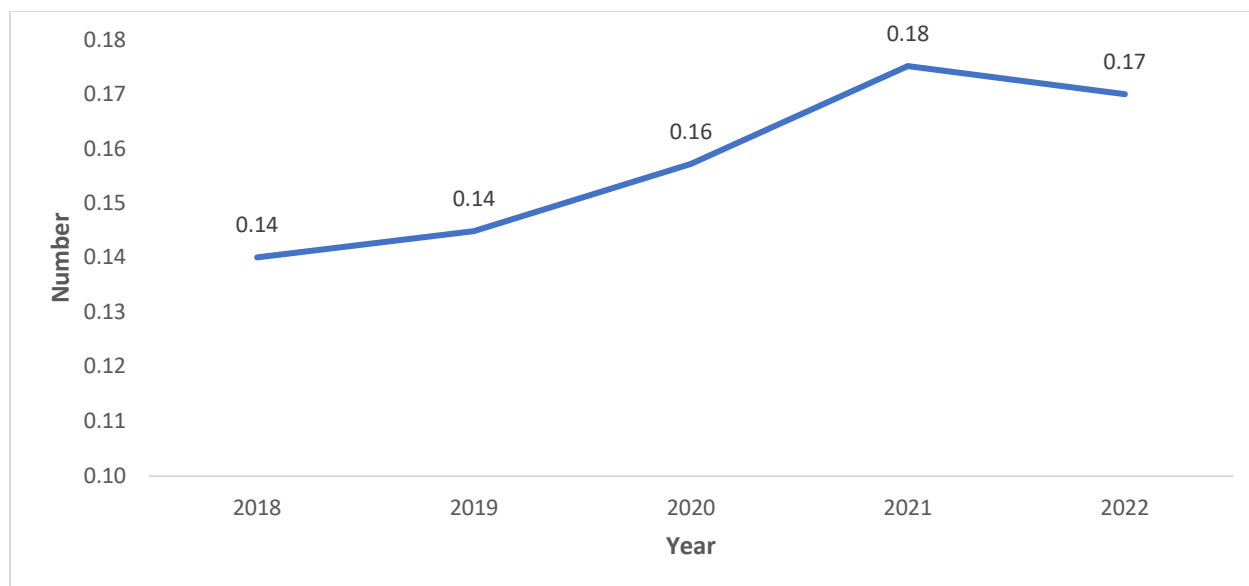


Figure 10 Trend in number of doctors per 1000 population, 2018-2022

Further analysis of the data showed that an inequity in the distribution of medical officers persist across the regions. Doctor-population equity index, using the simple ratio showed that the density of doctors in the Greater Accra region was 21 times higher than in the North East region.

The assessment year showed that the Greater Accra region recorded a better doctor to population density than the global target of 1 to 1,000 population. (Table 6). The Volta Ashanti and Bono regions also recorded better doctor to population density than the other regions. Five regions, including North East, Oti, Savannah and Western North, however, had lower doctor to population densities. These regions had one doctor attending to more than 10,000 population. The Upper East region had the worst performance with regards to this indicator although a consistent reduction has been achieved over the last five years, 2018-2022.

Table 6 Number of doctors per 1,000 population by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	N/A	N/A	N/A	0.09	0.09
Ashanti	0.17	0.16	0.17	0.18	0.16
Bono	0.20 ^a	0.24 ^a	0.25 ^a	0.18	0.15
Bono East	N/A	N/A	N/A	0.10	0.09
Central	0.14	0.14	0.16	0.16	0.14
Eastern	0.08	0.09	0.09	0.13	0.11
Greater Accra	0.33	0.35	0.38	0.39	0.42
North East	N/A	N/A	N/A	0.02	0.02

Region	2018	2019	2020	2021	2022
Northern	0.17 ^b	0.16 ^b	0.18 ^b	0.15	0.13
Oti	N/A	N/A	N/A	0.05	0.04
Savannah	N/A	N/A	N/A	0.02	0.03
Upper East	0.04	0.04	0.05	0.06	0.05
Upper West	0.07	0.07	0.07	0.10	0.10
Volta	0.13 ^c	0.13 ^c	0.15 ^c	0.17	0.17
Western	0.07 ^d	0.08 ^d	0.08 ^d	0.10	0.09
Western North	N/A	N/A	N/A	0.04	0.04

Source: Controller and Accountant General’s Department Payroll data, December 2022

Note

^a Doctor-to-population density (per 1,000) for Ahafo, Bono and Bono East regions

^b Doctor-to-population density (per 1,000) for Northern, Savannah and North East regions

^c Doctor-to-population density (per 1,000) Oti and Volta, 2018-2021 regions

^d Doctor-to-population density (per 1,000) Western and Western North regions

NA: Not applicable

Nurse-to-population ratio

There has been a considerable increase in the production of nurses over the last decade, resulting in an export of these professionals to Barbados based on bilateral arrangement between the two countries. Other countries have also expressed interest in this bilateral arrangement of export of health professionals in the country to support healthcare delivery in their settings, but this is yet to be finalised.

In the year under review, the number of professional nurses including community health nurses on the GoG payroll increased from 58,217 in 2021 to 62,643 in 2022, representing 7.6%. Consequently, the nurse to population density increased from 1.89 to 1.99 per 1,000 over the same period although marginal, compared to the 2020-2021 increase (Figure 11). Generally, there has been a consistent improvement in the number of nurses to population ratio over the 5-year period, 2018-2022. This achievement is higher than the WHO recommended standard of 1 nurse per 1,000 although the issue of inequitable distribution remains.

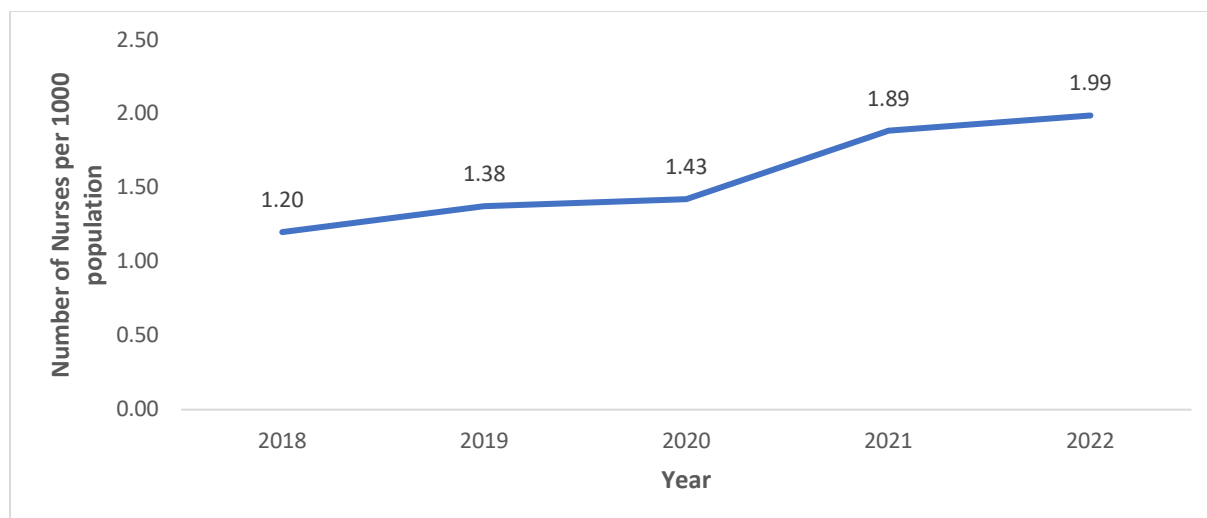


Figure 11 Trend in number of nurses per 1000 population, 2018-2022

At the regional level, there was high variations in the density of nurses. The nurse-to-population density in the Ahafo region, for example, was 2.5 times higher than that in the North East region. The Ahafo region recorded the best nurse to population density of almost 3 nurses per 1,000 population whilst North East region had the worst nurse to population density of 1.18 to 1,000 population (Table 7). In all, half of the regions, including Ahafo, Bono and Upper East, recorded higher nurse to population density than the national density of 1:99 per 10,000 population.

Table 7 Trends in number of nurses per 1000 population by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	N/A	N/A	N/A	2.25	2.93
Ashanti	1.15	1.26	1.31	1.81	1.93
Bono	2.57 ^a	3.31 ^a	3.40 ^a	2.58	2.70
Bono East	N/A	N/A	N/A	1.66	2.04
Central	1.45	1.63	1.65	1.82	1.83
Eastern	1.15	1.29	1.35	2.03	2.12
Greater Accra	1.35	1.48	1.56	1.75	1.84
North East	N/A	N/A	N/A	1.02	1.18
Northern	1.69 ^b	1.89 ^b	1.97 ^b	1.78	1.89
Oti	N/A	N/A	N/A	2.53	1.89
Savannah	N/A	N/A	N/A	1.37	1.46
Upper East	1.87	2.18	2.12	2.54	2.52
Upper West	1.56	1.95	2.03	2.27	2.31
Volta	1.77 ^c	1.91 ^c	2.12 ^c	2.01	2.34

Region	2018	2019	2020	2021	2022
Western	1.19 ^d	1.53 ^d	1.51 ^d	1.70	1.69
Western North	N/A	N/A	N/A	1.75	2.07

Note

^a Nurse-to-population density (per 1,000) for Ahafo, Bono and Bono East regions

^b Nurse -to-population density (per 1,000) for Northern, Savannah and North East regions

^c Nurse-to-population density (per 1,000) Oti and Volta regions

^d Nurse -to-population density (per 1,000) Western and Western North regions

NA: Not applicable

Regional and district public hospitals offering traditional medicine practice

In 2011, the Ministry started integrating traditional and alternative medicines in the healthcare delivery system to improve access to medicines. In this same year, nineteen herbal units were established in the various health facilities across the country to offer traditional and alternative medicines services to the population.

Trend over the last five years (2018-2022) showed that the number of regional and district public hospitals offering traditional and alternative medicine practice increased from 35 to 55, representing 57% (Figure 12). In percentage terms, the coverage of traditional and alternative medicines increased from 22.6% to 32% between 2018 and 2021 and dropped to 30.7% in the assessment year.

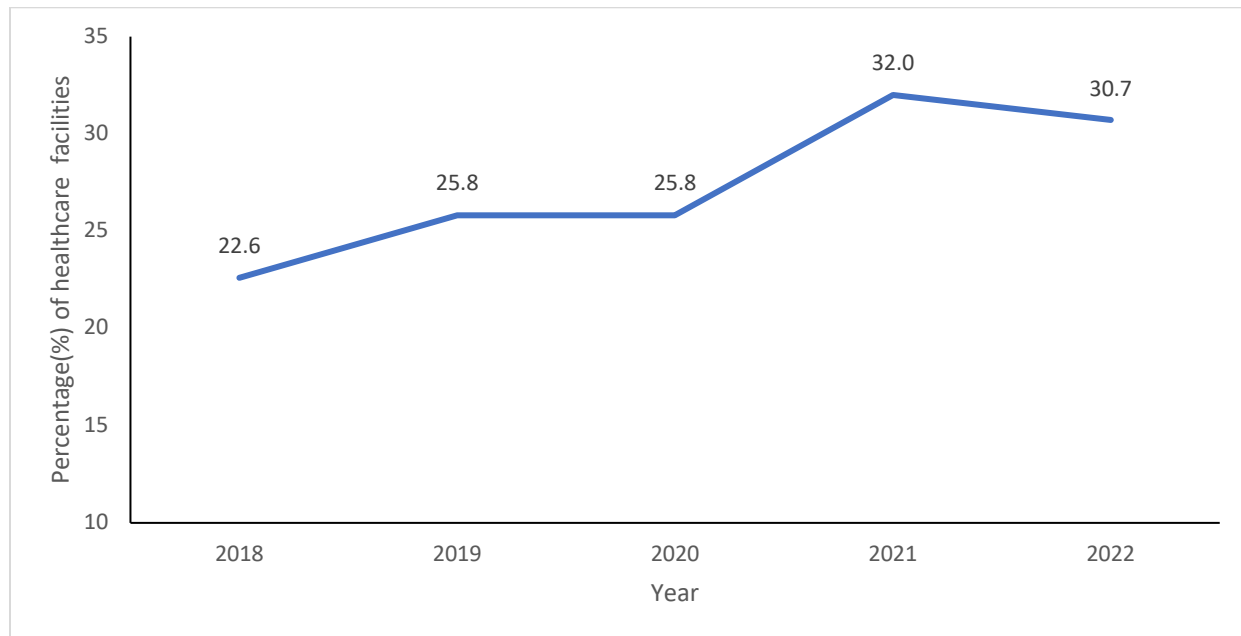


Figure 12 Trend in proportion of healthcare facilities offering traditional medicines, 2018-2022

Quality testing for food and drug products

In 2022, the number of medical products sampled and analysed by the FDA increased by 6 percentage points difference from 85% to 91% between 2021 and 2022, as shown in Figure 13. The FDA commenced Foreign Good Manufacturing Practices (GMP) in 2022. Out of the 58 licencing inspections conducted in 2022, 38 were foreign GMP with 3 facilities licenced. Products of these unlicensed foreign facilities were not allowed entry into the Country.

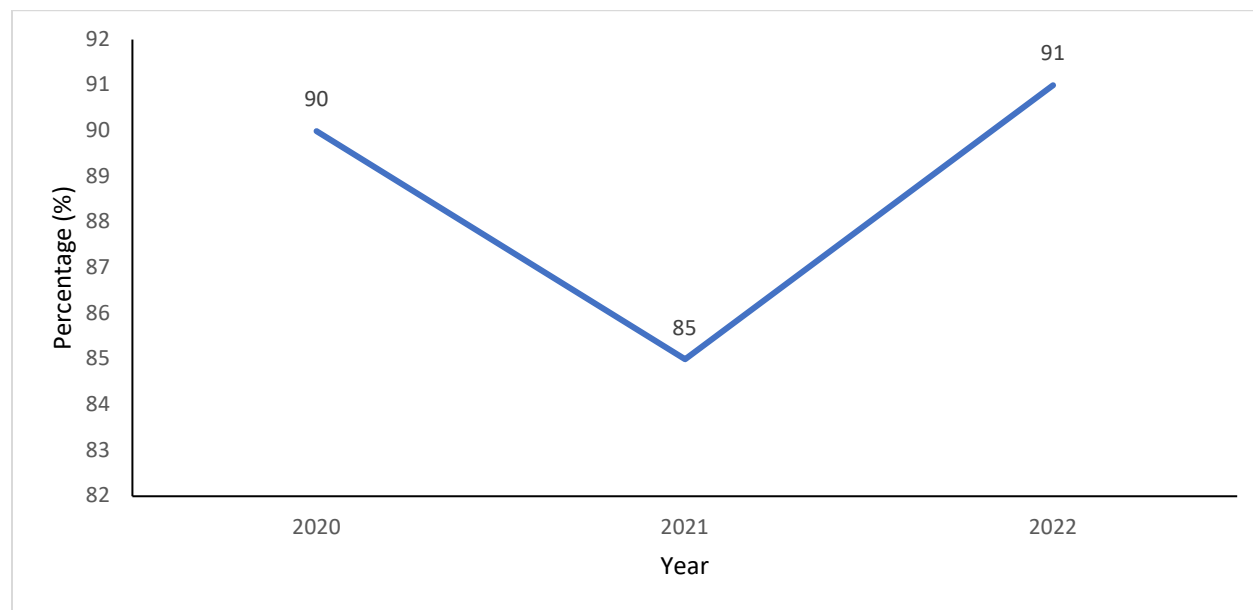


Figure 13 Trend in quality pass rate for food and medicinal products, 2020-2022

Rational use of medicines

Over past few years, there has been a clarion call by health experts and other global health bodies, including WHO to promote rational use of medicines. As a member country of the WHO, Ghana has headed this call by implementing a policy to promote rational use of medicines and to address the growing concern of polypharmacy and drug resistance. For instance, there is anecdotal evidence that many infections get better on their own; therefore, antibiotics should normally be prescribed for more serious bacterial infections.

In the year under review, the average number of medicines prescribed per patient encounter decreased marginally from 3.0 to 2.9 between the base year (2021) and target year (2022), achieving the set target of 3 medicines per encounter (Figure 14). A significant reduction was, however, achieved in 2019. Since then, there had been an increase, stagnating around 3 medicines per patient encounter.

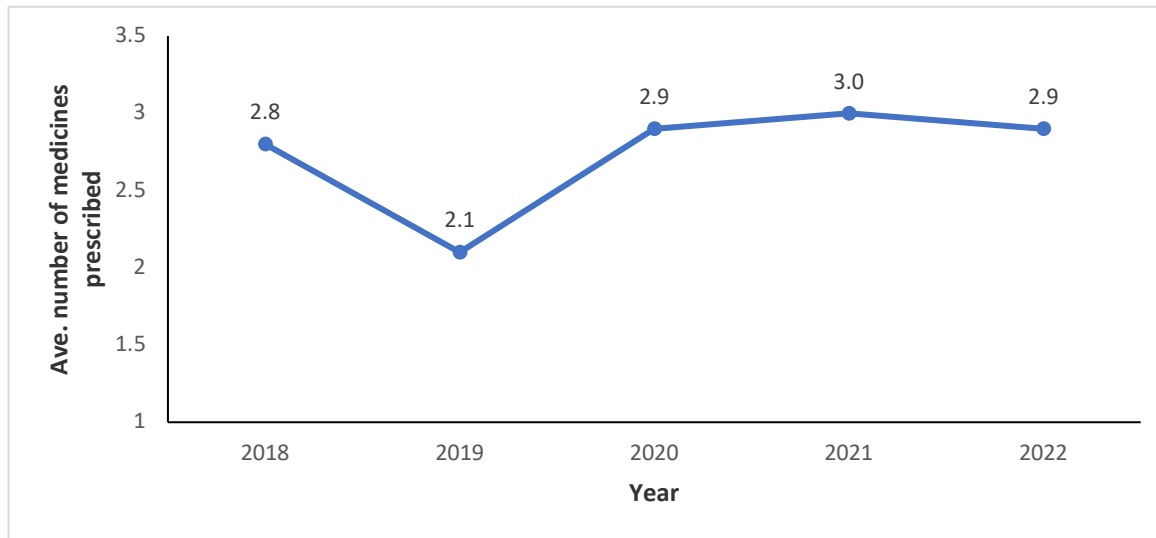


Figure 14 Trend in number of medicines prescribed per patient encounter, 2018-2022

Proportion of encounters with antibiotics prescribed

In addition, the proportion of patient encounter with antibiotics was assessed. There was a sharp decline in the percentage of encounters in which antibiotics were prescribed between 2018 and 2020. Since then, there has been a gradual increase in the prescription of antibiotics from 21% to 45% although there was a decline by 4.26% (or 2 percentage points difference) in the year under review compared to the previous year. This proportion of antibiotics prescribed is relatively high, considering that remarkable achievements were realised in 2019 and 2020 (Figure 15). The sharp rise in prescription of antibiotics from 2020 could be attributed to the outbreak of the COVID-19 pandemic, which required antibiotics and other medicines to treat it.

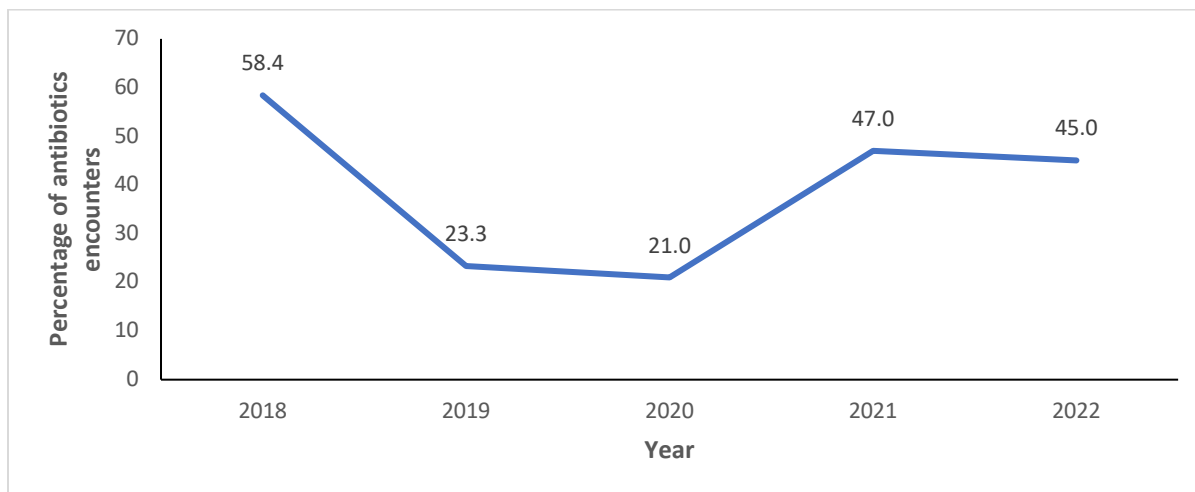


Figure 15 Trend in proportion of patient encounter with antibiotics, 2018-2022

2.3 Objective two: Reduce avoidable maternal, adolescent and child deaths and disabilities

The indicators in this domain are used to monitor the quality of maternal and child health services. The overall performance score for policy objective two is 0, interpreted as **fairly good** performance (Table 8). One (1) indicator (prevalence of wasting among children in under-five) out of sixteen (16) indicators was not assessed. Six indicators recorded a maximum score of 3; five indicators obtained a score of 0, and two indicators had -2.

Table 8 Performance score for policy objective two

Indicator	Performance score	Interpretation	Colour code
Midwife to WIFA ratio	3	Excellent	
ANC 4+ (%)	3	Excellent	
Stillbirth Rate	3	Excellent	
No. of children fully immunised (Using Penta 3 as proxy (%))	3	Excellent	
Institutional Neonatal Mortality Rate	3	Excellent	
Institutional Under 5 Malaria Case Fatality Rate	3	Excellent	
Institutional Maternal Mortality ratio	3	Excellent	
Midwife to WIFA population equity index (Geographical)	0	Fairly Good	
Prevalence of stunting among children under five years.	0	Fairly Good	
Institutional Under-five mortality rate (per 1000lb)	0	Fairly Good	
Institutional Infant Mortality Rate (per 1000lb)	0	Fairly Good	
Adolescent pregnancy rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	0	Fairly Good	
Mother to child HIV transmission rate at 18 months	-2	Below Average	
Skilled birth attendance coverage (%)	-2	Below Average	
Prevalence of underweight among children under five years	-2	Below Average	
Prevalence of wasting among children under five (%)	-3	Poor	
Overall	0	Fairly Good	

Trend analysis of key indicators under objective two

Maternal healthcare service

Access to quality maternal and child health services are crucial to achieving the SDG related goals. Antenatal utilisation, facility delivery and postnatal care provided within 48 hours are focused interventions to improve quality maternal and child healthcare. It is expected that women in the fertility age group (15-49 years), who visit health facility before pregnancy, during and after pregnancy would have a higher chance of improved health outcome.

In the year under review, the proportions of pregnant mothers making at least 1+ and 4+ antenatal care visits; receiving skilled delivery; and accessing postnatal care declined marginally (Figure 16). Proportion of births attended by skilled personnel declined from 63.5% to 62.6% between 2021 and 2022, compared to 88% in the 2022 DHS. Trends over the last five years (2018-2022), however, showed improvement of these indicators.

Implementation of the policies and programmes including the NHIS, free maternal care, community-based health planning and services (CHPS), safe motherhood programme, and the task-sharing policy appear to be contributing to improvement in family planning, antenatal care, skilled delivery, and postnatal care services. However, more efforts are needed from policymakers to improve the situation as the country strives to achieve the SDG of reducing maternal deaths to 72 per 100,000 live births by 2030 and under-five deaths by 25 per 1,000 live births.

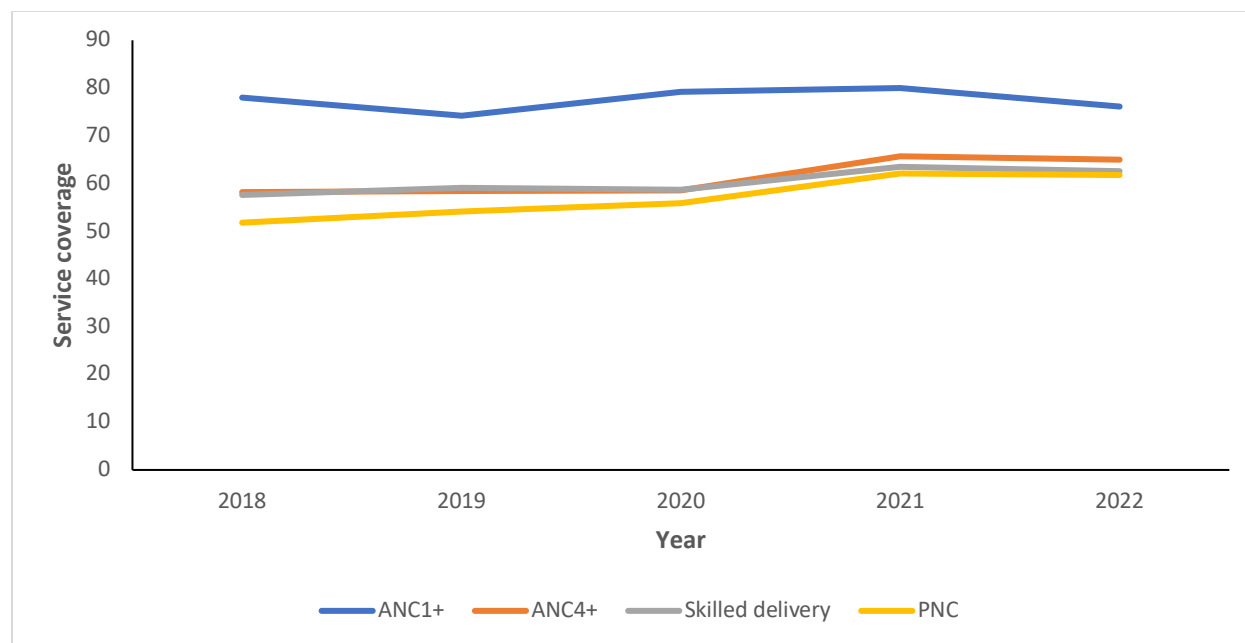


Figure 16 Trends in ANC, skilled delivery, and PNC coverage, 2018-2022

Geographical distribution of delivery attended by skilled personnel in the year under review showed that majority of the pregnant women in the northern part of the country accessed this service. Over 70% of pregnant mothers in the Northern, North East, Upper East, Upper West and Upper West regions received skilled delivery services, compared to the other regions (Table 9).

Table 9: Skilled birth attendance by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	57.1	59.9	61.0	68.3	66.0
Ashanti	54.9	53.3	53.7	60.8	60.6
Bono	60.9	68.1	68.3	66.5	66.9
Bono East	62.1	64.4	66.5	66.8	67.2
Central	65.3	64.8	66.0	66.0	64.8
Eastern	50.4	50.2	50.9	60.9	59.1
Greater Accra	58.3	57.1	51.7	52.0	51.1
North East	67.9	72.0	70.5	71.9	73.5
Northern	74.4	79.1	79.9	75.8	76.8
Oti	44.5	49.4	53.2	63.4	62.8
Savannah	59.6	59.9	57.7	61.2	62.6
Upper East	70.6	73.6	73.7	81.8	77.5
Upper West	68.7	70.3	71.4	76.7	73.1
Volta	50.8	46.1	47.4	58.2	58.1
Western	50.8	57.3	56.6	66.1	64.8
Western North	54.1	61.2	59.9	66.8	63.1

Institutional maternal mortality ratio (iMMR)

Generally, the number of women dying due to complications from pregnancy or childbirth has improved over the last five years. These deaths have declined from 147 to 102.6 per 100,000 live births between 2017 and 2021 (Figure 17). The last Maternal Health Survey (MHS) conducted in 2017, however, showed maternal mortality ratio of 310 deaths per 100,000 live births, indicating that there are more deaths in the communities that are not reported to the appropriate institutions to be counted.

The year under review, saw a decline from 109.2 to 102.6 deaths per 100,000 live births, representing 14.14%. Despite the wide variations in the regional figures, this achievement is encouraging as the country strives to achieve the global SDG target of at least 70 deaths 100,000 by 2030. The general improvement in this health outcome can be attributed to adherence to maternal health protocols and guidelines, and the implementation of maternal death audit recommendations.

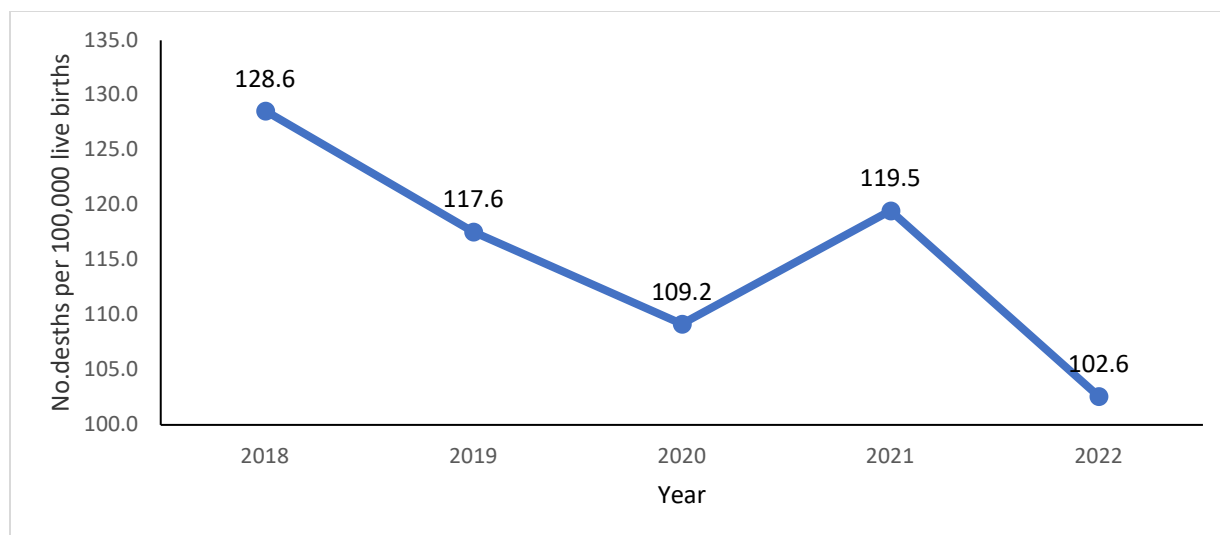


Figure 17 Trend in institutional maternal mortality ratio, 2018-2022

Disaggregation by administrative region showed that the regions in the northern sector of the country recorded relatively low maternal deaths compared to those in the southern part. The Oti region recorded the lowest maternal mortality ratio of 5.2 deaths per 100,000 live births, followed by the North East (Table 10). Due to the limited access to health services in the Oti region, it is more likely that majority of the deaths occurred outside the region through referral of complicated cases to higher level of care. All the regions except the Greater Accra, Ashanti and Eastern, recorded less maternal deaths per 100,000 live births than the national rate.

Table 10 Institutional maternal mortality per 100,000 live births by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	43.7	97.6	68.0	83.5	52.6
Ashanti	184.1	155.9	96.6	127.5	134.5
Bono	89.3	70.3	79.6	87.5	75.7
Bono East	79.9	105.3	91.5	71.7	87.9
Central	132.1	105.2	109.2	104.4	95.2
Eastern	124.3	139.1	143.1	112.1	120.3
Greater Accra	149.5	139.7	143.1	163.7	155.5
North East	105.5	59.9	58.8	84.5	30.3
Northern	136.7	144.0	120.2	98.6	95.2
Oti	56.7	54.9	93.9	61.1	5.2
Savannah	56.1	50.4	48.2	37.5	77.9

Region	2018	2019	2020	2021	2022
Upper East	91.1	79.2	90.7	98.0	65.6
Upper West	96.4	74.8	78.8	100.5	59.4
Volta	87.22	131.63	95.20	102.52	82.4
Western	134.30	106.08	113.01	118.62	100.8
Western North	79.16	34.88	60.93	75.58	57.2

Stillbirth, neonatal mortality, institutional infant, and under-5 mortalities

The four child health outcome indicators assumed a downward trend in the year under review (Figure 18). The death or loss of a baby before or during delivery (miscarriage and stillbirths) decreased from 12.8 to 11.2 per 1,000 live births between 2021 and 2022; the number of children who died in their first month of live (neonatal mortality) went down from 7.6 to 6.5 deaths per 1,000 live births, lower than the 17 deaths per 1,000 live births reported in the 2022 Ghana DHS; the number of newborns who died under one year of age decreased from 7.8 to 7.4 deaths per 1,000 (lower than the 28 per 1,000 live births reported in the 2022 DHS); and the number of children who died by the age of 5 years (under-five mortality rate) also went down from 10.7 to 9.8 deaths per 1,000 live births (lower than 40 deaths per 1,000 live births reported in the 2022 DHS), achieving the set target of 8.7/1,000 live births. Again, policies and programmes including the NHIS, free maternal care, community-based health planning and services (CHPS), death audits and implementation of the recommended actions have contributed to improvement in these indicators over the years.

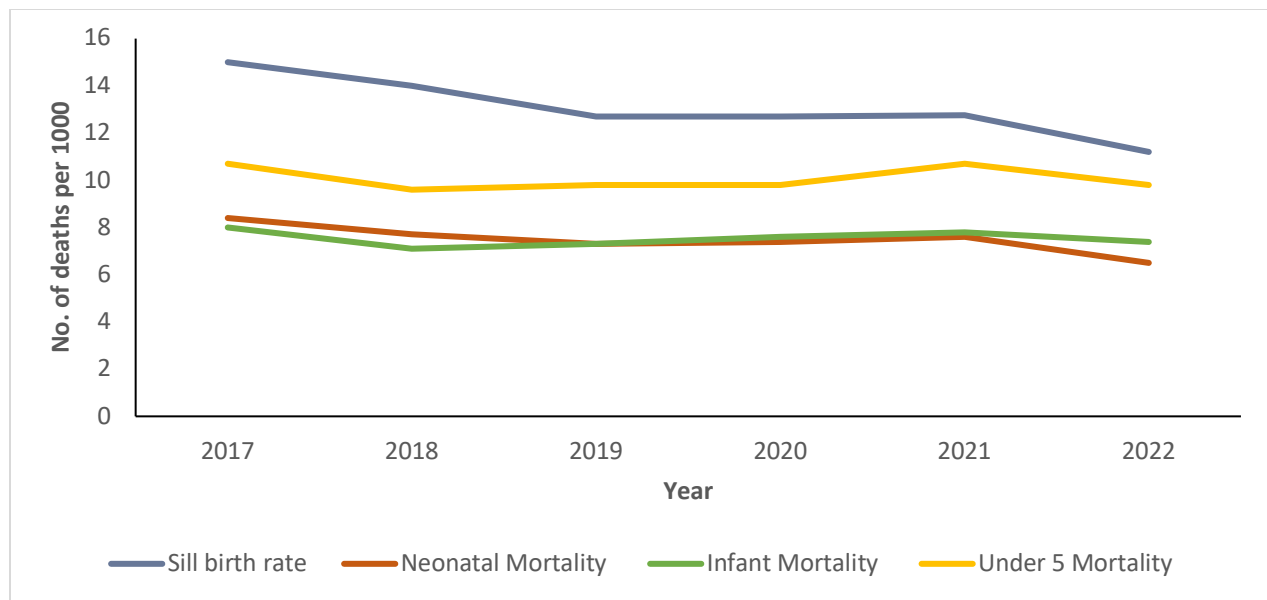


Figure 18 Trends in stillbirth, neonatal, infant and under-five mortality rates, 2018-2022

However, disaggregation of the neonatal deaths by region showed that the deaths are high in the urban regions (Greater Accra and Ashanti) and low in the less developed regions (Oti, Savannah, North East and Western North), as shown in Table 11.

Table 11 Institutional neonatal deaths per 1,000 live births, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	4.95	5.4	6.4	5.5	4.0
Ashanti	9.3	7.3	6.5	6.5	7.6
Bono	7.5	8.4	8.0	7.7	6.5
Bono East	8.0	7.2	6.2	7.9	7.5
Central	6.0	7.5	6.6	6.9	4.8
Eastern	6.7	6.5	8.2	6.7	7.7
Greater Accra	10.4	11.9	10.2	11.4	10.4
North East	4.8	2.9	4.0	4.6	2.7
Northern	9.8	10.1	9.78	8.5	4.6
Oti	3.5	3.0	2.8	1.9	2.2
Savannah	1.7	2.3	2.8	3.9	2.3
Upper East	6.3	8.1	6.8	6.8	6.5
Upper West	6.1	8.8	7.4	5.5	5.8
Volta	5.7	6.0	6.6	6.6	7.1
Western	8.8	7.1	6.6	5.1	5.1
Western North	3.5	3.4	2.7	2.2	2.7

Regarding the under-five mortality rate, half of the regions recorded lower death rates than the national rate of 9.8 deaths per 1000 live births (Table 12). The Western North region recorded the lowest under-five mortality rate of 4.7 deaths per 1000 live births, followed by Oti region. Generally, the under-five deaths are higher in the northern sector of the country (North East, Northern, Upper West) and the middle belt (Bono East and Bono). However, the national target of 8.7 deaths per 1,000 live births for the year under review was far achieved.

Table 12 Institutional under-five mortality by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	7.4	7.0	8.6	7.7	5.8
Ashanti	5.0	4.6	4.9	5.5	5.9
Bono	12.1	11.7	11	12.1	11.7
Bono East	14.9	13.1	10.9	13.2	13.4
Central	8.2	10.2	8.9	9.2	8.8
Eastern	9.4	9.0	10.1	9.1	10.9

Region	2018	2019	2020	2021	2022
Greater Accra	8.3	9.9	10.5	11.0	10.8
North East	12.6	17	17.3	18.8	15.7
Northern	16.2	12.7	13.2	15.1	15.1
Oti	6.9	6.7	6.0	5.5	5.1
Savannah	8.1	5.8	7.4	7.0	6.5
Upper East	15.3	14.7	12.6	12.7	10.7
Upper West	10.2	15.7	12.4	13.2	12.3
Volta	10.2	9.4	9.9	9.4	9.5
Western	14.7	12	10.9	10.1	9.7
Western North	6.2	5.9	6.0	6.1	4.7

Institutional malaria under-five case fatality rate

The severity of malaria among children under the age of 5 years has gone down in recent years in the country. In the year under review, a total of 144,769 patients below the age of 5 years were admitted with malaria, compared to 145,587 in 2022. Out of this number, 76 died, resulting in a case fatality rate of 0.05% (Figure 19). Trend analysis over the last five years has also seen remarkable improvement. It reduced from 0.16% to 0.10% between 2018 and 2019 before assuming an upward trend in 2020 when the COVID-19 pandemic hit. This, however, was short lived as the rate declined to 0.05% in 2022. The reduction in the target year (0.05% fatality rate) represents 44.44% compared to the previous year.

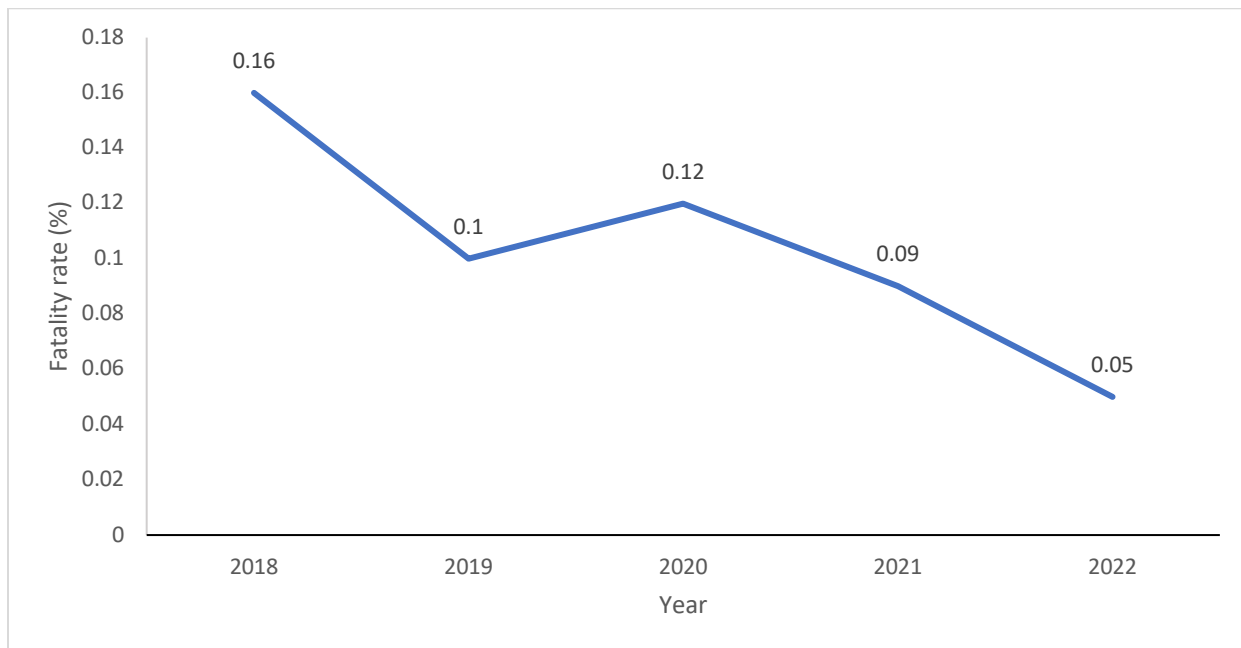


Figure 19 Trend in institutional malaria under-five case fatality rate, 2018-2022

Disaggregation of the malaria under-five case fatality rate by administrative region showed that there had been a considerable reduction in the Bono and Bono East regions over the last five years (Table 12). However, the case fatality rate in the upper west, Greater Accra and savannah regions went up in the year under review. Although there was a reduction of under-five malaria deaths in the Oti region (from 0.23 to 0.18) the region recorded the highest case fatality rate in the year under review. the Ashanti region has seen the lowest rates over the last five years but had no change between the base year (2021) and the target year (2022).

Table 12 Trend in institutional malaria under-five case fatality rate by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	0.06	0.06	0.09	0.06	NA
Ashanti	0.07	0.05	0.07	0.02	0.02
Bono	0.15	0.17	0.13	0.14	0.05
Bono East	0.34	0.24	0.17	0.23	0.12
Central	0.12	0.07	0.13	0.05	0.02
Eastern	0.17	0.11	0.08	0.08	0.07
Greater Accra	0.16	0.19	0.1	0.08	0.14
North East	0.32	0.15	0.15	0.14	NA
Northern	0.23	0.12	0.13	0.12	0.03
Oti	0.16	0.11	0.14	0.23	0.18
Savannah	0.17	0.07	0.23	0.07	0.11
Upper East	0.08	0.01	N/A	0.02	0.03
Upper West	0.24	0.14	0.26	0.14	0.16
Volta	0.13	0.19	0.28	0.25	0.10
Western	0.19	0.09	0.08	0.07	0.05
Western North	0.07	0.07	0.13	0.06	0.09

NA: Not available

Midwife to women in fertility age (WIFA) ratio

Women in fertility age (WIFA) is a core segment of the population that requires health care services such as family planning, antenatal care, skilled delivery, and postnatal care. Available data showed that midwife to women in fertility age population has improved over the last five years (Figure 20). It increased from 1.46 to 3.09 midwives to 1000 women in fertility age over the last five years (2018-2022). This finding is a remarkable improvement and needs to be sustained across all the administrative regions as the country strives to attain the related SDGs. The rate improved by 19.3% in the assessment year, from 2.59 midwives to 3.09 per 1000 women in fertility age.

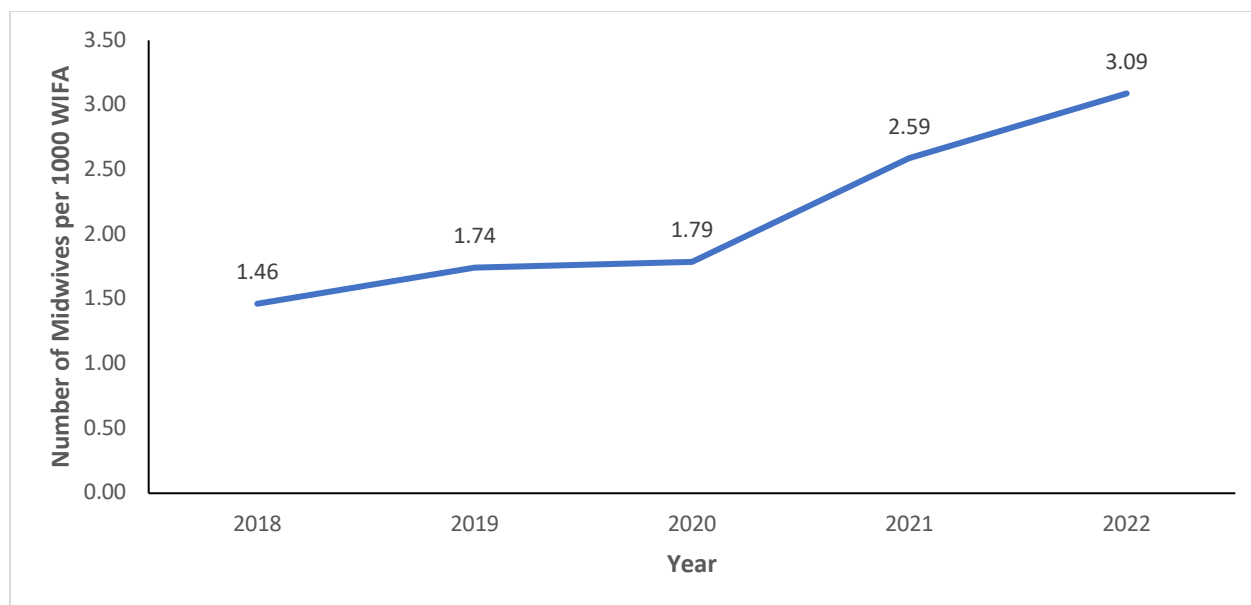


Figure 20 Trend in Midwife per 1000 Women in Fertility Age (WIFA), 2018-2022

Disaggregation of the data by region showed that all of them improved on the midwife to WIFA population density in the year under review (Table 13) although variations exist among them. Higher midwife to 1,000 WIFA population density was recorded in Bono, Upper West and Ahafo regions. These three regions had more than 4 midwives serving 1,000 WIFA populations. The lowest midwife to WIFA population density was posted in the North East region (1.77 per 1,000 WIFA population).

Table 13 Trends in midwife per 1000 WIFA population by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	N/A	N/A	N/A	3.00	4.16
Ashanti	1.74	2.05	2.09	3.12	3.72
Bono	3.35 ^a	4.36 ^a	4.51 ^a	3.97	4.53
Bono East	N/A	N/A	N/A	2.31	3.17
Central	1.37	1.70	1.68	2.19	2.61
Eastern	1.35	1.58	1.61	2.55	3.12
Greater Accra	1.38	1.62	1.75	2.19	2.70
North East	N/A	N/A	N/A	1.40	1.77
Northern	2.10 ^b	2.46 ^b	2.53 ^b	2.23	2.48
Oti	N/A	N/A	N/A	2.85	2.45
Savannah	N/A	N/A	N/A	1.93	2.24
Upper East	1.65	1.90	1.87	2.69	3.16
Upper West	2.53	2.62	2.60	3.75	4.28

Region	2018	2019	2020	2021	2022
Volta	2.05 ^c	2.27 ^c	2.42 ^c	2.39	3.18
Western	1.76 ^d	2.26 ^d	2.22 ^d	2.60	2.94
Western North	N/A	N/A	N/A	2.46	2.93

Note

^a Midwife-to-WIFA population density (per 1,000) for Ahafo, Bono and Bono East regions

^b Midwife-to-WIFA population density (per 1,000) for Northern, Savannah and North East regions

^c Midwife-to-WIFA population density (per 1,000) Oti and Volta regions

^d Midwife-to-WIFA population density (per 1,000) Western and Western North regions

NA: Not applicable

Stunting among children under-five years of age

According to the WHO, stunting is defined as “low height-for-age”. It is the result of chronic or recurrent undernutrition, usually associated with poverty, poor maternal health and nutrition, frequent illness and/or inappropriate feeding and care in early life”. It prevents children from reaching their physical and cognitive potential.

There has been improvement in the situation in the country over the last five years (2018-2022) due to targeted policy interventions, including the implementation of National Newborn Health and Strategy Action (2019-2023). The prevalence of stunting has seen a consistent decline from 2.4% in 2018 to less than one in 2022 (Figure 21). However, prevalence of underweight increased in the year under review from 1.40 to 1.50%, representing a change of 7.14%.

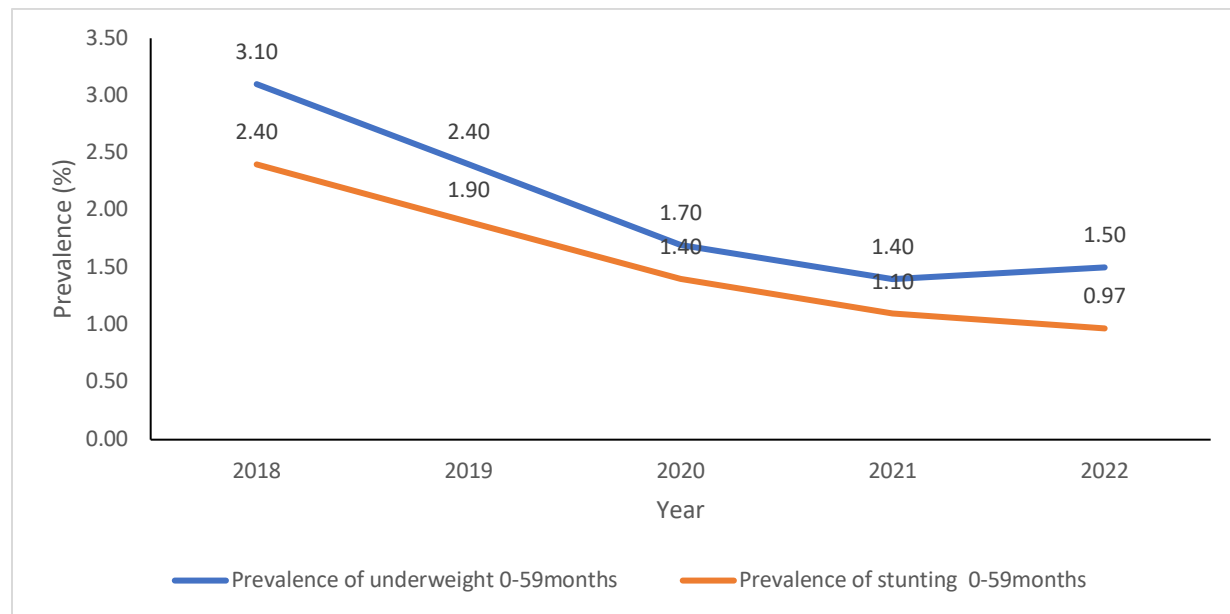


Figure 21 Trends in stunting and underweight among children under-five years, 2018-2022

Disaggregation of prevalence of stunting by geographical location showed that five regions (Eastern, Western North, Western, Savannah, and Upper East,) recorded improvement in this indicator (Table 14). Generally, the predominant occupation in these regions is farming; thus, they tend to produce more food for the country. Specifically, the Eastern region recorded the best of 0.35% and the Bono region, the worst of 2.10%.

Table 14 Stunting among children under-five years by regions, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	3.20	2.50	1.30	0.80	1.20
Ashanti	4.40	2.30	1.70	1.60	1.10
Bono	5.00	3.20	2.30	1.50	2.10
Bono East	4.90	1.90	1.50	1.30	0.89
Central	2.50	2.30	1.20	0.74	0.57
Eastern	0.49	0.40	0.31	0.48	0.35
Greater Accra	2.00	2.50	0.98	1.30	1.10
North East	1.30	1.10	2.00	1.40	1.60
Northern	2.20	1.40	1.60	1.00	1.00
Oti	16.50	2.30	3.60	1.40	1.40
Savannah	1.90	0.94	0.94	0.85	0.85
Upper East	2.60	2.60	1.20	1.80	0.91
Upper West	5.60	2.80	1.50	1.50	1.10
Volta	2.00	1.50	1.20	1.40	1.00
Western	1.70	1.30	1.10	0.58	0.56
Western North	2.70	0.57	0.61	0.93	0.50

Adolescent Pregnancy rate (10-19years)

The country recorded a total number of 102,878 adolescent pregnancies in the healthcare facilities in 2022. This represents a reduction of 6.1% from the previous year's number of 109,591. Generally, there has been improvement in the prevalence of pregnancy among the adolescent aged 10-19 over the last five years (2018-2022). Nonetheless, the prevalence rate is higher among adolescent aged 15-19 years than those aged 10-14 years (Figure 22). As expected, the rate among the 15-19 year group is, however, lower than the one reported in the 2022 DHS (109 pregnancies per 1,000 women).

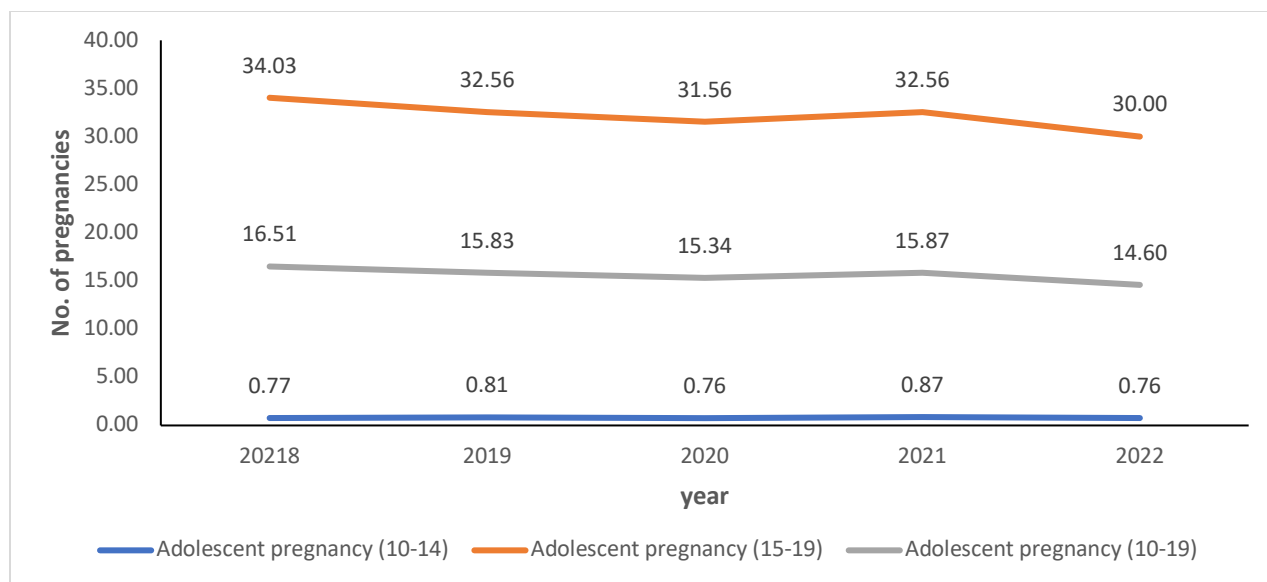


Figure 22 Number of adolescent pregnancies per 1000 women

In the year under review, the adolescent pregnancy rate reduced by 8.0% among the 10-19 year group; 12.5% among the 10-14 year group; and 7.7% among the 15-19 year group (Table 15). The rate recorded among the 15-19 year group is lower than the one (109 pregnancies per 1,000 women) reported in the 2022 DHS.

Regional disaggregation showed that adolescent pregnancy rate (per 1000 women) is the lowest in the Greater Accra region and highest in the North East. This could be attributed to poverty and other factors that are not readily available to the Ministry. Other regions including Oti, Savannah and Bono East region also posted high adolescent pregnancy rates of more 20 or more per 1000 women.

Table 15 Adolescent pregnancy per 1,000 women aged 10-19 years by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	18.85	17.38	16.30	19.99	15.99
Ashanti	14.01	13.96	13.46	14.12	13.15
Bono	16.92	18.11	13.59	15.35	15.14
Bono East	23.89	23.16	22.61	21.51	20.00
Central	20.09	17.27	16.53	16.06	14.90
Eastern	15.49	14.12	14.23	16.59	15.52
Greater Accra	9.71	8.93	7.97	7.28	6.77
North East	26.44	22.84	28.06	26.99	26.22
Northern	21.08	20.28	21.09	18.05	16.50

Region	2018	2019	2020	2021	2022
Oti	20.94	20.90	21.72	23.23	21.91
Savannah	26.31	28.84	25.10	24.71	21.92
Upper East	21.16	21.85	22.39	22.76	19.83
Upper West	20.08	19.76	18.41	18.12	14.25
Volta	14.73	14.47	14.75	17.17	16.14
Western	16.87	16.69	15.29	18.54	17.77
Western North	16.87	16.69	15.29	18.54	17.77

2.4 Objective three: Increase access to responsive clinical and public health emergency services

This objective focuses on the innovative ways to manage resource for delivery of quality healthcare services. In all, there were 26 indicators under this objective which included administrative indicators such as proportion of hospitals offering mental health, traditional and alternative medicine practice, facilities in good standing, bed occupancy rate, and length of stay at wards. It also has infectious disease indicators such as Tuberculosis, HIV/AIDS, Malaria, and many more.

Overall performance score for this objective is 0 on the scale of -3 to 3, representing a **fairly good** performance (Table 16). Twenty-One (21) out of twenty-six (26) indicators under this objective were assessed because the other indicators required the use of survey data, which was not available. Eight (8) indicators had a maximum score of +3; one (1) indicator obtained +2; one (1) indicator scored 1; six (6) indicators scored 0; two (2) had -1; and three indicators had -2.

Table 16 Performance score for policy objective three

Indicator	Performance score	Interpretation	Colour code
Family planning acceptor rate	3	Excellent	
HIV incidence per 1,000 population	3	Excellent	
Prevalence of hypertension	3	Excellent	
Institutional All-Cause Mortality	3	Excellent	
Surgical Site Infection Rate	3	Excellent	
Average response time to emergencies	3	Excellent	
Percentage of Planned Preventive maintenance activities implemented (Ambulances)	2	Very Good	

Indicator	Performance score	Interpretation	Colour code
Proportion of disease outbreaks identified, and response actions started within 24-48 hours	1	Good	
Blood collection index (BCI) per 1000 population	0	Fairly Good	
95-95-95 Target (HIV Infected persons who are receiving sustained ART)	0	Fairly Good	
TB case detection rate	0	Fairly Good	
Total estimated protection by contraceptive methods supplied (Couple Year Protection (CYP)	0	Fairly Good	
Prevalence of diabetes	0	Fairly Good	
Bed Occupancy Rate	0	Fairly Good	
TB treatment success rate (%)	-1	Average	
Ratio of Ambulance to population	-1	Average	
95-95-95 Target (HIV Positive people receiving ART with viral Suppression)	-2	Below Average	
95-95-95 Target (HIV Infected persons who know their HIV Status)	-2	Below Average	
Tuberculosis incidence per 100,000 population	-2	Below Average	
Malaria incidence per 1,000 population	-2	Below Average	
Average length of stay	-2	Below Average	
Prevalence of mental health disorders among women and young adults	-3	Poor	
Prevalence of NTDs (e.g Yaws, Bruli ulcer, etc)	-3	Poor	
Death rate due to road traffic injuries	-3	Poor	
Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	-3	Poor	
Hepatitis B incidence per 100,000 population	-3	Poor	

Indicator	Performance score	Interpretation	Colour code
Overall	0	Fairly Good	

Trend analysis of key indicators under objective three

Emergency medical services (EMS)

The mandate of the National Ambulance Service (NAS) is to provide a nationwide, comprehensively, and timely emergency medical services to all people living in Ghana. At present, all the 297 (100%) ambulance stations are functioning with a dedicated ambulance and mix of staff. In addition, there are other satellite stations to augment emergency medical services. This feat is achieved due to the government “one ambulance one constituency” initiative, which made it possible for all districts to have ambulance centres. However, the key challenge of the Service is lack of dedicated funding, which has resulted in patients being charged a token for transportation cost occasionally.

In 2022, the total number of emergencies responded to by the NAS decreased by 8.4% from 41,903 in 2021 to 38,397 in 2022 (Figure 23). This is the first dip in emergency cases responded to since 2019.

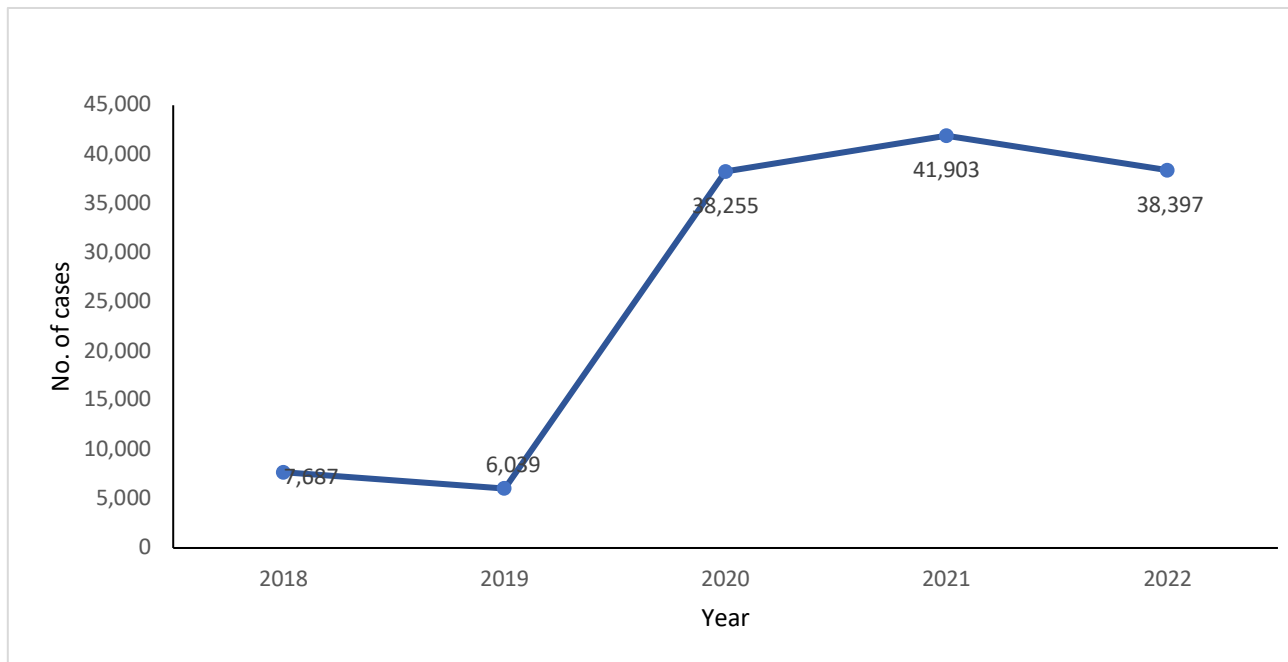


Figure 23 Trend of cases seen 2018-2022

However, there was an improvement in the response time to these emergencies. It increased marginally by 2 minutes, from twenty-two minutes, forty-three seconds (22.43) to twenty minutes, twenty-seven seconds over the same period (Figure 24).

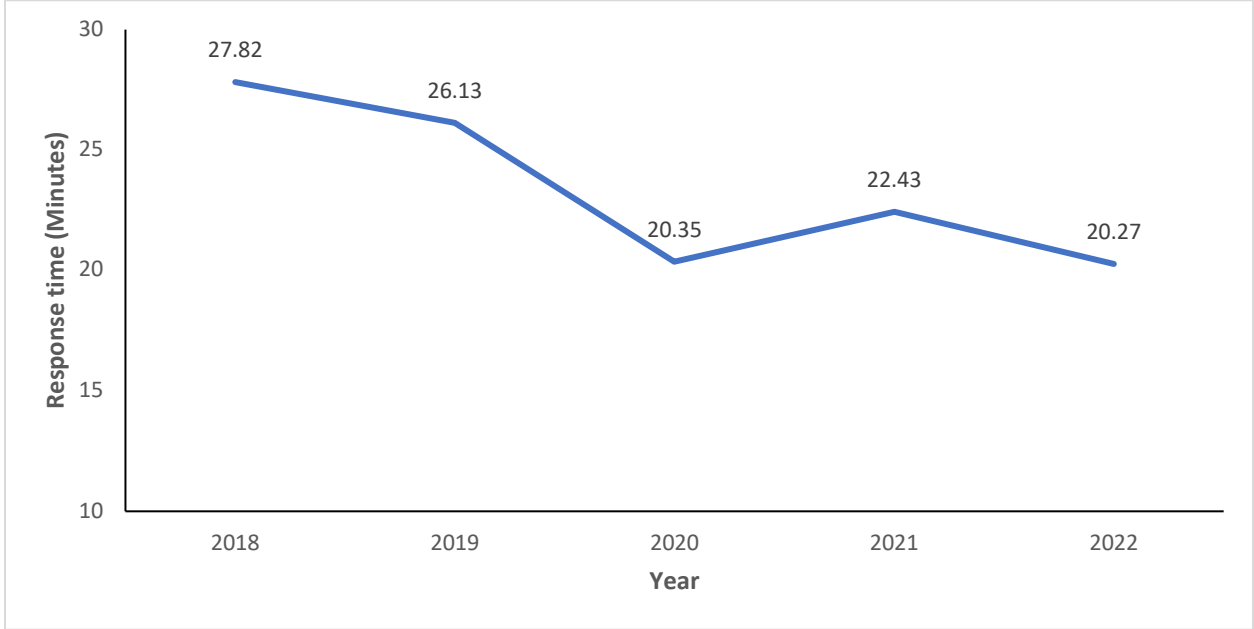


Figure 24 Case response time, 2018-2022

Regional distribution of the case response time showed that seven out of the 16 administrative regions recorded worse case response times than the national average (Table 17). Whilst the Upper East and Greater Accra regions posted the shortest case response time, the North East and Oti regions recorded the longest case response time of 23 and 33 minutes, respectively.

Table 17 Average case response time, case holding time, and vehicle engaged time by region, 2022

Region	Average case response time	Average case handling time	Average vehicle engaged time
Ahafo	0:16:28	2:11:47	4:03:57
Ashanti	0:15:50	2:12:42	3:52:19
Bono	0:14:38	2:46:12	5:07:08
Bono East	0:22:42	2:22:04	6:02:06
Central	0:17:43	2:07:51	3:39:15
Eastern	0:20:33	2:27:55	4:10:20
Greater Accra	0:15:46	1:44:55	2:57:27
North East	0:23:46	2:07:37	6:55:39
Northern	0:16:16	1:49:40	3:51:30

Region	Average case response time	Average case handling time	Average vehicle engaged time
Oti	0:33:48	2:55:32	7:43:51
Savannah	0:18:54	1:48:29	4:02:37
Upper East	0:21:42	1:45:48	5:08:12
Upper West	0:21:48	1:49:18	4:28:01
Volta	0:22:38	2:19:14	4:29:27
Western	0:24:26	2:03:01	4:41:44
Western North	0:20:07	3:34:50	8:36:17
Ghana	0:20:27	2:15:26	4:59:22

Source: National Ambulance Service

The Upper East, Savannah and Upper West regions posted the shortest case holding time (time taken to pick the patient until he/she is handed over to the receiving facility) of less than two hours whilst the Western North region recorded the longest case handling time and vehicle engaged time of more than 3 and 8 hours respectively.

Average vehicle engaged time, which represents the time taken for the vehicle to leave base and return to base, was lower in the Greater Accra, Central, Northern and Ashanti regions compared to the rest of the regions. This situation is probably due to the high density of health facilities and good road networks in these regions. The Western North, Oti, North East and Bono regions, however, recorded the high average vehicle engaged times because of long distance between these regions and the nearest referral facilities.

Proportion of hospitals offering mental health services

Mental health services remain a priority area in the health sector for attainment of UHC. This indicator measures the extent to which mental health services are provided at all levels of the health system. In 2021, the Authority in attempt to strengthen community mental healthcare services as the new paradigm, conducted community durbars, school health talks, and outreach services. A helpline was also activated to operate via toll-free call centre to allow the Authority receive feedback and improve on its services. In the year under review, all district and regional hospitals had mental health units that provided mental health services alongside the general services.

The top ten psychiatric conditions presented at the outpatient department over the last four years (2018-2022) are shown in Table 18. Schizophrenia, schizotypal and delusional disorders continued to be the topmost conditions and Mental Retardation, the least. Nonetheless, all the 10 top conditions went up in the year under review, compared to the previous year. Schizophrenia, schizotypal and delusional disorders increased from 2,542 to 4,414 (73.6%) in the year under review. Similarly, Mental Retardation condition went up by almost six folds, from 62 to 345 over

the same period. Mental Disorders due to Alcohol use is the only condition that increased marginally (1.5%).

Table 18 Top 10 causes of Psychiatric OPD attendance, 2018- 2022

No.	Condition	2018	2019	2020	2021	2022
1	Schizophrenia, schizotypal and delusional disorders	20,961	1,474	1,993	2,542	4,414
2	Epilepsy	23,329	574	1,127	1,166	1,331
3	Mental Disorders due to other psychoactive substance use	3,598	525	552	792	1,120
4	Depression	5,893	467	540	687	1,209
5	Bipolar Disorder	3,258	361	304	370	947
6	Mental Disorders due to Alcohol use	3,675	279	182	340	345
7	Dementia	1,311	152	185	224	258
8	Generalised Anxiety	2,922	67	87	101	151
9	Conduct/Behavioral disorders	143	67	57	87	280
10	Mental Retardation	1,232	64	36	62	345

Source: Mental Health Authority, 2022

Hospital bed availability

There has been an improvement in the number of beds available for admission in the hospitals over the years. In the year under assessment, it increased from 31,775 to 33,249 (4.6%) between 2021 and 2022. This translates into 1.1 beds per 1000 population. Together, the five Teaching Hospitals had a total of 4,124 beds available for admissions in 2022.

The regional breakdown showed that there was less than one bed per 1000 population in all the regions in the year under assessment, corroborating the “no bed syndrome” the country has been experiencing over the years (Table 19). Nonetheless, twelve out of the sixteen regions recorded better bed to population density. The Upper West recorded the best bed to 1,000 population of 0.14 whilst the Oti and Savannah regions had the worst bed density of 0.07.

Table 19 Hospital bed per 1,000 population by region, 2021-2022

Region	2021	2022
Ahafo	0.11	0.11
Ashanti	0.12	0.12
Bono	0.11	0.12
Bono East	0.10	0.10
Central	0.10	0.10
Eastern	0.11	0.12

Greater Accra	0.08	0.09
North East	0.08	0.08
Northern	0.11	0.12
Oti	0.07	0.07
Savannah	0.05	0.07
Upper East	0.09	0.08
Upper West	0.14	0.14
Volta	0.13	0.13
Western	0.10	0.10
Western North	0.11	0.11

Bed occupancy rate

This indicator measures utilisation of the available bed capacity in the healthcare facilities. Trend of the indicator over the last five years (2018-2022) showed a marginal increase of less than one percentage points difference, as shown in Figure 25. However, there was a dipped in 2020 probably due to the COVID-19 pandemic restrictions on facility attendance. In the year under review, the percentage of beds occupied by patients increased from the baseline rate of 56.1% to 59.0% (2.9 percentage points difference). This indicates that a little over 50% of the bed capacity in the healthcare facilities were utilised.

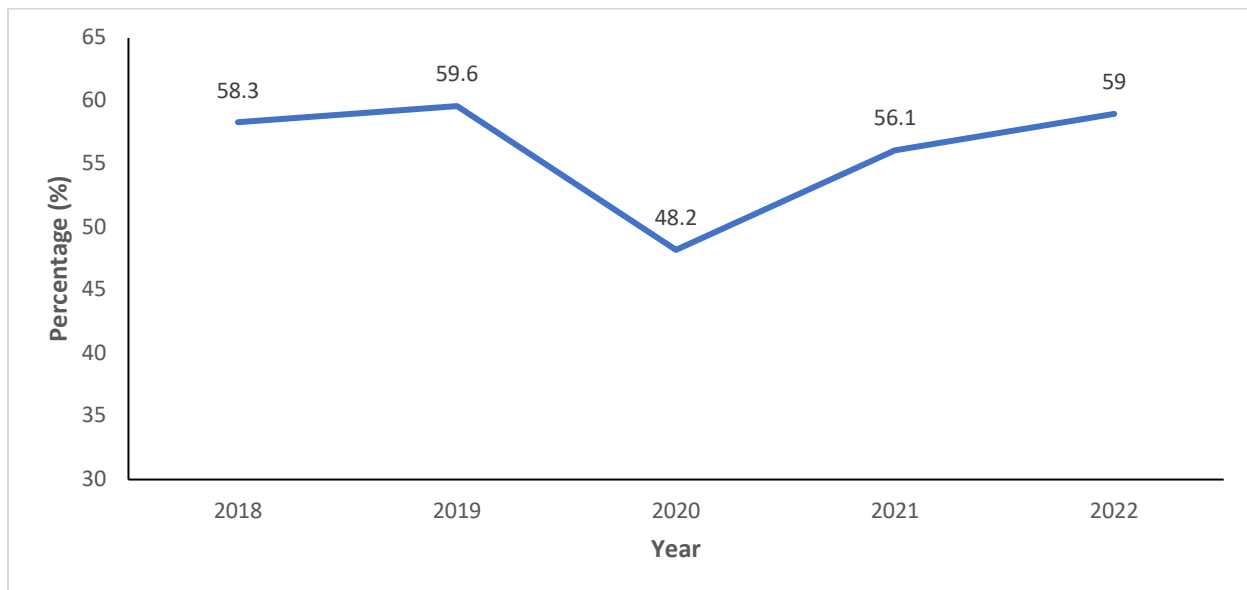


Figure 25 Trend in bed occupancy rate, 2028-2022

Average length of stay in emergencies

This indicator measures the efficiency of the hospital management. It is the average number of days a patient spends in an emergency ward. In 2022, there was a marginal decrease in the average length of stay in emergency, as shown in Figure 22. The number of days a patient stayed in the hospitals averaged 2.3 days, compared to the set target of 2 days for the year under review. The trend of this indicator over the last five years, however, shows a worrying situation, from 2.4 to 3.3 days. The situation remains same in the Teaching Hospitals; it averaged 2.2 days per patient in the emergency wards.

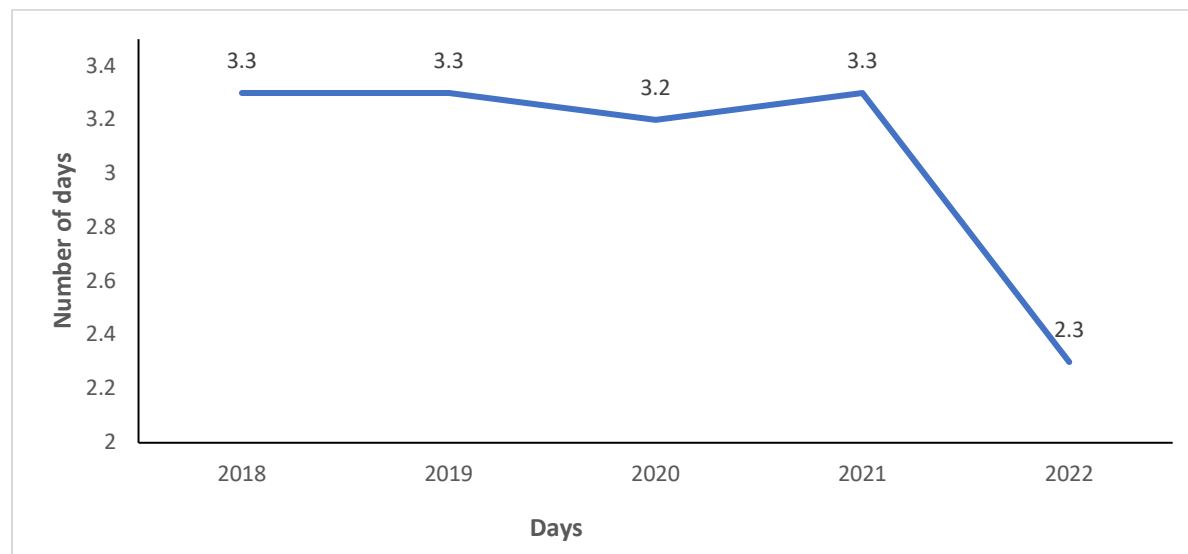


Figure 26 Trend in average length of stay in emergency, 2018-2022

Family planning

Expanding access to Family Planning and Reproductive Health (FP/RH) services is one of the best investments a country can make. FP/RH services can improve women and children’s overall health, reduce maternal and child mortality, and help prevent HIV infections. As a country, family planning services are provided at all levels of the healthcare system with basic training offered to health workers to deliver appropriate family planning services. In the year under assessment, the number of persons accepting to use family planning methods increased from 2.5 million to 2.7 million, resulting in a family planning acceptor rate to 36.1% (Figure 27). A trend over the last five years showed a sharp rise by 5.5 percentage points difference.

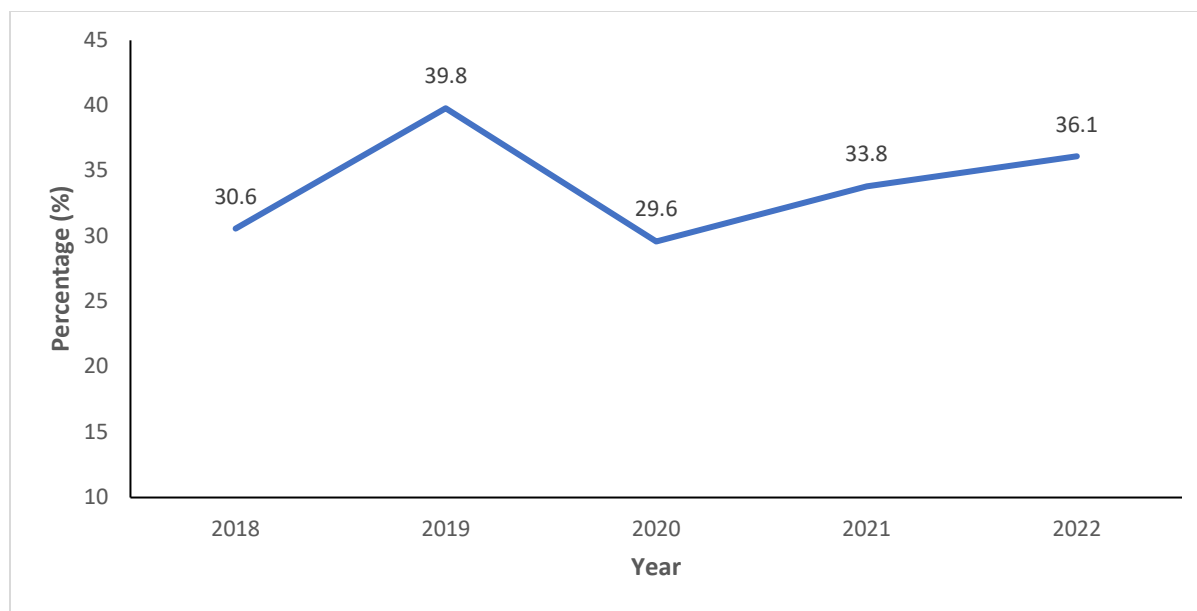


Figure 27 Trend in family planning acceptor rate, 2018-2022

The regional decomposition showed that less than half (6 out of 16) of the regions had higher family planning acceptor rate than the national rate of 36.1%, as shown in Table 20. Generally, majority of people in the Ahafo, Bono, Bono East, Upper East and Greater Accra regions had accepted to use family planning methods more than those in the other regions over the last five years. The Ahafo region recorded the highest family planning acceptor rate of 50.2%, followed by the Upper West region 49.9%46% in the year under review. The North East region, on the hand, recorded the worst family planning acceptor rate of 21%. With the inclusion of family planning services in the NHIS benefits package, it is expected that more gains would be made in subsequent years.

Table 20 Family planning acceptor rate by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	56.7	62.7	44.6	56.7	50.2
Ashanti	26.7	24.7	22.8	29.1	28.7
Bono	57.8	65.0	41.0	41.8	33.9
Bono East	47.0	47.7	41.1	43.8	43.4
Central	32.8	35.0	32.3	38.7	45.6
Eastern	28.4	28.5	25.0	30.2	29.9
Greater Accra	80.3	73.5	33.6	35.9	47.8
North East	25.8	50.4	23.7	21.6	21.0
Northern	31.4	33.5	28.2	27.8	26.5
Oti	32.3	28.0	31.7	34.8	34.4

Savannah	27.8	26.6	18.8	20.2	23.4
Upper East	30.3	31.3	31.8	35.8	33.1
Upper West	54.0	52.5	50.0	46.0	49.9
Volta	26.1	23.2	24.6	28.9	30.3
Western	27.8	31.4	29.0	34.0	38.1
Western North	23.3	27.8	24.5	27.9	26.5

The couple-year protection (CYP) which refers to the estimated protection provided by family planning methods during the year under review, based on the volume of all contraceptives sold or distributed free to clients had declined from 2.9 million to 1.6 million (45.9%) over the last five years after a marginal increase in 2019 (Figure 28). However, in the year under review, it increased from 1.4 million to 1.6 million (8.1%).

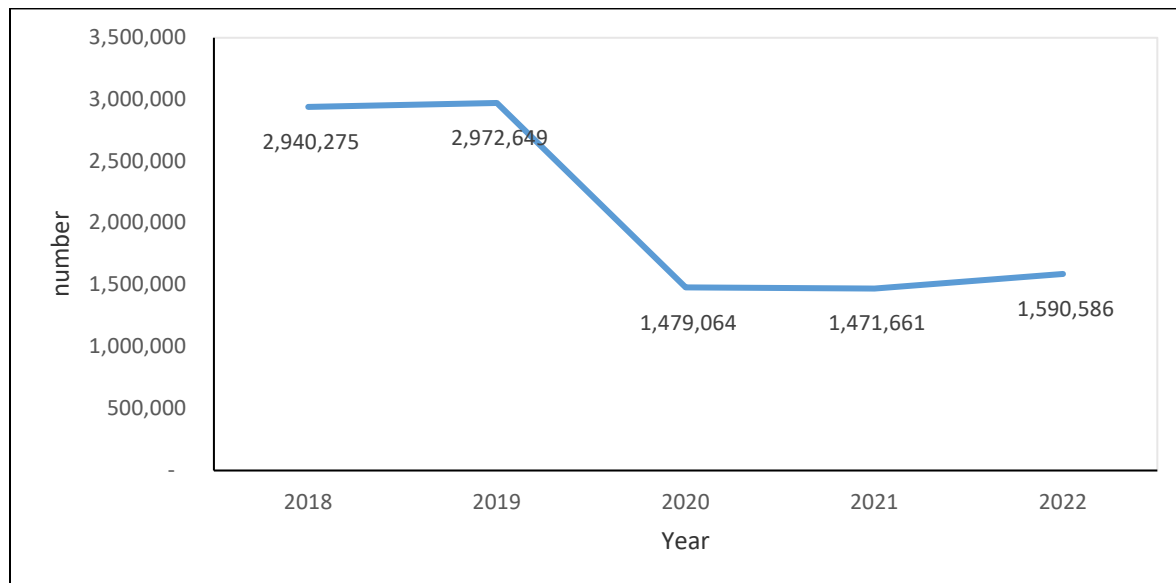


Figure 28 Trend in couple-year of protection, 2018-2022

Malaria incidence per 1000 population

The number of people getting infected with malaria has gone down over the last five years. The reported cases to the healthcare facilities per 1000 population had declined from 341 to 178 (47.8%) over the same period (Figure 29). The rate of decline had been slow since 2019, where a sharp drop was observed. In the year under assessment, however, the number of infections per 1000 population increased marginally from 176 to 178 (1.1%).

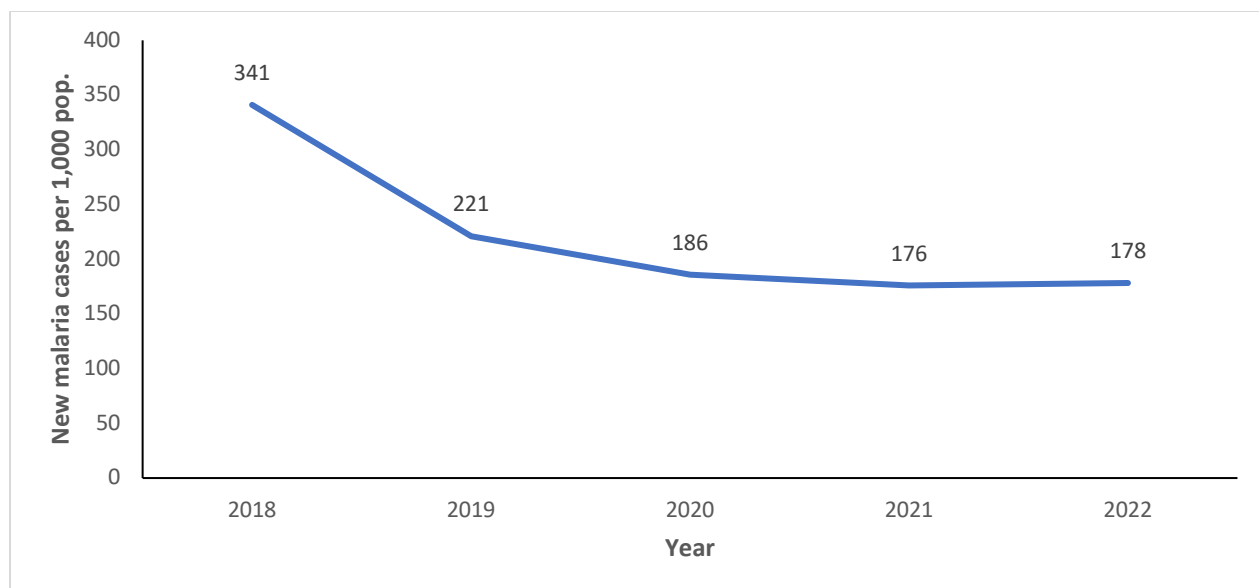


Figure 29 Malaria incidence per 1,000 population, 2018-2022

Regional distribution of malaria infection showed that the Greater Accra recorded the best incidence of 38.2 new cases per 1,000 population between 2018 and 2022. However, Upper East region recorded the worst malaria incidence of 349.2 new cases per 1,000 population. Five other regions (Bono, Ahafo, Bono East, Upper West and North East) also recorded worse incidence of more than 250 new infections per 1000 population (Table 21).

Table 21 Malaria Incidence per 1000 Population by region, 2018-2022

Ghana	2018	2019	2020	2021	2022
Ahafo	328.1	322.8	254.1	349.5	295.3
Ashanti	176.7	168.4	142.3	173.8	148.5
Bono	402.2	435.2	297.4	344.3	309.2
Bono East	357.5	388.2	300.1	266.5	269.3
Central	264.8	239.8	197.7	213.6	194.6
Eastern	239.1	223.3	194.3	272.8	240.3
Greater Accra	63.8	52.9	39.5	44.6	38.2
North East	142.4	194.7	198.2	231.1	256.5
Northern	150.5	151.1	128.3	121.1	116.9
Oti	219.9	235.7	202.9	199.8	209.4
Savannah	286.4	280.7	200.	185.2	206.7
Upper East	399.1	462.3	392.3	392.2	349.2
Upper West	335.2	422.6	336.1	317.8	299.4
Volta	187.1	184.	127.	191.7	146.5

Ghana	2018	2019	2020	2021	2022
Western	261.9	285.3	215.4	277.6	213.6
Western North	347.8	363.8	307.4	335.6	223.4

Prevalence of hypertension and diabetes

In 2019, the Ministry of Health revised the policy for the prevention and control of non-communicable diseases (NCDs) to address the increasing number of premature mortalities due Cardiovascular Disease, Cancers, Respiratory Diseases and Diabetes Mellitus.

Available data indicates that the number of patients diagnosed with hypertension increased from 172,796 in 2018 to 193,099 in 2022, representing 11.74%. In the same period, the number of diabetic patients increased from 617,563 to 622,849 (0.86%).

Trend analysis of prevalence of hypertension at the healthcare facilities showed that it had been less than 3% over the last five years (2018-2022) and that of diabetes hovered around less than 1%. In the year under review, the percentage of persons with hypertension stagnated at 1.98% between 2021 and 2022, whilst those with diabetes decreased marginally from 0.66 to 0.61% (Figure 30).

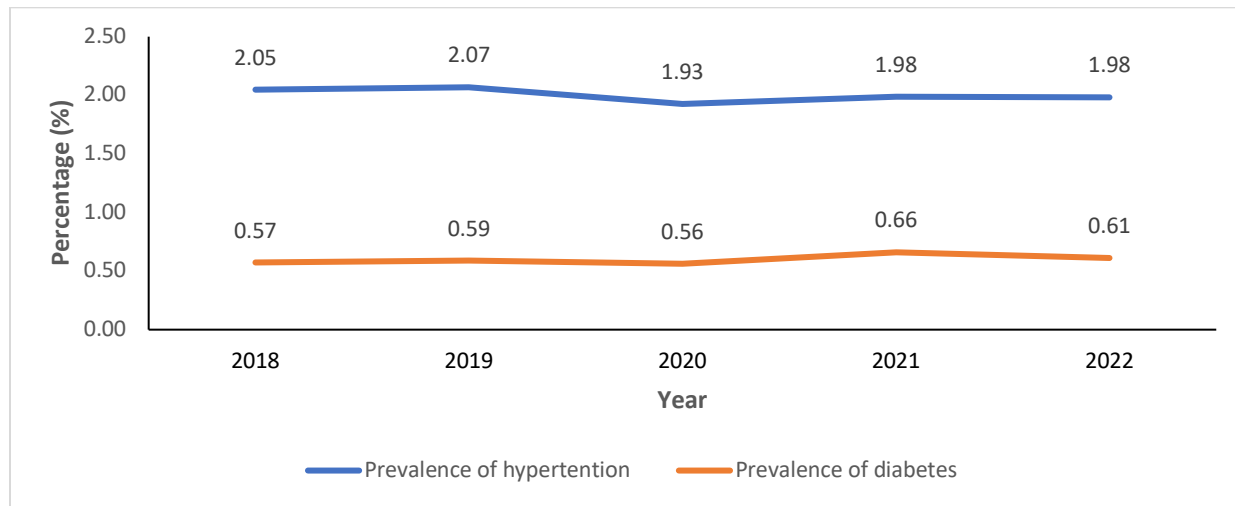


Figure 30 Trends in prevalence of hypertension and diabetes, 2018-2022

The reported prevalence of hypertension in this report is far lower, compared to the 2014 Ghana DHS figure of 13%. However, this variation is not surprising considering that there are many people with these conditions who are not reporting to health facilities for screening. Several measures, including setting of sensitisation programme to encourage people to seek care early; and regular outreach programme to screen people for hypertension and diabetes would be necessary to improve the data capturing and management of the disease.

All-cause mortality

The number of persons dying from any cause of condition has improved over the last three years (2020-2022) as shown in Figure 31. It declined from 22.9 to 19 per 1,000 hospital admissions. In the year the assessment, the reduction was greater, from 21.7 to 19 per 1,000 hospital admissions. Trend of the indicator over the last five years, however, had not shown much improvement.

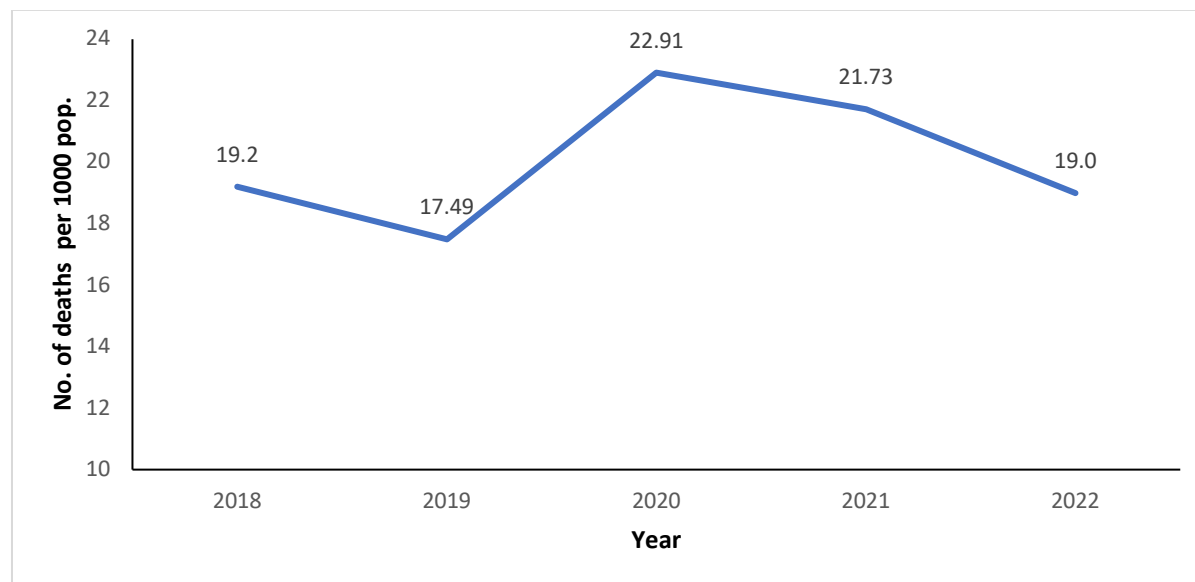


Figure 31 Trend in Institutional all- cause mortality rate, 2018-2022

Regional disaggregation of the indicator showed that the Ahafo region recorded the lowest all-cause mortality rate of 9.82 deaths per 1000 population, followed by the Western North region (Table 22). The Volta region, on the other hand, posted the worst all-cause mortality rate of approximately 31 deaths per 1000 hospital admissions in the year under review, followed by the Greater Accra region, which also recorded the worse performance over the last five years. Overall, four out of the 16 regions (Volta, Greater Accra, Eastern, and Bono) recorded all-cause mortality rates higher than the national rate of 19 deaths per 1,000 hospital admissions.

Table 22 Institutional all-cause mortality rate by region, 2018-2022

Regions	2018	2019	2020	2021	2022
Ahafo	15.44	9.24	14.35	12.33	9.82
Ashanti	11.00	10.43	14.65	13.10	12.24
Bono	18.75	18.87	24.71	24.85	26.01
Bono East	19.83	16.93	21.49	21.47	19.64
Central	20.95	19.03	24.64	22.44	19.44
Eastern	24.60	21.09	27.89	27.89	28.35

Greater Accra	33.39	30.39	35.81	31.74	29.86
North East	14.48	16.83	18.77	20.47	20.74
Northern	15.86	10.99	16.03	18.81	19.88
Oti	15.54	14.35	13.50	16.73	17.30
Savannah	15.99	11.09	8.80	13.42	11.88
Upper East	28.98	31.60	21.75	29.41	23.86
Upper West	17.33	15.75	15.32	20.53	18.43
Volta	31.73	29.33	29.41	35.57	30.77
Western	25.34	23.62	18.22	23.97	19.98
Western North	13.51	11.39	11.91	12.49	10.77

HIV incidence and prevalence

In 2022, a total of 16,574 new cases of HIV infections were recorded, compared to 15,225 in 2021, representing a change of 8.9%. New cases of HIV infections in the country went down marginally from 0.67 to 0.53% (0.20 percentage points difference) between 2021 and 2022 (Figure 32).

The percentage of new and old HIV infections in the population (prevalence rate), however, increased slightly to 1.6% (0.02 percentage points difference) over the same period. This probably shows improvement in the supply of ARTs to People Living with HIV (PLHIV) in the country.

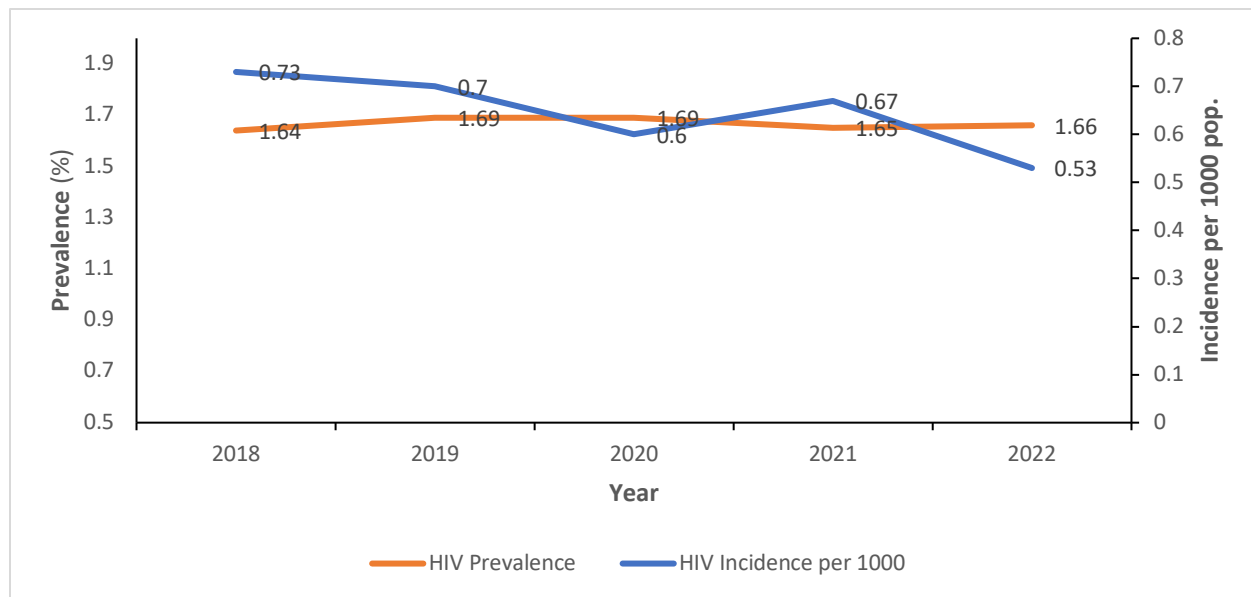


Figure 32 Trend in HIV prevalence and incidence, 2018-2022

At the regional level, North East region recorded the lowest new infections per 1000 population (0.14) whilst the Eastern and Greater Accra region recorded the highest rate of 0.69 per 1000

population (Table 23). Five other regions, including Bono, Ashanti, and Western North regions also had higher new infection rates than the national rate of 1.66 per 1000 population.

Table 23 Number of new HIV infections per 1000 population by region, 2018-2022

Region	2019	2020	2021	2022
Ahafo	0.69	0.11	0.56	0.54
Ashanti	0.78	0.10	0.58	0.63
Bono	1.03	0.10	0.79	0.68
Bono East	0.66	0.11	0.54	0.55
Central	0.50	0.11	0.30	0.42
Eastern	0.77	0.10	0.74	0.69
Greater Accra	1.12	0.09	0.57	0.69
North East	0.08	0.13	0.17	0.14
Northern	0.11	0.13	0.16	0.16
Oti	0.41	0.12	0.30	0.42
Savannah	0.23	0.12	0.26	0.32
Upper East	0.26	0.10	0.37	0.23
Upper West	0.25	0.10	0.33	0.39
Volta	0.47	0.10	0.49	0.43
Western	0.53	0.10	0.57	0.52
Western North	0.72	0.11	0.42	0.67

HIV 95-95-95

The estimated number of people living with HIV increased from 349,362 to 354,927 (1.6%) between 2021 and 2022. In year under assessment, 275,245 persons infected with HIV knew their status; 222,581 were on treatment; and 68,600 had their viral load suppressed.

The percentage of HIV positive individuals who knew their status increased from 72% to 77.5% (5.5 percentage points difference) between 2021 and 2021 (Figure 33). However, those who received sustained treatment decreased from 99% to 80.9% (18.1 percentage points difference). Likewise, those who were on treatment and had their viral load suppressed decreased from 95% to 68% (27 percentage points difference).

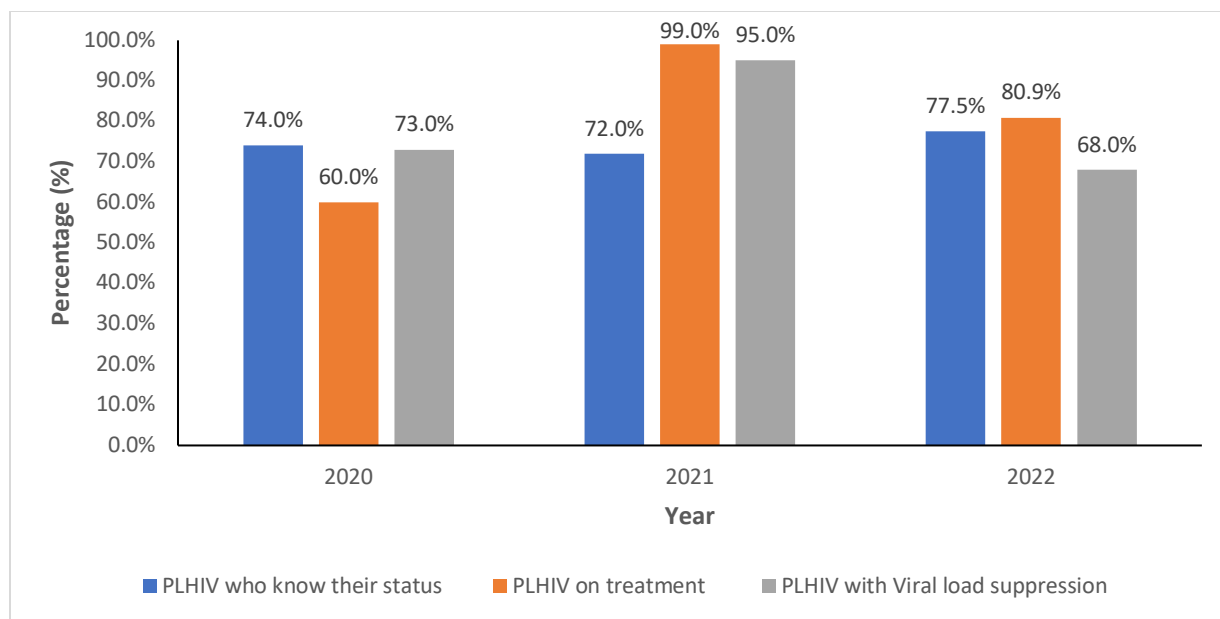


Figure 33 Percentage of PLHIV by knowledge status, treatment, and viral load suppression, 2020-2022

The decline in treatment is attributed to inadequate number of screening (or testing) and that in viral load suppression is because of reliability of test-kits and equipment and change in WHO loss to follow-up period from 90 to 30 days. This change in loss to follow up guideline indicates that a lot more of those on treatment would have their viral loads not monitored after the 30 days period. These results suggest that more efforts including scaling up screening and purchasing adequate number of reliable reagents and equipment are needed to speed up progress towards the attainment of 95-95-95 target by 2025.

Tuberculosis (TB) incidence rate

The number of new TB infections had increased from 14,602 to 16,526 (13.2%) over the last five years (2018-2022). Consequently, the number of new cases per 100,000 population (incidence) had increased from 43.4% to 52.5% (9.1 percentage points difference) over the same period, as shown in Figure 34. In the year under review, the new and relapsed cases per 100,000 population increased from 43.0% to 52.5% (9.5 percentage points difference).

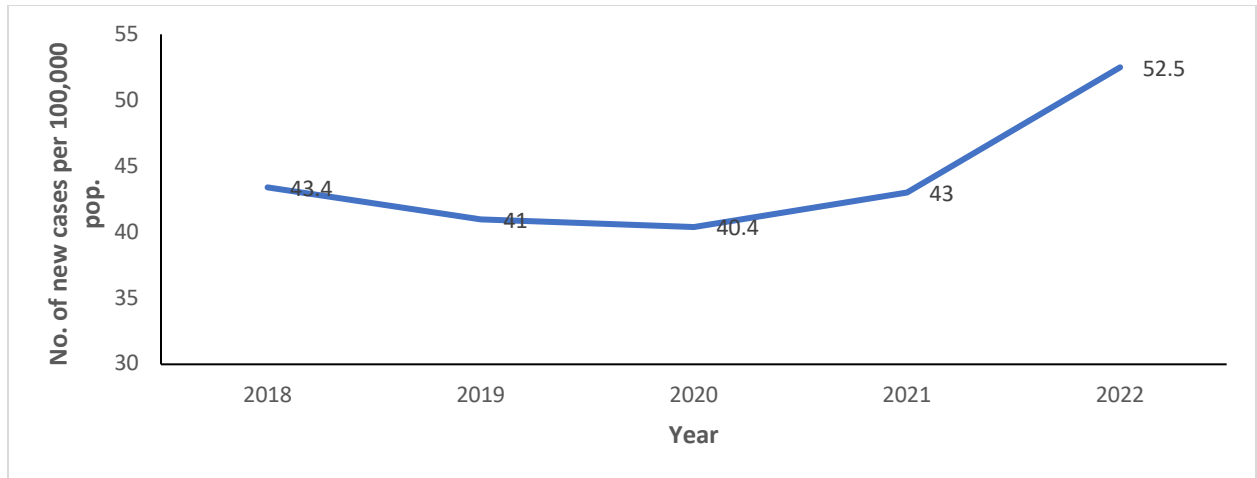


Figure 34 TB Incidence per 100,000 population

TB case detection rate

In 2022, the National Tuberculosis Programme reported 16,526 new and relapsed TB cases, an increase of 3,248 cases (24.5%) from the base year, 2021. This improved notification can be attributed to the introduction of the Sputum Sample Transportation, an intervention where sputum samples are transported through Ghana Post. Despite the increase in the number of cases, TB case detection rate declined from 54.5% to 30.3% between 2019 and 2021 (Figure 35). The year under review, however, saw an increase of 6.7 percentage points difference, from 30.3% to 36.7%.

Several challenges have been raised regarding the appropriateness of the survey projections of the number of occurrences of TB each year. Other notable concerns raised by the TB control programme include the issues regarding the sensitivity of screening tools and diagnostic algorithms, as well as low case suspicion index by health professionals.

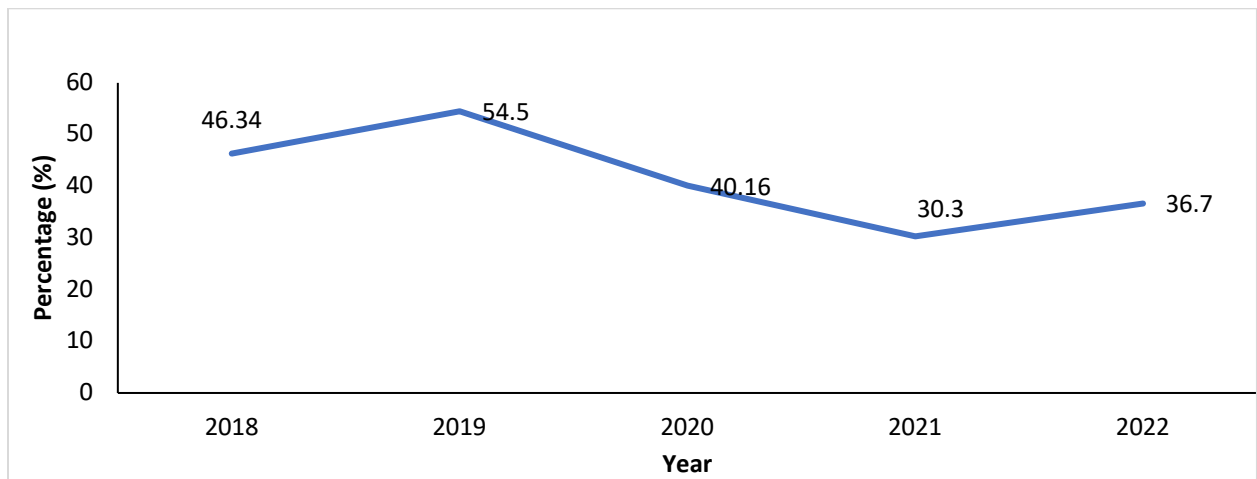


Figure 35 TB case detection rate, 2018-2022

At the regional level, the Western region recorded the highest detection rate of 92.1% whilst the Savannah region recorded the lowest rate of 24.1% (Table 24). The heavy mining activities in the western region could account for the high prevalence of TB cases in the region. Apart from Upper East and West regions, the other regions in the northern part of the country posted detection rates below 30%.

Table 24 TB case detection rate by region, 2018-2022

Region	2018	2019	2020	2021	2022
Ahafo	N/A	N/A	26.7	41.4	55.0
Ashanti	40.3	42.6	36.3	37.9	52.4
Bono	58.8	56.2	53.7	51.3	53.4
Bono East	N/A	N/A	86.4	46.5	49.5
Central	47.6	48	42.7	41.3	56.6
Eastern	52.6	51.9	44.5	48.8	67.5
Greater Accra	50.4	54.4	43.1	42.2	48.0
North East	N/A	N/A	22.9	27.9	28.7
Northern	21.7	22.9	19.8	24.8	25.6
Oti	N/A	N/A	51.6	42.2	50.7
Savannah	N/A	N/A	11	23.3	24.1
Upper East	54	54	42.1	45.7	55.3
Upper West	41.4	35.6	39.7	40.6	50.5
Volta	51.2	49	42.5	48.4	52.4
Western	63.3	65	60.5	69	92.1
Western North	N/A	N/A	27.3	38.9	36.0

NA: Not available

TB treatment success rate

The country has made progress in treatment success rate over the last three years after a drop in 2020 due to the COVID-19 restrictions. In the assessment year, the national TB programme successfully treated 87% of all detected TB patients, but this is a stagnation compared to the previous year (Figure 36). In the year under assessment, the programme commenced processes to reduce the number of patients defaulting treatment by ensuring that persons diagnosed with TB are recorded in the TB e-Tracker and the Institutional TB register. Patients are easily identified and initiated on treatment early. This partly contributed to the increase in notification in 2022.

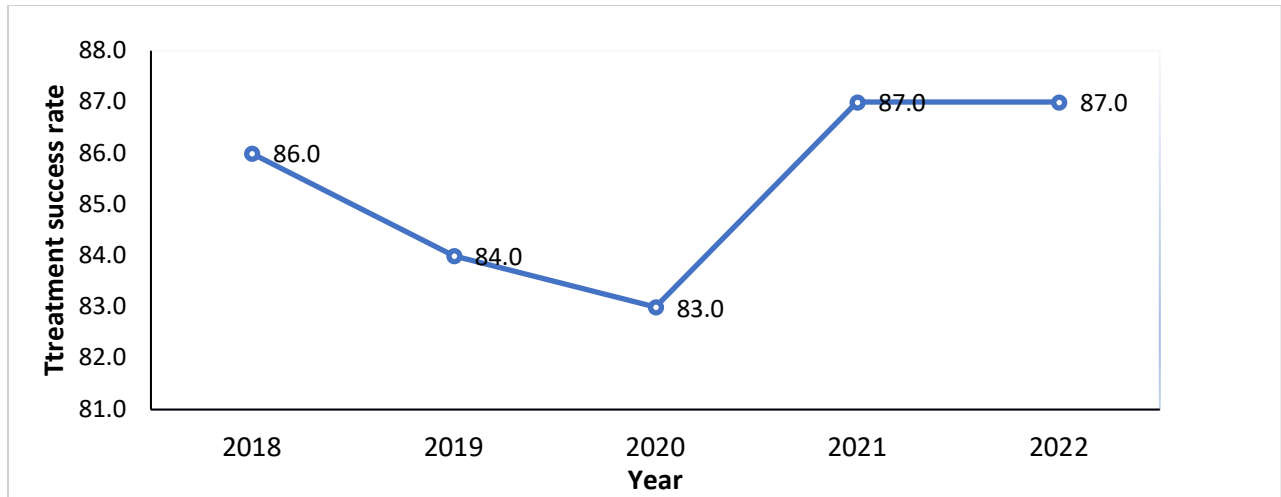


Figure 36 Trend in TB treatment success rate, 2018-2022

Surgical site infection rate

Surgical site infections (SSIs) occur among a small proportion of patients undergoing inpatient surgical procedures. Although SSIs are treatable with antibiotics, it is a major cause of mobility and mortality after surgery. Data available from the five teaching hospitals indicates that number of general surgeries increased by 14% from 21,366 in 2020 to 24,321 in 2021. In 2022, the number almost doubled to 46,807 representing 92% increase. In the same year, a total of 40,367 surgeries were performed at KBTH (23,152) and KATH (17,215) Teaching Hospitals, the two largest teaching hospitals in the country.

The number of people reporting back to facilities with infected wounds after surgery has seen a remarkable decline over the last three years (2020-2022), as shown in Figure 37. In the year under review, it declined to 1.7%, from 4% in 2021. This performance met the national target of less 5%.

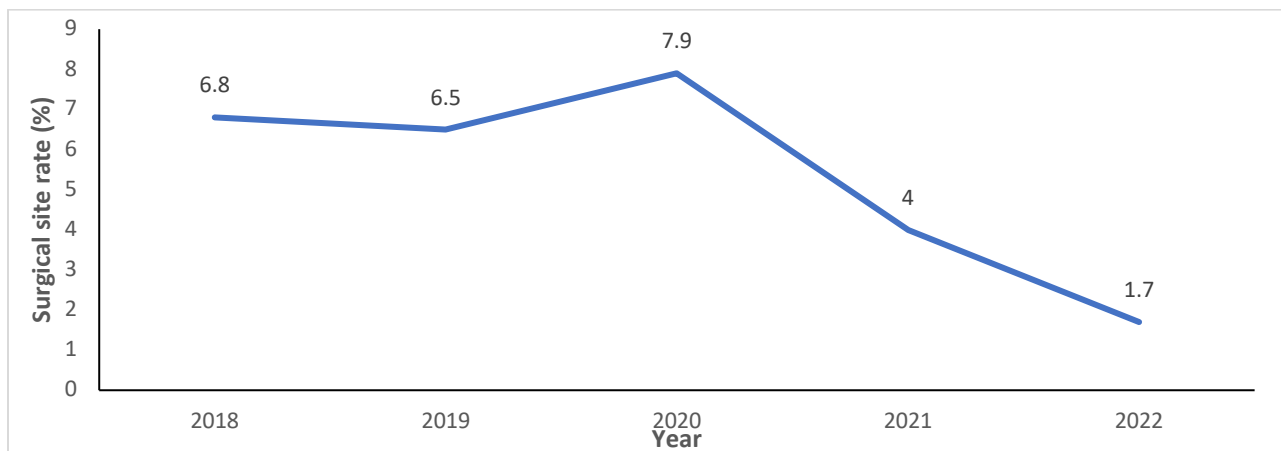


Figure 37 Trend in surgical site infection rate, 2018-2022

Note

Graph excludes data from the five teaching hospitals

Voluntary unpaid blood

The National Blood Service (NBS) organised 897 voluntary mobile blood collection sessions in 2022 compared to 646 sessions in 2021. In general, the units of blood collected across the country increased from 173,938 to 179,765 between 2021 and 2022. This resulted in a marginal improvement in the voluntary unpaid donations from 45,616 to 45,463, representing 0.1% over the same period.

Blood collection index per 1000 population (BCI)

The average number of blood donation per 1,000 population increased marginally from 5.7 in 2021 to 5.8 in 2022 as shown in Figure 38. This achievement, however, falls short of the national target of 10 donations per 1,000 population in the assessment year (2022). Trend over the last five years (2018-2022) showed that the country’s blood collection index stagnated around 6 per 1,000 population between 2018 and 2019. It then decreased sharply from 6.0 to 5.2 per 1,000 in 2020 due to the COVID-19 pandemic. Since then, there had been a gradual increase.

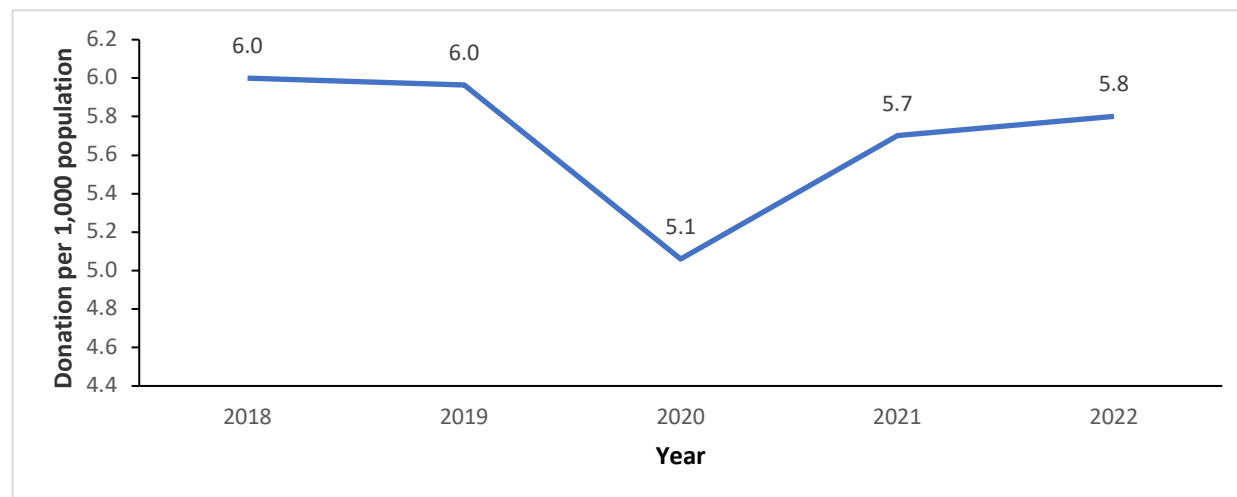


Figure 38 Trend in blood collection index, 2018-2022

Regional decomposing of the number of blood donations per 1,000 population showed that close to half of the regions (seven) recorded blood donation index higher than the national index of 5.8 in the year under review (Table 25). The Upper East region recorded the highest collection index of 10.7, followed by Bono East (7.8). The worst blood collection index was recorded in the Bono region (2.0), followed by the Oti region (3.0)

Table 25 Blood collection index by region 2022

Region	2018	2019	2020	2021	2022
Ahafo	8.3	6.7	6.9	7.2	6.2
Ashanti	4.3	4.2	3.4	5.0	4.4
Bono	3.1	2.7	2.5	2.3	2.8
Bono East	6.5	6.5	6.9	6.4	7.8
Central	3.9	4.4	5.6	5.2	5.3
Eastern	5.4	6.4	6.7	7.2	6.6
Greater Accra	8.0	7.7	5.8	7.7	7.5
North East	0.0*	0.2	0.0*	3.3	3.7
Northern	3.4	5.2	4.6	6.7	7.1
Oti	2.9	2.7	2.7	3.7	3.0
Savannah	1.4	0.0*	0.8	3.1	4.3
Upper East	6.2	9.2	9.0	8.8	6.8
Upper West	7.2	9.4	7.3	9.8	10.7
Volta	7.9	6.9	5.8	5.9	6.1
Western	5.8	5.9	4.1	4.2	4.5
Western North	4.4	5.6	4.4	4.8	4.0

Note

*No blood collection was reported

3.0 FINANCIAL PERFORMANCE

A total of GHS10.9 billion was approved for the MoH in the year under review (Table 26). However, the midterm budget review revised the 2022 budget downwards to GHS10.7 billion. As per the revised budget, GoG is the major source of funds for the sector, and it constituted 60.13% of the total budget. This is followed by IGF (27.44%), Donor (12.14%) and ABFA (0.30%).

Regarding expenditure, GoG remains the major financier of the sector, comprising GHS5.4 billion, representing 84.42% of the total health expenditure. Out of the total GoG expenditure, compensation of employees constituted 84.02%, Goods & Service and Capex constituted 0.15% and 0.25% respectively (not in table). IGF which is the second highest financier of the budget takes up GHS1.45 billion representing 49.34% of the total budget expenditure. Out of this, Goods & Service is 40.21% which supports service delivery (not in table).

There is a huge difference between the projection, collection, and use of IGF. As at the end of the third quarter, only 32.35% of the projected Goods & Services have been collected and used. This

may be due to reporting issues or possible delay of National Health Insurance Scheme (NHIS) claim reimbursement.

Table 26 2022 Budget Performance as of September 2022

Source of Fund	2022 Approved Budget	Allotment (Jan - Sept)	Actual Expenditure (Jan-Sept)	Execution Rate (%)
GoG	6,461,025,716	5,058,329,485	5,454,108,801	84.42
Compensation	6,165,200,000	5,026,580,717	5,428,771,273	88.06
Goods & Services	186,810,116	11,193,183	9,432,973	5.05
Capex	109,015,600	20,555,586	15,904,555	14.59
IGF	2,948,128,162	1,659,024,169	1,454,585,458	49.34
Compensation	407,821,000	190,557,704	189,407,279	46.44
Goods & Services	2,162,824,162	1,377,688,107	1,185,366,068	54.81
Capex	377,483,000	90,778,358	79,812,111	21.14
DONOR	1,304,216,000	1,128,086,369	1,128,086,369	86.50
Goods & Services	78,482,000	291,946,535	291,946,535	371.99
Capex	1,225,734,000	836,139,834	836,139,834	68.22
ABFA	32,424,000	18,474,690	8,706,941	26.85
TOTAL	10,745,793,878	7,863,914,713	8,045,487,569	74.87

Source: 2022 MoF Budget Statement and Economic Policy and MoH financial Statement

4.0 Implementation status of 2021 aide memoire

The Ministry of Health and its Development Partners held a business meeting to discuss keys issues that were identified during the 2021 Health Summit. The outcome of that meeting was translated into an aide memoire, which highlighted 65 activities under seven thematic areas to be implemented by the relevant Agencies alongside the programme of work (Table 27). Out of the total number of activities identified, three (5%) were completed, 29 (44%) were on-going, and 33 (51%) activities had no data reported as of December 2021.

Table 27 Summary of 2021 Aide Memoire Implementation

No.	Activity	Implementation Status
1	The Ministry of Health should complete skills gap analysis in the sector. The Human Resource for Health Directorate of the Ministry in collaboration with relevant agencies, is tasked to lead this action and ensure it is completed by August 2022.	Ongoing: Expression of interest floated to procure a consultant to lead the exercise.
2	Ghana Health Service should identify missed opportunities for children due for immunisation by August 2022.	Static and mobile clinics (outreach services) are being set up at concentrated areas such as marketplaces, schools, churches, mosques, etc to immunise children.
3	Ghana Health Service should strengthen primary healthcare within the urban areas: a. Pilot one urban region	Network of Practice with support from the world Banks and other partners are being implemented to reorganise PHC services in both urban and rural areas.
4	Ghana Health Service should establish wellness clinics at all levels of care and regularly monitor their operations.	Wellness clinics are established in considerable number of facilities across the country.
5	Ghana Health Service should strengthen and scale up the wellness clinics: a. Facilitate provision of infrastructure b. Create awareness c. Conduct home visits d. Undertake community engagement	This activity is ongoing.
7	Ghana Health Service should prioritise key activities within health promotion by June 2022.	Ongoing
8	Ministry of Health in collaboration with relevant agencies (GHS, HeFRA, NHIA, Pharmacy Council, etc.) should conduct comprehensive health facility surveys by August 2022. a. Health facility mapping b. Conduct SARA to determine patient/public satisfaction with	Completed: Report is nearing completion.

No.	Activity	Implementation Status
	health services delivery (quantity and quality)	
9	Ministry of Health should develop a health landscape analysis to identify the urban-poor population for immunisation by December 2022	Yet to be undertaken.
10	Ministry of Health should develop Urban Health Strategy	Yet to be undertaken
11	Ministry of Health should review the Holistic Assessment Tool by December 2022.	Completed: Tool used for the 2022 Holistic Assessment.
12	Ministry of Health should develop Health Information System policy, strategy, and costing: a. Implement data governance programme in the sector	Strategy completed. Awaiting implementation.
13	Ministry of Health should ensure completion of the Health Information Systems Strategy by December 2022 a. Incorporate suggestions and recommendations from the Summit into the strategy	Completed
14	Ministry of Health should develop digital health architecture guidelines by December 2022.	Ongoing: technical working being formed
15	National Health Insurance Authority (NHIA) should conduct actuarial study on modalities for inclusion of health promotion in the NHIS package list and advise MoH on the various scenarios. a. Conduct Health Technology Assessment	Actuarial study for inclusion of Family planning and diabetes screening completed. Currently, Family planning is part of the NHIS benefit package. A technical working group is established to conduct health technology assessments for informed decision making

5.0 THE COVID- 19 SITUATION

In the period under review, a total of 171,065 cases were recorded with 169,586 recoveries/discharges; 1,461 deaths; and 18 active cases (Table 28). Majority of the cases were detected in the communities through the enhanced surveillance approach.

Table 28 Confirmed cases of COVID-19 and Treatment Outcomes, 2022

Category	Number of cases	Recovered/ Discharged	Severe	Critical	Dead	Active
Routine Surveillance	62,241	161,907	0	0	1,461	18
Enhanced Contact Tracing	101,143					
International travellers (KIA)	7,681	7,679				
Total	171,065	169,586	0	0	1,461	18

****Severe-0, Critical-0**

The positivity rate, which indicates the percentage of people who tested positive for the virus out of the total test conducted is low (6.8%). Nonetheless, the rate is higher among cases detected through routine surveillance than those from the enhanced contact tracing in the communities and at the Airport (Table 29).

Table 29 Positivity rate by Surveillance type for samples tested in Ghana Mar 2020- Dec 2022

Surveillance Type	Total no. Tested	Total no. positive	Positivity rate
Routine Surveillance	503,774	62,241	12.4
Enhanced Contact Tracing	1,139,789	101,143	8.9
International travellers (KIA)	881,493	7,681	0.9
Total	2,525,056	171,065	6.8

Covid-19 Vaccination Programme (Vaccine procurement, supply, and deployment)

As of December 2022, the country had received a total of 34,047,598 doses of vaccines, of which about 38.1% were AstraZeneca and 32.4% were Pfizer-BioNTech (Table 30). Also, the number of persons receiving at least 1 dose of vaccine is 12,853,113, thus, 70.4% of the targeted 18.2 million population. This also represents 40.5 % of total population in Ghana. The number of persons fully vaccinated is 9,806,758 (53.7% of 18.2 million targeted population), representing 30.9% of total population. In addition, 3,102,301 persons have received booster dose.

Table 30 vaccine receipt update, December 2022

Summary of COVID-19 vaccines received in Ghana @ 31.12.2022

<i>Vaccine Brand Name_1</i>	SUM of Quantity	Prop (%)	Doses Distributed	Doses available
AstraZeneca	12,971,470	38.1%	12,971,470	0
COVID-19 Vaccine Janssen	8,788,850	25.8%	6,136,850	2,652,000
Moderna COVID-19 vaccine	1229620	3.6%	1229620	0
Pfizer-BioNTech	11,036,658	32.4%	10,388,478	648,180
Sputnik-V	21,000	0.1%	21,000	0
Grand Total	34,047,598	100.0%	30,747,418	3,300,180

<i>Source of Vaccine</i>	Quantity received	Prop (%)
COVAX	24,011,550	70.5%
AVATT/AU/WB	5,424,450	15.9%
Bilateral	4,611,598	13.5%
Grand Total	34,047,598	100.0%

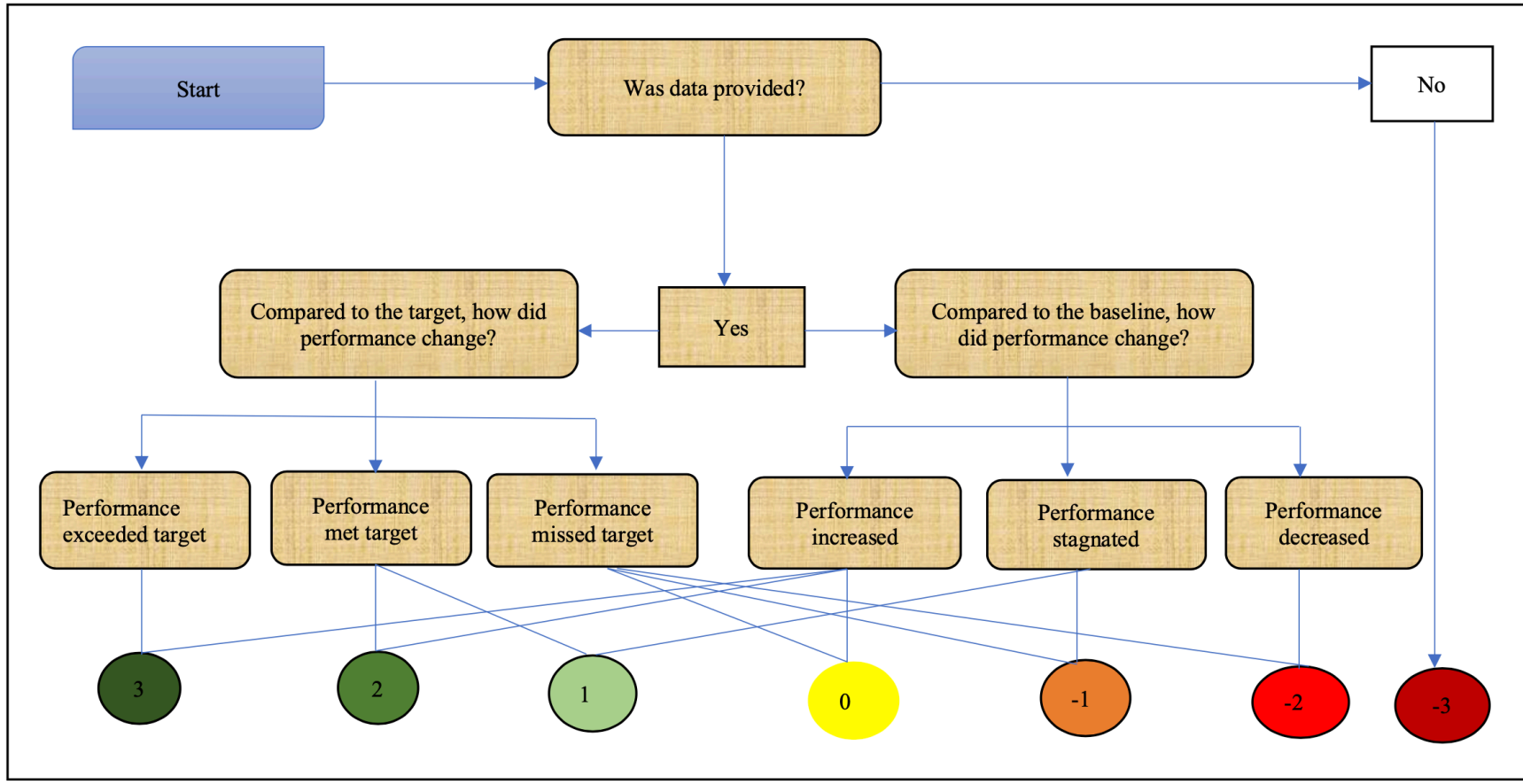
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Grand Total	34,047,598	100.0%

APPENDICE

Appendix 1: Performance assessment algorithm



Appendix 2: Trends in sector-wide indicators

MINISTRY OF HEALTH: ANNUAL HEALTH SECTOR HOLISTIC ASSESSMENT TRACKING TOOL (2022)												
S. No	Objective	INDICATOR	INDICATOR DIRECTION (+/-)	BASELINE	TARGET	2022 PERFORMANCE OUTLOOK						
				2021	2022	Actual	Relative to Target	Description of performance relative to Target	Relative to Baseline	Description of performance relative to Baseline	Performance Score	Score Description
1	Objective	Proportion of encounters with antibiotics prescribed	(-) Downward	21.0	18.0	45.0	-150.0	Missed	-114.3	Decreased	-2	Below Average
2		Government health expenditure as % of total government expenditure	(+) Upward	9.0	10.0	7.4	-26.0	Missed	-17.8	Decreased	-2	Below Average
3		Out-of-pocket expenditure as % of current health expenditure (CHE)	(-) Downward	38.0	36.0	N/A	** Missing Value**	***	**Missing Value**	***	-3	Poor
4		Proportion of population with large household expenditures on health as a share of total household expenditure or income (Catastrophic Health Expenditure)	(-) Downward	N/A	N/A	N/A	** Missing Value**	***	**Missing Value**	***	-3	Poor
5		Percentage of the population with active NHIS coverage	(+) Upward	54.4	57.0	54.5	-4.4	Missed	0.2	Increased	0	Fairly Good
6		Average percentage of clients satisfied with OPD/IPD services	(+) Upward	N/A	N/A	N/A	** Missing Value**	***	**Missing Value**	***	-3	Poor
7		Average number of medicines per prescription	(-) Downward	3.0	3.0	2.9	3.3	Exceeded	3.3	Increased	3	Excellent
8		Doctor to population ratio	(+) Upward	0.2	1.0	0.2	-83.0	Missed	-5.6	Decreased	-2	Below Average
9		Nurse to population ratio	(+) Upward	1.9	1.0	2.0	99.0	Exceeded	5.3	Increased	3	Excellent
10		Doctor population equity index (Geographical)	(-) Downward	19.5	1.0	21.0	-2000.0	Missed	-7.7	Decreased	-2	Below Average
11		Nurse Population equity index (Geographical)	(-) Downward	2.5	1.0	2.5	-150.0	Missed	0.0	Stagnated	-1	Average
12		OPD per capita attendance	(+) Upward	1.1	2.0	1.1	-47.0	Missed	-6.2	Decreased	-2	Below Average
13		Availability of essential medicines (Tracer Drug Availability)	(+) Upward	N/A	N/A	N/A	** Missing Value**	***	**Missing Value**	***	-3	Poor
14		Percentage of facilities in good standing with HeFRA	(+) Upward	29.0	50.0	40.0	-20.0	Missed	37.9	Increased	0	Fairly Good
15		Proportion of facilities offering Traditional & Alternative Medicine	(+) Upward	32.0	54.3	31.0	-42.9	Missed	-3.1	Decreased	-2	Below Average
16		Percentage of samples analyzed	(+) Upward	85.0	87.0	91.0	4.6	Exceeded	7.1	Increased	3	Excellent
17		Percentage of FDA regulated facilities licensed	(+) Upward	74.0	74.0	60.0	-18.9	Missed	-18.9	Decreased	-2	Below Average
18		Percentage of market outlets inspected	(+) Upward	100.0	100.0	91.0	-9.0	Missed	-9.0	Decreased	-2	Below Average
19	Objective	Midwife to WIFA ratio	(+) Upward	2.6	1.0	3.1	210.0	Exceeded	19.2	Increased	3	Excellent
20		Midwife to WIFA population equity index (Geographical)	(-) Downward	2.8	1.0	2.4	-140.0	Missed	14.3	Increased	0	Fairly Good
21		ANC 4+ (%)	(+) Upward	58.6	60.0	65.0	8.3	Exceeded	10.9	Increased	3	Excellent
22		Institutional Neonatal Mortality Rate	(-) Downward	7.6	7.1	6.5	8.5	Exceeded	14.6	Increased	3	Excellent
23		Mother to child HIV transmission rate at 18 months	(-) Downward	74.4	80.0	82.8	-3.4	Missed	-11.2	Decreased	-2	Below Average
24		Stillbirth Rate	(-) Downward	12.8	12.4	11.2	9.7	Exceeded	12.2	Increased	3	Excellent
25		Skilled birth attendance coverage (%)	(+) Upward	63.5	65.0	62.6	-3.7	Missed	-1.4	Decreased	-2	Below Average
26		No. of children fully immunized (Using Penta 3 as proxy) (%)	(+) Upward	94.2	95.0	96.7	1.8	Exceeded	2.7	Increased	3	Excellent
27		Prevalence of stunting among children under five years.	(-) Downward	1.1	0.6	1.0	-61.7	Missed	11.8	Increased	0	Fairly Good
28		Institutional Under-five mortality rate (per 1000lb)	(-) Downward	10.7	8.7	9.8	-12.6	Missed	8.4	Increased	0	Fairly Good
29		Institutional Infant Mortality Rate (per 1000lb)	(-) Downward	7.8	5.8	7.4	-27.6	Missed	5.1	Increased	0	Fairly Good
30		Institutional Under 5 Malaria Case Fatality Rate	(-) Downward	0.1	0.1	0.1	42.2	Exceeded	42.2	Increased	3	Excellent
31		Prevalence of wasting among children under five (%)	(-) Downward				** Missing Value**	***	**Missing Value**	***	-3	Poor
32		Adolescent pregnancy rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	(-) Downward	15.9	12.0	14.6	-21.7	Missed	8.0	Increased	0	Fairly Good
33		Institutional Maternal Mortality ratio	(-) Downward	119.5	128.0	102.6	19.8	Exceeded	14.1	Increased	3	Excellent
34		Prevalence of underweight among children under five years	(-) Downward	1.4	1.1	1.5	-36.4	Missed	-7.1	Decreased	-2	Below Average



MINISTRY OF HEALTH: ANNUAL HEALTH SECTOR HOLISTIC ASSESSMENT TRACKING TOOL (2022)



S. No	Objective	INDICATOR	INDICATOR DIRECTION (+/-)	BASELINE	TARGET	2022 PERFORMANCE OUTLOOK				
				2021	2022	Actual	Description of performance relative to Target	Description of performance relative to Baseline	Performance Score	Score Description
36	O b j e c t i v e T h r e e	Proportion of disease outbreaks identified, and response actions started within 24-48 hours	(+) Upward	100.0	100.0	100.0	Met	Stagnated	1	Good
37		Blood collection index (BCI) per 1000 population	(+) Upward	5.7	10.0	5.8	Missed	Increased	0	Fairly Good
38		95-95-95 Target (HIV Positive people receiving ART with viral Suppression)	(+) Upward	79.0	95.0	68.0	Missed	Decreased	-2	Below Average
39		95-95-95 Target (HIV Infected persons who are receiving sustained ART)	(+) Upward	79.0	95.0	80.9	Missed	Increased	0	Fairly Good
40		95-95-95 Target (HIV Infected persons who know their HIV Status)	(+) Upward	88.0	95.0	77.5	Missed	Decreased	-2	Below Average
41		HIV incidence per 1,000 population	(-) Downward	0.7	90.0	0.5	Exceeded	Increased	3	Excellent
42		Tuberculosis incidence per 100,000 population	(-) Downward	43.0	40.0	52.5	Missed	Decreased	-2	Below Average
43		TB treatment success rate (%)	(+) Upward	87.0	89.0	87.0	Missed	Stagnated	-1	Average
44		TB case detection rate	(+) Upward	30.3	74.0	36.7	Missed	Increased	0	Fairly Good
45		Prevalence of mental health disorders among women and young adults	(-) Downward	15.2	15.7	N/A	***	***	-3	Poor
46		Prevalence of hypertension	(-) Downward	13.0	12.0	2.0	Exceeded	Increased	3	Excellent
47		Prevalence of NTDs (e.g Yaws, Bruli ulcer, etc)	(-) Downward	25.0	50.0	N/A	***	***	-3	Poor
48		Family Planning Acceptor Rate	(+) Upward	33.8	32.0	36.0	Exceeded	Increased	3	Excellent
49		Total estimated protection by contraceptive methods supplied (Couple Year Protection (CYP)	(+) Upward	1,476,064.0	1,700,000.0	1,590,586.0	Missed	Increased	0	Fairly Good
50		Prevalence of diabetes	(-) Downward	0.7	0.2	0.6	Missed	Increased	0	Fairly Good
51		Death rate due to road traffic injuries	(-) Downward	N/A	N/A	NA	***	***	-3	Poor
52		Malaria incidence per 1,000 population	(-) Downward	176.0	135.0	178.0	Missed	Decreased	-2	Below Average
53		Bed Occupancy Rate	(+) Upward	56.1	65.0	59.0	Missed	Increased	0	Fairly Good
54		Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	(-) Downward	NA	NA	NA	***	***	-3	Poor
55		Institutional All-Cause Mortality	(-) Downward	21.7	20.8	19.0	Exceeded	Increased	3	Excellent
56	Surgical Site Infection Rate	(-) Downward	4.0	2.0	1.7	Exceeded	Increased	3	Excellent	
57	Average length of stay	(-) Downward	3.3	3.0	3.6	Missed	Decreased	-2	Below Average	
58	Hepatitis B incidence per 100,000 population	(-) Downward	104.5	90.8	N/A	***	***	-3	Poor	
59	Average response time to emergencies	(-) Downward	20.4	21.0	20.3	Exceeded	Increased	3	Excellent	
60	Percentage of Planned Preventive maintenance activities implemented (Ambulances)	(+) Upward	N/A	100.0	100.0	Met	Increased	2	Very Good	