Joint Ministry of Health - Development Partners

AIDE MEMOIRE

Accra, July 2006

Joint Ministry of Health - Partners Business Meeting
Trade Fair, La, Accra, 6 July 2006

Aide Memoire

1. PREAMBLE

A meeting of the Ministry of Health and its agencies, Christian Health Association of Ghana (CHAG), Development Partners and other key stakeholders was held on 6th July 2006.

The meeting discussed the draft aide memoir which reflects the outcomes of the independent review of the implementation of the 2005 Programme of Work and agreed on the way forward for 2006 and beyond. In addition the status of budget execution for 2006 was discussed. The meeting was regarded as a mini health summit due to the inability of the Ministry of Health to hold the summit as planned. It was preceded by a series of meetings between the Ministry of Health and Development Partners to discuss the reports of in-depth reviews which were conducted as part of the annual review.

These reviews covered the exemption policy, the financing strategy and resource allocation criteria, the common management arrangements for the Second 5 Year Programme of Work, the capital investment programme, the National Tuberculosis Programme and a Review of the burden of disease.

These series of meetings built consensus on the findings and recommendations of the reviews which formed the basis for the draft aide memoire which was tabled at the July 6th business meeting and was further discussed in a meeting on the 20th July 2006.

This aide memoire is the result of these discussions and it reflects the commitments of MOH and health partners towards improved performance of the health sector. In line with the CMA II, it also reflects the collective responsibility of health sector stakeholders for pursuing the timely availability of necessary resources as indicated in the agreed budget for implementation of the programme of work (2006) and for implementation of the recommendations made in this aide memoire.

2. GENERAL OBSERVATIONS AND RECOMMENDATIONS

The independent review noted that the health sector continued to make progress towards meeting the objectives of the 5YPOW II. However while funding to the health sector has increased substantially in the last four years, a lower than expected increase in service volumes and health outcomes has been achieved over the period. An incomplete set of regional reports, the unavailability of the aggregated 2005 financial data and the inability to finalize some of the in-depth review reports created information gaps for the Main Sector Review team. Some of the key reference reports were only available in draft form. Thus while the overall picture was clear to the review team, they lacked some empirical evidence to support their findings. The team identified a number of persisting system-wide problems that continue to create implementation bottlenecks. These include:

- incomplete budget execution and predictability in fund flows
- substantial growth in the wage bill and lagging labour productivity
- inadequate implementation of strategic innovations and adjustments to service delivery and
- duplicative functions, difficulties in coordination and performance management, and high administrative cost.

The review team acknowledged that these were difficult management challenges and called for some strategic reflections on how the gains can be consolidated and the risks managed in a way that will have a large future pay-off.

In order to avoid information gaps in review exercises the meeting agreed to revisit discussions on the timing of the annual review process, Key systemic challenges were usually discussed at the health summit and steps towards resolving some of them are captured as part of ensuing aide memoires. The MOH and Partners committed themselves to work towards full implementation of the recommendations of the previous Aide Memoires and use the monthly partners' meeting to address some of these problems. Specifically it was agreed that:

- MoH and Development Partners will agree on a programme for the 2006 review at the December 2006 monthly MOH/DPs meeting.
- MoH will ensure that review reports and aide memoires are distributed widely to all relevant health sector stakeholders.
- Final reports of the 2005 review and this aide memoire should to be distributed by the end of August 2006.
- An updated version of the progress concerning the November 2005 Health summit aide memoir to be discussed and attached to this aide memoire

3. ORGANISATION AND MANAGEMENT

3.1 Institutional arrangements

The review team noted the continuing weak collaboration among all key players in the health sector. The contributing issues ranged from subjective interpretations of the roles of Ministry of Health and the Agencies, the inadequate engagement with Civil Society and the Private Sector to duplications in responsibilities across agencies. The review cited the conclusions of the report of the Ministerial Task Team on Institutional Reform of the Health Sector and the latest draft report of the Common Management Arrangements review, both of which emphasized the issue of weak collaboration and coordination in the health sector.

The meeting concluded that the weak intra and inter sectoral collaboration has led to missed opportunities to leverage programmes initiated by other sectors, and there is a need to refocus efforts towards improving management of all key players. The meeting recommended that:

- As a key step towards the development of the Next Five Year Programme of Work, the Minister of Health should reactivate the Ministerial Task Team on Institutional Reform by the end of August 2006. The task team will report on the progress of their workplan at the October 2006 Summit. The assistance of an independent facilitator may be sought in this exercise.

3.2 Statutory bodies and regulation

The review team observed that the proliferation of Statutory Bodies in Ghana was a reflection of the country's undue reliance on administrative regulatory instruments and self-regulation by professional bodies. This has led to significant overlapping of the functions of some of the regulatory bodies. There were also indications of protection asymmetry in that providers' interests are protected more than that of consumers. The team also noted the ongoing work which seeks to simplify and update the regulatory environment of the health sector.

The meeting agreed that while immediate reforms were not needed, steps should be taken to improve the governance of service quality, service volume and service price. In this regard the meeting agreed that:

- The Consultative Forum for Regulatory Bodies to discuss important regulatory problems should be sustained and supported.
- An expert task force should be set up by the end of September 2006 to review the application of the regulatory arrangements in the heath sector, in order to simplify them and make them more effective particularly in the light of new sources of funding and increasing diversity of health care provision as part the 2007 POW.
- Regulatory bodies should be fully engaged in the annual review process.

3.3 Decentralization

The review noted the progress made in decentralizing management responsibilities to BMCs in the health sector, particularly in the area of service planning and the management of the non-wage budget. It also noted the role of BMCs in the annual review process which, to a large extent, recognizes the contribution of each BMC in the overall performance of each management level. However, the problem of funding local priorities and the involvement of the Local Government structures, especially at the district level, continued to be major weaknesses in the decentralization process.

Although financial decentralization has been substantial, the overall flow to the district level remained lower than expected and resource flow to the sub districts is still a problem. This is due in part to low financial management capacities at the sub district level and central level accounting for goods and services procured on behalf of districts and sub districts.

Efforts at decentralizing human resource management and administration have proceeded slowly with several local initiatives on staff development, engagement, deployment and retention. The review team believes that the low capacity at the district level should be addressed.

The meeting agreed on the need to consolidate the level of financial decentralization achieved by the sector by ensuring improved financial flows to sub districts. Furthermore, increased participation of the District Assemblies in the planning and implementation of health programmes at the lower levels should be pursued. Financial reporting should be improved to give clear indication of spending at the district level and below. It was concluded that:

- Steps should be taken to provide timely financial statements that capture all district level expenditure. This should cover both earmarked funding as well as spending at central level.
- The Ministry of Health (in consultation with the Ministry of Finance and Economic Planning) will work towards strengthening public finance management capturing all health sector expenditures at the district level
- Review of existing documents, developing guidelines and providing orientation on collaboration to District Assemblies and the district Health Authorities will be promoted in the POW 2007

3.4 Health Information Systems

The review team acknowledged the significant amount of activity on Health Information Systems in Ghana. They also noted that the development of health management information systems is challenging for all countries, including Ghana. The key observation was that the use of information in service management is low at all levels especially at the district levels. The problem of integrating different systems particularly that of financial management and service delivery information was also highlighted.

The meeting supported the multi-pronged approach to the development of the health information system in Ghana and the need to draw on the lessons to accelerate the development of a comprehensive system. Some major steps that have been initiated should be completed and current reliance on surveys and special reporting should continue. The following were agreed on:

- The collaboration between the Ministry of Health and the Health Metrics Network to strengthen the Health Information System should continue. This involves the assessment of the national and sub-national systems by the end of 2006.
- The MoH will continue to strengthen the capacity of districts in verification and validation of data and in utilization of results for monitoring, evaluation and planning. In this context district coverage surveys will receive continued support. Local government participation in performance hearings at the district level will also receive increased attention.
- Steps will be taken in the 2007 POW to ensure a closer link between the financial management and service delivery information to enable better performance assessment.

3.5 Capital Investment

Although the review of the Capital Investment Programme could not be finalized before the independent review, the team observed that a lot of work has been done in implementing the programme. Policies on development of primary care services have been strengthened and the hospital strategy has been reviewed with particular attention on levels of service, distribution and referral networks. Standardization of designs for facilities, criteria for medical equipment selection and maintenance procedures are areas where the sector has gained clarity which is currently informing investments in new construction and rehabilitation of facilities. The procurement procedures for capital projects including health transport have been refined and improved.

However, these developments have exposed further deficiencies in the planning, financing and project implementation capacity of the health sector. The policy and planning environment within which decisions are made on capital investments remain weak and inadequate. This has led to continued mal-distribution of facilities and the progressive expansion of services beyond the limits of available human resource and operating budget. There are continuing unresolved issues in roles and responsibilities and the role of Development Partners in the oversight of capital investments programme has been limited. Development Partners have not provided appropriate support to assist in the development of good management and monitoring methods for measuring physical progress and expenditure against set benchmarks and milestones.

The meeting was concerned about the inadequate coordination of the multiple sources of capital investment and the levels of commitments being undertaken without adequate planning for their recurrent cost implications. There was also the concern that the pace of expansion of facilities is placing substantial pressure on the services budget which may probably be unsustainable. At the same time a significant proportion of projects have not been completed due to changing priorities or inadequate capital budget. The meeting also noted that despite a number of attempts there is no register of facilities, assets register or consolidated accounting for capital investments in the sector. The following steps were therefore agreed on:

- The Ministry of Health will organize a meeting of all stakeholders to discuss the final report on the review of the capital investment program before the October 2006 health summit.
- The Ministry of Health will integrate the implementation of a Health Services Planning Methodology and Framework for capital investments in the POW 2007-2011 to ensure

uniform development of facilities, equipment and transport within limits of available operating funds and human resources.

- The Ministry of Health will present a complete overview of financial commitments on infrastructure already entered into that has to be honored by the Ministry's budget in 2006 and later, in time for the 2006 September MOH/Development Partners monthly meeting
- The Ministry of Health will in collaboration with Development Partners develop and institute a routine progress and expenditure tracking system for capital investments to be operational in 2007.
- The Ministry of Health will make adequate provisions in the next Common Management Arrangements to guide the institutional and managerial roles for approval and funding of capital investments.

3.6 Procurement

The review team observed that the health sector has made substantial progress in the development of procurement capacity. The procurement procedure manual (PPM) has been revised within the context of the new procurement law. Procurement plans for MOH and all its agencies are in place and form the basis of all procurement activities. Achievements over the past year include a reduction in procurement lead time from 18 months to 12 months and reduction in price to international buying prices for most of the goods purchased.

The meeting agreed that some improvement is still required in the procurement systems to ensure efficient service delivery. This includes the need to improve procurement capacities at the lower levels and the need for improvement in documentation and record keeping. The following were therefore agreed on as the next steps:

- Increase exposure and training of managers in the use of the PPM at the regional and district levels, with particular emphasis on record keeping and filing of procurement documents. It should be reflected in the 2007 POW.
- Take steps to update the procurement registers at the BMC level.

3.7 Performance Management

The review team observed the existence of several mechanisms for performance management. Particular note was made of the agreement signed between agencies and the Minister of Health and between Directors and the Heads of Agencies. The team observed that while these were intended to promote accountability they also strengthen the decentralization process and introduce a performance management culture in the health sector. The team believes that further consolidation can be achieved if other supporting systems are developed in tandem. These include systems for resource allocation and for rewarding high performance, simplification of the measures for assessing performance and improved investments in performance audits.

The meeting agreed that the there was enough experience to allow the performance management system to be simplified and refined so that it becomes an effective incentive for improved performance rather than an onerous administrative task. It is also important to work towards linking input and output data within the monitoring and evaluation framework to allow easy and effective assessment of performance. The performance agreement system should also be expanded to cover all BMCs to make managers more accountable.

It was agreed that:

- A Ministerial Task Team should be put together to review the effectiveness of the inter agency service level agreements and the performance management system before the end of 2006 to inform the 2007 process.

4. FINANCING THE SECTOR AND FINANCIAL MANAGEMENT

4.1 Health Sector Resources

The review team observed that the health sector had benefited from increased resources during the period of assessment but raised equity and efficiency concerns about the use of these resources. Key concerns were the growth in the wage bill to about 97% of GOG allocation to the health sector which has not been matched by the increase in the service budget. It is the view of the team that such imbalance increases the reliance on IGF, which tends to reduce access to health services by the poor. They also observed a persisting trend of increased funding to the hospital sector at the expense of primary health care. Issues related to predictability of financial releases, timeliness of financial reporting and persisting complex disbursement procedures were all identified as contributing to resource mobilization and disbursement in the health sector.

The meeting noted that the complexity of health sector funding was going to be deepened by the shift to MDBS, which is consistent with the Paris Declaration on Aid Effectiveness. It was felt that such a shift could lead to an overall reduction of health sector resources. A major concern was the potential loss of sectoral dialogue with partners which may lead to a possible reduction in the partnership arrangement and dynamics. It was agreed that while shifting to MDBS, care should be taken so that such negative trade offs are avoided. Integration into the MDBS of Sectoral Budget Support based on a strong forum for technical dialogue involving the MoH, MoFEP and all Development Partners could be a strategy to avoid such unwanted effect. A call for a more strategic management of earmarked funds was also made with emphasis on ensuring that earmarked funds contribute to the priorities identified in the POW and improving planning, alignment and reporting against the health sector budget.

At the November 2005 Health summit, the MOH and Development Partners reached an agreement on the health sector resource envelop and financing gap for 2006 POW. The MOH has since mobilized additional resources from GoG and Development Partners to fill the financing gap, and a revised budget has been discussed. The agreed budget has been attached to this aide memoire.

To this end, it was agreed that:

- Actions for improving financial management outlined in the 2006 PoW should be executed and linked with general public finance reforms pursued by MOFEP.
- In view of the shift to MDBS, the MoH and Development Partners should engage the MoFEP to find ways of improving the predictability of resource flows and institute measures to avoid a decline in total non-wage funding for the health sector.
- A revised comprehensive 2006 health sector budget with clarifications of changes in relation to the November 2005 agreed budget has been discussed and its agreed version is attached to this aide memoire.

4.2 Health Sector Revenue

The sources of revenue to the health sector are changing in three mains ways.

1. The National Health Insurance fund which will replace Internally Generated Funds
2. the shift to budget support by some of the health partners currently contributing to the Health Fund

3. Reduction in the health fund relative to the earmarked funds

The meeting noted that there are uncertainties on how the changing pattern will impact on health sector financing and performance. The meeting also agreed that even though the NHIF allows for broad based funding of the health sector, it will be prudent if the fund is not used at the initial stages to fund cash flow in the health sector as this will affect its sustainability.

To sustain revenue mobilization for the health sector, the meeting agreed on the following:

- The National Health Accounts updating exercise should be finalised by the end of 2006 to give more clarity to the changing pattern of financing in the health sector.
- In the preparation of the 2007 POW, the MoH will collaborate with Partners who provide earmarked funding to mainstream their earmarked funds into the POW to ensure that earmarked funds contribute to the priorities identified in the POW and improving planning, alignment and reporting against the health sector budget.
- MoH and its agencies, with the support of MDBS Partners, will engage MOFEP in the sector coordination and dialogue on health sector financing through monthly meetings, joint field visits and continuation of health summits and business meetings.

4.3 Cash Flow and Expenditure

Cash flow into the health sector was erratic during the year. The Royal Netherlands Embassy withheld 11.8 million USD due to late submission of the sector audited accounts by the MOH. Danida delayed in releasing funds because of over-spending on the capital budget and the GOG service vote was not disbursed for lack of funds. The unpredictability of fund flows makes the task of decentralized management of budget impossible. Furthermore, the general trend is one of increasing expenditure on personal emolument (item 1) and capital investments (item 4), both of which are crowding out non-staff recurrent expenditures (items 2 and 3).

There was a general consensus that while the rise in the personal emolument may be stemming the brain drain it has not been an effective driver in improving performance. The need to improve health worker productivity by protecting items 2 and 3 was underlined along with the proposal to make drastic cuts in capital investments.

The main consensus was on the need to increase dialogue with stakeholders and to seek more clarity in the difficulties outlined. In this regard the meeting agreed that:

- A public expenditure tracking study in the field should be initiated before the end of 2006 with the aim to illuminating the main blockages in the system to flow of funds.
- The MoH will hold discussions with the MoFEP and Development Partners to find ways of improving the predictability of resource flows, including the problems caused by shifting to monthly disbursement and accounting.
- Development partners and the MOH should make themselves fully aware of the CMAII arrangements, as well as the contractual obligations to ensure that contributions to the health sector are paid regularly, especially early in the financial year when reserves are low. A disbursement schedule will be distributed during the monthly health sector group meetings to monitor performance in disbursements.

4.4 National Health Insurance Fund

The review observed that the National Health Insurance Scheme had made significant progress since its establishment in 2003. Currently 120 District Mutual Health Insurance Schemes have been established and over 22% of Ghanaians have been registered with over

72.5% belonging to the exempt category. About 3.9% of the population has been registered as indigents, which is higher than 0.5% target provided in the law but lower than the estimated 27% of the population currently classified as very poor. While the National Health Insurance Fund has accumulated funds, there are threats to its financial viability due to constraints to growth of its income, the benefit package as currently designed which is seen as too comprehensive and the initial administrative overheads of the scheme which is assessed as very high. The increased service activity and utilization rates are also already threatening viability of functional DMHIS.

The general consensus on the NHIS is that the scheme needs a cash flow analysis to review its financial sustainability as currently designed. Although in surplus at the moment, the fund initially should not be allowed to finance cashflow in other parts of the system without careful attention to the impact this might have in its future viability. The meeting therefore agreed that:

- The report on the study of the financial sustainability of the NHIS, undertaken with support from the ILO will be shared with Development partners.
- The MoH and Development partners will discuss issues around financial sustainability with the NHIC before the October 2006 health Summit. This could lead to recommendations to improving financial sustainability.
- MOH will estimate the total IGF for 2007 to include the inflows from the NHIS. The outcome will be incorporated in the 2007 budget.

4.5 Exemptions

The exemption policy is one of the key pro-poor policies of the health sector. However its implementation has been plagued with problems. While the overall funding of exemptions has been increasing the package of exemption is still under-funded. It is acknowledged that it would not be possible to fully finance the existing exemptions arrangements estimated at more than 600 billion cedis annually. The plan is for the NHIS to take over the role of protecting the poor from unaffordable health care cost. However, this is unlikely to happen till the coverage of NHIS increases beyond 50%. For this reason the exemption programme needs to be sustained. The options for doing this, as proposed by the review team, are to:

(a) keep the exemptions programme as a partially funded venture,

(b) cut the exemptions programme, funding it more adequately, or

(c) alter it to be more selective.

The meeting agreed on the need for a critical review of the exemptions schemes with these options in mind. The review should also outline a framework for the management of the transition from the GoG/Health Fund to the NHIF funding for exemptions. It was also agreed that steps should be taken to make good the indebtedness to health facilities so that those who have stopped providing services could resume. The meeting was informed that 40 billion cedis have been approved for the NHIC to reimburse debts related to the 2005 exemptions. In addition 20 billion cedis have been released by the MOFEP for the 2006 Exemptions. The following commitments were agreed on:

- Exemptions arrears up to the end of 2005 will be reimbursed by the middle of September 2006 through the NHIF. MoH to provide a status report in October 2006.
- A task force representing all stakeholders will be established by the end of September to address the weaknesses in the present exemptions system. Their responsibility will include ways of sharpening the pro-poor focus of the exemptions policy and

mechanisms for funding exemptions during the transition. The first draft report will be presented in the December monthly meeting of MOH/Development Partners.

- To ensure that the transition from GOG-Health Fund financing of exemptions to the NHIS financing of exemptions is carefully managed, the MoH/NHIS will provide a status report at the quarterly business meetings.

5. SERVICE DELIVERY PERFORMANCE

5.1 Priority Public Health Programme

Although the 2005 targets were not fully achieved, the review observed that the coverage of key public health interventions has been increasing steadily. The team however concluded that the pace of increase in coverage is not fast enough to ensure achievement of the Millennium Development Goals. It was noted that the targets have not been achieved because in some cases either the set targets were not realistic or there were problems with defining, measuring and reporting on the key health indicators. The overriding reason for the slow progress in achieving the targets were also identified as inadequate funding of priority health and nutrition interventions. There is, nevertheless, confidence that the current health delivery system can deliver key service outputs if strategic innovations and adjustments are introduced.

The meeting agreed that the major challenge is to ensure that resources for health priorities are made available at the district level and called for steps to ensure that from a planning perspective districts allocate sufficient funds for these priorities. To do this the following commitments were reached:

- Resource allocation at central and district levels in the 2007 POW and the next 5YPOW should be directed to the delivery of priority health interventions thereby ensuring a balance between disease control, health and nutrition promotion activities.
- Existing guidelines on engaging the District Assemblies and the Social Welfare Department and Civil Society Organisations in identifying high risk and vulnerable groups should be applied more vigorously to ensure that services are targeted to them at the district level.

5.2 Clinical care

The coverage of clinical care as measured by OPD per capita and hospital admission has also been increasing steadily even though the 2005 targets were not achieved. It was the view of the review team that the current utilization of hospital beds suggests an over-capacity and inefficiency of the hospital sector. They also concluded that the measurement of quality of care posed problems and in their opinion the sector wide indicators for quality have their limitations.

The meeting agreed on the need to take a more critical look at efficiency issues in the hospital sector and to ensure that future investments in health facilities are carefully informed by such analysis. The Ministry of Health will also take steps to improve management systems at the hospital and district levels.

It was agreed that while some limitations cannot be ruled out in the attempt to nominate sector wide indicators, lessons from the use of current indicators should be drawn on in the development of the next set of indicators for sector assessment. The meeting agreed on the following commitments:

- Analysis of the efficiency of hospital sector will be included in the POW 2007 to guide future investments.

- Efforts should be made to improve the quality of care indicators in the next 5YPOW.

6. HUMAN RESOURCE DEVELOPMENT

The major challenges identified by the review report with respect to human resources in the health sector were the production and retention of adequate numbers of various staff to deliver health services to the population and the issue of health workforce productivity including equity in distribution. The review noted that these challenges have been confronted over the years and agreed that these were very difficult issues and would require time for key results to emerge.

6.1 Production and retention of adequate numbers of staff

The ratios of health workers to population have declined over time. One of the key strategies for addressing this challenge is the expansion of facilities to train more health professionals. In addition the Ministry of Health has also drawn up a mixed plan of incentives which has been operational over the years with the impact still to be determined.
It was generally acknowledged that the brain drain of health workers will be difficult to resolve in the short run given the high reputation of Ghanaian health workers abroad and the global shortage of nurses and doctors. The review team was of the opinion that the production of non tradable skills for the Ghanaian health market is probably the only public sector production strategy that is viable in the longer term.
The meeting agreed on the need to revisit the Human Resource Development Policy and Strategy and continue work on the incentive package taking into consideration lessons from the pilot initiatives. The need to tackle the human resource issue as part of the next Five Year Programme of Work was also discussed. The meeting therefore agreed that:

- The revision of the Human Resource Policy and Strategy should be finalized before the end of 2006 and should form the basis for the Human Resources Development Programme within the next 5YPOW. This should include a quantified plan for scaling up training of middle level personnel comprising medical assistants, health assistants and laboratory staff.

- As a way of improving staff retention at the lower levels, the Ministry of Health would work with District Assemblies and other stakeholders to promote local sponsorship to health training institutions.

6.2 Human Resource management and workforce productivity

The inequitable distribution of health workers between urban and rural areas and between the north and south of the country has been a recurrent theme for several years. It is possible that the proposed pay reforms will strengthen the incentives to work in more remote rural areas, particularly by limiting the number of posts in the Greater Accra area and offering `pay for the job' in more remote and under-staffed areas. In the longer term, this problem is only likely to be resolved when regional health authorities can recruit the key staff they need at competitive rates.

The meeting was concerned about the continuing increase in funding for personal emoluments and the fact that this has so far not been translated into higher service volumes. The inequitable distribution of health staff leading to severe imbalance between regions was seen as the most immediate human resource concern and it was agreed that local involvement in the decision making in Human Resource Development would go a long way to mitigate the problem. The meeting therefore agreed that:

- The Ministry of Health will continue to commit itself to the decentralization of the Personal Emoluments to increasingly give regional and district directorate some control in recruitment and placement.
- The deprived area incentives scheme should be reviewed and results integrated into the next 5YPOW.

7.COMMON MANAGEMENT ARRANGEMENT

The review team observed that the CMA II reflected a particular set of circumstances in the evolution of Ghana's health services, marked by institutional reforms and evolving relationships with international donors. It provided the platform for joint financial and operational planning, monitoring, establishment and management of the health fund and policy dialogue. The team also observed that the CMA II was rather exclusive in order to provide incentives for the donors to join the health fund. However circumstances have changed with the establishment of the NHIF, the move towards Multi-Donor Budget Support and relative increase in global and other earmarked funds. These changes have profound implications for the relationship between MOH and its Agencies, the MOH and MOFEP and between MOH, MOFEP and international donors. They also have implication on the funding of Civil Society Organisations' activities particularly as they move towards strengthening their collaboration with the MOH.

The meeting agreed that a new CMA is required to respond to these changes in the health sector. This is particularly so as central systems for planning, financing, procurement and monitoring have become stronger and provide the basis for transactions within the sector. Also the increasing need for greater participation of civil society and private sector in health delivery requires being captured better in the new CMA. The meeting therefore agreed that:

- A new Common Management Arrangements should be developed as part of the process of developing the next 5YPOW. This should address the observation related to the changes from the in-depth review.

- The current MOU should be amended to allow other partners to sign the aide memoire.

8. THE DEVELOPMENT OF THE NATIONAL HEALTH POLICY AND THE NEXT 5YPOW

Partners were briefed on the efforts to develop the National Health Policy and how that links to the next Five Year Programme of Work. Partners were also briefed on the content of the draft National Health Policy and the consensus building programme outlined. They were also informed that a strategic framework will be developed, a basic outline of which was ready for further development, and will form the basis for the drafting of the Five Year Programme of Work.

Partners expressed concern about the timing of the development of the National Health Policy and especially the Next Five Year Programme of Work as these are key documents which will be required as the basis for financial commitments to the sector. They therefore urged the team to speed up the processes to ensure that the draft documents are available to be discussed at the next health summit in October 2006 and finalized by the end of the year.

APPENDIX I: AIDE MEMOIRE - PROGRESS REPORT

Recommendation	Aide Memoir	Time Frame	Progress to date	Comments
SERVICE DELIVERY				
1. Conduct Maternal Mortality Survey	Dec 04	By end 2005	Ongoing – 9 billion has been approved by in the 2006 budget for MOH. Funding gap of 10 Billion, and funds are being sought. Table of activities and budget developed to request for funds on quarterly basis. TOR for the following items is being developed, vital registration, analysis of WHO 2002 survey and designing of questionnaire.	
2. Scale-up the priority health interventions (i.e. ANC-plus, IMCI-plus and EPI-plus	Dec 04	By end 2005	Ongoing – Unicef has agreed help in the IMCI-plus and the ministry is now having IMCI in 100 districts and each district have one trained IMCI personal. The ANC and EPI-plus is on course.	
3. Accelerate roll-out of the CHPS programme	Dec 04		Completed - Roll out plan developed for all the ten (10) regions. 199 CHPS compounds are providing service, 126 of these constructed by MOH/GHS in the seven (7) regions have been completed as at December 2005, 73 zones operating in rented premises.	*80 more CHPS compounds earmarked for construction in 2006, budgeted for in 2006 budget*
4. Continue to fund ITNs, ACT and Contraceptives	Dec 04		Ongoing - ACTs to be funded from Global fund and user fees. $1.45million was provided in the budget for ACTs $4million provided for Contraceptives in 2005 budget. $3million estimated for ITNs but not funded	Funding gap of $3.78 still exists for ITNs and ACTs
5. Provide adequate fund for ARVs	Dec 04		$1.5million earmarked to support HIV/AIDS. Funding from TAP and Global fund	
6. Strengthen the capacity of the Health Education and Nutrition units	Dec 04		*Part of the priority health policy actions for MDBS 2006-2009*	

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Recommendation	Aide Memoir	Time Frame	Progress to date	Comments
7. Create the balance between the Medical and more developmental approach required to ensure continuum of HIV/AIDS care	Dec 04		Ongoing	
8. Partners agreed to focus their finance for potable water in twenty guinea worm endemic districts.	Dec 04		Evidence not available	
PROCUREMENT / CAPITAL INVESTMENT				
1. Ministry of Health will commission an in-depth review of the Five year capital investment plan in line with the health summit aide memoire of 29 April 2005	Oct. 05		*Capital Investment review completed.*	
HUMAN RESOURCES				
1. Strengthen the management of Human Resource Development	Dec 04		*Piloting of decentralization of PE and Human Resource Management to begin as soon as funds are released for capacity building and infrastructural development.*	
2. Develop a strategic plan to strengthen and accredit regional and district health training sites for GCPS	Dec 04		on-going	
3. Give priority attention to the production of enrolled nurses, community health nurses and midwives, and medical assistants.	Dec 04		The CHNs training center has been increased to nine. *preparations far advanced to begin another CHNTS in Western Region in October 2006; recruitment of candidates in progress .* The rest are on-going.	
4. Scale up the training of middle level personnel in particular the training of Medical Assistants and enrolled nurses	April 05			
5. Ministry of Health will set up a committee to oversee postings and allocation of new graduates from the nursing and medical schools and postgraduate colleges	Apr. 05		Not yet implemented	
6. Ministry of Health will re-package the incentive package, test, evaluate, and scale up implementation using lessons from the piloted initiatives.	Apr. 05		Initial report and recommendations of the team to review and repackage the incentive and under study.	
ORGANIZATION AND MANAGEMENT				
1. Identify opportunities for collaboration	Dec 04		Ongoing - A collaboration tool has been developed and regional representatives have	
2. Continue to foster closer collaboration with other players in the	Dec 04			

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Recommendation	Aide Memoir	Time Frame	Progress to date	Comments
health sector			been trained as TOT. 2006 Guidelines for planning requested districts to collaborate with stakeholders	
3. Continue inter-sectoral collaboration at implementation level with focus on creating new relevant coordinating networks, e.g. dialogue with Ministry of Women & Children Affairs to establish an inter-sectoral body for coordinating Maternal and Child Health.	April 05			
4. Strengthen the existing system of ranking and benchmarking of regional performance and expand to all BMCs. Follow up action on performance should be instituted.	April 05		Ongoing - The GHS has developed a monitoring framework for monitoring regional and district plans. The performance monitoring framework at regional level has been revised and being implemented. A follow-up system has been instituted.	
5. The Ministry of Health and its agencies will establish systems for better negotiation of targets with all the levels taking into consideration the sector wide policies, priorities, targets and available resources, as part of a more decentralised planning and budgeting process, resulting in a better link between priorities, results and resources	Apr. 05		On-going.	
6. Plan for the preparation of the next Five Year Programme of Work will be discussed at next Business Meeting	Apr. 05		*Preparatory work soon to start on the next five year POW*	
7. Operationalize Ministry of Health's private health sector policy	April 05		*In progress*	
8. The Development of the next Five Year Programme of Work	Oct. 05		*Not started*	
9. The Ministry of Health will continue its intersectoral collaboration at implementation level with focus on creating new relevant coordinating networks, e.g. dialogue with Ministry of Women & Children Affairs to establish an intersectoral body for coordinating Maternal and Child Health	Oct. 05		*On-going*	
10. The Ministry of Health will continue to improve the quality of district planning and its continued alignment with national priorities	Oct. 05		*Ongoing*	
HEALTH MANAGEMENT AND INFORMATION				
1. Develop Information System Architecture	Dec 04	By end 2005	Ongoing - Developed an e-health strategy, systems analysis is ongoing and a strategic plan is being developed.	Although behind schedule, progress is being made.
2. Complete the Implementation of IME Recommendation on Information System	Dec 04			

APPENDIX I: AIDE MEMOIRE - PROGRESS REPORT

Recommendation	Aide Memoir	Time Frame	Progress to date	Comments
3. Continue with the implementation of the road map for the development of a comprehensive information system	April 05			
FINANCING THE HEALTH SECTOR				
1. Advocate for Global Fund for AIDS,TB, and Malaria to be channelled through the Health Account	Dec 04		Not implemented	
2. Participate in the Public Expenditure Tracking Survey	Dec 04		Representatives of MOH on PETS training. Proposal to conduct PETS on specified areas submitted to DFID for support	
3. Discussions on the 2003 audit reports will be held at the next business meeting.	Apr. 05		*2003 Audit report discussed with DPs*	
4. Revise the accounting for the centrally procured items to show allocation to the districts and sub-districts.	April 05		*Ongoing*	
5. Make financial information increasing available to sub-district managers and explore options for further decentralising financial management to the sub-district level.	April 05		Ongoing - A study has just been completed to understand and document the evidence. A policy decision would be taken to decentralize funding to sub-districts.	
6. Broaden the Guidelines for identifying the poor for financial protection	Oct 05		Implemented - Being implemented in line with the LI	
7. A need based budget will be prepared as part of the planning of the next five-year programmes of work,	Oct. 05		Not implemented, next 5YPOW not begun.	
8. explore options for presenting the Programme of Work and budget using the MTEF Format	Oct. 05		**yet to be implemented*	
9. The Ministry and Partners will continue with efforts to capture all sources of funds in the sector budget	Oct. 05		On-going. *Harmonization and alignment of funds to the sector in progress. Allocation criteria for NHIF developed and awaiting parliamentary approval.*	
10. Ministry of Health will dialogue with Ministry of Finance and Economic Planning, and Development Partners to step up efforts to mobilize resources for the sector.	Oct. 05		*On-going; dialogue regular.*	
11. Ministry of Health will estimate the backlog of exemptions refund	Oct. 05		*Estimation of backlog of exemptions done as part of exemptions review. Arrangements being made to refund the backlog of exemptions to the institutions*	

APPENDIX I: AIDE MEMOIRE - PROGRESS REPORT

Recommendation	Aide Memoir	Time Frame	Progress to date	Comments
12. Ministry of Health and Development Partners will strengthen efforts to ensure that earmarked funds are aligned with and support the National priorities and budget as expressed in the Common Management Arrangement II, the five year POW as well as the annual POWs.	Oct. 05		*On-going. The development Partners and the Ministry have formed a small group to prepare and work out things to harmonise and align earmarked funding.*	
13. Ministry of Health will undertake a review of people's ability to pay the health insurance premium with a view to ensure that all poor and indigents are covered in the future	Oct. 05		*Not implemented*	

Completed / implemented recommendations

1.	Review the TB Programme	Dec 04		*Review completed, report circulated for comments*	Service delivery
2.	Revise the format for the presentation of the Capital Investment Plan in the PoW	Dec 04		*Completed - Applied to the 2005 and 2005 POWs*	Procurement
3.	The accounting for the centrally procured items will be revised in order to show allocation to the districts and sub-districts	Apr. 05		completed	Procurement
4.	Ministry of Health will complete the POW 2006 Capital Investment Plan in line with agreements in previous aide memoirs	Oct. 05		*Completed, discussed with DPs and other stakeholders*	Procurement
5.	Ministry of Health will revise the human resource strategy	Apr. 05		*New HR Policy and strategy document developed. Draft document available*	Human resource
6.	Complete further analysis of Infant and Child Mortality	Dec 04	By end Feb.	Completed	Service delivery
7.	The Ministry of Health will issue guidelines to District Health Management Teams (DHMT) on collaboration with district assemblies and other sectors at the district level. The guidelines may request DHMT to forward their plans through District Chief Executives and involve the District Assembly Social Services Committee and other sectors in the planning and implementation of district activities.	Apr. 05		*Implemented. DCEs and District Assemblies actively participating in the review processes.*	Organization and management
8.	Issue guidelines to District Health Management Teams (DHMT) on collaboration with district assemblies and other sectors at the district level. The guidelines may request DHMT to forward their plans through District Chief Executives and involve the District Assembly Social Services Committee and other sectors in the planning and implementation of district activities.	April 05		*Implemented*	
9.	The signing of future aide memoires	Oct. 05		*Discussed and clarified as in MOU with partners.*	
10.	Ministry of Health will develop a new health policy as part of the process of developing the next five-year programme of work	Oct. 05		*Draft copy of new health policy available*	
11.	The MOH will determine the focus of the 2005 Annual Review with Partners.	Oct. 05		*completed*	
12.	Integrate the National Health Insurance budget into 2006 PoW	Oct 05		Implemented - Projections from NHIL incorporated in the 2006 POW and budget. *NHIF allocation formula developed for use*	Health information
13.	Develop a new health policy as part of the process of developing the next five-year programme of work. Other relevant sectors	April 05		*Health policy developed, draft document available.*	Organization and management

will be consulted and their concerns included in the new health policy.				
14. Develop an appropriate format for presenting the budget in the POW	Dec 04		Completed	financing
15. Channel earmarked funds through the aid pool account.	Dec 04		completed	
16. Provide forum on the new resource allocation formula	Dec 04		*Resource allocation formula developed.*	
17. Review the criteria for allocating resources after taking into account new evidence from the Ghana Demographic and Health Survey and other source as well as available information on performance.	April 05			
18. Sub districts should be more involved in the implementation of the sub-district budget. To that end, the Ministry of Health will make financial information increasing available to sub-district managers and explore options for further decentralising financial management to the sub district level	Apr. 05		Implemented.	
19. The Ministry of Health will work with Development Partners to conduct an analysis of health financing environment, health expenditures and an investment plan.	Apr. 05		*Completed*	
20. The Ministry of Health will review the criteria for allocating resources after taking into account new evidence from the Ghana Demographic and Health Survey and other source as well as available information on performance	Apr. 05		*Resource allocation criteria reviewed*	
21. Financing of exemptions will continue until the National Health Insurance Scheme is able to cover the financing of health services of the poor. Exemptions should however be implemented without creating disincentives for people to join the insurance schemes	Apr. 05		*Financing for exemptions catered for in 2006 budget*	
22. MOH agreed to provide a clarification on the possible 400% overrun of the Item 4 budget for 2003.	Oct. 05		completed	financing

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