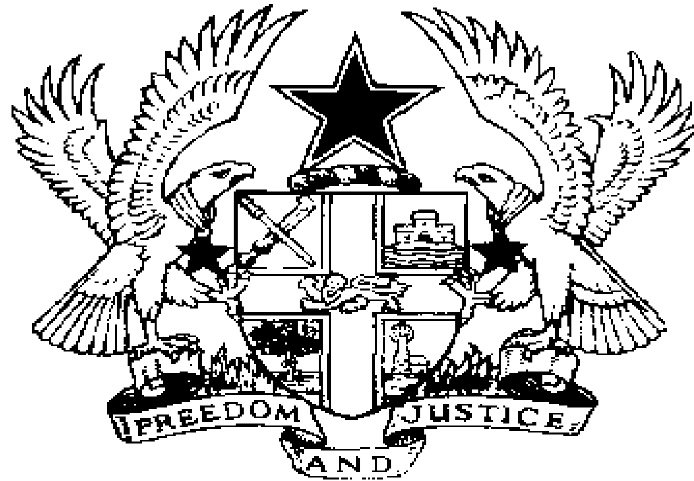
Ministry of Health
Ghana



Independent Review
Health Sector Programme of Work 2010

Ghana

(Draft Report)

April 2011

Independent Review
Health Sector Programme of Work 2010

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The Review Team

Accra, April 2011

List of abbreviations and acronyms (to be updated in final draft)

ADHA	Additional Duty Hours Allowance
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ATF	Accounting Treasury and Financial
BCC	Behaviour Change Communication
BMC	Budget Management Centre
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community Health Planning and Service
CIP	Capital Investment Plan
CMA	Common Management Arrangement
CMR	Child Mortality Rate
CMS	Central Medical Stores
CYP	Couple Years Protection
DA	District Assembly
DANIDA	Danish International Development Assistance
DCE	District Chief Executive
DFID	UK Department for International Development
DHA	District Health Administration
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DMHIS	District Mutual Health Insurance Scheme
DP	Development Partner
EC	European Commission
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunisation

FC	Financial Controller
FP	Family Planning
GH¢	New Ghana cedis
GAS	Ghana Ambulance Services
GBS	General Budget Support
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Services
GOG	Government of Ghana
GMA	Ghana Medical Association
GPRS	Ghana Poverty Reduction Strategy
GSS	Ghana Statistical Services
GWEP	Guinea Worm Eradication Programme
HA	Holistic Assessment
HF	Health Fund
HIPC	Highly Indebted Poor Countries
HIRD	High Impact Rapid Delivery
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Directorate
IALC	Inter-Agency Leadership Committee
ICB	International Competitive Bidding
ICT	Information & Computer Technology
IEC	Information, Education and Communication
IGF	Internally Generated Funds
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IRP	International Reference Price
IRT	Independent Review Team
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency

KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MA	Medical Assistant
MCH	Maternal and Child Health
MDBS	Multi Donor Budget Support
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MOFED	Ministry of Finance and Economic Development
MOLGRD	Ministry of Local Government and Rural Development
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NAS	National Ambulance Services
NBTS	National Blood Transfusion Services
NCD	Non-Communicable Disease
NDPC	National Development Planning Commission
NHI	National Health Insurance
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance System
OPD	Out-Patient Department
PE	Personal Emoluments
PFM	Public Financial Management
PNC	Post Natal Care
POW	Programme of Work
PPM	Planned Preventive Maintenance
PPME	Policy, Planning, Monitoring and Evaluation

PPP	Public-Private Partnership
RCH	Reproductive and Child Health
RDHS	Regional Director of Health Services
RH	Reproductive Health
RHA	Regional Health Administration
RHMT	Regional Health Management Team
RHNP	Regenerative Health and Nutrition Programme
RSIMD	Research Statistics and Information Management Directorate
SBS	Sector Budget Support
SD	Supervised Delivery
SWAp	Sector-Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
TH	Teaching Hospital
TTH	Tamale Teaching Hospital
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Executive summary

The independent health sector review 2010 was carried out from March 9th to March 31st 2011. The overall objective of the 2010 annual review is to assess the sector performance and determine the extent to which the 2010 Programme of Work (POW) has been relevant in providing guidance to the sector. Original Terms of Reference (TOR) have been adjusted and the scope of the review has been reduced in line with the available expertise in the review team. Apart from the holistic assessment of the sector the review was supposed to focus on 4 of 5 of the priority areas of the POW (reducing inequity in health outcomes, reduce maternal and child mortality (focus limited to maternal /reproductive health), improve healthy lifestyle by prevention and control of communicable (CD) and non-communicable diseases (NCD), and strengthen governance) as well as financial management. As agreed with the MoH, the review team focused this year especially on district health management. Prevention and control focused on NCDs only.

Holistic assessment, sector performance and selected POW priorities

The holistic assessment 2010 scores the sector performance as 'highly performing', with a total score of 3+. It should be noted that no population based survey data were available for the 2010 assessment, meaning that all indicator results are service based (which means that it reflects the reported activity of the public sector, the mission sector and only part of the private for profit sector) or reflect public sector management. On the one hand this means that true coverage of some service indicators is likely to be underestimated (e.g. supervised delivery) but also that data are as good as the standard data collection, reporting and validation system is. However, data quality also affected previous year assessments and some major efforts have been invested this year by GHS in validating data quality. It is however recognised that data quality and completeness is yet to be improved.
The 'highly performing score' may somewhat overestimate true performance as appreciated by the IRT, but overall the IRT confirms that, with the exception of some important areas, the sector has been performing well. However, there is still scope for improvement and some key areas require urgent attention.

In 2010 *several service delivery indicators continued the positive trend documented in last year's review*. The coverage of supervised deliveries increased (now at 48%), institutional maternal mortality decreased and the average number of outpatient visits per capita continued previous years' remarkable increase (now at 0.89 per capita). The cumulative number of patients initiated on antiretroviral treatment also continued to increase (plus 41% compared to 2009). On the other hand *coverage of EPI, ANC and FP services experienced worrying negative trends* that need further analysis and action. While 3 regions have been identified as regions excelling in selected key indicators in 2010 (UWR for supervised deliveries and institutional MM; ER for Penta 3 coverage and FP acceptance rate; and WR for ANC and OPD per capita), Volta region is an outlier regarding many indicators and requires attention.
Although the coverage of supervised deliveries improved in 2010, the *equity indicator for supervised deliveries worsened significantly*, indicating a widening gap between the highest and lowest performing region. *Nurse to population and doctor to population ratio increased* respectively by 1.8% and 1.5% compared to 2009. The *number of functional CHPS zones has increased by 51%* (!), a sign of GOG's devotion to improving equity in geographical access to services. The number of OPD visits under NHIS increased from 2.4 million in 2007 to 18.7 million in 2010. The IRT observed that a very large number of OPD visits were by insured patients (between 85 and 95% of total OPD). However OP and IP data do not provide information about people not accessing the services. The *fundamental question whether poor and marginalized people do not access health services due to financial or other barriers remains*. The IRT recommends assessing accessibility via a national survey.

Maternal mortality remains high and with the present progress, MDG 5 will not be attained in 2015. It is therefore laudable that maternal health gets so much attention at district level, but difficult to understand why the ANC attendance rate dropped significantly over the past two years. *Supervised delivery remains low and timely referral remains a problem in many districts*, even if creative solutions are introduced at operational level; and costs or referral is outside the NHIS package. The EmONC assessment has at last been completed but too late to factor findings into the 2011 budget and POW; and only 4 out of 10 regions have received EmONC equipment (of which 2 in 2010). The *acceptance rate and use of FP remains also a challenge* with a continuous drop in FP uptake from 33.8% in 2003 to a low 23.5% (!) in 2010. The IRT recommends to analyse the reasons for this major drop; and, pending the results, consider covering FP under the NHIS (while adding the necessary

resources to NHIA); and consider initiating demand side financing for maternal care in order to increase access to delivery services.
Non communicable diseases (NCD) did not receive much attention at the regional and district level in 2010 but important activities have been carried out at central level, including developing the national policy for prevention and control of NCD. There exists no focal person for NCD at regional level and limited competence for prevention, control and management of NCD at district level. Guidelines for managing NCD are absent at facility level. Although prevalence of some NCD is alarming, the lack of focus on NCD reflects a continuous bias towards communicable over non communicable diseases by both political and professional actors in the health sector.
Of the 4 milestones agreed for the 2010 POW, two were fully achieved: a) *Essential Nutrition actions implemented in all regions with emphasis on complimentary feeding*; and b) *Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas*. One milestone was partly achieved: *New organizational architecture for the sector agreed; organizational change roadmap agreed; organizational development plans completed.* The last milestone was not achieved, but work was in progress: *Health Industry strategy developed within the framework of public private partnership (PPP).*

Central Governance

Governance *of the sector provides a mixed picture but some important changes have occurred or been initiated in 2010*. The MoH has started a process of internal reorganisation with a view to strengthening MoH key functions and revitalising / reviewing performance contracts with health agencies; a process that needs full support (both from central agencies and DPs), also with a view to reduce the still perceived dichotomy between MoH and GHS, and avoid duplication of functions. The M&E function is a point in case that requires strengthening under the MoH. The IALC met regularly and its functioning is appreciated by all agencies interviewed as key to counter fragmentation and support harmonised approaches between different central agencies. Seven draft health bills are now with the PSC for finalisation. The IRT however noticed some inconsistencies that still need to be addressed and is of the opinion that some proposed bills may enhance rather than counter fragmentation. Other 2010 achievements include the finalisation of the CMA III, the JANS review, the preparation of the HSMTDP (pending finalisation of the M&E framework).

Remarkably, the *NHIA has become more transparent and more cooperative* with MoH and other health agencies, a positive change in leadership style, which was appreciated by all central agencies interviewed and also noted by the IRT. Coverage of registered members continued to increase (now at 16.9 million members[1]), OP utilisation by insured members has substantially increased and average lead time of reimbursement of claims has been substantially reduced. NHIA has also strengthened key functions of the central organisation. Understandably, NHIA faces still some legal, organisational and technical challenges: the draft Bill is still pending; renewal of cards by members is often untimely; cost containment and financial sustainability require continuous attention. Testing capitation payment as planned in the pilot project will be crucial in order to potentially address sub-optimal provider and client behaviour.

Nine out of 23 actions agreed upon in the April Summit Aide Memoire between DPs and GOG have not been completed, including main actions related to PFM and private sector policy and involvement. *Two main areas of concern raised by the 2009 IRT still require further action: the high costs of drugs and the fragmented funding to districts.* Coordination amongst DPs is an area that requires continued attention and several DPs have expressed some concerns with the use / effectiveness of the existing mechanisms for sector dialogue (technical and strategic).
Importantly, for the first time ever, the health sector budget passed the 15% Abuja target[2] and increased both in absolute and relative terms (USD 28.6 per capita compared to USD 25.6 in 2009). However, the *proportion of non-wage GOG recurrent budget allocated to district level and below decreased by 25%* from 62% in 2009 to 46.8% in 2010, a reported drop that requires attention[3].

District Governance and Management

The IRT assessed district governance and management through assessing the health system building blocks. *Main impression on district and DHMT performance was positive and dynamic*. *Maternal health and CPS are*

[1] No 2010 data were provided for members with a valid card. By the end of 2009 coverage of valid card holders was estimated by NHIA at 48%.
[2] There may still be an issue of double counting of NHIF, but this was probably also the case in previous year's budget.
[3] This indicator would be much more meaningful if reflecting actual expenditures.

high on the district agenda and are supported through creative, innovative, locally-developed solutions, some of which are examples of best practice that can serve other districts. *Non-communicable diseases and access to services by the poor and vulnerable is not on the main agenda*.

In the districts visited, *most annual district plans are not 'comprehensive'*, a concept that may require clarification and a rational approach. *District hospitals tend to be 'virtually' too much separated from DHMT management and oversight*, resulting in sub-optimal use of scarce resources and potentially in sub-optimal quality of care and referrals by peripheral facilities. *Regions and districts request greater decentralised authority on HRH management*. Nobody at district level seems to be trained in HR management and formal HR training plans are not available at district level. *Information management* requires continuous attention and regular updating of skills. The main problem observed is with data entry, validation and understanding at facility level. Available transport is generally well managed, but *ambulance services are absent in many districts*, forcing DHMTs to develop local, creative but generally sub-optimal solutions for emergency referrals. *Drugs supplies at facilities have greatly improved since the NHIA came on stream*. Some stock outs happened in 2010 (e.g. TB drugs, FP commodities, bed nets) which is unacceptable in the context of Ghana. Several DHMTs lacked sufficient skills in pharmaceuticals and laboratory. *Main issues raised by DHMTs* have not changed over the past years and include insufficient, irregular and inflexible funding; lack of guidelines on how to use funds, especially IGF; availability of HR; strategies to improve staff retention and motivation; lack of ambulance services and essential equipment (e.g. EmONC); and data management.

Public finance management

In the narrow sense of systems, *budget planning and preparation* are relatively well established, but timelines for budget preparation remain very tight. The lack of timely budget information leads by default to incremental budgeting. Budgets are supposed to include all resources including IGF and earmarked programmes but this is not always the case and outstanding debts with suppliers are kept off the budget (but are recorded). *Allocation guidelines* have been established but are not based on a comprehensive assessment of total flows of fund to each region and district. As a consequence, redistribution of funds happens only in a narrow sense, overlooking the broader picture.

Aggregate budget execution was relatively good in 2010, but *at operational level it remains the Achilles heel of the PFM systems*, mainly because of fragmented and partially earmarked flows of funds, with limited discretion at the spending unit. Comprehensive feedback from the top to the spending levels on the actual budgets and timing of the releases is lacking; and there is no functioning tracking system in place that provides information on the status of the releases throughout the system. Regarding IGF, the NHIS is becoming increasingly dominant. The IRT noticed that *several health providers were building up capital in the IGF drug account* and would argue that there is scope for a controlled broadening of the discretion of the drug account, provided that minimal thresholds are respected. In contrast to this surplus, *all BMCs indicate to rely extensively on supplier credits*. Also, districts are introducing innovative ways to share financial resources between sub-district and district level.

Marked progress was made in 2010 in implementation and training of the ATF manual. Aggregate quarterly financial reports are prepared on a regular basis but are not used by management to monitor policy implementation. Both MoH and GHS have enrolled under the first phase of the introduction of the Ghana Integrated Financial Management Information System (GIFMIS). Its roll-out will impact on all financial operations within the health sector. *The PFM Working group only met once in 2010.* The 2009 IRT recommendation to reprioritise within the PFM strengthening plan was not given follow up (although some actions were pursued) and the IRT noticed little effort with key GOG actors to reinvigorate the working group.

The Internal Audit, which is well established in the health sector, is hampered by insufficient staff levels and operational resources. In terms of *external audit*, under the auspices of the Auditor-General, a private firm was hired in 2010 to audit the 2009 accounts of the MoH. Furthermore, the Ghana Audit Service performed regular audits of BMCs. Audit Report Implementation Committees (ARIC) were in place in most but not all BMCs visited. The public discussion of the MoH 2007, 2008 and 2009 audit reports took place on March 24th, 2011. *The Public Audit Committee insisted on the need to strengthen internal controls and to act more aggressively in cases of fraud and embezzlement*.

Recommendations

The recommendations are summarised in the table in section 5 of the report.

1. Introduction

The independent health sector review 2010 was carried out from March 9th to March 31st 2011. It is part of a broader annual review including Budget Management Centre (BMC) reviews and performance hearings (involving districts, regions and heath related agencies); the inter-agency review; the health partner's review; and the in-depth review of some agreed key areas. The Ministry of Health (MoH) and its agencies brief the Parliamentary Select Committee on Health on the sector performance, progress and challenges. Finally, findings and recommendations are discussed at the Health Summit, actions agreed and the way forward mapped out.

The independent sector review has been carried out annually for many years by a mixed international and national expert team. This year's preparation of the independent review was less adequate/timely than before and as a result of late contacting only few international experts were available. During the inception meeting MoH introduced a large team of local consultants and confirmed that they would be full-time participating. As was the case during previous reviews, only few local consultants worked regularly with the independent review team and no local consultant was available full-time. The limited team may explain some of the gaps or less than desired in-depth analysis of some aspects of the TOR. The less than satisfactory preparation fits within the last year's observation regarding some 'fatigue' plaguing this intensive annual process of reviews. On the other hand the independent review team (IRT) confirms that collaboration with different stakeholders at district, regional and central level was good. However, some of the requested information has been made available rather late in the process or is still pending (e.g. financial performance data). Also, the quality of the holistic assessment inevitably reflects the quality and completeness of the data received and to some extent was sub-optimal at the time of writing the draft report. Timing of the independent review is obviously too early to get a fully validated, complete and comprehensive set of previous year's service, management and financial data in time. It should be noted however that few countries indeed would be able to deliver those data by mid March.

This year, next to the annual holistic assessment to be completed, the ToR specified the following key areas for review: a) reducing inequity in health outcomes, taking supervised deliveries as a proxy; b) maternal / reproductive health; c) prevention and control of communicable and non-communicable diseases; d) governance and administration; and e) financial management.

At the first team meeting with the MoH it was agreed that this year a major focus would be specifically on district level governance and management (complementary to the focus on governance at the central level last year). Further, given the limitations of the review team, it was decided by the IRT to focus on non communicable diseases (where action is most required) rather than on communicable diseases. Although not mentioned in the TOR the IRT added a progress review of the actions agreed in the April 2009 Summit, as this reflects part of the performance in 2010.

Section 2 of the report summarises the findings of the holistic assessment 2010. The full holistic assessment is presented in annex 2. Governance is discussed in section 3 and covers central level, district level, financial management, an update on progress made on the actions resulting from the 2009 review and an assessment of the 2010 milestones. Section 4 discusses progress made in equity, maternal / reproductive health and non-communicable diseases. The main conclusions and recommendations are summarised in section 5.

2. Holistic Assessment of the health sector performance in 2010[4]

2.1 Overall score

The Holistic Assessment of the health sector was performed for the first time in 2008. The assessment was done as part of the annual health sector review to provide a structured and transparent methodology to assess progress in achieving the objectives of the annual POWs and the 5YPOW 2007-2011.

The 2010 POW was developed during the transition from the 5YPOW 2007-2011 to the HSMTDP 2010-2013. Most of the indicators from the 5YPOW have been continued in the 2010 POW, but the indicators have been clustered under new Thematic Areas 1 to 7. The MOH informed the IRT that the holistic assessment tool has not been redefined, and the holistic assessment of the 2010 POW was, therefore, based on the original 5YPOW indicator clusters.

Of the 4 milestones specified in the 5YPOW for 2010, three milestones made way into the 2010 POW. The 5YPOW milestone for Thematic Area 1: *Working group representing private and public sectors established to propose private investments to promote wellness* was not included in the 2010 POW. Instead, a new milestone was specified in the POW 2010: *Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas.* The IRT considered this milestone to be part of Thematic Area 3 (Capacity Development) in the holistic assessment.

The conclusion of the holistic assessment is that the health sector in 2010 was *highly performing*, with a sector score of +3. Goal 3 (*reduction of inequalities in health services and health outcomes*), service delivery indicators (Thematic Area 2), capacity improvement indicators (Thematic Area 3) and governance and financing indicators (Thematic Area 4) were generally improving. The score of Goal 2 (*Reduce the excess risk and burden of morbidity, disability and mortality especially in the poor and marginalized groups*) was neutral.

GOAL 1	n/a
GOAL 2	0
GOAL 3	+1
THEMATIC AREA 1	n/a
THEMATIC AREA 2	+1
THEMATIC AREA 3	+1
THEMATIC AREA 4	+1
Sector score	**+3**

Table 1: **Sector score**

Of the 4 milestones agreed for the 2010 POW, two were fully and one partly achieved: a) *Essential Nutrition actions implemented in all regions with emphasis on complimentary feeding*; b) *Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas*. One milestone was partly achieved: *New organizational architecture for the sector agreed; organizational change roadmap agreed; organizational development plans completed.* The draft Bill for the creation of the Health Coordination Council is submitted to the

[4] The complete version of the holistic assessment is presented in annex 2.

Parliamentary Select Committee. The last milestone was not achieved, but work was in progress: *Health Industry strategy developed within the framework of public private partnership (PPP).*

	2006	2007	2008	2009	POW 2010 Goal	2010	Source
Goal 1: Ensure that children survive and grow to become healthy and reproductive adults that reproduce without risk of injuries or							
Infant Mortality Rate (IMR) per 1,000 live births	71	-	50	-	n/a		
Under 5 Mortality Rate (U5MR) per 1,000	111	-	80	-	n/a		
Maternal Mortality Ratio (MMR) per 100,000 live births	n/a	-	451	-	n/a		
Under 5 prevalence of low weight for age	18%	-	13.9%	-	n/a		
Total Fertility Rate	4.4	-	4	-	n/a		
Goal 2: Reduce the excess risk and burden of morbidity. disability and mortality especially in the poor and marginalized groups							
HIV prevalence among pregnant women 15-24 years	3.2	2.6	2.2	2.9	1.9		
Incidence of Guinea Worm			501	242	200	**8**	CHIM
Goal 3: Reduce inequalities in health services and health outcomes							
Equity: Poverty (U5MR)	1.18		1.72		n/a	-	
Equity: Geography, services (supervised deliveries)	2.05	2.143		1.49	1.90	**1.79**	CHIM
Equity: Geography, resources (nurse:population)	4.14	2.257	2.03	1.87	2.00	**1.83**	HR-MOH
Equity: NHIS, gender (Female/Male active member ratio)	n/a	n/a				-	
Equity: NHIS, poverty (Lowest wealth quintile/whole population active	n/a	-	1.3		n/a	-	
Thematic Area 1: Healthy lifestyle and healthy environment							
% households with sanitary facilities	60.70%	-	-		n/a	-	
% households with access to improves source of drinking water	78.10%	-	-		n/a	-	
Obesity in adult population (women aged 15-49 years)	25.30%	-	9.3%		n/a	-	
Thematic Area 2: Health. Reproduction and Nutrition Services							
% children 0-6 months exclusively breastfed	54.0%	-	-	-	n/a	-	
% deliveries attended by a trained health worker	44.5%	32.1%	42.2%	45.6%	50.3%	**48.2%**	CHIM
Family planning acceptors	25.4%	23.2%	33.8%	31.1%	n/a	**23.5%**	CHIM
% pregnant women attending at least 1 antenatal visit	88.1%	91.1%	97.8%	92.1%	70%	**90.6%**	CHIM
%U5s sleeping under ITN	41.7%	55.3%	40.5%	n/a	50%	**n/a**	
% children fully immunized (proxy Penta 3 coverage)	84.2%	87.8%	86.6%	89.3%	87.9%	**84.9%**	CHIM
HIV clients receiving ARV therapy	7,338	13,429	23,614	33,745	51,814	**47,559**	CHIM
Outpatient attendance per capita (OPD)	0.55	0.69	0.77	0.81	0.82	**0.89**	CHIM
Institutional Maternal Mortality Ratio (IMMR) per 100,000 live births	187	230		170	185	**164**	CHIM
TB treatment success rate	73.0%	79.0%	84.0%	85.6%	86%	**86.4%**	CHIM
Thematic Area 3: Capacity Development							
% population within 8 km of health infrastructure	n/a	-	-	-	n/a	-	
Doctor:population ratio	15,423	13,683	13,499	11,981	11,500	**11,479**	HR -
Nurse:population ratio	2,125	1,537	1,353	1,537	1,100	**1,510**	HR -
Thematic Area 4: Governance and Financing							
% total MTEF allocation to health	16.2%	14.6%	14.9%	14.6%	11.5%	**15.1%**	MOH
% non-wage GOG recurrent budget allocated to district level and below	40.0%	49.0%	49.0%	62.0%	50	**46.8%**	MOH
Per capita expenditure on health (USD/capita)	25.4	23.01	23.23		26	**28.64**	MOH
Budget execution rate (Item 3 as proxy)	89.0%	110.0%	115.0%	80.4%	95%	**94.0%**	MOH
% of annual budget allocations to item 2 and 3 disbursed to BMC by end of June	n/a	n/a	23.0%	39.0%	40%	**31%**	MOH
% population with valid NHIS membership card (active members)	17.7%	36.2%	44.7%	50.0%	60,2%	-	
Proportion of claims settled within 12 weeks	n/a	n/a	n/a	n/a	40%	-	
% IGF from NHIS	45.0%	n/a	66.5%	83.5%	70%	**79.4%**	MOH

Table 2: Sector Wide Indicators 2006-2010, greyed out indicators are not measured on annual basis

Table 2 summarizes the values of sector-wide indicators for the 5-Year Programme of Work and annual targets specified in the 2010 Annual Programme of Work. Please note that the indicators have been clustered according to the 5YPOW and not the 2010 POW to enable the holistic assessment.

2.2 Service delivery

The theme of the 2010 Programme of Work was "Going beyond strategy to action" to ensure better results and accelerate the attainment of targets, especially the MDGs. Indeed, in 2010 several service delivery indicators continued the positive trend documented in last year's review. The coverage of supervised deliveries increased, institutional maternal mortality decreased and the average number of outpatient visits per capita continued previous years' remarkable increase. On the other hand coverage of EPI, ANC and FP services experienced worrying negative trends. Detailed analysis reveals large interregional variations of both performance and resources, which is discussed below.

MDG 4

In 2010, the coverage of Penta 3 immunization dropped by 4.9% to 84.9%. Nine regions out of ten experienced a drop in coverage, only Eastern Region sustained performance. The most significant drop was recorded in Upper East Region with 16% decline from 106% to 89% Penta 3 coverage. The Region, however, continued to perform above the national target and better than the national average.

As observed in 2009, Greater Accra Region had the lowest coverage of Penta 3 at 69.9%. In 2009, an EPI survey in Greater Accra Region showed significantly higher coverage of Penta 3 compared to the routine reports, which indicates a possible underreporting within the routine health management information system.

The IRT recommends investigating the causes for the observed drop in Penta 3 coverage.

MDG 5

One of the health sector priorities for 2010 was to decrease maternal and child mortality through improvement in family planning, skilled deliveries, access to blood services, comprehensive abortion and neonatal care and malnutrition to achieve the MDGs.

In 2010, the coverage of pregnant women, who received one or more antenatal care visits, continued the previous two year's negative trend and dropped by 1.6% to 90.6%. Volta Region has the lowest coverage at 70.9%, which is almost 20 percentage points under the national average.

While the proportion of deliveries attended by a trained health worker continued the positive trend since 2007 and increased by 5.6% to 48.2%, the target of 50.3% was not met. Please refer to the equity section (section 4.1) for a more detailed discussion of this indicator.

Despite the focus on FP in the 2010 POW, the number of FP acceptors decreased by almost 25% in 2010 compared to 2009, and is now at 23.5%. Surprisingly, FP indicators have been excluded from the draft HSMTDP 2010-2013 provided to the IRT. FP is an essential component of the strategy to reach the MDGs, and the **IRT recommends reintroducing a FP indicator in the HSMTDP monitoring framework**.

The institutional MMR declined by 3.5% to 164, which is below the target of 185. For the purpose of year-on-year comparison, the previous years' estimation practice has been continued for the holistic assessment. There are, however, challenges with estimating this indicator due to pollution of the routine health information data by TBA deliveries and exclusion of maternal deaths recorded at teaching hospitals. Probably this practice of estimating the IMMR has been in place for many years. For a detailed discussion of the IMMR indicator, please refer to annex 2.

Previous reviews have warned against the practice of using IMMR as proxy for national MMR. With increasing use of facilities for deliveries, better transport, etc. IMMR may indeed take an ever-growing share of total MMR.

MDG 6

The cumulative number of patients initiated on antiretroviral treatment continued to increase and was 41% higher in 2010 compared to 2009. 85% of patients who ever started ARV therapy were receiving treatment in 2010. About 9% were lost to follow-up, 5.4% died and 0.5% stopped treatment. The TB success rate slightly increased to 86.4% in 2010, which is above the target of 80%. Compared to 2009, the number of Guinea Worm cases reduced by 97% to just 8 cases in 2010, with

Ghana closing in on full eradication. All cases were from Northern Region and the last case was reported in May 2010.

OPD

Outpatient visits per capita continued previous years' increase and reached the 2010 target. Upper East Region continued to have the highest OPD utilisation with almost 1½ visit per capita. Since 2006 Upper East Region has almost tripled the OPD per capita rate. On one hand, this is could be an indication of significant improvement in access to health services in the region, but on the other hand the steep and rapid increase could result from a cross-border effect from Burkina Faso and Togo or from over-prescribing and overuse of services. The increased utilisation of services puts a large pressure on both human and financial resources, which should be a subject for closer assessment.

Greater Accra Region has the lowest rate at 0.52, but this may partly be explained by exclusion of Korlebu Teaching Hospital's OPD visits from the regional figure and by presence of a strong private sector for which data are only exceptionally collected. Northern Region experienced stagnation from 2009 to 2010 and maintained performance at a low 0.53 visits per capita.

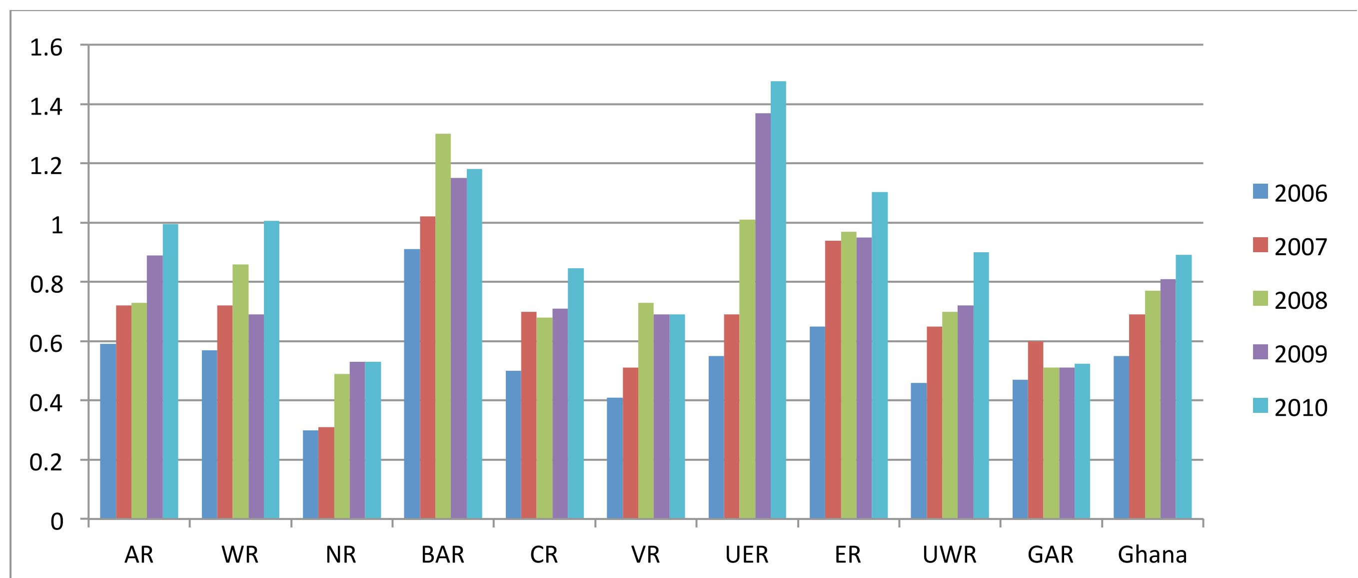

Figure 1: OPD visits per capita by region, 2006-2010, source CHIM

2.3 Regions of excellence and regions requiring attention

In the review of POW 2009, the IRT introduced the concept of "Region of Excellence", which has been continued in the review of POW 2010. The selection of a region is based on subjective judgement by the IRT based on selected indicator trends.

In 2010, no single region stood out as the most excellent performer. Different regions had presented the most positive trends for different indicators. Below is a table of the three best performing regions in 2010.

	Penta 3	ANC	Supervised deliveries	FP acceptor rate	Institutional MMR	OPD per capita
Most positive trend	0.0%	4.2%	25.6%	1,8%	-40.9%	45.7%
National trend	-5.0%	-1.6%	5.6%	-24.5%	-3.5%	10.0%
MDG 5: **UWR**	-8.8%	-1.0%	**25.6%**	-13.8%	**-40.9%**	25.0%
EPI: **ER**	**0.0% (!)**	-3.4%	-1.5%	**1.8%**	41.2%	16.0%
OPD: **WR**	-2.1%	**4.2%**	-1.4%	-39.0%	-7.4%	**45.7%**

Table 3: Regions of excellence

The regional analysis indicates that a number of Volta Region's indicators had a worrying negative trend from 2009 to 2010. Furthermore, Volta Region generally had low performance rank compared to the other 9 regions.

	Penta 3	ANC	Supervised deliveries	FP acceptor rate	Institutional MMR	OPD per capita
Most negative trend	-16.0%	-20.2%	-15.2%	-39.0%	60.5%	-0.1%
National trend	-5.0%	-1.6%	5.6%	-24.5%	-3.5%	10.0%
Volta Region	**-14.1%**	**-20.2%**	**-15.2%**	**-19.0%**	**50.3%**	**0.2%**
Trend rank (1 is highest)	9/10	10/10	10/10	5/10	9/10	9/10
Performance rank	9/10	10/10	10/10	7/10	9/10	8/10

Table 4: Region requiring attention

The coverage in Volta Region of Penta 3, ANC and supervised deliveries, institutional MMR and OPD per capita were among the lowest in Ghana.

The analysis suggests that Volta Region may require special attention in 2011, and the **IRT recommends specific support to Volta Region in order to identify the causes of worsening performance**.

Key recommendations

- **Analyse why ANC, FP and EPI indicators have substantially decreased** and why, with a few exceptions, it applies to most regions. Based on the analysis, develop a sector-wide action plan to redress the situation ASAP in 2011 and implement.
- **Perform together with the RMO of Volta Region a careful analysis of the region's and district specific performance** vis-à-vis all sector–wide indicators. Define issues both with data collection / validation and with service /management performance. Develop a regional and district action plan to redress the situation and implement.
- **Build capacity within the MoH M&E department** to collate all health, service and management related data of GHS (including CHAG), all central agencies (including Teaching Hospitals) and analyse sector-wide indicators for policy relevance; and for implementing the annual sector holistic assessment by the MoH M&E department.

3. Governance and health sector organisation

3.1 Central level governance

The 2009 IRT observed, after a 15 year period of aiming at a comprehensive, sector-wide, integrated approach regarding health service organisation and health service delivery, *a tendency of evolving again to an increasingly fragmented approach in the health sector*. As indicated in the 2009 IRT report, this was reflected in several dynamics in the sector, but mainly through: a) an increasing number of health (related) agencies without effective communication between agencies and without performance based / results based financing; b) a greater complexity/variety in health financing mechanisms; with an increasing tendency to earmarking financial and programme resources for district level; and more emphasis on clinical / curative care through health insurance financing; and c) a loss of focus in the respective POWs, moving from a theme based to an agency based focus. At the same time, the sector was observed to be constrained by some *major inefficiencies* which included: a) the delays in funding and in reimbursements; b) the high prices for medicines; and c) the learning by doing process of the national health insurance. Fragmentation was said to be enhanced by a weak MoH having some carrots to improve sector and agency performance but no sticks.

Although one year is short to expect fundamental changes in governance of the health sector, the IRT has observed some important efforts to affect change. Some of those are yet at an initial stage, but promising if implementated well.

The *MoH has started a process of internal reorganisation and strengthening of key functions*. Reportedly, this would include the following: a) Strengthening the budget function under PPME, by bringing planning and budgeting together, separate from policy analysis; b) strengthening the M&E function under PPME and review its job description; c) revitalising the external aid coordination unit; and d) strengthening the procurement monitoring function. In addition, the MoH is reviewing the mechanism of performance based contracting with health agencies, with a view to strengthen a results based approach. The effects of the above proposed changes are yet to be seen[5].

The Inter-Agency Leadership Committee (IALC) met quarterly in 2010[6]. All key agencies (GHS, NHIA, CHAG) confirm that the IALC has been quite effective in its attempt to improve sharing of information between agencies and reduce fragmentation. All interviewed agencies appreciate the IALC, who would become a legal body, the Health Coordination Council, under the MoH, as pictured below (in lieu of the 'National Health Service').

[5] The IRT has not seen a new organogramme of the MOH reflecting the above changes. The information has been provided by the Chief Director.

[6] The IRT only got the minutes of the last meeting.

PROPOSED HEALTH STRUCTURE

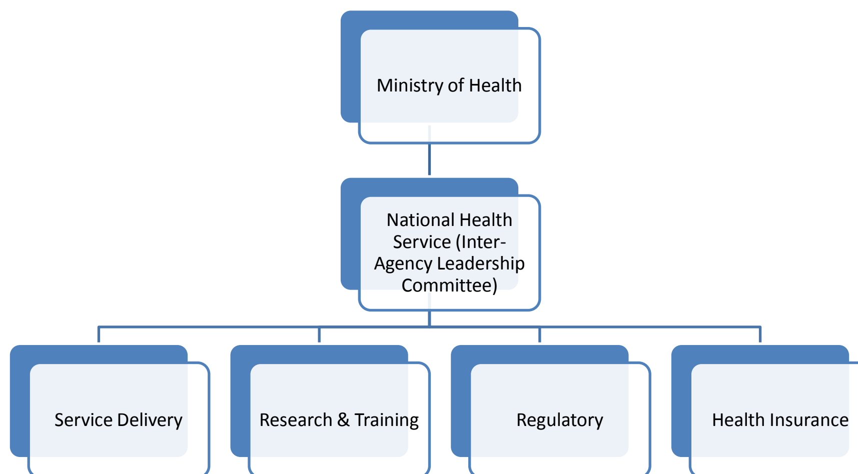

Figure 2 Draft organogramme with MoH, IALC and central agencies

All eight Regulatory Bodies would come under the Regulatory function. Service delivery would encompass GHS, TH, NBTS, NAS, CHAG, quasi government facilities and NGOs. Research & training would cover the Centre for Research into Plants Medicine, the Ghana College of Physicians and Surgeons and the Training Institutions. The NHIA is part of the above proposed structure and MoH confirmed that NHIA now considers itself and behaves as a health agency accountable to MoH. A draft Health Coordination Council Bill has been submitted to the Parliamentary Select Committee (PSC).

In addition to the above mentioned draft bill, another 6 draft Bills have been submitted by the MoH to the PSC[7], as well as the NHIS Bill by the NHIA[8].

The IRT Notes with interest the proposed changes both within MoH and formalising the structure of the Health Coordinating Council, pictured as an intermediary between MoH and the agencies. Given that this is still at a proposal stage, the IRT would like to share the following observations:

- The *Draft Bill of the Health Coordination Council (HCC)* specifies that it will strive at joint decision-making between agencies, ensuring alignment with sector priorities, foster problem-solving, create synergies between agencies and improve sector efficiency and effectiveness. It will act as a health sector adviser or "cabinet" to the Minister and provide input and direction into the MoH policies, amongst others. *While the effectiveness of the IALC has been appreciated in 2010 and its formalisation in a legal structure is understood, the HCC should not replace essential MoH functions*. These include formal contracting between MoH and agencies; accountability of agencies to MoH; regulatory functions; etc. The IRT noted that the draft Bill lists a regulatory function (regulating the activities of the health sector and agencies) under the HCC, which it considers inappropriate.

[7] Bills submitted: mental health bill; general health service bill; health professions regulatory bodies bill; health institutions and facilities bill; traditional and alternative medicine bill; medical training and research bill; and the health coordinating council bill.
[8] The IRT did not receive a copy of the draft NHIS Bill.

- The Draft HCC Bill lists the members of the Governing Body of the Council. *It includes all actors or agencies mentioned in the above diagram but omits the following*: CHAG, Allied Health Services Board, Private Hospital and Maternity Board, Health Training Institutions. In order to be fully representative and effective, the IRT recommends considering adding the above agencies. In the future, when the Private Health Sector Alliance becomes a representative body for the private sector, it would be logic to also include it as a member.
- *Some of the proposed Bills risk to further increase fragmentation of the sector and to some extent waste resources* a) the mental health bill (why is a separate structure needed for mental health and not for child health?) foresees a parallel structure with regional and district offices rather than integrating and resourcing mental health services in GHS (with the appropriate priorities and resource do so effectively); b) the Regulatory Bodies would have decentralised offices up to district level (why does one need a regulatory body – as opposed to function) at the district level?; c) what is the need for a separate Mortuaries and funeral activities Agency or an Ambulance Council? Interestingly, the reflection of how to structure the health sector seems to have been done in isolation of planned reforms in Local Government at regional and district level. At least none of the draft bills mentions this future change.
- The IRT learned from different agencies that the agency is *accountable to the Minister* of Health and not the Ministry and that this should remain so. While from a legal point (as per specific agency statutes) this may be so, agencies should understand that the Minister, for practical reasons, would delegate this to the Chief Director.
- Some key agencies observe that the *MoH has a tendency to go beyond its core function* (policy development, health and health sector regulation, sector level planning & budgeting, sector-wide monitoring and evaluation, procurement) and go into ‘operations ‘ or ‘implementation’ (which is considered the core business of the respective agencies). Examples given were the transfer of item 3 budgets directly to the regional/district level in 2010 bypassing the central GHS[9]; or the POW 2010 for CHAG (as published in the MoH 2010 POW) which does not adequately reflects the CHAG priorities but rather the MoH priorities; or the regenerative health unit with MoH rather than GHS, … . CHAG expressed some frustration with how their own priorities were not well reflected in the document and how some MoH priorities such as the implementation of CHPS were enforced[10]. While understanding the frustration of the agencies, the above examples are illustrative of a continuous (healthy?) tension between policy and action, between respective responsibilities, which one would find in any decentralised system. It is the role of the agencies to keep the MoH alert about its core function and of the MoH to request agencies to deliver / perform and align with sector priorities. It is also the role of the MoH to request CHAG to implement national priorities and provide additional resources to do so, if needed. This also reflects some of the still existing or perceived dichotomy between MoH and GHS (an observation also made by several DPs, see further). Interestingly, both MoH and GHS state that their roles are well defined and that there is no dichotomy. Is it a real issue or merely a perception?
- More important seems the risk and inefficiency of *potential areas of duplication* between MoH’s core functions and agency functions. Or *less than satisfactory functioning* of some of the MoH core business. One example of possible duplication, discussed further, is the M&E function of the MoH (or responsibilities for regenerative health, health education). One example of less than satisfactory functioning is budgeting, resource allocation and public finance management (see section 3.3).
- *The M&E function of the MoH needs fundamental strengthening and developing*. Sector performance analysis and assessing policy relevance is supposed to be the core business of

[9] The IRT understood that this only happened once or twice and was the result of a directive by the Minister.
[10] CHAG would rather continue mobile outreaches.

the M&E department of MoH, but this function is yet to be fully developed. The core capacity of validating and analysing DHIMS data lies with the GHS. While this is logic in the sense that GHS should be able to assess its performance with a view to improve or maintain it, it's de facto scope of activity is wider: all CHAG facilities, some non-CHAG mission facilities, some (but very variable by district) private for profit facilities report HIMS data via the DHMT to GHS; Teaching Hospital data are partly covered (Tamale hospital) under GHS and other TH data are added to come up with sector-wide data; while some other agencies are not covered. Rather than using existing capacity of GHS, *the M&E department should have a well established capacity to do a full sector-wide analysis (merging data from GHS, teaching hospitals, private sector, all other agencies)*. While it can delegate some functions to the responsible GHS department, it should not overload this with functions it should develop itself (also to avoid the above stated dichotomy and overlap). Also the holistic assessment and the analysis of its relevance should be a core responsibility of the M&E department and not a function outsourced to international consultants.

- *Accreditation of public and private facilities* is a function presently carried out by NHIA (see further). According to NHIA it remains as such in the draft NHIS Bill; according to MoH this is still being debated. During the meeting with the IRT, the NHIA mentioned that this function required considerable resources and time from NHIA. Also the post-accreditation monitoring still needs to be developed. In line with the 2009 IRT recommendations, the IRT would recommend to develop a separate agency for accreditation and post-accreditation monitoring outside of the NHIA, in order to avoid potential COI and not to overload NHIA with non-core business functions.
- Licensing of providers is under the responsibility of respective regulatory councils. In order to promote maintaining quality of services both with public and private providers, the IRT recommends to develop the concept of a *renewable, time-limited provider licensing system*; with the renewal depending on fulfilling some specific quality related criteria (such as following specific courses to update/maintain skills, participating in conferences and peer reviews, etc.). This system exists in many countries and is effective in maintaining professional quality.

Other important elements that have been implemented in 2010 include the *finalisation of Common Management Arrangements III (CMAIII)* and the *JANS Review* (based on which the HSMTDP has been re-assessed). The HSMTDP is in a pre-final stage, awaiting finalisation of the M&E part.

The *Commodity Security Draft Action Plan* attempts to address one of the major sector inefficiencies (as mentioned in the 2009 IR), the high costs of drugs. It seems however that the action plan limits itself to the public sector (CMS, RMS) and does not look at factors determining prices in the mission and private for profit sectors. In addition, solutions are basically aimed at improving efficiency of the existing CMS and RMS, without analysing complementary options: e.g. how competition could lower drug prices.

Collaboration between NHIA and other agencies including MoH, GHS, CHAG as well as transparency by NHIA has remarkably improved over 2010. This has been confirmed by all agencies interviewed and is perceived as a change of leadership style at NHIA. The IRT had a very informative, transparent and positive meeting with the NHIA top management and NHIA presented its performance data also at the DP performance review meeting. According to NHIA its coverage of registered members at the end of 2010 is at 16.9 M (or 69% by the end of 2010[11] – provisional data; compared to 62% by the end of 2009) an overall increase of 16% compared to 2009[12]; the number of active members

[11] Calculation by IRT based on 2004 population figures

[12] The independent review happened two weeks after an Oxfam publication claiming that the NHIS coverage in Ghana would rather be at about 18% of the population. This publication raised a lot of heated debate. While

(members having a valid / renewed membership card stood at 48%, according to NHIA (figures of end 2009, no update received). DHIMS data confirm that the OP attendance by insured patients significantly increased in 2010 (74% of all OP, up from 67% in 2009), expectedly in line with increasing membership coverage. Delayed reimbursement of claims, as was confirmed by all agencies and districts interviewed, has substantially been reduced and is now claimed by NHIA to be less than 3 months[13]. The NHIA has now visited 2.915 health facilities out of an estimated 5000 facilities in the country. Of those 2.647 have been accredited, of which 849 in 2010. It also strengthened its collaboration with LEAP, and (as observed during the field visits) citizens being confirmed as poor by LEAP, are registered as poor under the NHIS. The NHIA confirms that the definition of poverty as well as the identifying mechanisms still requires further attention by the Ministry of Social Welfare[14] (see also district management).

NHIA has restructured and strengthened its central organisation in 2010 amongst others by setting up of new divisions / cells or strengthening existing ones, as follows: the clinical audit division, claims processing centre, internal audit, strategic division and procurement.

The pilot project which was initially foreseen to start in 2010 is still in the pipeline. Amongst others NHIA plans to test capitation payment for OP services up to district hospital level and with a gatekeeper function. Depending on how the new financing mechanism is being implemented, it could allow to fundamentally changing provider's attitude and behaviour. In the present set-up increasing OP attendance and prescribing more drugs allows generating more revenue for the provider. This is reflected in the ever increasing OP attendance and the high number of drugs prescribed. Capitation payment allows for cost containment by agreeing on an annual payment per registered patient (including services, drugs and referrals). Given the difficult financial situation of NHIA today (a deficit of GHc 40 M at the end of 2010 - provisional), cost containment through different strategies will become increasingly a major challenge for NHIA.

Now that average reimbursement lead time has become more acceptable, ongoing discussions between NHIA and service providers are more at the technical level (e.g. values of reimbursement; prices of the new drug list; the positive and negative effects of clinical audits[15]; developing provider

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the IRT has no evidence of true coverage (which would require survey-based population data), based on the sample of health districts and facilities visited by the IRT (see further) and the high and ever increasing coverage of insured OPD attendance across the country (see DHIMS data 2010), it would expect that the truth is closer to the coverage data claimed by the NHIA than those claimed by Oxfam. While Oxfam raises a number of important and valid points that indeed affect the setting up of insurance schemes and therefore also apply to NHIA (see amongst others the above challenges still faced by the NHIA), it also puts into question the need for a social health insurance in Ghana and the alternative less costly option of a free public health system. While recognising the extra cost of setting up the needed administrative structures to manage the health insurance and the limited contribution of the annual premiums in financing NHIS, the IRT considers it the responsibility of the GoG and the civil society of Ghana to make fundamental decisions about which future systems to develop.

[13] The NHIA states that all claims are now being reimbursed in less than 3 months. GHS and CHAG confirmed this general trend. Four out of five districts visited (March 2010) had all claims reimbursed up to late November or December. One district still awaited reimbursement of November claims. A more detailed analysis of Ashanti region data suggests that not all claims are yet reimbursed within 3 months (see annex 3). The IRT has not been able to ascertain whether the periods of delays included late submission by providers.

[14] The IRT is of the opinion that identifying the poor is not the responsibility of the NHIA / DHIS. The Ministry of Social Welfare should develop the mechanisms and procedures to do so and provide the information on poor people to be covered by NHIS to the DHIS/NHIA. It is of concern that the LEAP programme does not cover the full country and that most likely still large numbers of poor or vulnerable people fall between the cracks.

[15] Some providers find the clinical audit too harsh in punishing: reportedly, a 25% 'error' rate in a sample of claims submitted by the provider could result in a deduction of 25% of all claims submitted.

profiles[16]). Also the timely renewal by clients of the membership remains problematic in the sense that many clients would only renew the card when they need services, which is not all in line with the insurance principle and may further undermine NHIA's revenue.

One major challenge faced by the NHIA is to match revenue with expenditure. On the one hand pressure on the NHIA to cover more for less will remain. However, when new drugs (e.g. FP) or services (e.g. covering transport costs for emergencies) are being proposed under NHIS coverage, sufficient additional resources need to be foreseen. Also, the market costs of drugs in Ghana is too high, an issue which NHIA is well aware off and would like to address. On the other hand, there is definitely scope for NHIA to better contain costs by providing the right incentives for clients to refrain from 'shopping' or 'adverse selection', and for providers to misuse the system in order to increase revenue.

Finally, *coordination between Development Partners (DPs) is an area that still could be improved* (as is the case in many countries). Positive points, amongst others, are the finalisation of the CMAIII between the GoG and DPs; the participation of DPs in important undertakings such as the JANS review and the development of the HSMTDP. Also the action points agreed following the IRT 2009 (as laid down in the April Aide Memoire) are reportedly closely monitored by the DPs. *An overview of progress on actions is* presented in section 3.4. The IRT however noticed some examples of continued weak alignment (e.g. parallel reporting requirements at district level by specific DPs and /or UN organisations) and less than satisfactory harmonisations (e.g. including the IRT itself, four different missions have been looking into aspects of PFM issues the past month).

Although *policy dialogue between MoH and DPs* is generally considered good and regular; and mechanisms for dialogue exist, several DPs have expressed concern about: a) discussions being more of a technical than a strategic level; b) meetings often being attended by too many people to be efficient; c) senior health staff are not always being present which tends to make the dialogue less decision oriented; and d) the dichotomy between MoH and GHS (mentioned earlier) which makes it sometimes blurred who to contact with a specific request. It is not clear to the IRT whether existing mechanisms for regular dialogue (e.g. monthly meeting; quarterly meeting; bi-annual business meeting) specify which forum is for technical or strategic dialogue and whether the right people are present for this type of dialogue. Also, channels of communication (e.g. should I contact MoH or GHS?) should be clear. Much effort has been invested in describing mechanisms for effective dialogue in the CMA III. These need to be tested and, if necessary, amended.

[16] Developing a profile for each provider by the NHIA is not yet feasible at this stage. However it will become possible once claim management becomes fully computerised, say for all hospitals, to develop a provider profile and to follow-up on outliers (those providers or facilities whose service and drug prescribing falls outside the 'normal' or 'average' behaviour).

Key recommendations

- **Strengthen MoH institutional capacity & authority**
  - ✓ **Continue supporting the ongoing re-organisation of MoH**. This would require confirmation of the role of the MoH (and those of different agencies vis-à-vis the role of the MoH), strengthening its core functions (skills and capacity especially in domains that are considered weaker such as budgeting and M&E), avoiding duplication (with core functions and capacities of health agencies) and possible gaps.
  - ✓ **Perform an organisational assessment** of the MoH versus roles and a skills and capacity assessment versus tasks (this also involves those agencies that cover some tasks that are similar to / potentially overlapping with MoH tasks); an example is monitoring & evaluation (see below)
  - ✓ **Develop a roadmap & development plan** for institutional / organisational change, if considered relevant
  - ✓ **Provide technical support** to carry out the above assessment and strengthen key functions as needed
  - ✓ As part of the above recommendation, **develop the M&E function of the MoH**, including the sector-wide performance analysis function and holistic assessment (see recommendations under the holistic assessment)
- **Further develop the regulatory framework for the sector**
  - ✓ **Harmonise and finalise the draft bills**, avoiding fragmentation and setting up unnecessary bodies, with a view to, as much as possible, integrate functions in existing structures
  - ✓ Consider setting up a specific agency for **accreditation**
  - ✓ Consider developing **renewable licensing** of public / private providers with a view to promote quality
- **Continue to address excessive costs and financial sustainability of the sector**
  - ✓ Ensure **future financing & cost containment of NHIS**
  - ✓ Assess whether the Commodity Security Action Plan covers the right actions to **reduce drug costs.** Consider widening the plan to include actions to address mission and private for profit sectors drug prices; and possibly allow for more (selective) competition.

3.2 District level governance

The IRT visited six regions. In three of those the IRT focused specifically on district level governance, management and organisation (UWR, UER, WR). In the other three regions (ER, AR, BAR) the main focus was on public finance management (PFM, see section 3.3). Given the main focus of last years' review on central governance, the IRT focused some efforts on district level governance this year. During its visits to 5 districts it used the main health system building blocks as guidance for its review and assessed management of maternal health and non-communicable diseases as the entry point. Maternal health and non-communicable diseases are dealt with more in detail in section 4. A sample of 5 districts may not be representative of the situation in all districts. IRT observations have therefore to be taken as pointers that need further analysis / follow-up and discussion.

Overall impressions

Overall appraisal of the dynamics observed in the districts visited is positive. Although district health management teams (DHMT) do not always have the full complement of skills required for the job they are in general a dynamic, motivated team of professionals that aim at doing a good job with the means they have. They try to solve problems introducing creative solutions, even if those solutions are not always ideal or per preferred standard (e.g. emergency referral of women in labour on a motorbike) or according to the 'book' (e.g. sharing of revenue between sub-district and district level). Creativity may however lead to 'best practices' that could be an example for other districts (e.g. the network of means of transport for emergency referrals and the list of preferred phone numbers provided to women attending ANC – see section 4).

Although team building skills and team management may not be part of a formal training of DHMT, they function very much as a team, share information regularly, plan and try to solve problems jointly. In all districts visited the link between the DHMT and the District Assembly (DA) seems to be rather effective both during annual planning exercises and –to some extent- in implementation and problem-solving. Interestingly, much time of the DHMT is spent on meetings (and minutes / records) but none of the DHMT members met by the IRT was ever trained in meeting / presentation / recording skills (an idea for the leadership training course?). Supervision of sub-district health facilities (public and private not for profit) is carried out regularly, tools / checklist exist and are used, findings are shared within the team, feedback is provided to facilities. Supervision of clinical care may be the weakest element (depending on the composition of the DHMT and the degree of involving the district hospital staff –DH- in supervision).

Remarkably, maternal health and CHPS (functioning, supervision and extending coverage), are very much on the agenda of the DHMTs and indicators on supervised deliveries and functional CHPS coverage underscore the positive effects of this focus. *On the contrary, non communicable diseases and poverty (access to health services for poor or vulnerable people) are much less on the agenda* (see sections 4.3 and 4.1).

Comprehensive Planning and action

Most annual district health plans are not comprehensive in the sense that: a) they most often exclude private for profit providers and locally active health NGOs; b) the hospital plan is not always integrated in the district health plan; and c) it contains only limited information on other relevant health related sectors. Plans are made without consideration of a realistic resource envelope and limited resources becoming available during the year are partly earmarked (e.g. disease programs, GFATM) which means that some district priorities are not met. Positive is the link with the district planning exercise, the involvement of the District Planning Officer in the health planning and the involvement of the District Health Committee / DA in the implementation. District health plans are

part of the overall district Plans. But basically the other sectors face the same problem as health ('virtual planning' without a realistic resource envelope), making part of the district planning exercise obsolete.

There are however good examples that can serve as best practices or learning experiences for other districts. The district plan of Embellele covers all 3 private health providers in the district; they are supervised monthly (as is the case for all public facilities) and provide HMIS data regularly. While NGOs are often not included in the district plan, collaboration during implementation happens.

The definition of comprehensiveness may need some clarification. If the DHMT (or DD) is ultimately responsible for the health of the people living within the district, this would require that the DD / DHMT not only deals with health promotion, prevention, cure and care through all public health facilities / providers (including the district hospital and the community level), private not for profit (CHAG et al) and for profit providers, health NGOs, health insurance but also deals with health related issues under the responsibility of other sectors (e.g. environment; water and sanitation; gender issues; food inspection; poverty & health such as access to health services and health insurance; education & health). While it may not be realistic for the DHMT to fully cover all of the above aspects in the district health plan, some data / information on, links with, quality assurance of, and progress made should be documented in the district annual plan and/or annual report.

The IRT is of the opinion that comprehensive planning in itself is useful but should be dealt with in a rational / feasible way. The situation is quite different between for example an urban district in Accra and an isolated district in UER. 'Comprehensiveness' should be translated in the local context and DHMTs should develop a (multi-year, step-by-step) action plan how to progressively make the district planning and action more comprehensive in terms of involving all actors and all health related sectors.

District health & hospital health: two worlds apart?

The 'virtual' split between the district hospital and the DHMT is of some concern[17]. The split seems to be even more obvious when the district hospital is a CHAG hospital or when the relationship between the District Director (DD) and the Medical Superintendent (MS) is strained[18]. While recognising that effective working relationships also depend on individuals (and therefore the situation may vary substantially between districts), *the IRT is of the opinion that closer collaboration between DHMT and DH would increase efficiency, service quality and sector performance*, as follows: a) joint planning brings actors closer, enhances mutual understanding and promotes potential collaboration in relevant areas; b) involving hospital staff in supervision of clinical care in health facilities would enhance quality of decentralised care and potentially lower unnecessary workload at the hospital[19]; c) using complementary resources increases efficiency (e.g. using the hospital pharmacist, lab technician in supervising health facilities if the DHMT lacks those skills); d) jointly developing referral mechanisms and guidance on 'how to refer' could improve the timeliness and the physical condition of patients arriving at the hospital and enhance their chances to survive; e) providing the patient feedback sheets to the respective referring facility (which now are being kept at the hospital – for no use); f) analysing hospital OP and IP data (complementary to the data from the other district facilities) by the district HIS Officer allows for making more sense of district health and management data for decision-making. The IRT is of the opinion that district hospitals function

[17] In several of the districts visited the DHMT had no copy of the hospital plan and the DH had no copy of the district health plan.

[18] In most districts the DD is not a medical doctor, making the hierarchical relationship with the MS of the hospital not always easy.

[19] It should be noted that present financing mechanism induces incentives for providers to attract more outpatients at their facility; hospitals may therefore not be in favour of supervising care at decentralised facilities, if this would lower OP attendance at the hospital.

too much in isolation of the rest of the district as if 'in their own cocoon', de-linked from some of the public health reality outside. This seems to be even more so for CHAG hospitals. This split is also a concern in many industrialised countries and present trends are to open up the inward looking of hospitals, strengthening the links with referral facilities / providers and outside communities, comprehensively dealing with patients (taking charge of patients through a comprehensive approach: from home - local facility or provider – specialist care / hospital – follow-up / post care at the local facility – home based follow-up). This requires a fundamental change in attitude of health providers but this is not impossible in Ghana – even more so with the growing coverage of CHPS and close-to-home services provided by CHOs. The ongoing leadership training course could strengthen collaboration between DHMT and DH staff.

Human resource management

Both regional and district level staff would like to have more authority on staff management. Hiring and firing is not the authority of the district level, except for casual staff. Disciplinary action is to some extent decentralised (either district or region) but the local culture makes it difficult to discipline staff, referring decisions on disciplinary action upwards in the system[20].

Complaints voiced by regional and district level are: a) virtual appointments by the central level of medical doctors: appointed staff never arriving at the place of appointment; b) casual staff, trained and invested in locally for many years, apt for the job and willing to work in isolated / less attractive places, cannot be appointed under the civil service; they are replaced by centrally or regionally appointed staff (but how long will they be willing to stay?), de-motivating the casual worker; c) districts are fully dependent on vacancies being filled by decisions at central or regional level, which do not always take into account main local priorities; and d) there are little incentives[21] to motivate staff to work in isolated areas (rural allowances do no longer exist[22]).

The districts visited have *no HR training plan*[23] and are not fully aware of all existing or newly developed training opportunities[24] for different categories of staff.

Interestingly, in the districts visited *nobody of the DHMT staff is trained in human resource management*. Even when main authority on HRH is still centralised, there is a need to train DHMT staff in HR management: developing a HR training plan; motivating staff; assessing skills & skills gaps; disciplinary action; staff performance assessment (e.g. 360° peer performance assessment); contracting and managing casual workers; career planning and opportunities for career enhancing / additional training; etc.

Information management

District HIS officers met by the IRT are knowledgeable and motivated. They make efforts to validate the data received from peripheral health facilities and analyse district data for some decision-making[25] . *These dynamic staff require continuous back-up and support* in order to maintain / improve their skills and further the positive dynamics.

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[20] Reportedly, firing staff is very exceptional in the Ghana public sector and is the authority of the central level.
[21] The IRT noticed several positive initiatives such as the building of pleasant doctor's accommodation in UER to attract doctors at district level; the post basic midwifery training offered to CHOs after 3 years post qualification experience in deprived areas (as compared to 5 years for other CHOs).
[22] CHAG facilities still offer incentives such as free accommodation, a 7% topping up of the basic salary, etc.
[23] This would require information of all staff on basic training received, additional post-graduate training done, passed participation in ad-hoc courses and present skills gaps requiring further training.
[24] For example the degree course for DHMT staff at the PH school.
[25] Positive examples were increased EPI efforts after HIS data showed low EPI performance in the first quarter; analysis of hospital OP and IP data in order to perform a separate analysis of district data reflecting the district

Main problems faced are the quality of data entry, validation and interpretation at peripheral facility level. This is an area of concern that needs to be addressed, also when the new DHIMS 2 will come on stream (computerisation may help to identify some data errors but does not per se solve the problem of garbage in, garbage out)[26]. Health facilities (and the DHMT office) have very few performance data visualised in graphs and diagrams on the wall, a custom that seems to have disappeared with the presence of laptops but is very useful for engaging in performance discussions with staff, visitors (e.g. DPO) and clients.

Much is expected from the DHIMS 2 to be launched later this year. It is still to see whether the new tool will allow for getting rid of (or at least greatly reducing) parallel reporting (requested both by different programs, UN agencies and some DPs) which to a large extent is unnecessarily burdening the workload of health and HIS staff.

Only one district visited claims to have a *client complaints management system* in place at all health facilities (customer officer and mobile phone link to the DD). Complaints management seems to be mostly limited to suggestion boxes at main facilities such as hospitals.

Transport Management

Well trained transport managers (managing the vehicle fleet and drivers) and drivers (defensive driving; preventive maintenance) with relevant tools in place and updated (vehicle records) seems to be the standard for GHS.

Main problems are the *lack of ambulance services* in several districts visited and the reported *frequent breakdown of recently provided* motorbikes[27]. And the perception of the DHMT that funds for transport do not take into account district specific conditions (e.g. distances to be covered; difficult to reach areas; unavailability of maintenance facilities in the district; etc.).

Districts have developed *creative solutions for referrals in the absence of ambulance services* (e.g. using taxi services that are plenty in one district in WR; developing a network with public and private motorbikes in UER; providing ANC attendants with a priority list of telephone numbers – see section 4). There is obviously a need to improve on ambulance services being provided nation-wide. Whether the National Agency for ambulance services will provide part of that solution soon is still to be seen. As for other domains, the IRT is not convinced that centralisation through parallel agencies is the most efficient management solution.

Drugs and supplies management

Generally all districts report that *stocks of medicines and supplies have greatly improved since the NHIS came on stream.* Some reported (unacceptable) out of stock in 2010 were medicines for TB, SP, FP commodities and bed nets.

Several of the DHMTs visited *lacked skills in pharmaceuticals* (lack of pharmacist or pharmacy technician as a DHMT member) and were not using the district hospital pharmacist to strengthen the DHMT skills.

It was noticed that *prescribing high numbers of drugs and increasing drug turn-over* seems to have become an income-generating activity for health facilities. Also, drug accounts at sub-district levels seem to have considerable balance (see section 3.3).

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population as well as total data including many patients from Ivory Coast (resulting in indicator performance higher than 100%).

[26] Transferring the information from the GHS patient file / record to the monthly tally sheet (which is the first step of data collection) is not a simple undertaking and may be prone to content and quantitative errors.

[27] Reportedly this would be the case with some motorbikes manufactured in China.

Financial management

Financial management at district level is being dealt with in section 3.3.

Main issues raised by DHMTs

From a DHMT perspective the following issue and gaps make it hard for them to perform and live up to the expectations:

- ✓ Insufficient funding versus plans; irregular flow of funding resulting in irregular activities; some funding with strings attached (especially programme funds requiring fast disbursement) interfering with planned activities; resource allocation not needs based (e.g. funds for transport).
- ✓ Lack of flexibility in using allocated funding and absence of clear guidelines how some funds (e.g. IGF for drugs remaining on bank account) can be used.
- ✓ Availability of HRH (vacancies for midwives; CHOs; pharmacy technician; lab technician) and training opportunities for health staff
- ✓ Staff retention and motivation factors for attracting staff to deprived areas (e.g. staff housing, rural allowance, CHPS compound)
- ✓ Lack of appropriate ambulance services
- ✓ Lack of essential equipment (e.g. EMONC)
- ✓ Data understanding, validation and use at facility level

Performance contract of DHMT

Does it make sense to engage the DHMT via performance-based or results-based contracting? In principle this would be the preferred modality but this should take into consideration and preferably adapt some of the following realities: a) the gap between plans and available funds; b) the fragmented and partly inflexible funds; c) resource allocation that does not consistently take into account local needs; d) the limited authority of and action by the DHMT on staff issues; and e) limited authority of the DD on the DH resources.

This can be addressed by some or all of the following actions: a) study the total resource flow coming into the district and streamline / simplify resource flows and use (e.g. consider single pipeline funding to DHMT of most of the GOG, programme, SBS funds; allow use of IGF drug funds for public health / preventive activities if balance on drug accounts exceeds future needs for drug purchase and payment of debts (see section 3.3 for more detailed analysis and recommendations); b) single pipeline funding to district level would allow using one consistent resource allocation formula rather than multiple different ones (see section 3.3); c) train DHMT staff in HR management and reinforce the authority of DHMT staff on staff discipline; consider progressively decentralising HRH management; d) reinstate or strengthen the authority of the DD on the DH; alternatively or complementary, seek ways to optimise collaboration between DHMT and DH staff.

Key recommendations

- Assess how **comprehensive district health planning and implementation** can be strengthened in a rational, district-specific way and requests DHMTs to develop a local multi-year action plan or specific roadmap for progressively increasing comprehensiveness of the plan; and asses how best to **integrate the hospital** more in the district-wide management with a view to optimise resource use and efficiency of service delivery
- **Assess resource flows in districts** and how resources can be optimally used for supporting priority public heath activities (e.g. IGF; disease programme funds; single pipeline funding). Set up a dedicated TWG (including central, regional and district staff both from GHS and CHAG) to study the above and develop guidelines for resource flow and resource use at district level (see also section 3.3)
- **Train DHMT in HR management.** Consider progressively decentralising elements of **HRM** (also consider the context of the upcoming LG reform).
- Continue work started on **adapting working and retention conditions for deprived areas** (conditions of work, housing, allowance, training opportunity, etc.)
- Assess whether the ongoing **Leadership Training Course** addresses the following issues and if not, how it could address all or some of the following: to strengthen collaboration between DHMT and DH staff; to build DHMT skills in meeting and presentation; in staff performance assessment (360 degree peer assessment) and possibly disciplining staff.

3.3 Public Finance Management

This section contains the review of Public Finance Management (PFM) in the Health Sector in 2010. It looks into the systems, the performance of the systems in 2010, and the activities undertaken in 2010 to improve their functioning. A detailed discussion and analysis can be found in Annex 3.

Budget Planning and Preparation

In the narrow sense of systems, budget planning and preparation are relatively well established. Sector guidelines were issued, based on the guidelines from the Minister of Finance, and a series of preparation workshops was organised in 2010 (in preparation of the 2011 budget). However, *timelines for budget preparation were still very tight*, measured in days rather than weeks. In some cases, districts reported that due to the short timelines, the region would budget on their behalf. The lack of timely expenditure information in a format relevant for budget preparation leads by default to incremental budgeting against the budget of the preceding year(s) and less against actual expenditure figures.

Budgets are supposed to include all resources, including IGF and earmarked programmes. In practice, this is not always the case. To some extent budgets are drawn up after the fact, based on actual revenues and expenditures (this leading to a situation where expenditure equals budgets to the digit precise, basically neutralising the policy and accounting functions of the budget in the first place). Furthermore, outstanding debts with suppliers are kept off the budget, even though they are recorded separately alongside the annual accounts (for district level BMCs).

There is still *significant 'below the line budgeti*ng', that is, the (re)allocation of resources to or between policy objectives other than approved by the appropriation act. The official policy in this regard has been strengthened: both the 2010 and 2011 budget guidelines stating firmly that "no form of off budget expenditures will be tolerated", but it is unclear what instruments are in place today that would enforce this policy.

Allocation guidelines and criteria have been established in different ways. However, *there are a couple of limitations to the current application of allocation criteria*: (i) the existence of many parallel flows of earmarked funds, over which spending units can exercise little influence; (ii) allocation guidelines are not based on a comprehensive assessment of total flows of fund to each region and each district, including Item 1, Item 4, donor funding and net IGF; (iii) the budget guidelines only contain aggregate ceilings per item (or per source of funding) but not per region or district, allowing for limited ex-ante policy steering, and (iv) there is no comprehensive feedback that would allow to adjust allocation criteria against actual expenditure and against absorption capacity. As a consequence, redistribution of funds happens only in a narrow sense, and is overlooking the broad picture, due to which policy relevance of criteria cannot be established.

Key recommendations

- Use district level data (from quarterly and annual accounts 2010) for a **study into the overall financial envelope per district** (and region), and test policy relevance of current (and potential) redistribution and allocation criteria. **Consider merging some parallel resource flows into a single more comprehensive 'pipeline' funding to districts**, allowing for more discretionary use at local level and more consistent use of agreed resource allocation criteria.

Budget execution

Aggregate budget execution was relatively good in 2010, with total expenditure a little above five percent over budget. *However, at the operational level, budget execution remains the Achilles heel of the PFM systems in the health sector*. Aggregates overstep the critical fact that the health system contains many different flows of funds, which are treated in a segregated way. Furthermore, quite some of these funds are earmarked for particular purposes and allow for little discretion at spending unit level. As a consequence, the sector's financial system is characterised by many different but small transactions to districts (most not exceeding 5000 Cedis), unreliability of inflows, and limited discretion at the spending unit. Nevertheless, funds are being provided regularly to all regions and districts, even though release patterns are relatively unpredictable.

Besides unpredictability of actual flows, there is also a *lack of comprehensive feedback* from the top to the spending levels on the actual budgets and timing of releases. As a consequence, most BMCs do not spend against approved budgets, but against releases or cash flow which also hinders proper annual planning of activities. Additionally, they cover part of the uncovered "expenditure" by supplier credit.

Despite the structural dependence on the reliability and timeliness of releases, *there is no functioning tracking system in place that can provide quality information on the status of releases throughout the system*. As a consequence, the information on (the quality of) budget execution is rather patchy and incomplete, and it is difficult to identify clear patterns in timeliness and volumes of releases, the underlying causes, and potential solutions to increase the quality of budget execution.

Regarding Internally Generated Funds (IGF), the NHIS is becoming increasingly dominant[28]; MoH resources have become increasingly less important for general operations, and virtually irrelevant for district hospitals. Although IGF is primarily tagged for operational expenses (Item 3 in particular), a significant part of IGF is used for additional Item 1 spending (casual workers), and investment activities (30% of the health sector investment expenditure in 2010 was covered by either IGF or NHIF). The Review Team noted that *several health providers were building up capital in the IGF drug account, in contrast with the services (or non-drug) account*. The Review Team would argue that there is scope for a controlled broadening of the discretion of the drug account, provided that minimal thresholds are respected. To establish these, a more comprehensive analysis would be required, based on the 2010 financial statements of BMCs.

In contrast to this surplus, *all BMCs indicate to rely extensively on supplier credits*. These credits are both off-budget and off-accounts, but are monitored at BMC level. However, there is no comprehensive overview as of yet.

Districts are introducing innovative ways to share financial resources between sub-district and district level. For example some DHMTs levy an overhead on IGF income at sub-district level (varying between 5% and 7% in some of the districts visited). In one new district the DA Finance Committee was levying contributions from sub-district health facilities 'based on capacity' to fund DHMT accommodation, office equipment and operation costs.

Key recommendations

- **Strengthen release tracking information from source to expenditure**, and produce quarterly management updates (including analysis of the causes of delay).
- **Conduct a comprehensive analysis of accumulation of funds in drug account**, and review guidelines to allow for increased flexibility of funds if appropriate. Also **develop guidelines for sharing revenue** between sub-district and district level.

Accounting and reporting

In 2010, marked progress was made in terms of implementation and training of the Accounting, Treasury and Financial Reporting Rules and Instructions (the "ATF-manual"). All BMCs visited had received the manual and had been trained. Accounting and reporting at BMC level was appropriate, and BMCs could produce proper monthly and quarterly financial reports upon request. Regional Health Administrations requested all district administrations, district and regional hospitals for a quarterly vetting of accounts before submission to the GHS HQ. Thus, the health sector has

[28] This has two consequences. First, health providers are less reliant on central government for day-to-day operations, and can act as more financially autonomous bodies within the health system. Second, health providers are financially dependent on a good functioning health insurance system, due to which the sustainability of the NHIS has become a sector-wide issue.

established a relatively sound (albeit manual) method for preparing its accounts, providing a reliable basis to work from.

Aggregate quarterly financial reports have been prepared in 2010 on a regular basis, but in all cases with more than three months delay. Their use for financial management purposes would increase if this delay could be brought down. Furthermore, *these reports are not used by management to monitor policy implementation*, nor to engage with donors on discussion on aid effectiveness and increased use of country systems.

Both MoH and GHS have enrolled under the first phase of the introduction of the Ghana Integrated Financial Management Information System (GIFMIS). Initial preparations were done at both sites, including the establishment of an implementation team and the drafting of an implementation plan. Although GIFMIS is in essence an accounting and reporting tool, its roll-out will impact all financial operations within the health sector (in particular commitment and expenditure controls), and will require strong coordination and involvement of senior management. Although roll-out has been slightly delayed at the Controller and Accountant General's Department, who is leading the process, the introduction of the General Ledger in 2011 will mark a first critical litmus test for the MoH to move onto the system.

Key recommendations

- **Establish general practice of formally discussing the Quarterly Financial Statements** and collect and record feedback on the statements in view of improving quality of information and policy relevance.
- **Increase senior level involvement in GIFMIS implementation** in view of empowerment of implementation teams within MoH and GHS, and establish tight working relationships between MoH and GHS GIFMIS Implementation teams.

External scrutiny and audit

The Internal Audit has been well-established in the health sector, but is hampered by insufficient staff levels and operational resources to execute is legal mandate properly. In terms of deliverables, the Internal Audit provided regular reports. The MoH Internal Audit division provided four quarterly reports in 2010. The GHS Internal Audit Division provided two half-yearly reports in 2010.

In terms of *external audit*, under the auspices of the Auditor-General, a private firm was hired in 2010 to audit the 2009 accounts of the Ministry of Health. Furthermore, the Ghana Audit Service performed regular audits in the BMCs visited by the Review Team. This also included the private facility (benefiting from GoG resources for personnel emoluments) for which a payroll audit was conducted. The planned Procurement Audit was tendered, but no contractor was commissioned for lack of quality of the bids.

Audit Report Implementation Committees (ARIC) were in place in most but not all BMCs. In all cases the ARIC consists of members of management, with the Financial Officer and/or Internal Auditor participating either as a member or as ex-officio. Responsiveness to audit recommendations was considered as sufficient by the Internal Auditors.

In recent years, an important backlog of audit reports piled up at Parliament, but in particular in 2010 the Public Accounts Committee has been forthcoming in discussing them. The public discussion

of the MoH 2007, 2008 and 2009 audit reports took place on March 24th, 2011 (during this Independent Review) and was live broadcast on television. *The PAC insisted on the need to strengthen internal controls and to act more aggressively in cases of fraud and embezzlement*. The report of the PAC was not available before the end of the review, and could not be assessed.

PFM Strengthening and Coordination

The Health Sector PFM working group convened only once in 2010 (on September 30th) for information sharing purposes. The PFM Strengthening Plan was tabled, but not discussed. The latest update on progress dates back to May 2010. The Recommendation to reprioritise within the strengthening plan was not given follow up, although in practice some actions were pursued whereas others were not. *The Review Team noted little traction with the key actors in Government to reinvigorate the working group*.

Key recommendations

- **The lack of pro-active coordination on PFM issues** seems unjustified by the needs and activities in the sector, and the overall request by the Government of Ghana to improve the use country systems. Critical issues that need to be tackled and which would be on the agenda of the PFM working group, are:
  - ✓ periodic discussion of the Quarterly Financial reports (output of which is used to improve the next report)
  - ✓ introduction of GIFMIS and the consequences for expenditure, accounting and reporting at all levels, including the collaboration between MoH and GHS (which is supported by three key DPs in the Health Sector, i.e. Denmark, UK-DFID and World Bank);
  - ✓ improvement of release tracking and preparation of management feedback
  - ✓ coordinate PFM assessments and missions by DPs
  - ✓ identification of impediments for DPs in using country systems and set the agenda to increase their use
  - ✓ identification and commissioning of analytical work (as indicated above)
  - ✓ PFM related audit recommendations for follow up.

3.4 Implementation of the April 2010 actions (2009 Recommendations)

Out of 23 actions specified in the April 2010 Summit Aide Memoire as a follow-up on the annual review of 2009 performance, 8 actions have been fully completed and another 4 actions have started but either have not been completed or further actions have been planned in 2011 (the latter concern mainly HRH actions and the draft Bills). Nine actions have not been completed. These include PFM actions, Private sector policy and involvement, funding / harmonisation of HMIS, finalising the SMTDP, factoring the findings of the EmONC assessment in the 2011 budget/plan and reviewing the format of the regional and district performance reviews. Two more actions were not assessed by the IRT because of lack of information. The actions and level of achievement of each action is presented in table format in annex 4.

3.5 Health sector 2010 milestones

Essential nutrition actions

Implementation of Essential Nutrition Actions (ENA) is ongoing in all ten Regions[29] with emphasis on timely complementary feeding. The main challenge reported is the quality of information provided to women and limited funding. In addition to the above ENA, a malaria and nutrition project started in 3 out of 5 targeted regions (and covered 919 communities at the end of September 2010), with a main focus on community management of acute malnutrition (CMAM). See annex 5 for more details on nutrition actions.

The milestone was achieved in 2010.

Health Industry Strategy

Milestone 2010: *Health Industry Strategy developed within the framework of public private partnership*

The Ghana Private Sector Analysis carried out in 2009 was completed early 2010 and presented during the Health Summit. In addition a Market study[30] on the private sector was carried out in 2010. As an outcome of the first study the Private Health Sector Alliance of Ghana was established in December 2009. This structure is still to be formally recognised by all sector partners and to be legalised (ongoing with support from the Rockefeller Foundation).

The above two documents will inform the ongoing development of the Private Sector Health Policy. The expectation is for the policy to be ready by the end of 2011.

The milestone was not achieved in 2010.

New organisational architecture

Milestone 2010: *New organisational architecture for the sector agreed upon (organisational change road map agreed upon & organisational development plans completed)*

According to the MoH PPME, the new organisational structure concerns the instalment of a Health Coordination Council, replacing the existing Inter-Agency Leadership Committee. According to the Draft Bill[31] proposed to the Parliamentary Select Committee, the purpose of the Council is to ensure effective integration of the health sector agencies in the public interest. It would strive to "foster Ghanaian health sector unity through collaboratively determining priorities, discussing issues, sharing strategic ideas, examining results to date, shaping policy and strengthening overall strategic

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[29] ENA comprises of early initiation of breastfeeding within 30 minutes of birth and exclusive breastfeeding for the first 6 months; timely complementary feeding; feeding the sick child; use of iodised salt; adequate intake of vitamin A supplement and iron; and maternal nutrition. Most recent survey data indicate limited coverage as follows: iodized salt at 32.4% (2007 MICS), timely initiation of breastfeeding at 35.2% (2007 MICS) and complementary feeding at 63% (2008 DHS).

[30] Final Report on Health in Africa

[2] Deloitte and IFC, Initiative Market Survey, Spanning the Realm of PHIs, Ghana, August 10, 2010

[31] Health Coordinating Council Bill, 21st July 2010.

direction". The Council is an administrative and advisory body providing a platform for a holistic coordination of activities of all health delivery agencies, health regulatory bodies, health research and health training institutions; and to ensure the collaboration and governance of the health sector agencies.

The draft Bill is not yet final and still contains some omissions (CHAG and Private Sector are not mentioned in the list of members of the Governing body) and possible errors (one mentioned function is to regulate, monitor and review the activities of the health sector agencies; the IRT is of the opinion that regulation, is outside of the authority of the PSC).

The milestone was partly achieved in 2010.

Specialist services in deprived areas

Milestone 2010: *Hold roundtable dialogue with universities (medical schools) and other key stakeholders on effective specialist services in deprived areas*

MoH HRH has held several meetings with the universities (MoE). Specialist training by Ghana College has been re-organised in specialist sandwich courses for some specific disciplines (gynaecology, paediatrics, etc.; but not yet for ENT, ophthalmology, etc.), combining attachment at the TH and attachment at the district level under supervision by staff of the TH (regional specialist). This increases availability of specialist services at district level in selected districts, but appropriate tariff levels for specialist services at district level still need to be negotiated with NHIA.

The milestone was achieved in 2010.

4. Selected main 2010 POW priorities

4.1 Reducing inequity in health outcomes

Supervised deliveries

In 2010, the previous 4 years' positive trend was reversed and *the equity indicator for supervised deliveries worsened significantly*, indicating a widened gap between the regions with the highest and the lowest performance. Despite the worsening trend of the indicator, the indicator ratio achieved the target of being below 1.9.

Six of Ghana's ten regions improved coverage of supervised delivery, but four regions experienced negative trends. While Western Region, Eastern Region, and Greater Accra Region experienced a minor decrease, Volta Region reduced coverage with over 15%.

Many regions experienced a dramatic drop from 2006 to 2007, but all regions except Volta Region have improved performance significantly since 2007.

Upper West Region reversed the negative trend experienced in 2009 and improved coverage of supervised deliveries with more than 25% in 2010.

The IRT finds the trend in Volta Region worrying, which is discussed in more detail below.

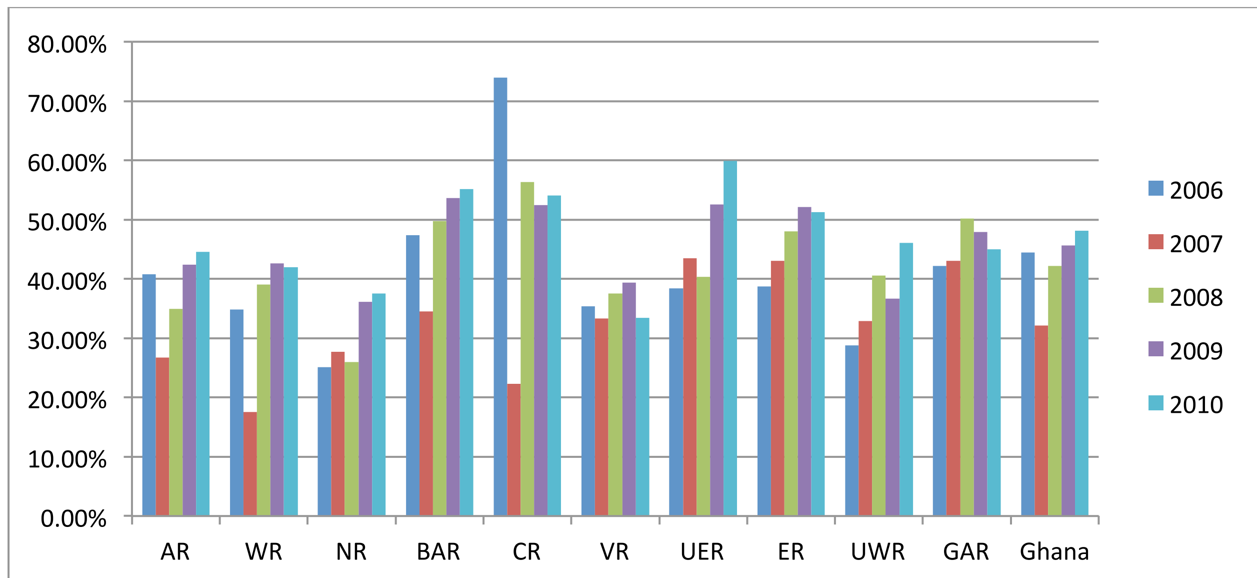

Figure 3: Supervised deliveries by region 2006-2010, source CHIM

Geographical access

The *nurses to population ratio continued the previous years' improvement* with 1.8% more nurses in 2010 compared to 2009. In 2010 the nurse to population rate was 1:1,510, and the indicator did not reach the target of 1:1,100. The trend towards more equitable distribution of nurses improved slightly to 1:1.83 and attained the target of a ratio below 1:2.0.

Upper East Region continued to have the highest nurse to regional population ratio with one nurse per 1,121 inhabitants. Like in 2009, Ashanti Region had the lowest number of nurses per population, but continued last year's increase in total number of nurses with 6.2% to one nurse per 2,045 inhabitants.

Northern Region experienced a significant increase of midwifes in 2010, but still has Ghana's second lowest number of midwifes per population (after Western Region). This is reflected in the proportion of supervised deliveries, which is far below national average at only 37.5%.

In 2010, both Volta Region and Upper West Region experienced significant reduction in the number of midwifes, but the regions are still above the national average. Midwifes are much needed in these two regions since Volta Region had Ghana's lowest coverage of supervised deliveries and Upper West Region had Ghana's highest rates of neonatal and infant mortality[32].

The *doctor to population ratio increased from 2009 to 2010 by 1.5%* and achieved the target of less than 11,500 individuals per one doctor (lower is better).

Northern Region experienced 70% increase of doctors from 50 to 85, which likely can be attributed to the expansion of Tamale Teaching Hospital and a satellite training centre for foreign-trained doctors, and the region is no more having the poorest doctors to population rate. It was not possible for the IRT to access whether district hospitals in Northern Region benefited from the increased number of posted doctors. This could be a topic for deeper assessment.

The lowest number of doctors in total and also per population was registered in Upper West Region. 17 doctors provide services to 682,451 inhabitants, and the doctor to population ratio was

[32] Ghana Demographic and Health Survey 2008

calculated at 1:40,144. This is almost 8 times worse than Greater Accra Region with one doctor per 5,073 inhabitants. With a total of 881 doctors, 41% of Ghana's publicly employed doctors were practising in Greater Accra Region.

The Community-based Health Planning and Services (CHPS) initiative is the strategy adopted by the MOH for improving equity in geographical access to health care. Among the essential elements of the CHPS strategy is the creation of community health compounds. Community Health Officers (CHOs) carry out clinical and community outreach services including household visits, antenatal and postnatal care, provision of family planning services, health education, and child immunization. CHOs normally refer deliveries to the nearest clinic, but may perform emergency deliveries. The CHPS facilities serve as a vital referral link between the community and health facilities. *The number of functional CHPS zones has grown from 345 in 2007 to 868 in 2009 and has further increased with 51% to 1,311 in 2010, which is a sign of government's devotion to improving equity in geographical access to services*.

Financial access

In Ghana, the OPD per capita figure is greatly increasing, and financial analysis reveals that a growing share of IGF revenue is generated from services paid by NHIS. The number of OPD visits under NHIS increased from 2.4 million in 2006 to 18.7 million in 2010. During field visits it was confirmed that OPD contacts at health facilities to a very large extent were insured patient contacts (between 85% and 95% of OPD contacts in the facilities visited). This indicates both that health utilisation has increased due to NHIS and that the majority of OPD contacts are with insured patients, suggesting a substantial coverage of the Ghanaian population[33]. Previous studies and reports have raised concern about limited enrolment onto NHIS by the poorest and most marginalized. OPD and IGF figures cannot tell us whether the increased health utilisation benefited the population as a whole or was limited to a population with under-representation of the poor and marginalized. *The fundamental question of whether poor and marginalized Ghanaians do not access health service due to financial or other barriers remains.*

A national survey is required to answer this question. The survey should not only estimate the proportion of NHIS card holders within the various wealth quintiles, but also seek to determine their health seeking behaviours. This analysis could indicate whether socio-economic status provides a significant barrier to obtaining health care; as well as provide background information on reasons why some people do not register with the NHIS.

Individuals without an NHIS membership card are expected to pay the same fee for services, as the facility gets reimbursed from NHIS. The fees have seen steep increases over the past years, and while the increased out-of-pocket fee for non-insured persons may well increase the incentive to enrol, *a concern is that the poorest, who cannot afford the NHIS premium, now face a double barrier to the formal health system*; unaffordable premium and increasingly unaffordable out-of-pocket fees.

During the review of 2010 the IRT visited Upper West Region, which is one of Ghana's poorest regions and historically had some of Ghana's poorest performance indicators. Despite these predicaments, a report from NHIS shows that Upper West Region has the country's highest health insurance coverage rate. Sissala East District Health Management Team and the district health insurance office explained that the high coverage results from a concerted effort of IEC activities and support from local government, traditional leaders and NGO's; local NGO's actively identified poor

[33] The NHIA, by the end of 2010, claims to have 16.9 M people or 69% (IRT calculation) of the whole population registered with NHIS. The total number of valid members (with its membership being regularly renewed) was estimated at 48% late 2009. The high frequency of insured OPD contacts could be in line with the membership coverage data presented by NHIA, but this can only be verified through a population based survey.

people in the district and paid for their NHIS membership; the district social welfare office identified a list of poor persons to benefit from the LEAP project, and the office collaborated with the district health insurance to automatically enrol these LEAP beneficiaries onto the health insurance; and Ghana AIDS Commission registered HIV positives and paid for their membership. *In 2010, Sissala East District Health Insurance reported coverage of 94% of the district population, of which 81% were active members* (i.e. active membership coverage of 77% of the population). In other districts visited by the IRT, CHAG facilities paid for the NHIS premium for poorer people, when attending the facility. In most districts visited by the IRT, access to services by poor or vulnerable people was not really on the agenda of the DHMT. While the IRT recognises that identifying the poor is the responsibility of the Ministry of Social Welfare, concerted action could be more effective if the DHMT would provide information on vulnerable people (e.g. through CHOs and through facility staff) to the local representative of the Ministry of Social Welfare and DHIS.

A new health insurance premium structure with a lifetime contribution of about GHc 100-200 is proposed as part the current revision of the health insurance act. Future premium payers will benefit from lifetime health insurance membership, but the steep increase from today's premium of approximately GHc 7-48 will most likely present an excessive barrier for many informal workers. One option presently being considered is to split the payment of the life time premium over several years in order to reduce the financial barrier. Given that no firm decision has yet been taken on the final modality of the life time premium, the *IRT recommends careful consideration to mitigate the negative effects the lifetime premium could have on financial equity and access to health services for the poorest*.

Key recommendations

- Carry out a **national survey to estimate the proportion of NHIS card holders** (and valid card holders) within the various wealth quintiles, but also seek to determine their health seeking behaviours. This analysis could indicate whether socio-economic status provides a significant barrier to obtaining health care; as well as provide background information on reasons why some people do not register with the NHIS; and whether the insurance premium has been covered by a third party.
- **Put poverty and equitable access to health services on the agenda of the DHMT and DA**.

4.2 Maternal and reproductive health

Maternal health

Maternal mortality remains high in Ghana; with the current slow progress, the MGD 5 will not be attained by 2015. There are significant disparities in institutional maternal mortality ratio across the 10 regions in Ghana, but these are difficult to interpret. As per DHS 2008, maternal mortality ratio decreased in all regions except Greater Accra where maternal mortality ratio has worsened by 87.6 per 100,000. Given the less than satisfactory progress, the health sector is redoubling efforts to reverse the trend.

The *district implements a comprehensive ANC (Antenatal Clinic) programme that is linked to CWC* (Child Welfare Clinic). Newborns and their mothers receive three monitoring visits to assess the

newborns' health. Some districts have developed specific strategies that encourage collaboration between midwives at the sub-district level and TBAs at the community. Women attending ANC at the hospital are screened and all those with previous history of caesarean, postpartum haemorrhage, eclampsia, hypertension and the elderly identified as at risk clients. Special counselling clinics are organised for these women together with their spouses and they are advised to deliver in the hospital. Although the number of women attending the ANC at least four times during pregnancy continues to raise, the coverage of pregnant women who received at least one antenatal care visit dropped by 7% since 2008 to 90.6%. No specific reasons are known for this drop in attendance during two consecutive years. Volta Region has the lowest coverage at 70.9%, which is almost 20 percentage points under the national average (see Holistic Assessment). The causes of the high drop out rates in ANC attendance need to be carefully investigated.

In 2010, midwives received specific *training on the use of partograph*. Knowledge in the use of partograph promotes confidence, reduces prolonged labour, caesarean sections and intrapartum still births (WHO, 1994). Midwives are however not always able to put this knowledge into practice in the sub-district facilities because most women arrive late at the facilities, usually at the second stage of labour.

EmONC is being implemented in all 10 regions, but not yet at with full complement of required resources (midwives, equipment). Four regions have so far received EmONC equipment: Eastern and Brong Ahafo in 2009 , Ashanti and Northern regions in 2010. In order to accelerate the achievement of MDG 5 by 2015, *immediate steps should be taken to provide equipment to the remaining 6 regions.*

The 2009 independent review recommended that findings of 2010 EmONC assessment should factored into the 2011 APOW and budget. Data was collected from 1271 facilities across the 10 regions for the EmONC assessment. Analysis of EmONC assessment data has been completed early 2011 and a fact sheet developed on key findings. With assistance from the DPs, several EmONC policies were reviewed including policy guidelines on PMTCT in line with the new WHO recommendations, PMTCT training manual and the Maternal Death Audit guidelines.

In 2010, the following *training* were conducted to boost the skills of health: TOT on Safe Motherhood Clinical Skills training for Regional Resource Teams, comprehensive Abortion Care training for midwives and distribution of MVA kits, TOT on Lactation Management and Jadelle insertion and removal.

Districts visited by the IRT bring creative and workable solutions to enhance maternal health. In one district in UWR obstetric emergency protocols have been simplified into a poster format for easy reference by midwives in the labour ward. The protocols aid midwives and nurses to manage emergencies while waiting the doctor on call. The hospital offers ultra-sound services to all pregnant women purposefully to detect any foetal distress. The district hospital with assistance from the National Blood Bank established a functional blood bank. The blood banks are mainly to support maternal health services and particularly deliveries. In order to reduce maternal deaths, audits are in principle conducted on all maternal deaths. This is generally confirmed by observations in the field. Maternal audit develops the culture of responsibility among health staff and the local community. In some other districts all mothers delivering at home are traced and followed-up by health staff together with the TBA who did the delivery. It was observed in some districts that some CHO's did not feel comfortable conducting emergency deliveries. Such CHOs should be identified and provided additional training to enhance their skills in delivery.

Comprehensive abortion care has been introduced in all regions. Under the current law, abortion is illegal but permissible under specific circumstances such as rape or when the mother's health will be compromised. The service is provided at the district hospital. Women are ultrasound scanned before abortion and medical abortion is used up till 10 gestation weeks. Vacuum extraction is used after 10

gestation weeks. In Tumu district hospital, for example, about 122 cases received comprehensive abortion care in 2010, of which about 56 came with induced abortion and bleeding. Sub district health staff counsel women about the service and refer to District Hospital for abortion. NHIS pays for treatment after unsafe induced abortions. Fresh abortions are paid for by the patient and range from 20-50 GHC. The logic of non payment for fresh abortion escapes the IRT.

Supervised Delivery

Supervised delivery remains low in Ghana; the 2008 DHS reports the percentage of supervised deliveries at 58.7% (including public and private facilities). Several long and short term measures including the expansion of midwifery school intake, redistribution of midwives, life saving skills training, CHPS and free delivery have been instituted to increase supervised deliveries (Ghana MAF, 2010). The 2010 POW, aimed to achieve 50.3% coverage of supervised delivery (this target covers mainly public and CHAG facilities and is therefore below the DHS 2008 figure). Although this target was not met, *there was a modest increase from 45.6% in 2009 to 48.2% in 2010* (see Holistic Assessment), continuing the progress since 2007. Poor staff attitude and unsatisfactory facilities were identified as key factors affecting delivery in facilities, next to cultural and other barriers. The IRT noticed that districts made efforts to improve on local conditions. In the UWR, TBAs are encouraged to accompany women in labour to the facilities to deliver. The TBA is provided the opportunity to observe the delivery and receives all benefits that she would have received if conducting the delivery herself. In the UER, women who deliver in public institutions are provided food (flour water) and this also encourages delivery in the health facilities. In the Western Region, the PROMISE project registers all ANC women and encourages them to delivery at health facilities. They also follow up at home on all pregnant women after delivery to check upon the health of the mother and newborn.

Referrals still remain a problem in many districts. Three out the five districts visited had no ambulance services. Although regional and district hospitals are well equipped to handle complicated labour cases, the main issue is how to timely transport women in labour to these facilities. The national ambulance service is said to be expensive (and probably not yet able to ensure district based services).

Several districts have adapted innovative ways transporting women to the hospital. In some districts of the Western Region, where private transport is easily available, the districts have identified dedicated taxi drivers who provide ambulance services for women in labour. The drivers are expected to send the women to the facilities and then receive payment for their service later. In the UER, identified motorbikes riders are used ambulance during labour. In the UWR, the GHS have set up a telephone directory of all senior health personal and opinion leaders including RDHS, DDHSs, DMOs, DPHNs, ambulance drivers, Chiefs, and Assemblymen, midwives, CHOs among others. This telephone directory is distributed to all facilities in the community to aid the referral processes. In case of an emergency, all personal needed to attend to the case are informed in advance before the ambulance arrives with the patient. Although the use of the ambulance is free, family members are expected to replace the fuel used to convey the case from the community to the hospital. Family members pay about 4 gallons of gasoline for the use of the ambulance. The *NHIS does not cover the cost of conveying women in labour to the facilities*. The fact that the additional costs of transporting the women in labour together with the responsible TBA to the nearby hospital or health facility is not covered may be one of the major factors explaining the reluctance of mothers to deliver at the facility (next to the other factors mentioned above). *One of the most important reasons explaining the recent major drop in maternal mortality in Bangladesh is thought to be the demand side financing covering this cost of both the mother and the TBA. The NHIS should consider covering this cost.*

Key recommendations

- **Provide ASAP the EmONC equipment to the remaining 6 regions**. Continue research into the reasons of low institutional deliveries and adopt best local practices to encourage institutional deliveries. Specifically, **consider investing on the demand side** (rather than only on the supply side) by covering the costs of transport for both the mother and responsible TBA to the nearby equipped facility.
- **Invest in improving referral and emergency services**

Provision of Family Planning Services

FP prevents unwanted pregnancy and reduces the risk of maternal deaths from pregnancy-related complications and unsafe abortion. Family Planning (FP) activities were implemented in all districts visited by the IRT and all districts had copies of the National FP protocol to guide them in counselling and preparing clients for services. However, *the acceptance and use of FP remains a challenge*. Although, according to the DHS (2008), the use of modern contraceptives methods has been relatively constant over the last five years : from 19% in 2003 to 17% in 2008, recent data from the GHS shows a *continuous decline in FP uptake from 33.8% in 2008 to 31.1% in 2010*. From the districts visits, several factors were identified which could account for this negative trend and low uptake. These factors include a) lack of male involvement in family planning; b) stock-out of depo provera; c) misconception about FP.

Reportedly, *male dominance* still weighs heavily on women's ability to freely use FP methods. Most women require expressed permission from their husbands to use FP. Men tend to view women's ability to control their fertility as a sign of autonomy and power. Apparently, many women feign illness in order to get the opportunity to go to the clinic for FP services. Rather than an individual decision, the use of FP seems a matter but between spouses and to some extent their families. More efforts should be made to involve men in FP activities.

Some districts reported *stock-out of depo provera in 2010*. These reports were confirmed at the national level. Although Ghana has a National Contraceptive Security (CS) Strategic plan, supported by a Financial Sustainability Plan (FSP), the issue of commodity stock-out keeps occurring. For a country like Ghana, investing considerable resources in health, this is no longer acceptable. The Family Health Division of the GHS has taken note of this as they reviewed the 2004-2010 CS strategic plan to take care of the frequent commodity stock-out.

Most women hold several *misconceptions about the use of FP*. Reportedly, young women believe that the use of FP before your first birth affects their ability to have children in future. Also use of contraception is associated with promiscuity and is frown upon by women. Financial access to FP commodities also remains a challenge mostly in rural communities as most women are unable to afford the cost of contraceptives because they cannot ask their husbands for money to take FP.

At district and sub-district level there is limited capacity to provide some of the long lasting methods particularly implants (Jadelle and norplant) as few health staff have the skills to provide such services. More resources should be committed to training midwives and CHOs to provide these services. *From a public health point of view there is a strong case for NHIS to add FP (including long*

lasting methods[34]*) to the services it insures*. As discussed, the national needs should be estimated and the resources added to the annual budget of NHIS[35]. Currently the NHIS covers clinical services such as vasectomy. The NHIS could also consider providing money for the provision of long lasting methods to women at the current subsidised cost.

Key recommendations

- **Ensure men's involvement in FP activities**. Strengthen behavior change communication that will foster social change and re-orient spouses and families instead of individuals.
- In order to increase continuous access to FP, **consider adding FP commodities and /or including free access to long lasting FP methods under NHI** (this may require adapting the draft NHI Bill). Broadening the insured package would require adequate increase of annual resources for NHIA.

4.3 Non Communicable diseases

Non communicable diseases are grouped into four main categories: a) the traditionally called chronic diseases such as diabetes, cardiovascular diseases, chronic lung diseases and different forms of cancer; b) genetic disorders such as sickle cell anaemia; c) injuries with chronic physical impairment; and d) special disorders causing problems such as hearing impairment. Other chronic diseases such as mental health disorders, HIV and AIDS and oral diseases are addressed by other specific programmes. NCDs constitute about 18.5% of the top ten cases of mortality (MOH, 2007).

Table 5. Proportion of new outpatient diseases due to NCDs in public health facilities (excluding teaching hospitals), 2006-2010

Disease	2006	2007	2008	2009	Jan-Oct 2010
Hypertension and other heart diseases	2.9	4.2	3.3	3.7	3.7
Hypertension	2.8	4.0	3.2	3.5	3.5
Diabetes	0.5	0.9	0.7	0.7	0.8
Injuries and poisoning	2.3	2.2	1.8	1.8	1.6
Asthma	0.2	0.3	0.3	0.4	0.4
Sickle cell disease (SCD)	0.12	0.15	0.11	0.11	0.13

Source: Centre for Health Information Management, GHS, 2010.

[34] The 2008 DHS reported that 41% of women preferred depo provera to other FP methods.
[35] Reportedly, the annual need for FP commodities is estimated at USD 4 million (or roughly 1.5 to 2 % of the total annual budget of NHIA).

The Table above shows that the proportion of OPD cases due to hypertension increased from 2.8% in 2006 to 3.5% in 2010. There was a corresponding increase for diabetes from 0.5% to 0.8% over the same period. That of SCD has however been more stable at around 0.13% on average, despite the relatively small number of cases.

The POW 2010 mentions four main broad activities on NCDs which includes:

- Promoting healthy lifestyles
- Establishing screening and proper management programmes for diabetes, hypertension, cancers, sickle cell, and asthma
- Conducting research into NCD
- Establishing national cancer registry

The *Regenerative Health and Nutrition Programme* (RHNP) emphasises healthy lifestyles through healthy diet, exercise, rest and environmental cleanliness. Health promotion is the major strategy for informing the community about regenerative health and nutrition programme. In 2010, television and radio programmes were organised at the national level. Also posters and banners continued to be displayed at various vantage points. Stakeholders meetings were held with the Pentecostal Council and the Moslem Peace Council to introduce the programme.

The MOH collaborates with key agencies such as GHS, Ghana Education Service, National Sport Council, Ministry of Education, Ministry of Local Government and Rural Development among others to promote regenerative health. Although the RHNP is managed by the MOH, it is expected that its activities are implemented by the GHS, the Ghana Education Service and the National Sports Council but it is not very clear whether there is any formal agreement to this effect. The main challenge reported is how to scale up the programme through the GHS as a key collaborator.

Although the national level confirms that guidelines for screening and management of NCDs exist ('also on the worldwide web'), *no guidelines were available or known the at district and sub-district level*. However, some screening activities take place at the operational level. Reportedly, all adults above the age of 18 attending a health facility have their BP taken. Ad hoc screening for BP, BMI and breast examination are organised by NGOs and Churches during important festivities or national and international events. Also, occasional health education programmes about healthy lifestyles are broadcasted via local radio stations.

Management of NCDs was generally weak at the peripheral health facilities visited by the IRT. In the districts, health education and promotion activities are often tied to other programmes such as malaria, TB, HIV/AIDs and polio and do not systematically cover NCDs. Systematic screening for cancer has not been established. Cervical cancer screening using visual inspection with acetic acid (VIA) is only available at Ridge hospital in Accra and South Hospital in Kumasi. Some private health institutions provide cervical cancer screening services. However, these services are expensive and are accessed only by those who can afford. In 2010, Ridge Hospital provided cervical cancer screening services to about 1800 women using VIA and about 2 to 3% were VIA positive.

On the advice of the Sickle Cell Foundation of Ghana, a technical Advisory Committee (TAC) on Newborn screening for SCD was inaugurated by the Minister of Health in November 2010. The TAC met in December to draw up plans on the roll-out of a nationwide newborn screening programme for SCD. In 2010, both the public and private health facilities in Kumasi screened about 20,082 newborns for SCD and about 1.8% were considered to have possibly SCD.

Cancer registration is still done in the two teaching hospitals in Kumasi and Accra. In 2010, the KATH registry in addition to collecting data from the Radiotherapy centre also collected data from the Pathology Department. Current challenges include few data registration officers at NCDCP, unplanned trained staff transfers within and across hospitals, limited coordination between the

KATH and Accra Registries, incomplete data and software problems for national prevention data management.

In 2010, *the NCDCP completed the draft National Policy for the Control and Prevention of NCDs.* The main objectives are to reduce the incidence of chronic NCDs; to reduce and prevent unhealthy lifestyles that contribute to NCDs; to reduce morbidity associated with NCDs; to improve the overall quality of life in persons with chronic diseases. Also, the strategic framework for NCDs, the national cancer care plan and the sickle cell anaemia strategic plan were developed. However, these documents are yet to be distributed to implementing agencies in the regions and districts.

Although there is no coordinated research plan, the NCDCP undertook a systematic review of studies on hypertension in Ghana published between 1975 and 2009. The review found that the prevalence of hypertension amongst 18 years+ ranged between 19% and 48% (sic!) during this period. The University of Ghana Medical School completed a WHO multi-country longitudinal Study on global AGEing and adult health (SAGE) in 2010. The study in Ghana was nationwide and it involved 5,573 adults and elderly (18 years +). There is a *perceived need at NCDCP for a coordinated and systematic research agenda on NCDs.*

One fundamental management problem is that the *NCD control programmes have no focal persons at the regional level and no staff designated for NCDs activities at the district level*. In addition to this, the NCDCP is faced with *chronic under funding* to carry out planned activities. Financial support is often provided by NGOs and pressure groups interested in NCDs. Such funds are usually earmarked for specific disease conditions particularly sickle cell, diabetes or cancer.

Summarising, NCD did not receive much attention at the regional and district level in 2010 but important activities have been carried out at central level, including developing the national policy for prevention and control of NCDs. Although prevalence is alarming, the lack of focus on NCDs reflects a continuous bias towards communicable over non communicable disease by both political and professional actors in the health sector. It is important to note that the ever increasing effects of NCDs on the disease profile of Ghanaians needs attention and the time to act is now.

Key recommendations

- **Speed up the dissemination of the strategic framework for management, prevention and control of NCDs and implement the screening guidelines for NCDs**
- **Plan and budget for NCD** prevention, control and management in the 2012 national plan and budget. **Introduce a major focus on NCDs in 2012 district health plans**.
- **Appoint regional NCD focal persons as TOT to train district staff and support DHMTs in developing a NCD focus in the district health plan**. Use the CHOs to trace, follow-up and counsel chronic patients regarding regular clinical follow-up and treatment. **Ensure the operational link between the responsible nurse at the health facility dealing with chronic patients and the CHOs living in the area of respective patients.**

5. Main conclusions and recommendations

Holistic assessment, sector performance and selected POW priorities

The holistic assessment 2010 scores the sector performance as 'highly performing', with a total score of 3+. It should be noted that no population based survey data were available for the 2010 assessment, meaning that all indicator results are service based (which means that it reflects the reported activity of the public sector, the mission sector and only part of the private for profit sector) or reflect public sector management. On the one hand this means that true coverage of some service indicators is likely to be underestimated (e.g. supervised delivery) but also that data are as good as the standard data collection, reporting and validation system is. However, data quality also affected previous year assessments and some major efforts have been invested this year by GHS in validating data quality. It is however recognised that data quality and completeness is yet to be improved.

The 'highly performing score' may somewhat overestimate true performance as appreciated by the IRT, but overall the IRT confirms that, with the exception of some important areas, the sector has been performing well. However, there is still scope for improvement and some key areas require urgent attention.

In 2010 *several service delivery indicators continued the positive trend documented in last year's review*. The coverage of supervised deliveries increased (now at 48%), institutional maternal mortality decreased and the average number of outpatient visits per capita continued previous years' remarkable increase (now at 0.89 per capita). The cumulative number of patients initiated on antiretroviral treatment also continued to increase (plus 41% compared to 2009). On the other hand *coverage of EPI, ANC and FP services experienced worrying negative trends* that need further analysis and action. While 3 regions have been identified as regions excelling in selected key indicators in 2010 (UWR for supervised deliveries and institutional MM; ER for Penta 3 coverage and FP acceptance rate; and WR for ANC and OPD per capita), Volta region is an outlier regarding many indicators and requires attention.

Although the coverage of supervised deliveries improved in 2010, the *equity indicator for supervised deliveries worsened significantly*, indicating a widening gap between the highest and lowest performing region. *Nurse to population and doctor to population ratio increased* respectively by 1.8% and 1.5% compared to 2009. The *number of functional CHPS zones has increased by 51%* (!), a sign of GOG's devotion to improving equity in geographical access to services. The number of OPD visits under NHIS increased from 2.4 million in 2007 to 18.7 million in 2010. The IRT observed that a very large number of OPD visits were by insured patients (between 85 and 95% of total OPD). However OP and IP data do not provide information about people not accessing the services. The *fundamental question whether poor and marginalized people do not access health services due to financial or other barriers remains*. The IRT recommends assessing accessibility via a national survey.

Maternal mortality remains high and with the present progress, MDG 5 will not be attained in 2015. It is therefore laudable that maternal health gets so much attention at district level, but difficult to understand why the ANC attendance rate dropped significantly over the past two years. *Supervised delivery remains low and timely referral remains a problem in many districts*, even if creative solutions are introduced at operational level; and costs or referral is outside the NHIS package. The EmONC assessment has at last been completed but too late to factor findings into the 2011 budget and POW; and only 4 out of 10 regions have received EmONC equipment (of which 2 in 2010). The *acceptance rate and use of FP remains also a challenge* with a continuous drop in FP uptake from 33.8% in 2003 to a low 23.5% (!) in 2010. The IRT recommends to analyse the reasons for this major drop; and, pending the results, consider covering FP under the NHIS (while adding the necessary

resources to NHIA); and consider initiating demand side financing for maternal care in order to increase access to delivery services.

Non communicable diseases (NCD) did not receive much attention at the regional and district level in 2010 but important activities have been carried out at central level, including developing the national policy for prevention and control of NCD. There exists no focal person for NCD at regional level and limited competence for prevention, control and management of NCD at district level. Guidelines for managing NCD are absent at facility level. Although prevalence of some NCD is alarming, the lack of focus on NCD reflects a continuous bias towards communicable over non communicable diseases by both political and professional actors in the health sector.

Of the 4 milestones agreed for the 2010 POW, two were fully achieved: a) *Essential Nutrition actions implemented in all regions with emphasis on complimentary feeding*; and b) *Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas*. One milestone was partly achieved: *New organizational architecture for the sector agreed; organizational change roadmap agreed; organizational development plans completed.* The last milestone was not achieved, but work was in progress: *Health Industry strategy developed within the framework of public private partnership (PPP).*

Central Governance

Governance *of the sector provides a mixed picture but some important changes have occurred or been initiated in 2010*. The MoH has started a process of internal reorganisation with a view to strengthening MoH key functions and revitalising / reviewing performance contracts with health agencies; a process that needs full support (both from central agencies and DPs), also with a view to reduce the still perceived dichotomy between MoH and GHS, and avoid duplication of functions. The M&E function is a point in case that requires strengthening under the MoH. The IALC met regularly and its functioning is appreciated by all agencies interviewed as key to counter fragmentation and support harmonised approaches between different central agencies. Seven draft health bills are now with the PSC for finalisation. The IRT however noticed some inconsistencies that still need to be addressed and is of the opinion that some proposed bills may enhance rather than counter fragmentation. Other 2010 achievements include the finalisation of the CMA III, the JANS review, the preparation of the HSMTDP (pending finalisation of the M&E framework).
Remarkably, the *NHIA has become more transparent and more cooperative* with MoH and other health agencies which was appreciated by all central agencies interviewed and also noted by the IRT. Coverage of registered members continues to increase (now at 16.9 million members[36]), OP utilisation by insured members has substantially increased and average lead time of reimbursement of claims has been substantially reduced. NHIA has also strengthened key functions of the central organisation. Understandably, NHIA faces still some legal, organisational and technical challenges: the draft Bill is still pending; renewal of cards by members is often untimely; cost containment and financial sustainability require continuous attention. Testing capitation payment as planned in the pilot project will be crucial in order to potentially address sub-optimal provider and client behaviour.

Nine out of 23 actions agreed upon in the April Summit Aide Memoire between DPs and GOG have not been completed, including main actions related to PFM and private sector policy and involvement. *Two main areas of concern raised by the 2009 IRT still require further action: the high costs of drugs and the fragmented funding to districts.* Coordination amongst DPs is an area that requires continued attention and several DPs have expressed some concerns with the use / effectiveness of the existing mechanisms for sector dialogue (technical and strategic).

[36] No 2010 data were provided for members with a valid card. By the end of 2009 coverage of valid card holders was estimated by NHIA at 48%.

Importantly, for the first time ever, the health sector budget passed the 15% Abuja target[37] and increased both in absolute and relative terms (USD 28.6 per capita compared to USD 25.6 in 2009). However, the *proportion of non-wage GOG recurrent budget allocated to district level and below decreased by 25%* from 62% in 2009 to 46.8% in 2010, a reported drop that requires attention[38].

District Governance and Management

The IRT assessed district governance and management through assessing the health system building blocks. *Main impression on district and DHMT performance was positive and dynamic*. *Maternal health and CPS are high on the district agenda* and are supported through creative, innovative, locally-developed solutions, some of which are examples of best practice that can serve other districts. *Non-communicable diseases and access to services by the poor and vulnerable is not on the main agenda*.

In the districts visited, *most annual district plans are not 'comprehensive'*, a concept that may require clarification and a rational approach. *District hospitals tend to be 'virtually' too much separated from DHMT management and oversight*, resulting in sub-optimal use of scarce resources and potentially in sub-optimal quality of care and referrals by peripheral facilities. *Regions and districts request greater decentralised authority on HRH management*. Nobody at district level seems to be trained in HR management and formal HR training plans are not available at district level. *Information management* requires continuous attention and regular updating of skills. The main problem observed is with data entry, validation and understanding at facility level. Available transport is generally well managed, but *ambulance services are absent in many districts*, forcing DHMTs to develop local, creative but generally sub-optimal solutions for emergency referrals. *Drugs supplies at facilities have greatly improved since the NHIA came on stream*. Some stock outs happened in 2010 (e.g. TB drugs, FP commodities, bed nets) which is unacceptable in the context of Ghana. Several DHMTs lacked sufficient skills in pharmaceuticals and laboratory. *Main issues raised by DHMTs* have not changed over the past years and include insufficient, irregular and inflexible funding; lack of guidelines on how to use funds, especially IGF; availability of HR; strategies to improve staff retention and motivation; lack of ambulance services and essential equipment (e.g. EmONC); and data management.

Public finance management

In the narrow sense of systems, *budget planning and preparation* are relatively well established, but timelines for budget preparation remain very tight. The lack of timely budget information leads by default to incremental budgeting. Budgets are supposed to include all resources including IGF and earmarked programmes but this is not always the case and outstanding debts with suppliers are kept off the budget (but are recorded). *Allocation guidelines* have been established but are not based on a comprehensive assessment of total flows of fund to each region and district. As a consequence, redistribution of funds happens only in a narrow sense, overlooking the broader picture.

Aggregate budget execution was relatively good in 2010, but *at operational level it remains the Achilles heel of the PFM systems*, mainly because of fragmented and partially earmarked flows of funds, with limited discretion at the spending unit. Comprehensive feedback from the top to the spending levels on the actual budgets and timing of the releases is lacking; and there is no functioning tracking system in place that provides information on the status of the releases throughout the system. Regarding IGF, the NHIS is becoming increasingly dominant. The IRT noticed that *several health providers were building up capital in the IGF drug account* and would argue that there is scope for a controlled broadening of the discretion of the drug account, provided that

[37] There may still be an issue of double counting of NHIF, but this was probably also the case in previous year's budget.
[38] This indicator would be much more meaningful if reflecting actual expenditures.

minimal thresholds are respected. In contrast to this surplus, *all BMCs indicate to rely extensively on supplier credits*. Also, districts are introducing innovative ways to share financial resources between sub-district and district level.

Marked progress was made in 2010 in implementation and training of the ATF manual. Aggregate quarterly financial reports are prepared on a regular basis but are not used by management to monitor policy implementation. Both MoH and GHS have enrolled under the first phase of the introduction of the Ghana Integrated Financial Management Information System (GIFMIS). Its roll-out will impact on all financial operations within the health sector. *The PFM Working group only met once in 2010.* The 2009 IRT recommendation to reprioritise within the PFM strengthening plan was not given follow up (although some actions were pursued) and the IRT noticed little effort with key GOG actors to reinvigorate the working group.

The Internal Audit, which is well established in the health sector, is hampered by insufficient staff levels and operational resources. In terms of *external audit*, under the auspices of the Auditor-General, a private firm was hired in 2010 to audit the 2009 accounts of the MoH. Furthermore, the Ghana Audit Service performed regular audits of BMCs. Audit Report Implementation Committees (ARIC) were in place in most but not all BMCs visited. The public discussion of the MoH 2007, 2008 and 2009 audit reports took place on March 24th, 2011. *The Public Audit Committee insisted on the need to strengthen internal controls and to act more aggressively in cases of fraud and embezzlement*.

Recommendations

The recommendations summarised in the table below are meant to help the MoH, the respective agencies and civil society to address the above constraints for maintaining and continuously improving high level sector performance.