Ministry of Health
Programme of Work 2003

Report of the External Review Team

Accra, May 2004

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Acknowledgements

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Abbreviations

AFP ..... Acute flaccid paralysis
AIDS ..... Acquired immune deficiency syndrome
ANC ..... Antenatal care
ART ..... Anti retroviral therapy
ACSD ..... Accelerated Child Survival and Development Project
BOR ..... Bed Occupancy Rate
BPEMS ..... Budget and Public Expenditure Management System
BMC ..... Budget management centre
CDR ..... Case detection rate
CFR ..... Case fatality rate
CHAG ..... Christian health association of Ghana
CHIM ..... Centre for health information management
CHO ..... Community Health Officer
CHPS ..... Community health planning and service
C-IMCI ..... Community component of integrated management of childhood illness
CMA ..... Common Management Arangement
CPR ..... Contraceptive prevalence rate
CVA ..... Cerebro-vascular accident
DA ..... District Assembly
DHS ..... Demographic and health survey
DOT ..... Directly observed therapy
DPT ..... Diphtheria pertussis and tetanus
EmOC ..... Emergency obstetric care
EPI ..... Expanded programme on immunization
EsOC ..... Essential obstetric care
GHS ..... Ghana Health Service
GOG ..... Government of Ghana
Govt ..... Government
GP ..... General Practitioner
GPRS ..... Ghana poverty reduction strategy
GWEP ..... Guinea worm eradication programme
HC ..... Health centre
HIV ..... Human immunodeficiency virus
ICP ..... Integrated care pathway
IEC ..... Information education and communication
IGF ..... Internally Generated Funds
ILO ..... International Labour Organisation
IMCI ..... Integrated management of childhood illness
IME ..... Information monitoring evaluation
IMR ..... Infant mortality rate
IPD ..... Inpatient department
IPT ..... Intermittent preventive treatment
ITN ..... Insecticide treated net
KNCV ..... Anti TB Association of the Netherlands
MDA ..... Ministries, departments and agencies
MDG ..... Millennium development goals
MDR ..... Multidrug resistance
MMR ..... Maternal mortality rate
MOH ..... Ministry of health
MOU ..... Memorandum of Understanding
NACP ..... National AIDS control programme
NDC ..... Non communicable disease control
NDPC ..... National Development Planning Commission
NHI ..... National Health Insurance
NID ..... National Immunisation Day
NMCP ..... National Malaria control programme
NTP ..... National Tuberculosis control programme
OPD ..... Outpatient department
PE ..... Personal Emoluments
PH ..... Public health
PLWHA ..... People Living with HIV/AIDS
PMTCT ..... Prevention of mother to child transmission
PNC ..... Postnatal care
POW ..... Programme of work
PPH ..... Postpartum haemorrhage
PPME ..... Policy planning and monitoring unit
PPRHAA ..... Peer and Participatory Rapid Health Appraisal for Action
QC ..... Quality control
RBM ..... Roll back malaria
RCH ..... Reproductive and child health
RDU ..... Rational drug use
RHMT ..... Regional health management team
SD ..... Supervised delivery
STG ..... Standard treatment guidelines
STI ..... Sexually transmitted infections
SWAp ..... Sector wide approach
TAMC ..... Traditional and Alternative Medicine Council
TB ..... Tuberculosis
TBA ..... Traditional birth attendant
TH ..... Teaching hospital
U5MR ..... Under five mortality rate
WHO ..... World health organization
Wt/A ..... Weight for age

Chapter One: Overview of the Report

This report of an independent review team into progress with implementing the 5 year Programme of Work during 2003 comes at the end of an internal review process that has involved self-review of performance by each of the Budget Management Centres, district and regional performance hearings, regional reports, agency wide reports, self-assessments by donor partners, and detailed studies of maternal mortality, clinical services, monitoring and evaluation, poverty and inequality of access to services, as well as technical reviews covering the main priority health interventions. A wealth of other material has been generated and presented at national level performance hearings. Moreover, this year's review follows on from a very comprehensive review undertaken in 2002, the report of which was published in May 2003. Our task has been to sort through this avalanche of previous reviews and analysis in order to form a view on the progress of the health sector in 2003, and reflect on priorities for the remainder of 2004 and the POW for 2005. In addition to reviewing the previous literature, we have based our views on discussions with local informants and field visits to Upper West and Brong Ahafo regions.

Table 1.1 reproduces the overall Objectives of the 2003 health sector review, as set out in the terms of reference, and the extent to which we were able to cover these topics, which depended in large part on the existence of evaluative material for us to synthesise. As proposed in the terms of reference, we have tried to be 'selective, focused and strategic'.

Table 1.1: Coverage of the Terms of Reference

Objective	Extent Covered
1. Identify and analyze the implications of the changes and trends in the health policy and institutional environment on the 5 Year Programme of Work and CMA	1. We discuss MOH/GHS, Health Insurance, CHPS, and to some extent development partners, but not decentralisation to DAs.
2. Analyze trends in performance using sector wide indicators	2. Covered in detail in Chapter 2.
3. Assess strategies and progress in reducing inequality in health services	3. Covered in detail in Chapter 5.
4. Assess progress in institutional reforms and development, service delivery, organization management and economics and financing of the health sector.	4. Covered in Chapters 2-4.
5. Assess the roles performance and contributions to performance of BMCs, Agencies, and Partners	5. Attribution of performance to specific contributions not attempted, other than analysis of OPD visits (Chapter 2), regional performance on output and efficiency (Chapter 2 and 3), and disbursement performance (Chapter3).
6. Review the partnership arrangements between MoH and Agencies, between the Public and Private Sectors, and between the MOH and Partners including other sectors.	6. Some analysis of partnership arrangements in chapter 4, main focus on public sector.
7. Identify constraints to policy and programme implementation	7. Institutional, management, budgetary, information, and human resource constraints are addressed.
8. Review the incentive environment and opportunities for sustaining and/or improving performance	8. Incentive discussion mainly covers agency and staff incentives and budget management.
9. Recommend priority actions for discussion and adoption at MoH-Partners Summit	9. Proposed priority actions from our Chapter 6 recommendations are identified in this chapter.

Performance in 2003

Our detailed review of the SWAP performance indicators in Chapter 2 shows that 2003 was a second year in which little progress was achieved towards the strategic objectives of the five-year programme of work (Box 1.1). The lack of progress came in spite of an overall increase of nearly thirty percent in health sector expenditure since 2001. The problem is that

the increase in spending has paid for increases in personal emoluments and in investment while the real level of spending on the administration and service budget is lower than in 2001. Better-paid staff in more and better facilities have therefore lacked the financial means to be more productive. There has also been a further decline in the proportion of spending allocated to districts, at the expense of increased shares for the headquarters and regional levels. Although there are some factors particular to 2003 that partly explain this trend, it does need to be reversed. Our view is that the original concept of preventive and primary healthcare based on resources managed by the districts remains valid.

Box 1.1: Summary Judgement of 2003 Progress on 5Year POW Targets

1. Improve Geographical & Financial Access
   Against a background of increasing under 5 mortality, no consistent improvement observed, OPD/capita stagnating, some improvement in hospital admissions.
2. Improve Quality of care in facilities & Outreach
   Quality not well captured in sector-wide indicators, but improvements in tracer drug availability, maternal mortality audits, and TB cure rates (though TB cure rate still low). Clinical Care review suggests quality often poor in OPD and IPD. Immunisation coverage did not sustain good 2002 levels.
3. Improved efficiency
   Need better indicators of efficiency, but probably declined (expenditure increase not matched by output increase), and regional analysis reveals huge variations (Ch 3).
4. Collaboration & Partnership
   Private health policy issued, innovation fund yet to start, CHAG MOU signed, TAMC formed and started training. But communication, e.g., on insurance has been weak.
5. Increase resources & manage them equitably & efficiently
   Increased spend on PE and investment but non-salary recurrent spend fell in real terms, low share to districts, insufficient preference to poor regions, late and unpredictable funding. Human resources financial incentives improved, Doctor numbers improved, nurses fell.
6. Bridge the inequality gap
   Little explicit targeting of poverty, planning of CHPS needs improvement, lack of funding preference to poor regions, one very poor region (North) receives very low funding.
7. Sustainable financing that protects the deprived & vulnerable
   High IGF reduces access by the poor; exemptions not working to protect the poor; insurance may help long term but modalities still unclear.

Main theme of our report

Our recommendations are presented in tabular form in Chapter Six. In order to ensure that our recommendations have taken adequate account of what has gone before, we undertook a detailed analysis of previous recommendations and their current status (Annex 1.1), repeating those that remained relevant, dropping some, and developing or modifying others where events have moved on or new analysis suggested that modification was needed.

The main theme of our recommendations and of this report can be summarised as:
"improving performance through improved targeting and management of resources."

From the long list of recommendations in Chapter 6, we would emphasis five sector priorities that should receive particular emphasis in 2005, and progress on which will determine whether the 2005 POW is eventually judged a success:

Five Sector Priorities for 2005
1. Malaria
2. Improving performance management – with particular focus on communication throughout the sector
3. Improving the allocation and management of the budget
4. Progressing the pro-poor agenda (for which progress on 1, 2 & 3 is necessary but not sufficient)
5. Managing the challenge and risks of health insurance (which if handled badly could undermine progress on 1, 2, 3, & 4)
[6. HIV/AIDS is a sixth major issue and a threat, but not one we addressed given the recent major review.]

We propose the following actions for specific discussion at the Partners Summit:

Malaria

- Malaria is by far the largest single health problem in Ghana, accounting for over 40% of outpatient visits, and it warrants much higher priority than it currently gets, with an urgent need for meeting the increasing public demand for treated bednets.

Performance Management

- Provided commitment is established with the senior management of MOH and the key implementation agencies including the GHS, a facilitated change management process (as recommended in previous reviews and Aide Mémoires) would still be valuable in strengthening the management of resources, and in overcoming problems of poor communication and unresolved tensions in the interpretation of the mandates of MOH and GHS. Health partners should provide support for an initial facilitated workshop to launch this process.
- National and Regional managers should define more specifically the main priorities for each programme, and provide regular and targeted supervision and feedback to regions and districts.
- Encourage line managers at all levels to provide regular supportive feedback to staff, to improve performance and aid staff motivation and retention.
- Facilitate performance improvement by extending the sector wide indicators to include analysis of staff workload, and of the relation between inputs, outputs and outcomes, as recommended by the 2001 review, and as attempted in this report. Indicators of cost-effectiveness and staff productivity should be developed, reported as part of the annual review process, and used as the starting point for analysis of the reasons for differences in performance, and for action to narrow the gaps by applying lessons from the good performers.
- Establish the data depository recommended by the IME report.
- Task teams should take the recommendations of recent technical reports forward with quarterly reporting of progress.
- Maintain good past performance in implementing those recommendations that are accepted by assigning clear responsibility, and continuing to track progress by reporting back to partner group meetings using the policy matrix table developed in June 2003.

Budget Allocation and Management

- Improve inter-regional equity by increasing the non-wage recurrent budget share of the four poorest regions, from about 26% in the 2004 budget towards the GPRS

target of 39%[1]. Particular attention needs to be given to increasing the budget of the Northern region, one of the poorest regions yet the one that receives least resources in per capita terms.

- Substantially increase the non-salary recurrent budget in real terms in 2005, with the share of the districts increased in order to reach the 42% target share. This will require restraint in other areas of spending in order to limit the future share of resources taken by personal emoluments and investment.
- Implement the recommendations in Chapter 3 to reduce delays and improve the predictability of funding, including advance notification of disbursement dates by donor partners, and MOH identification of specific expenditure priorities to be protected from cuts and given preferential treatment through early fund releases.

Progressing the Pro-Poor Agenda

- Tackle low access to services by the poor and vulnerable by explicit identification of where the poor are, and specific targeting of services to meet their needs. Detailed poverty maps have just become available and will be extremely useful for achieving this. They should be widely publicised and used in the health system for analysis, planning, and implementation of all programmes, including CHPS.
- The focus on targeting resources to achieve greater impact and greater reduction in poverty-related inequalities should be reflected in the performance contracts that are being signed between MOH and Agencies and by GHS with BMC managers.

Managing the Challenge and Risks of Health Insurance

- Urgent and sustained actions are needed to contain the risks of the national health insurance scheme by ensuring that adequate resources are devoted to managing the introduction of the scheme, supported by first-rate technical assistance. If it can be financed and made to work, the national health insurance scheme has potential to improve access to health services while also acting as an agent for improving their quality. The scheme only plans to cover the 20% of health costs currently met from IGF, but the resulting increase in demand will probably also require a significant increase in the budget of the MOH. The experience of other countries with schemes less ambitious than the approach being introduced in Ghana is that they are very difficult to get right, and there are high risks. Dilemmas still needing to be solved include how best to identify the poor and protect them from charges, setting of appropriate charges that are affordable but will be financially viable for the range of services envisaged, preparing for and handling the work implications of billing and processing, conducting detailed financial analyses of the overall scheme and of the implications for the non-insurance MOH budget, and meeting the financing requirement for implementing the scheme, to name just a few.
- The definition of the poor who will have their premiums paid or heavily subsidised needs to be drawn broadly, and will probably need to cover upwards of 10% of the population. There is a particular risk that health insurance will otherwise further increase the existing inequality of access to services. Insurance will draw Government resources into meeting the increased demand of those who are covered by the scheme, who will increase their utilisation of health services. If the definition of the poor who qualify for subsidy is drawn too narrowly, the effect of the increase in demand from those who are willing and able to pay will be to squeeze out the poor. Those who are not covered because they are not eligible to have their premiums paid will find that the budgets available for the de facto free or deferred payment services

[1] The Resource Allocation Proposal for the Ghana Health Sector prepared by PPMED GHS(undated, 2003).

to which they currently have some access will be further squeezed as providers give preference to meeting the demands of the insured patients.

Despite the slow progress of the last two years, Ghana is a country that achieves relatively good health outcomes for modest expenditure of resources[2]. If progress is made across the areas covered by these recommendations, then public sector health services in Ghana will both need and deserve a significantly increased budget share, making rapid progress towards the 15% share targeted at Abuja.

Comments on the review process

The annual review process places a heavy demand on the time and human and financial resources of the health sector. The time between reviews is short for making progress on one set of recommendations before the next review unloads another list. It is unusual to have quite such a heavy analytical review process at such frequent intervals, and consideration could be given to moving towards a major review every second year, with largely internal progress reviews based mainly on the performance indicators in the intervening year. This would need attention to ensuring that a complete set of indicators is available and has been verified for consistency before the review starts.

The team would have benefited from earlier confirmation of team members to facilitate task planning, more time for advance preparation and review of documents, and more information on the internal review process, e.g., advance copies of the guidelines for performance reviews and performance hearings[3].

Many aspects of the review process are good. The increasing attention to enhancing peer review processes at district and regional levels enables a good exchange of experiences, and there appears to be good capacity to identify innovations. The district comparison table is interesting, but needs a column for comments, explanation of levels and variations. The main weaknesses are that the review does not really confront poverty and inequality in the indicators and analysis. It does not address selective targeting or selective application of interventions based on the local environment, either national or within regions and districts. Chapter 5 and the associated annex make specific suggestions about how this can be achieved. The lack of indicators of relative efficiency or cost-effectiveness makes it difficult to distinguish results achieved by good performance from those that simply reflect high expenditure. The performance of the under-resourced Northern region for example looks far better once low spending is taken into account.

The follow up to previous recommendations has been generally good. In June 2003, the innovation of a Policy Matrix was introduced, listing the agreed measures, with relevant staff asked to report on progress for feedback to subsequent quarterly meetings. We strongly endorse this approach, which should be a permanent and institutionalised part of the review process.

[2] Human Development Report tables, 2003.
[3] PPMED/GHS (2003) GHS Annual Performance Review of the 2003 Programme of Work: Guidelines for performance hearing and reporting by budget and management centres. GHS. December

Table 2.1: Trend of sector-wide performance indicators, 2001-2003

INDICATORS	INDICATORS	BASELINE 2001	PERFORMANCE 2002	PERFORMANCE 2003	MOH TARGET 2003	DHS RESULTS 2003
HEALTH STATUS	Infant mortality rate	57	55	NA	57	64
	Under five mortality rate	108	100	NA	108	111
	Maternal Mortality ratio	214	204	204.5	214	NA
	% Under five years who are malnourished (underweight)	25	NA	NA	23	NA
SERVICE	HIV sero prevalence among reproductive age	2.9	3.4	3.6	3.8	NA
	% Supervised deliveries	49.2	52.6	51.9	55	47
	Tuberculosis cure rate	48.9	53.8	Not applicable	50	
	% Family planning acceptors	20.3	21	22.6	25	21.6
	% ANC coverage	93.5	93.7	91.2	99	92
	% PNC coverage	52.9	53.6	55.8	NA	NA
	EPI coverage - DPT3	76.3	77.9	76	80	76.4
	EPI coverage - measles	82.4	83.7	79	85	83.2
ACCESS	Population to Dr ratio	22,811	22,193	17,489	20,500	NA
	Population to Nurse ratio	2,043	2,080	2,598	1,800	NA
	Outpatient visit per capita	0.49	0.49	0.5	0.55	NA
	Hospital admission rate/1000pop	34.9	34.1	35.9	36	NA
	CHPS zones completed (functional CHPS zones)	19	39	55	NA	NA
QUALITY	% Maternal audits to maternal deaths	<10	NA	85	20	NA
	Under five malaria case fatality rate	1.7	NA	3.7	1.5	NA
	% Tracer drug availability	70	NA	93	85	NA
EFFICIENCY	AFP non polio rate	2.8	NA	1.3	3	Na
	Number of guinea worm cases	4,739	5,611	8,290	<1000	Na
	Bed occupancy rate	64.7	65.5	64.1	70	Na
FINANCIAL	% GOG budget spent (allocated) on health	9.1	7.6	9.5	8	
	% GOG recurrent budget for health	10.2	10.5	12	12	

This chapter discusses the performance of the health sector including the different regions in 2003, based on detailed review of the performance indicators, and covering in detail the progress achieved on clinical care and public health services, and the follow up to the clinical care review and the technical reviews. The chapter also discusses monitoring and evaluation and the follow-up to the IME report. Recommendations are discussed in the body of the text, and are brought together in tabular form in Chapter 6.

This chapter does **not** discuss issues related to emergency care and 24 hours services (the National Ambulance Service for Greater Accra and Ashanti Regions); school health and overall health education; Eye Care and the prevention of Blindness, Non Communicable

Disease Prevention and Control (NCD); traditional medicine; Infrastructure; Laboratory services and X-Ray; Maintenance, Teaching Hospitals and Regulatory Bodies.

2.1 Performance Indicators and targets

2.1.1 Reliability and completeness of the data

This review draws on material provided by the GHS/PPME department, more detailed information from the various GHS programmes, the power point presentations of the many Technical Reports 2003, nine out of ten Regional Performance Reports 2003, and the Observer Team's reports from all the regions. This information was reinforced and deepened by the four preparatory studies conducted around March 2004 (Maternal Mortality in Ghana, Clinical Care Services Review, Information, Monitoring and Evaluation Systems and the Pro-Poor study). The team drew on the preliminary DHS 2003 report in order to compare population-based data of DHS1993, DHS 1998 and DHS 2003 with the data collected by GHS and MOH through the health institutions. Finally, an overview was made of the recommendations of the 2001 and 2002 review reports and subsequent discussions as reflected in the various Aide Mémoires since 2001. All these written materials were discussed with relevant persons at national, regional and district levels (see annexes with the documents and the persons interviewed during the assignment). The information is summarised in Table 2.01, Annex 2.01 -2.03 (Tables 2.02-2.04) and in Annex 2.04 and 2.05 (Tables 2.05 and 2.06).

Although the authors have tried to ensure consistency in the use of data, the completeness, reliability and usefulness of the data at district/regional and national levels is hard to assess. Our judgement on completeness was based mainly on the extent to which private sector data is captured; reliability is indicated by the extent to which regional reports are consistent with national figures; we also made an assessment of the extent to which the regions used the data they were reporting in assessing progress and to inform future plans. The current data collection at GHS/PPME level is often late. Data come in through the various national programmes and through the regional reports. Inconsistencies in these two data sets do occur that are not always clarified. GHS/PPME was only able to finalise its Statistical Report based on the 2003 sector-wide indicators in late April, towards the end of the external review mission. This was a problem for the review, but also suggests that senior management of MOH and GHS have not prioritised the collection and analysis of performance data for their own management purposes.

MOH/GHS publishes its own analysis with graphs and percentages and some tables, but does not publish a full statistical digest to enable others to perform different types of analysis, or check the assumptions underlying the analysis. This is a major problem making it difficult to verify or hold MOH/GHS accountable for the quality of the data and analysis they produce.

Data is not always consistently defined. For example, figures from CHPS in some regions are included in the summary sector-wide performance report whereas in others they are not. Similarly, inclusion of data from the self-financing private sector varies between sources. Completeness of reporting is not consistently recorded and poor applications of quality control mechanisms for their reliability at regional levels do not allow for the necessary corrections. However, as presented below, some important output indicators at national level do correspond quite well - using the population proportions from the 1984 census - with the population based information recently collected by DHS[4]. This indicates that at least for

[4] The 1984 census gives a population proportion of < 1 year as being 4%, whereas the census of 2000 gives a figure of 2.8%. As the 2000 census has officially been adopted, MOH in formal presentations uses the 2.8% as the denominator, but that figure gives very high values for most of the outputs (DPT3, Measles, ANC and SD). As this report shows, the preliminary 2003 DHS figures are quite close to the GHS figures, using the 4% proportion for the less than 1 yr old.

these indicators, figures collected by MOH/GHS do provide a reasonably accurate picture of what the situation is in the country.

2.1.2 Target setting by MOH and GHS

Some of the targets that have been proposed for 2004 are ambitious relative to the achievement in 2003, for example the target of 0.6 OPD visits per capita looks difficult to achieve. MOH and its agencies need to discuss targets and performance in order to arrive at a common understanding of what is feasible to achieve with the available resources. These considerations have a bearing on the performance contracts that are in the process of being signed between the Director General of GHS and the Regional Directors of Health. GHS staff may be reluctant to sign up to ambitious MOH targets without assurances of additional (staff and financial) resources, and understanding on a monitoring process that takes into account the resources actually available.

Table 2.2: Selected Performance Indicators against Targets

Indicators	MOH Targets 2003[5]	Achievement* 2003 (actual)	Target Achieved	MOH Targets 2004[6]
OPD Visits/capita	.0.55	0.50	No	0.60
Hosp Admis/1000	36	35.9	No	38
U5 Malaria CFR %	1.5	3.67	Yes	1.2
TB Cure Rate#	50	53.6	Yes	65
CPR %	25	22.6	No	28
ANC Coverage %	99	91.2	No	99
PNC Coverage %	--	55.8	Yes	55
Supervised Deliv %	55	51.9	No	80
DPT3 Coverage %	80	76	No	100

* = The figures presented here include Teaching and Psychiatric Hospitals.
# = From 2002 Cohort Analysis

2.1.3 Overall performance of the sector

As Table 2.3 shows, the performance of most of the indicators over the last three years (since the start of Second Five Year POW) has remained stable or gone down. The table summarises the most salient features:

Table 2.3: Selected performance indicators during POW II, 2001-2003

Indicators	2001	2002	2003	DHS 2003	Better/Worse	Reliability GHS data
OPD Visits/capita	0.49	0.49	0.50	NA	Stable	Not known
Hosp Admission/1000	34.9	34.1	35.9	NA	Better	Not known
Bed Occupancy Rate	64.7	65.5	64.1	NA	Stable	Not known
TB Cure Rate#	44.9	58.9	53.8	NA	No trend	Not known
CPR	20.3	21	22.6	18.7	Better	Reliable
ANC Coverage	93.5	93.7	91.2	92	Worse	Reliable
PNC Coverage	52.9	53.6	55.8	NA	Better	Not known
Supervised Delivery*	49.2	52.6	51.9	47	Stable	Reliable
DPT3 Coverage	76.3	77.9	76	76.4	Stable	Reliable
Measles Coverage	82.4	83.7	79	83.2	Worse	Reliable
HIV Sero-Prevalence	2.9	3.4	3.6	Coming	Worse	Not known
Guinea Worm Case	4738	5611	8290	NA	Worse	Not known

* = "Supervised Delivery" = deliveries by health professionals & Trained TBA; DHS = deliveries by health professionals.
# From 2002 Cohort Analysis

Interestingly, the outputs that are measured both by the existing institutional information system – using 4% under-1yr proportion from the 1984 census (see earlier footnote) - and the population based figures from DHS, show a clear similarity. This suggests that we can

[5] MOH,The Ghan Health Sector Annual Programme of work 2003, January 2003
[6] MOH, The Ghana Health Sector Annual Programme of work 2004, January 2004

have some confidence that the output data coming from MOH/GHS (for ANC, SD, CPR and EPI coverage) are reliable indicators of the performance by the service delivery system.

These findings are substantiated by the preliminary DHS 2003 impact figures that show a reverse between 1998 and 2003 in the previously declining trend in IMR and U5MR (Table 2.4 below). Region specific data are expected soon and these will provide a more complete picture of the situation in the four poorest regions of the country. Unfortunately, no population based Maternal Mortality study has been conducted and therefore no reliable data on this important indicator can be presented. The institutional Maternal Mortality figures will be presented under the Public Health section (RCH).

Table 2.4: Trend of Impact Indicators 1993-2003 from DHS and CWIQ

Impact Indicators	DHS 1988	DHS 1993	DHS 1998	DHS 2003
National IMR	77	66	57	64
National U5MR	155	119	108	111
National MMR	NA	NA	NA	NA
< 5yrs Underweight (Wt/A)		27.4	24.9	Coming
< 5 with Stunted Growth (CWIQ)			28.5 (CWIQ)	32.5 (CWIQ)

In general, one can say that while Hospital Admission and Contraceptive Prevalence Rates (CPR) have improved, most of the other outputs (OPD, Reproductive and Child Health, EPI and TB) have remained the same or decreased.

The review team therefore concludes that for the 2001-2003 period, the stagnation in most performance outputs - already visible in the Review of POW 2002 - has continued and that most targets set by MOH for 2003 have not been met. However, looking at a longer period of 15 years (1988-2003), DHS output figures have improved.

Data from the 2003 Statistical Report of GHS shows the volume of OPD visits and Hospital Admissions by Agency, thus providing some insight into the relative volume of work of each of them, as they contribute to the overall service delivery in the sector (Table 2.5).

Table 2.5: OPD and Hospital Admissions by Agency, 2003

	GHS	CHAG	2 Teaching Hosp	Quasi- Govt	Private
OPD %	68	14	9	6	3
Admissions %	53.7	27.1	13.5	4.1	1.8

Note: Military and Trust Hospitals in Accra are not included. Private not complete.

2.2 Clinical Care and Hospital Services

2.2.1 Overview

As part of the Quality of Care improvement measures, the following outputs have been mentioned in the POW 2003:

Expected output:

- *Wide dissemination of the Patient Charter will be undertaken at all levels*
- *A system of grading and accreditation to be developed for the sector*
- *Customer services in 10 regional hospital established*
- *Waste management policy and guidelines disseminated*

While the Patient Charter - developed under the auspices of the GHS - has been distributed, widely and has been found by the review team in several facilities, the achievements related to the other three outputs are more difficult to substantiate.

2.2.2 Performance figures

OPD visits in general have remained the same, but important regional variations can be observed with Brong Ahafo[7] (0.64) and UER (0.59) scoring higher than the national average (0.50) and NR (0.32) and GAR/VR (both 0.38) having the lowest scores. As it is not always clear what exactly is included in these figures, they should be looked at with some caution (it is unclear to what extent self financing private providers and CHPS data are included). Nevertheless, attendance is an indicator of service utilisation and thus provides an indication of accessibility (geographical, financial, cultural etc), quality of services and drug availability.

The other clinical care performance indicators show some modest improvements (Table 2.6 below): Hospital Admission Rates, Bed Occupancy Rates and tracer drug availability (probably due to increased use of IGF). The Under Five Malaria Case Fatality Rate is decreasing (from 3.74 in 2002 to 3.67 in 2003). Unfortunately, no SWAp indicators are collected that measure specific Quality of Care activities. The team suggests including additional quality related indicators to be defined by the Clinical Care Task team.
Although of great importance, other services conducted through the hospitals will not be discussed here (Eye Care, Specialists outreach visits).

Table 2.6: Clinical Care performance indicators during POW II (2001-2003)

Clinical Care Indicators*	2001	2002	2003	Observations
OPD Visits per capita	0.49	0.49	0.50	Stable
Hosp Admission Rate	34.9	34.1	35.9	Better
Bed Occupancy Rate (BOR)	64.7	60	66	Unclear[8]
Bed Turnover Rate	40.6	39.6	39.7	Stable
Average Length of Stay (days)	5.8	6.0	5.9	Stable
Specialist Outreach Visits (days)	135	160	175	Better
Under Five Malaria CFR	NA	3.74	3.67	Stable
% Tracer Drug availability	70	85	93	Better

* Source: CHIM Report 2003.

2.2.3 Recommendations on Clinical Care

The Clinical Care Services Review, undertaken in March 2004 as part of the Review of POW 2003, provided an excellent report with more detailed observations and suggestions with regard to the performance of clinical services. The current 2003 Review Team therefore presents below only the most important conclusions and recommendations, as highlighted in Table 2.7 below. The full list is provided in the Review Report itself on p. 49-52.

In summary, Clinical and Hospital Care is a very broad subject that suffers from a large variety of people and managers to address the issues. It is important that the 2003 Clinical Care Services Review Report is widely distributed. The various issues summarised in Table 2.7 should receive concerted time and attention from the MOH as well as GHS.
The Review Team suggests GHS/MOH constitute a task-team composed of managers from various institutions that will study these recommendations and report to GHS and MOH.

[7] Brong Ahafo has a relatively large number of persons covered by insurance schemes than in other regions, in on district even achieving 31%.
[8] Table 2.3 bed occupancy figures differ from CHIM and suggest little change in occupancy rates over the last 3 years.

Table 2.7: Findings and recommendations of the Clinical Care Review

Issues	Findings and conclusions	Main Recommendations
Levels of Care	Most hospitals provide two or three different levels of hospital care. Most patients are bypassing lower level facilities to go directly to the hospitals, causing extremely long waiting times and congested services. This is most evident in urban areas	MOH to adopt standard definitions for three levels of hospital care (different from types of hospitals) MOH/GHS: Every large hospital should have a Primary Facility close to its entrance with the same level of staffing and type of services as other primary facilities (no GP's)
Clinical Care Services	21 % of patients are dissatisfied with the services in public facilities Cost of care is the single most important barrier to access (public) services. Clinical Effectiveness is not really reported Waiting time in hospitals is around 4-6 hrs	GHS to develop more clinical & treatment protocols (STG), as well as effective methods for ensuring health staff know and practice them. Do Patient Satisfaction surveys 1x/yr GHS: Waiting times should be monitored and services re-organised to reduce them.
Clinical Care Management	Clinical Care in OPD and IPD is often of poor quality (no triage, no privacy, poor equipment, too much lab analysis, no planning of care, no patient folders); There is no practise on risk management Quality control of drug use should be done routinely. Late reimbursement of exemptions stimulates the collection of IGF funds.	MOH: Train Midwives in Life Saving Skills GHS: Introduce Integrated Care Pathways (ICP) for Malaria, TB, CVA and PPH and improve bed management. Develop a complaints policy. Review Patients charts (p.24) and Rational Drug Use (RDU, p.27) regularly. Large hospitals should have drug manufacturing units Develop strategy to introduce risk mgmt. MOH: Re-imbursements for exemptions should reach facilities early to avoid poor drug supply.
Roles and practice	The THs have 80% of the country specialists. There is very little team work between nursing and medical staff Mid-level managers have not enough authority to run their wards	MOH: Develop attractive packages for specialists to support rural services (p.33). MOH: Expand IMCI initiative to improve care by non-medical staff. Give nurses more authority to take effective decisions. Stimulate teamwork. GHS: Establish National QC system for Lab services
Organisation Management	Supervision often not focussed on weak spots Continuous monitoring of systems and practises in hospitals is rare. There is little sharing of experiences (PPRHAA).	Focus supervision on weak performance (standards, quality, care mgmt). Improve procedures. Give mid-level managers more authority and accountability. Introduce Peer and Participatory Rapid Health Appraisal for Action by Hospital Managers.

2.3 Public Health Services

2.3.1 Reproductive and Child Health Programme

For RCH, the POW 2003 only mentions access to the provision of Essential Obstetric Care (EsOC), the training of staff in IMCI, the training in Adolescent friendly services and the revision of IEC material on maternal health. Expected outputs have been included, but no reference is being made to the RCH specific performance indicators and how the proposed measures will impact on them, nor have relevant indicators for IMCI or EsOC been provided.

Expected output:

- *IMCI scaled up*
- *Improved access to essential obstetric care delivery in every district*
- *All district hospital provide adolescent friendly services*

To observe trends and validate the performance in RCH, selected indicators have been shown in tables 2.8 and 2.9.

ANC utilisation is in general very high; a fact confirmed by the DHS 2003 figures. The average number of ANC visits per client, a measure of confidence in the system, also rose from 2.8 in 2001 to 3.1 in 2003. However, the ANC target of 99% set by MOH may be too

high to attain and should be reviewed. The coverage of PNC is increasing satisfactorily; the MOH target for 2004 (55%) has already been met in 2003. Supervised deliveries of around 52% are little changed on the previous year and may even have declined, suggesting that the MOH target of 80% in 2004 may be quite unrealistic. Moreover, the definition of 'supervised delivery' includes attendance by staff who lack formal midwifery training, which limits the benefits to mother and child survival.

Table 2.8: Trend in RCH indicator performance 2001-2003

RCH Indicators	GHS 2001	GHS 2002	GHS 2003	DHS 2003	Observations
ANC Coverage	93.6	93.7	91.2	91.9	Worse (target 99)
ANC Average No Visits	2.8	2.9	3.1	NA	Better
PNC Coverage	52.9	53.7	55.8	NA	Better
Supervised Delivery* Nation	49.3	52.6	51.9	47	Stable (target 55)
Contracep Prev Rate (CPR)	20.3	21	22	18.7	Better
% Malnourished Children	25%		NA	coming	--
Institutional M. Mortality	2.6	2.0	2.2	NA	Unclear GPRS: 1.6/1000 (05)[9]
% Maternal Audits	60	75	85	--	Better (73-100%)
Caesarean Section Rate	4.7	5.3	6.0	--	Better (WHO: 5-15%)

* = "Supervised Delivery" = deliveries by health professionals & Trained TBA; DHS = deliveries by health professionals.

Table 2.9: Trend in RCH indicator performance DHS, 1993-2003

RCH Indicators	DHS 1993	DHS 1998	DHS 2003	Observations
ANC Coverage	86	87	92	Better
Supervised Delivery	44	44	47	Better (not much)
CPR %	10	13	18.7	Better
DPT3 coverage %	62	67	76.4	Better
Measles Coverage %	64	61	83.2	Better
IMR/1000Lbs	74.7	61	64	Worse
<5 MR	132.8	110	111	Worse
Children <5 yrs Underweight %	27.4	24.9		

Contraceptive Prevalence Rate (CPR) is slowly but steadily increasing since 2001. This is confirmed by DHS: figures have increased between 1998 and 2003 from 13 to 18.7%. Although the Institutional Maternal Mortality Rate has stagnated at the high level of 220/100.000 more Maternal Audits have been carried out. What is not clear is the quality of the audits and what is being done with the findings. More in depth information seems required.

As part of the RCH activities, the IMCI expansion has started since it was first piloted in three districts in 2000. Health workers in 33 districts have been trained and 145 sub-districts in 38 districts are implementing C-IMCI. The first pre-service training for Medical Assistant Trainees has been conducted. Two recommendations from the national review are re-stated here:

- Include private providers in case management training
- Look for cheaper alternatives for IMCI training.

Given the importance of further reinforcing the IMCI strategy, inclusion of one of its indicators in the SWAp indicators might be considered.

[9] The Maternal Mortality Review conducted in March 2004 (as part of the review of the 2003 POW) mentions the target of the GPRS being 1.6/1000 live births in 2005 and the target of MDG being 0.54/1000 live births in 2015. However, it is not clear whether these figures refer to institution based (as presented in this table) or population based data. As no population based figures are available, the real situation concerning Maternal Mortality in the country remains unclear.

The review team is of the opinion that based on these figures and on the results of the Maternal Mortality Study - that was undertaken as part of the Review of the 2003 POW - the RCH division might have to shift its focus more explicitly towards the following priorities:

- Improve supervision and feedback to (deprived and low performing) regions on the basis of their reporting systems
- Supervise and stimulate actions to be taken by the various hospitals on the basis of their Maternal Audits. Increase and provide facilities for Post Abortion Care
- Develop a strategy for more intensive collaboration with other actors in this field, like CHAG, the private-for-profit sector, transportation managers etc.
- Review the referral system for Emergency Obstetric CARE (EmOC) and take appropriate actions in terms of staff needs, communications, exemptions etc. Distinguish between urban and rural needs for EmOC.
- Conduct a national population-based Maternal Mortality Survey
- Scale up IMCI related activities in all regions, in the pre-service curricula of all teaching facilities and in the private sector.
- In addition, study the Community IMCI model of the NR and UER and apply the findings to the other deprived regions (see details in the Pro-Poor Review page 35).

2.3.2. National Malaria Control Programme (NMCP).

The 2003 POW provides the following expected outputs for Malaria:

Expected output - Malaria:

- *Review of anti-malaria drug policy will be initiated*
- *A team with requisite skills for re-treatment of ITM will be established at all regional centres*

The programme focussed in particular on the provision of ITNs for children and pregnant women. This was done through advocacy and collaboration with the private sector, other sectors and MDA, working in the field of Roll Back Malaria (RBM). The performance in selected malaria indicators is shown in Table 2.10.

Table 2.10: Performance of Malaria related indicators, 2001-2003

Malaria Indicators	GHS 2001	GHS 2002	GHS 2003	Observations
Under Five Malaria Case Fatality Rate		3.74	3.67	Stable (sentinel data)
< 5 Yrs under Bed Net	12.2%		NA	DHS 2003: 14.6%
< 5 Yrs under ITN	4.1%		NA	DHS 2003: 3.5%
% of all OPD cases		40	43	

Among other achievements, the Malaria programme has prepared a new anti-malaria drug policy (almost finalised); trained 500 providers on new case management; produced a manual for school teachers and community agents; started intermittent preventive treatment (IPT) for pregnant women in 20 selected districts; initiated in Volta region an ITN voucher system with funding from DfID. The programme continued to collaborate with private sector, NGOs, donor community and academic institutions in drug efficacy, insecticide resistance and programme intervention studies.

However, progress in the implementation of the RBM programme is slow, as many administrative and technical problems are encountered. Visits by the Review Team to the regions and districts revealed high awareness and demand for ITNs, but they are seriously undersupplied. Only 85.000 ITNs have been distributed in 2003 by GHS against a target of 2000.000 ITNs. Re-treatment of ITNs is hampered by the lack of chemicals in the periphery. The price of ITNs has now been established at ¢ 20.000, which seems affordable for a large part of the population, but given the relative low price, the consumer demand for ITNs cannot

be met[10]. Evidence from UER and NR suggests that the real poor will only be able to afford around ¢ 5000/Bednet.

There is a strong case for a substantial increase in public sector distribution of ITNs to meet unmet demand. Private sector involvement, supported by regulation of quality, is also highly desirable to increase availability of nets. The poverty report advocates price control of nets manufactured and distributed by the private sector. This would not improve access to nets by the poor, but would be likely to discourage the growth of private sector marketing of nets. A better alternative is to learn from the social marketing approaches that have been widely used for marketing condoms, and are beginning to be used for ITNs, making subsidised supplies available for marketing through private channels at regulated prices reflecting the costs and risks involved[11].

Some highly relevant recommendations to accelerate the current Malaria control efforts are presented on page 34 of the Pro-Poor report:

- Adapt educational campaigns for the use of ITN to local contexts
- Study the community based distribution strategy for ITN in Upper East Region, which used a multi-stakeholder approach (Red Cross, itinerant vendors, others)
- Subsidised distribution of nets should aim at a maximum fee of ¢ 20.000; subsidies should be considered for the poorest (at ¢ 5000 or free);
- Re-treatment of ITNs should be offered free of charge to communities.

2.3.3 National Tuberculosis Control Programme (NTP)[12]

The POW 2003 mentions the intention to: i) undertake a review of the national programme in order to improve management of TB control in the districts and more involvement of the private sector; ii) review the TB drug treatment regime; and iii) supervise more closely patient treatment. The expected outputs are summarised below:

Expected output:

- *TB diagnostic centres will be set up in every district*
- *TB control activities visibly reflected in the budgets at the district level*

The most important activities undertaken by NTP in 2003 are review meetings, DOTS expansion in urban areas, elaboration of the treatment regime and staff training. Table 2.11 presents some relevant NTP performance indicators.

Table 2.11: TB related indicators 2000-2003

TB related Indicators	GHS 2000	GHS 2001	GHS 2002	GHS 2003	Observations
Case Detection Rate/100.000	58	62	59	59	Stable; (NTP data)
TB Cure Rate	44.9	48.9	53.8	--	Better
TB Defaulter Rate	14.4	17.6	14.6	--	Stable

Note: Performance of Three Northern Regions dropped significantly between 2000 – 2002Source: NTP report 2003; Cure and Defaulter rates reflect analysis on previous year's cohort.

NTP can show some encouraging achievements. The TB Cure Rate is going up, although it remains far below the international accepted standard of 85%. With an estimated Case Detection Rate of around 60% (WHO norm is 75%), the NTP unfortunately detects insufficient number of cases to really make a difference. CDR and Cure Rates in the four Northern Regions are substantially lower that in the middle or southern belt of the country.

[10] The price for ITNs in the private sector is between ¢ 60.000 to 100.000. An excellent overview of the issues relating to the Poor and Malaria (including the pricing policy of ITN) is given in the March 2004 Review of the Ghana Health sector's Pro-Poor Agenda (p.30-34)

[11] See Chapter 5.

[12] Note: The National Unit of the NTP is also responsible for the implementation of the Yaws and the Buruli Ulcer Programme. These activities will not be discussed here.

Overall these disappointing results are understandable, given the constraints in providing the various support services to the NTP. Laboratory facilities are often absent, sending of smear containers from sub-district HC to District Laboratories is fraught with problems and no nationwide Quality Control system exists to monitor the quality of the lab analysis. In addition, the Pro-Poor team reports increasing treatment failures, high defaulter rates (due to stigmatisation) and additional costs for laboratory work, daily transport, X-Ray, hospital admissions (mission hospitals) and syringes and needles[13].

The review team suggests the following priority actions for the NTP:

- Develop as a matter of urgency the new National Treatment Manual and prepare a nationwide training plan to revitalise the NTP
- Develop inventory of DOTS based facilities to allow for more targeted support to all regions. Consider starting Community Based DOTS in areas where this is feasible.
- Focus the NTP on the 26 poorest districts in the country (GPRS);
- Undertake a Costing study on TB management to know more on the costs of the exemptions and of drug procurement;
- Develop Quality Control Systems nationwide for all sputum microscopy and Multi Drug Resistance (MDR).
- Improve the distribution system and management of drugs.
- Strengthen collaboration with HIV/AIDS programme (VCT).
- When felt useful, seek support from WHO Stop TB and KNCV.
- Undertake a Tuberculin survey to estimate the real TB Incidence in the country.

2.3.4 National AIDS Control Programme (NACP)

HIV prevalence is rising in the country (Table 2.12). In 2003, the NACP conducted a HIV Sentinel Survey that showed:

- Median Prevalence in Ghana rising from 3.4% in 2002 to 3.6% in 2003
- Prevalence increased from 2.3 in 2000 to 3.6 in 2003 (> 50% increase)
- Prevalence is increasing in 30-49 age group and declining in the 15-19 yr group.
- Out of 30 sentinel sites, 8 (including 2 rural) had a prevalence of > 5% with substantial variations between the regions.

The population based prevalence figures coming from the DHS 2003 will allow for a validation of the sentinel data and provide more detailed information on distribution of the disease among regions.

Table 2.12: HIV/AIDS related indicators 2001-2003

HIV/AIDS related Indicators	GHS 2001	GHS 2002	GHS 2003	DHS 2003	Observations
HIV Sero Prevalence (median)	2.9	3.4	3.6	Coming	Range 0.6 – 9.2%
VCT Centres	0	4	26		Better
ART/PMTCT Centres	0	2	19		Mother to Child transmission is 15%
Sentinel sites	22	24	30		30 sites in 28 districts
Cases	9329	8946	7.215 (till September)		Cumulative 72.580 (03)
PLWHA	--	--	6000 on ART in 2006		

For NACP, the 2003 POW mentions continuation of the management of STI (training of staff in Syndromic Approach) and the promotion of Safe Sex. NACP is to introduce ART Treatment for HIV positive pregnant women (PMTCT) and expand ART treatment from 2 to 4 hospitals (2 TH, 1 Govt H and 1 Mission H). Currently there are about 300 new patients per month seeking ART Treatment.

[13] The external review of the NTP by KNCV, conducted in April 2002, mentions indirect costs for TB treatment in the range of ¢ 250.000 to 350.000 per treatment.

Expected output HIV/AIDS:

- *The treatment of HIV positive pregnant women will commence at eight new sites across the country*
- *Syphilis screening will be introduced at ten sites across the country.*

NACP is also involved in Home Based Care, District Response Initiative, support for PLWHA, development of National guidelines, resource mobilization and finalization of the National Policy on HIV/AIDS/STI.

Challenges for the next year as reported by the HIV/AIDS programme are the scaling up of the national response especially for treatment, care and support to 24 sites that will provide comprehensive care. All this will require substantial funds, estimated at US$ 90M. This compares with total annual public expenditure of only $167mn on the entire health sector. It is unclear to what extent this money will be used predominantly for ART-related expenditure or will partly be used for preventive/promotional work and for strengthening the overall service delivery system. When so many other health priorities are under-funded, Ghana will need to make some painful choices regarding the affordable level of public funding for ART treatment, particularly if additional long-term funding has not been secured to cover all of the incremental costs.

The Joint Review of Ghana's national HIV/AIDS response (April 2004) provides a detailed list of suggestions and recommendations for the MOH, the NACP and the Ghana AIDS Commission (GAC).

The Review Team suggests strengthening the pro-poor nature of the existing HIV/AIDS strategy as follows:

- Encourage and expand the establishment of VCT centres in particular in the northern regions. Demand is expected to rise.
- Improve targeting of intervention programmes on high-risk groups; for example analyse secondary data to improve targeting of condom use among young persons (15-24 years).

2.3.5 EPI Programme

The EPI programme is expected under POW 2003 to: i) train EPI managers in all districts to review and discuss the earlier Audit reports; ii) revise the monthly forms; and iii) strengthen the cold chain system.

Expected output:

- *Improve efficiency in vaccine use*
- *Improve management of data for EPI planning*

The expected outputs presented above cannot be discussed here, because no information (annual report) has been made available to the team.

The objectives of the programme are to: i) sustain high routine coverage of 80% for all antigens in every district; ii) interrupt transmission of wild poliovirus. In addition, the programme will ensure the accelerated control of measles (strengthen case based surveillance) in places where measles still occurs.

The high 2003 coverage rates reported by GHS are confirmed (or even exceeded) by the DHS 2003 (Table 2.13). The epidemic of wild circulating Polio Virus (8 Polio cases in 8 districts, spread out over 6 Regions) calls for effective micro-planning and targeting to be able to reach every child (routine and NID).

Table 2.13: EPI related indicators 2001-2003

EPI related Indicators	GHS 2001	GHS 2002	GHS 2003	DHS 2003	Observations
DPT3 Coverage	77	77.9	76	76.4	Stable
Measles Coverage	82.4	83.7	79	83.2	Worse
AFP Non Polio Rate	2.8	2.0	1.3	NA	(Target 1.0)

District by district data provided by the programme shows:

- 53 districts have a coverage of > 80%
- 57 districts have a coverage < 80%
- No district was below 50%

This type of information will allow more focused (and targeted) district-by-district based support and supervision.

2.3.6 Guinea Worm Eradication Programme (GWEP)

Key activities of the GWEP suggested in the POW 2003 are the application of Abate, the distribution of filters, case containment through the follow-up of reported cases and health education. Training of volunteers will take place in areas that are in need and efforts will be undertaken to provide these communities with potable water sources (protected wells etc).

Expected output:

- *Initiate plans to provide 25% of endemic communities with portable water.*

Despite these laudable plans, Guinea Worm cases have increased over the last three years: from 4739 in 2001 (baseline) to 5611 in 2002 up to 8290 in 2003. The number of districts affected by the disease has risen to 15 in 2003 (NR 9, being responsible for 72% of all cases; BAR 3, VR 2 and UWR 1). This situation is quite worrying and demands concerted (intersectoral) efforts by the highest levels of MOH and GHS.

2.3.7 Summary on Public Health Services

Public Health Programmes have worked hard during 2003 and some have been able to maintain most indicators at the same level of performance as in the previous year. However, most have not been able to make a leap forward and improve their performance substantially. Many valid reasons can be given for this steady state: late and insufficient disbursement of funds, serious staff shortages (quality and quantity) and sometimes unclear and conflicting instructions from the top management.

However, this Review Team found in addition to these constraints, the following weaknesses that can be improved and could – if adopted - help the programmes to make that leap forward:

- Target setting should start in the regions in discussion between the national and regional programme managers (GHS and CHAG). Only when these three 'parties' have reached agreement can these region-specific targets be brought to the national level to be discussed between GHS, CHAG and MOH.
- Similar to reviews on district performances, Regional Performance Reviews should take place once a year, where regional managers, GHS managers and MOH jointly discuss strengths and weaknesses of each region, resulting in a clear identification of the problems and joint decisions of what needs to be done on a region specific basis.
- Finally, National & Regional managers should define more specifically the main priorities for each programme and provide feedback on the reports the regions do produce.

2.4 Regional Performances in 2003

2.4.1 Comparison between regional performances

The team reviewed both 2002 and 2003 regional reports. All regions included their region specific sector wide indicators in their annual reports. The quantitative figures have been put together in the Annex 2.03 Table 2.04, while the more qualitative observations from these reports have been summarised in Annexes 2.04 and 2.05, Tables 2.05 and 2.06.

Despite this impressive data set, an assessment of the region specific performance with regard to the Sector Wide indicators is not easy to provide for the following reasons:

- There are differences in the source of the data (some come from CHIM, others come from the national programmes or from the data provided by the regions themselves). This points to the observation made by the IME Review that there is an urgent need to define a single authoritative source for the data to be used at national and regional levels (see section 1.5 below).
- The widely different realities between these regions do not allow for a simple comparison of output or process data. There are simply too many variables (money, staff, politics, support etc) that come into play in implementing the various activities.

The main feature that this Review Team observed was the absence of content related technical feedback on the data and text. National programme managers (both GHS and MOH) do not seem to give much of their time to provide comments on what the reports have to say. Two important features noted by the reviewers are:

- Some regional reports are very informative and analytical and do provide a wealth of relevant information to understand their performance, their constraints and their plans for the next year. Others are incomplete; just provide figures with very little reflection and are clearly of insufficient quality to allow for priority setting or overall management. Whatever the case, no feedback is provided.
- All reports are bulky (between 80-120 pages) and aim to inform the higher levels of management. They seem of little use to the management of the region itself. The Regional Health Management Team (RHMT) does not use them as a tool. In the best of circumstances, they provide a useful account of what has been done in the previous years. Often they are a necessity to respond to the national requirements and are put together by doing cut/paste from the previous annual reports.

The review team believes that discussion and feedback by national (programme) managers to the RHMT on the basis of their annual reports is crucial for improving regional performance. Such annual feedback should be comprehensive, taking all components of these regional reports into account: policy, programmes, finance and human resources.

2.4.2 Ranking of regional performance

To allow for more detailed feedback, the review team has tried to rate the results of the 10 regions on the basis of the available DHS figures for the highest and lowest results for the RCH and EPI indicators (Tables 2.14 and 2.15). This provides an impression where future effort needs to be focused in order to narrow inequalities between regions.

Table 2.14: Highest Results on output according to DHS figures 2003

Rank from Top	ANC	SD	FP	DPT3	Measles	Overall
1	GAR	GAR	GAR	CR	UER	GAR 3/5
2	BAR	AR	BAR	BAR	VR	BAR 3/5
3	WR	BAR	ER	AR	GAR	AR 2/5

Table 2.15: Lowest Results on output according to DHS figures 2003

Rank from Bottom	ANC	SD	FP	DPT3	Measles	Overall
1	Northern	Northern	Northern	Gr Accra	Northern	NR 4/5
2	Upper W.	Upper W.	Upper W.	Northern	Western	UW 3/5
3	Volta	Upper E.	Central	Upper E.	Eastern	UE 2/5

The review team wants to point out that this type of analysis might be useful for national managers to prepare themselves to give feedback and comments on the performance of the regions. Detailed analysis of the figures provided by the regions and a clear identification of the problems in the various programmes is needed to provide the RHMT with the necessary feedback for them to improve their work. The regional performance analysis presented above is just a simple tool to do so. It needs to be considered alongside information on the resources used to achieve the results (see Chapter 3).

2.4.3 Performance of the four deprived regions

The tables presented above once more show that the deprived regions indeed do score lowest among all regions of the country[14]: the Northern Region has the poorest overall performance (on RCH and EPI indicators), whereas Upper West and Upper East are the numbers 2 and 3 respectively.

Table 2.16: Performance of the four most deprived Regions vs National average (2003)

Indicators	Central	Northern	Upper West	Upper East	National Avg	Observations
IMR 2003					64	
UFMR 1998	142	171	155	155	111	
Population to Dr Ratio*	38.554	76.080	32.786	50.541	17.489	Worse
Population to Nurse Ratio*	2900	4070	3169	3159	2598	Worse
OPD Visits per capita	0.49	0.27	0.46	0.59	0.50	Worse
Hosp Admission Rate	32.9	37.7	50.5	41.1	35.9	Better
Bed Occupancy Rate	61	59	48	47	64.1	Worse
Under Five Malaria CFR	NA	NA	2.7	2.4	3.67	Undecided
TB Cure Rate (all cases)	47	26	20	41	53.8	Worse
CPR	26	16	36	19	22.6	
ANC Coverage	102.5	102.7	88.7	100.2	91.2	Better
PNC Coverage	69.7	62.1	75.8	50.1	55.8	Better
Supervised Delivery	67	39.2	67.3	44.9	51.9	Variable
DPT3 Coverage	83	85	87	83	76	Better
Measles Coverage	81	92	88	84	79	Better
HIV Sero-Prevalence	5.4	2.1	2.2	3.5	3.6	Better
Reported Institutional Mat Mort.	159	240	100	248	220	
Number of Maternal Deaths	71	72	18	42	543	--
% Maternal Audits	84	60	100	100	85	
% Indicators worse than national	46	54	29	43		
Public Spending p.c. ($)	5.21	3.15	5.93	12.76	5.26	
IGF p.c. ($2003)	1.03	0.07	0.32	0.61	0.90	

* = Staff ratios are based on CHIM figures, which include all Public Institutions (GHS, TH, Psychiatric Hospital) and CHAG (excluding Quasi and Private facilities).

[14] A similar analysis based on GHS 2003 figures did not provide similar findings, indicating that regional GHS data at this moment cannot be used for reliable comparison of performance between regions.

Table 2.16 compares some of the other sector performance indicators within the four deprived regions with the national average. It is striking that outcome indicators such as UFMR are worse due to higher poverty, and availability of staff is significantly worse, but the majority of the output indicators in these four poor regions are at or above the national average. The Northern region, which receives very low budget resources and has by far the worst staffing problems, not surprisingly has low utilisation of hospital beds and low numbers of outpatient visits, but does well on immunisation and ANC/PNC. Chapter 3 provides further discussion of cost-effectiveness and staff productivity by region.

It is unclear whether the introduction of free deliveries in the four poor regions resulted in an increase in supervised deliveries, with only the Central region showing a significant increase (Table 2.17):

Table 2.17: Performance Trend in Supervised Deliveries, 2001-2003

RCH Indicators	GHS 2001	GHS 2002	GHS 2003	DHS 2003	Observations
Supervised Delivery* Nation	49.3	52.6	51.9	47	Stable (target 55)
Supervised Delivery Central	36	66	67		Better
Supervised Delivery NR	40.8	41.2	39.2		Stable
Supervised Delivery UWR	63.9	67.5	67.3		Stable
Supervised Delivery UER	42.2	42.5	44.9		Better

* = "Supervised Delivery" = deliveries by health professionals & Trained TBA; DHS = deliveries by health professionals.

2.5 Information, Monitoring and Evaluation (IME)

As part of the Review of the 2003 POW, an appraisal of the Information, Monitoring and Evaluation (IME) System for the Health Sector was conducted in March 2003 by a team of national and external consultants. The appraisal was commissioned to review the overall information systems in MOH and the various implementing agencies (GHS and its BMCs, CHAG, TH, Regulatory bodies and private sector providers) to see how they can be structured to respond to the new set of management requirements.

The Review Team has no intention to repeat the many detailed and relevant observations made in the appraisal report. The reader is asked to consult the specific sections he/she is interested in. Here, only parts relevant for the overall POW 2003 Review is presented together with recommendations that the team finds of particular relevance for the various stakeholders (Table 2.18). It is important to distribute and share the IME Review Report with all the managers of the MOH and the various Agencies and discuss the immediate next steps that could be carried out (p.30-31). Just like the Clinical Care Review, MOH/GHS could install a task-team to review all the observations and suggestions and report back to headquarters.

Table 2.18: Findings and recommendations of the IME report, March 2004

Issues	Findings and conclusions	Main Recommendations
Overall	Reporting and data utilisation within parallel programmes is quite strong. However, use of information for overall management and reviews is weak, as 'problem identification' often is not taking place. No routine data flow to corporate wide decision making.	Create data repositories that contain information from all parallel programmes at the level of MOH. Strengthen the use of that information for comprehensive analysis and problem identification at MOH, Agency and BMC levels. Unified system is needed rather than better coordination!!!
Structures	There is no policy to guide implementation of new information systems (or adapt existing ones) There is no comprehensive data repository for any agency of for the whole sector. District Hospitals report to regions and Regional Hospitals report to national levels.	Establish information units within each Agency to handle agency-wide information and within MOH to handle SWAp information from all Agencies and the MOH itself (MHIS). Within MOH create a new Directorate RSIM, separate from the Directorate PPME. Within GHS separate CHIM from PPME Within TH, create separate THIS (p.18) Hospitals should report to the health administration at their respective levels
Tools	Standardised formats and tools exist and are used, but there is endless filling of forms. System is data-driven and has limited relevance for district or patient management.	Agencies and BMC should collect relevant management information next to the indicators required by their performance agreements. Information should be disaggregated to the district level (HISP!!)
Quality	Use of data during supervision is stimulated, but there is limited feedback on overall performance. There are many possible sources of error that are normally not corrected. Little use of data. Disconnect between planning and monitoring (LF)	Corroborate data obtained through routine systems. Start using Logical Frame Work (LFW) to link planning with output (M&E) and resources. Peer reviews and joint supervisions should be stimulated as part of management reviews.
Flow	Data flow is limited within the programmes and not brought to a central body within MOH. MOH/PPME has no access to performance indicators from any of the Agencies.	There should be institutional will to convince the programmes to adopt the new system. One authoritative source for each data should be defined. Private providers should be linked to the system
Human Resources	Staffing patterns at BMC and Agency levels insufficient (quality and quantity)	Identify staff with weak capacities; develop basic training (on statistics and ICT) for data managers. Create career path for them
Definitions	There is a lack of clarity on the financial indicators and those of CHPS. Most of the Sector Wide indicators correspond quite well with existing international indicators	Review the Sector Wide Indicators list and define clearly what information is requested. For each indicator, provide a technical definition, its interpretation and the sources
Targets	Target values are sometime set without the advice of the programme managers or without discussion with the various Agencies. They are sometimes set at unrealistic levels	Target values for baseline, annual figures and 5Yr POW should be added for each level. They should be discussed with responsible managers to avoid frustration.
In-equalities	MOH does provide some district-disaggregated data. The MOF does not.	Comparing district indicators will provide sensitive and specific indication of inequality. A district health account study could help

2.6 Implementation of recommendations since POW 2001

The team reviewed the many recommendations made in the course of the last three years (since POW 2001) in relation to performance of the sector. Annex 2.06 (Table 2.23) provides an overview of the recommendations since POW 2001 by subject and by source together with comments made by the Review Team as to what happened to each of them. As far as performance is concerned, it appears from this annex that a substantial part of the recommendations have been addressed either explicitly or implicitly through the activities of the various agencies and departments concerned (MOH and GHS). With the adoption of the sector wide indicators, most of the detailed recommendations in this area have been taken

care of, while most of the service related recommendations have been implemented over the years by the various programme concerned.

Outstanding remaining issues are:

- Need to improve the consultation process between MOH, GHS and the Regions to reach agreement on the data provided and on the targets to be set; disaggregation of the data for the various agencies and the inclusion of indicators related to resource shifts towards primary services, between recurrent and capital expenditure and expenditure by line item.
- Patient satisfaction surveys are being done in the regions but results are not included in the sector wide reporting; drug charges are rarely clearly mentioned in health facilities at all levels.
- Prominent focus on TB control not yet visible, while issues around ART coverage and local production remain for further discussions

2.7 Conclusions and recommendations on sector performance

Conclusions and Recommendations of this Chapter are brought together in tabular form in Chapter 6.

Chapter Three: Resource Allocation & Management

3.1 Overview of Health Sector Financing

The share of GOG funded expenditure devoted to the health sector has increased steadily from 9.1% in 2001 to 9.8% in 2003, partly due to Government policy, but also reflecting high pay awards and the fact that MOH spending is dominated by salaries that can not be reduced when there are funding shortfalls. Actual shares have therefore exceeded budgeted shares (Table 3.1). The proportion of GOG recurrent budget spent on health has also risen from 10.6% in 2001 to 12.1% in 2003 explained by increases in Personal Emoluments. This resulted in a squeeze in the proportion of GOG non-wage recurrent spending on health from 8.1% in 2001 to 4.7% in 2003.

Table 3.1: Sector-Wide Financial Indicators

Indicators	MOH target - 2006	2001	2002 Budget	2002 actual	2003 Budget	2003 actual	2004 Budget
% GOG budget spent on health		9.1%	7.6%	9.3%	9.5%	9.8%	8.2%
% GOG recurrent budget spent for health	11.0%	10.6%	10.5%	11.5%	12.0%	12.1%	10.7%
% GOG recurrent health spending on non-salary items (2 & 3)		8.1%	12.1%	5.9%	7.5%	4.73%	6.0%
% of earmarked donor funds to total donor fund	40.9%	62.3%	44.7%	32.8%	40.8%	39.5%	41.3%
% IGF from prepayment schemes		NA		NA		NA	NA
% spending on district and below (items 2 & 3)	42%	48.5%		40.9%	47.8%	35.36	45%

Source: Programme of Work, 2003; Ministry of Health Financial Statements 2001, 2002 and 2003 (draft); Minister of Finance & Economic Planning Economic Policy and Budget Statements February 2002, 2003 and 2004.

In terms of real 2003 prices, Table 3.2 below shows that total expenditure by GOG and development partners has increased by nearly 30% since 2001, but that this is composed of a nearly 50% increase in Personnel Emoluments and a more than doubling of investment spending (mainly HIPC), while the service and administration budget fell sharply in 2002 and has yet to recover to 2001 levels. Better-paid staff in more and better facilities have less public sector money with which to do useful work.

Although the share of Government spending going to health has increased, there is now an urgent need for accelerating progress towards the Abuja target of spending 15% of the budget on health. The case for additional GOG expenditure on public sector health services will be reinforced if the health insurance programme succeeds in its objectives. The intention is that there will be a significant increase in subsidies to the poor to enable them to participate in the health insurance scheme, while those already with access to health services will increase their use of them once they are covered by insurance. The proposed additional sources of funding for health such as the 2.5% on the VAT rate will be required for financing the direct cost of the insurance scheme, including subsidies to those unable to pay[15]. However, the transfer of significant additional resources to the consumer for accessing health care from Government will have significant knock-on effects on the budget required by the health sector service providers. The proposed health insurance will cover only the 20% or so of health costs presently financed from IGF. The implication is that each extra $1 spent on and by the health insurance schemes could require additional Government spending of up to $4 on Government health services in order to meet the demand. Of course, there is some scope for increased output from the existing resources, but it is clear that a successful national insurance scheme would not only require a big increase in

[15] Cichon, Michael, Charles Normand, Florian Leger and David Lambert Tumwesigye (2003), Ghana Social Trust Project, Comments on the Proposed National Health Insurance System in Ghana, Discussion Paper No 2, ILO, April 2003.

financing to exempt the poor from existing charges, it will also require a big increase in the direct budget for funding increases in those health costs that will continue to be directly met by Government.

Table 3.2: Total expenditure (GOG & DPF) by items, 2001-2003 (in 2003 constant prices)

Items	2001 (¢ Bn)	2002 (¢ Bn)	2003 (¢ Bn)	Increase on 2001 (%)	Share of increase on 2001 (%)
Personal emoluments	511.30	714.46	757.87	48.2	79.9
Administration expenses	124.07	169.62	93.38	-24.7	-9.9
Service expenses	338.20	273.10	335.94	-0.7	-0.7
Investment expenses	88.75	122.02	183.67	106.9	30.8
Total	1,062.32	1,279.19	1,370.86	29.0	100.0
Increase from 2001	-	20.4%	29.0%		

3.1.1 Recommendations

- The recommendation of the 2002 review to maintain pressure for increasing the health share of GOG funds to reach the Abuja declaration of 15% is endorsed, with particular focus on increasing the budget for non-wage recurrent expenditure, and a particular focus on restoring the share of spending at district level and below. This can be done by submission of non-wage recurrent resource requirements for scaling up implementation of health service programmes to cabinet.

3.1.2 Sources of Funding

Health care expenditure in Ghana for the year 2003 was financed by the traditional sources[16] and proceeds from HIPC. Table3.3 shows that Government (including HIPC) financed a little over half of total expenditure, donors about one quarter, IGF about 14%, with the balance 10% from commercial credits. GOG financing for investment came 99% from HIPC, with commercial credits and donors accounting for the bulk of investment spending.
Even though a few Health Insurance schemes are operational and the National Health Insurance Act had received Presidential Assent, the Ministry of Health is yet to introduce proceeds from Health Insurance as a source of funds in its accounts.

Table 3.3: Actual Expenditure by Source and Items 2003

	GOG (¢ Bn)	Financial Credits (¢ Bn)	IGF (¢ Bn)	Health Fund (¢ Bn)	Earmarked Funds (¢ Bn)	HIPC (¢ Bn)	Total (¢ Bn)	% of Total
Personal emoluments	757.871		16.851				774.722	45%
Administrative expenses	28.964		59.281	64.42			152.665	9%
Service expenses	44.404		151.764	122.889	168.645		487.702	29%
Investment expenditure	0.701	166.078	8.441	70.95		49.041	295.211	17%
Total	831.940	166.078	236.337	258.259	168.645	49.041	1,710.300	100%
% by Source	49%	10%	14%	15%	10%	3%	100%	

Table 3.4 demonstrates that all categories of expenditure experienced significant differences between planned and actual at every stage from budget release to disbursement to BMCs to actual expenditure. There are a number of significant delays, leading to profound differences between the cash actually available and the intended pattern of disbursement, including significant payments arriving outside the budget year they were intended to finance. We therefore devoted some effort to analysis of the nature and causes of delays in 2003, and possible remedies.

[16] Government of Ghana Funds, User Fees and Donor Funds.

3.1.3 Budgets, Releases, and Disbursements

Table 3.4 shows that releases from all sources exceeded the budget resulting in a total release of 121% of the 2003 budget. The favourable outturn is attributable mainly to the fact that the donor budget included in the 2003 health budget was significantly lower than what donors had firmly committed to the sector. This was because of a now resolved misunderstanding that the donor budget ceiling given by MOFEP was only indicative. They are not intended to limit the amount of donor support to the Ministry of Health.

Table 3.4: Budgets, Releases, Disbursements, Bn Cedis, 2003

	GOG (¢ Bn)	Financial Credits (¢ Bn)	IGF (¢ Bn)	Health Fund (¢ Bn)	Earmarked Funds (¢ Bn)	HIPC (¢ Bn)	Total (¢ Bn)
Budget	893.414	0.00	220.00	261.205	179.675	61.6	1615.894
% Released	101%	NA	115%	144%	106%	112%	121%
Budget released	902.270	166.078	253.123	376.366	189.743	68.841	1,956.421
% Disbursed to BMCs	97%	100%	96%	73%	89%	100%	92%
Amount Disbursed	876.851	166.078	242.02	275.410	168.645	68.841	1,797.845
% Spent	95%	100%	98%	94%	100%	71%	95%
Actual expenditure	831.940	166.078	236.337	258.259	168.645	49.041	1,710.300
Actual as % budget	93%	100%	107%	99%	94%	80%	106%
Excluding FCs							96%

As shown in Table 3.4, ¢1,797.845bn (92%) of total budgetary releases were disbursed to BMCs for implementation of the Programme of Work. The lowest disbursement rate was registered against the Health Fund. The less than 100% disbursement rate is explained by late releases from donors due to defaults by the Ministry of Health in meeting conditions precedent to releases (mainly problems in financial reporting after withdrawal of previous consultancy support.) There were also problems in disbursement by the World Bank, related to the requirement for prior MOH spending for WB to reimburse. Both problems have subsequently been resolved. MOH have overcome transition problems following withdrawal of consultants and are almost up to date on financial reporting (Q3 financial statement one month late, Q4 nearly complete and will be within 2 months of due date). WB has agreed to change their procedure to one in which disbursement is based on future cash-flow forecasts rather than on reimbursing GOG spending.

GOG disbursement was affected by delays in transferring releases from the Ministry of Finance and Economic Planning to Ministry of Health. For example, the fourth quarter GOG Service release of ¢10.15bn was not credited to MOH account by Bank of Ghana until 22 February 2004, reducing the amount of GOG expenditure for the year.

Out of the total of ¢1,797.845bn disbursed ¢1710.300 was expended. Table 3.3 shows that 45% was spent on Personal Emoluments[17] and 38% was spent on Administrative and Service expenses while 17% went to Investment Expenditure.

3.1.4 Expenditure by Level

Table 3.5 shows that less than one third of the increase in public expenditure since 2001 went to district level. These figures are after allocating to districts those parts of national and regional expenditures that can be identified as having been incurred on their behalf.

[17] Personal Emoluments comprises Salaries and Additional Duty Hours Allowance.

The share of the district level in total spending remained at 39% in 2003, about the same as in 2002 but below the 43% achieved in 2001.

Table 3.5: Total expenditure (GOG & DPF) by levels, 2001-2003 (in 2003 constant prices)

	2001 (¢ Bn)	2002 (¢ Bn)	2003 (¢ Bn)[18]	Increase on 2001 (%)	Shares 2003 (%)	Share of Increase on 2001 (%)
MOH	25.52	166.91	204.83	702.5	14.94	43.8
THS-Teaching Hosp.	140.39	172.40	162.44	15.7	11.85	5.4
GHS	36.54	33.50	35.15	-3.8	2.56	-0.3
THS-Psychiatric Hosp.	28.67	43.50	43.49	51.7	3.17	3.6
Reg. Health Service	149.07	209.37	235.61	58.1	17.19	21.1
Dist. Health Service	344.71	437.77	457.23	32.6	33.35	27.5
Subventions	67.54	71.40	63.47	-6.0	4.63	-1.0
Total	792.44	1134.85	1202.22	51.7	87.70	100.0
Earmarked unallocatable	269.88	144.34	168.65	-37.5	12.30	-32.8
Total	1062.32	1279.19	1370.86	29.0	100.00	

A breakdown of GOG and donor-funded non-wage recurrent expenditure shows a similar pattern (Table 3.6). MOH and GHS headquarters significantly exceeded their intended share of non-wage recurrent expenditure (Administrative and Service expenses). Conversely, spending of District Health Services was 35.36% of the total instead of 47.78% planned and 42% required by the 5YPOW[19].

Table 3.6: Non-Wage Expenditure by BMC Groups (Health Fund & GOG)

	2003 POW		Actual expenditure		5YPOW Target
Level	Amount ¢ Bn	%	Amount ¢ Bn	%	%
MOH – HQ	35.669	9.98%	34.62	13.28%	8%
GHS – HQ	24.167	6.76%	25.65	9.84%	7%
Sum HQ	59.836	16.75%	60.27	23.12%	15%
THs	40.19	11.25%	23.95	9.19%	13%
Psych Hosp	25.68	7.19%	19.28	7.40%	7%
Sum Tertiary	65.87	18.43%	43.23	16.58%	20%
Regional Health Service	60.877	17.04%	64.99	24.93%	23%
District Health Service	170.752	47.78%	92.189	35.36%	42%
Total Non-Wage Recurrent	357.335	100.00%	260.679	100.00%	100%

The shortfall in district level spending was caused by four main factors.

First, service delivery inputs procured centrally are charged to HQ when they should properly be reallocated and charged to the appropriate level based on issues from the Central Medical Stores. The MOH accounting system registers expenditure against the level where it was incurred and the CMS accounts are yet to be integrated into the mainstream MOH accounting system.

Secondly the cost of new initiatives like the National Health Insurance Scheme and the National Ambulance Service were charged to MOH-HQ. These expenditures need to be isolated when analysing expenditure by level.

Thirdly, during 2003, the MoH attempted to improve the timeliness of disbursements from the central level by issuing bulk cheques to Regions for reallocation to BMCs. This did not work well as the disbursements that reached BMC bank accounts were below what was

[18] 2003 total of Cedi Bn 1370 equals GOG plus Health Fund disbursement plus actual HIPC and earmarked spending. Late amendments to Table 3.4 came too late to be reflected in Table 3.6. Conclusions would not be affected.
[19] The 5YPOW had a target of 15% for HQ non-wage recurrent spending in 2003.

disbursed from the centre. The difference was explained by regional level procurement on behalf of BMCs. Despite no real growth in the total health sector expenditure in 2003, the regions increased their spending by nearly 17% in real terms, while district level real spending actually fell. MOH has reverted to the previous system in 2004.

Fourthly, delays in accessing funds from GOG and Collaborating Partners persisted in 2003. This coupled with the intermediary disbursement processes between MOH-HQ and district level BMCs meant that disbursed funds are received at districts too late for effective utilisation.

Although there are factors to explain the increase in the MOH share, factors such as central CMS procurement presumably also applied to earlier years, and it is surprising that the MOH budget is now very much larger than the GHS HQ budget, having been smaller in 2001. The increase does not seem wholly consistent with the policy and regulation role for MOH that was envisaged in Act 525. Even if some of the remaining increase in central expenditure represents spending on behalf of districts, the trend seems inconsistent with decentralisation of budgets and decision-making to fund integrated services at district level, holding districts accountable for the use made of the funds. We believe the district centred approach remains valid, and the increase in the share taken by the centre and the regions is undesirable.

We are unable to provide a breakdown of expenditure within Districts, as the Sub-District is only a BMC of record and separate accounts are not prepared. Analysis is feasible, but requires time-consuming manipulation and analysis of accounting data.

3.1.6 Recommendations

- The non-salary recurrent budget needs to be substantially increased in real terms in 2005, with the share of the districts increased in order to reach the 42% target share. This will require restraint in other areas of spending in order to limit the future share of resources taken by personnel emoluments and investment.
- MOH should explore the possibility of transferring disbursements to BMC bank accounts to reduce the lead time between issue of cheques at HQ and clearing of cheques at BMCs. This will reduce transaction costs in terms of man hours spent issuing cheques and travelling cost between BMCs, regions and HQ.
- The Ministry of Health should continue its plan to re-organise the Central Medical Stores and the Regional Medical Stores to ensure that it serves the needs of BMCs. The accounting system at the CMS and RMS should also be improved to provide information on transactions with BMCs. This will facilitate accounting for centrally procured items distributed through the CMS system.
- Explore how expenditure by the sub-district can be tracked at present and the scope for doing so in future using the BPEMS coding.

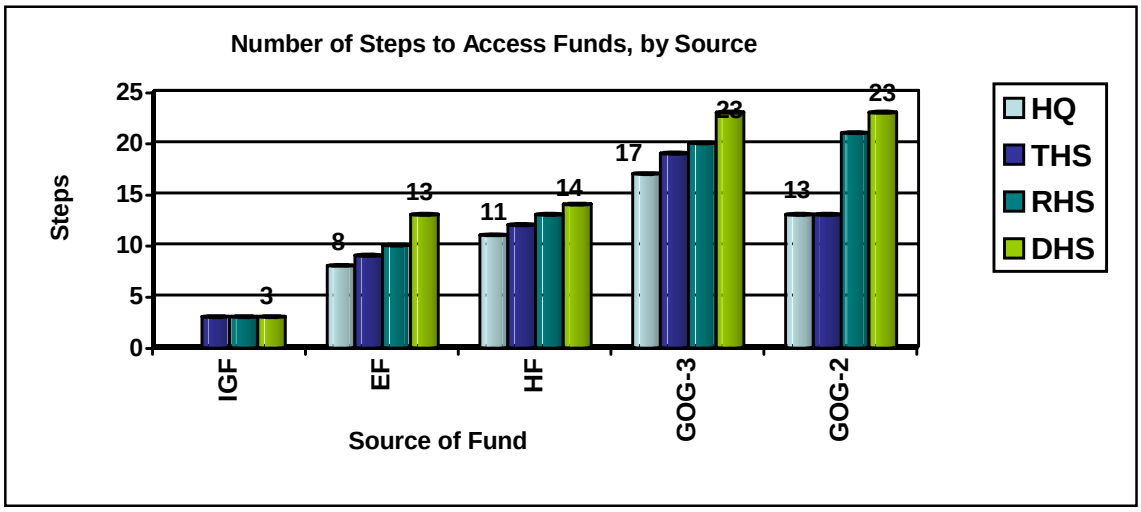
3.2 Disbursement Procedures

3.2.1 Timing of budget releases

The schedule at appendix 3.1 showing timing of releases from GOG Service and Health Fund donors, and disbursements to BMCs for 2003, highlights average delays of six months and three months for receipt of GOG Service Fund and Health Fund respectively. Disbursements to BMCs are also delayed by an equivalent six months and three months respectively for GOG Service and Health Fund. Based on the release procedures in appendix 3.2, delays in accessing GOG Administrative Expense budget may be longer than that for GOG Service budget.

3.2.2 Procedures for Release of Funds

Procedures for release of funds vary for each source of funding and for each donor partner but generally, Health Fund releases are dependent on publication of quarterly financial statements by the Ministry of Health. Appendix 3.2 shows procedures for accessing funds from GOG, Health Fund, Earmarked Funds and IGF. Appendix 3.1 shows that there are 3, 13, 14 and 23 steps to accessing IGF, Earmarked Fund, Health Fund and GOG Funds respectively (see graph). It is imperative to find ways to reduce the steps in accessing GOG funds, especially Item 2 – Administrative Expenses. It is also desirable to reduce the duration of each step in the process. This can be achieved if releases from Government and donors are made to pre-agreed schedules. Currently the GOG Service budget is released as a block grant into a central bank account at MOH-HQ. Cheques are then written for individual BMC in line with their GOG Service budget. The GOG Administration budget is not released this way except for the teaching hospitals. If a budget release arrangement similar to that of the teaching hospitals is put in place for the whole ministry it will greatly improve access to GOG Administrative budget.



3.2.3 Recommendations

- To reduce the delays in release of funds to the Ministry of Health, MOH should negotiate and agree with its partners, including Government of Ghana, specific budget release dates that must be met unless a written explanation is provided as to why a scheduled release can not be made. This will ensure that funds are received in time for disbursement to BMCs.
- MOH should seriously negotiate with MOFEP to have its GOG Administration budget released in the way the Service budget is released.
- MOH and its agencies should decide on priority service delivery levels and programmes that must be shielded in the event of marginal cuts in budget releases. This will reduce the delay in re-prioritising disbursements when budgetary releases are less than programmed.
- A disbursement plan for disbursement to BMCs should be agreed and communicated to all agencies of the ministry and its partners during the first quarter of each year. Any expected changes to this plan during the year should also be communicated.

3.3 Financial management issues

3.3.1 Legislative Reforms

Four laws that impact on the financial management procedures in the Ghana public sector were passed by Parliament and received Presidential Assent in 2003. These laws are the Health Insurance Act, 2003 (Act 650), the Financial Administration Act, 2003 (Act 654), the Internal Audit Agency Act, 2003 (Act 658) and the Public Procurement Act, 2003 (Act 663). With the exception of the Health Insurance Act the MOH has already made significant progress in the direction of the provisions of the new laws. It is however necessary for MOH to review its existing accounting, procurement and internal audit documents in the light of the new laws and undertake structured training of staff to bring them up to date on the provisions of the new laws.

3.3.2 Internal Audit

The Internal Audit Agency Act 2003 makes it mandatory for all Ministries, Departments and Agencies to have adequately staffed internal audit units. The Ministry of Health has been strengthening its internal audit systems since 1998. While some gains have been made in terms of staffing and coverage, it is opportune for the Ministry of Health to use the passage of the Internal Audit Agency Act to further strengthen its systems. Challenges that are facing the internal audit units in the ministry and its agencies include office accommodation, staffing, technical training and logistics. While the MOH is making efforts to address these challenges internal audit capacity can be enhanced if earmarked donor funds are used to augment support for internal audit.

3.3.3 External Financial and Procurement Audits

The external financial and procurement audits of Ministry of Health are complete up to 2002. The 2003 financial audit began in April 2004. Appointment of the procurement auditors for 2003 is in progress. Past financial audit reports have been issued late because the draft financial statements that are the subject of the audits were submitted late. The recommendations of the audits are therefore implemented one year late. Procurement training, which was one of the key recommendations of the 2001 audit, is yet to be carried out. This has been planned for 2004.

3.3.4 Payroll Management

The Ministry of Health's capacity to work through the existing systems to ensure a clean payroll remains a challenge as revealed by consecutive audit reports. The challenge is with staff movements that are not reflected in changes on the payroll because of inactions ranging from BMC managers to payroll operatives at MOH-HQ and CAGD-HQ as well as the payroll processing cycle. The MOH is proposing a collaborative effort by key players to address the problem. This effort should be monitored to ensure that the desired outputs and follow up actions are achieved.

3.3.5 Recommendations

- MOH and Donors should consider providing earmarked funds to support development of the technical capacity of the internal audit units of the ministry headquarters and its agencies. This support should include training and skills development, joint audits and logistics.

3.4 Efficiency and Cost-Effectiveness

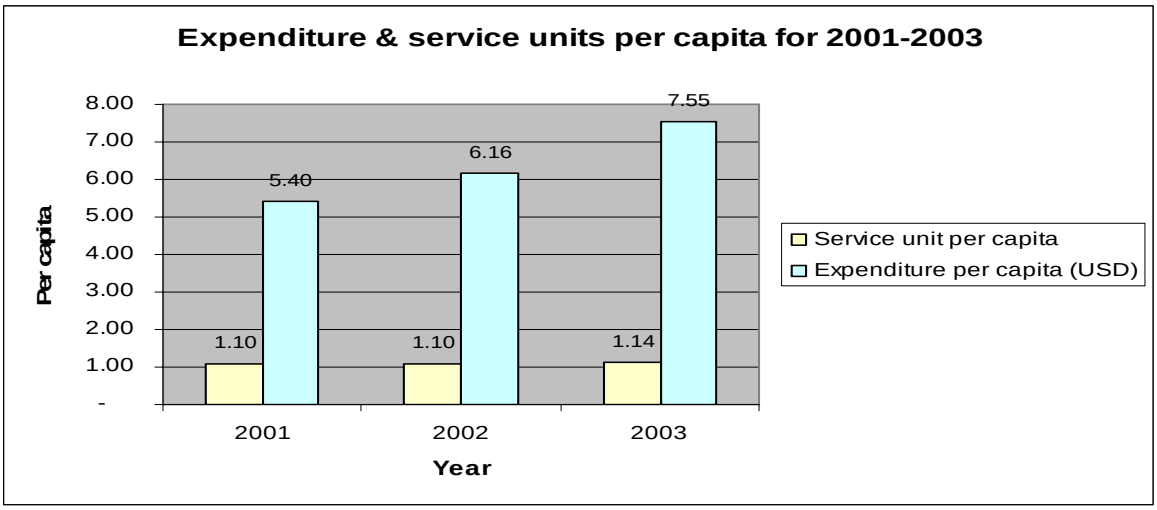
3.4.1 Has higher spending increased service output?

Health systems produce a wide range of outputs of different types, and it is difficult to find a fully satisfactory way to measure output. The easiest measures to use are numbers of OPD

visits and numbers of hospital bed-nights. We have used a weighted average of the two, which we call a 'service unit.' Our estimate simply adds hospital admissions and OPD visits together, but with inpatient admissions given a weight of 18 compared to a weight of 1 for OPD visits. This is based on the assumption that an inpatient day is three times as valuable as an outpatient visit (broadly equivalent to the cost difference), and that the average hospital stay is 6 days, hence a hospital stay on average should be weighted as equivalent to 18 OPD visits. This is a crude estimate: the calculation could be done more precisely if there is interest in the method. Alterations to the weights across plausible ranges do not in fact make much difference to the results. The measure could also be extended to include vaccinations and outreach, as is done in Mozambique. Though crude, some interesting patterns emerge.

Spending on public sector health services in Ghana has increased in real terms by nearly 30% since 2001, yet this increase in expenditure has yet to be fully reflected in indicators of output, which grew far more modestly. In per capita terms, the overall output of health services has hardly improved since 2001 (Figure 3.1).

Table 3.2 shows that nearly 80% of the increase was accounted for by the increased cost of personal emoluments. The 48% increase in real personnel emoluments has not as yet been matched by similar increases in the productivity of the staff, probably reflecting the problem that staff are unable to produce significantly higher health outputs when the budget for non-salary service and administration inputs is lower than in 2001.



3.4.2 Regional Expenditure and Health Sector Output and Efficiency

Analysis of the regional breakdown of expenditure shows that per capita Government health expenditure (GOG plus Health Fund) is only marginally higher in the poorest regions ($4.98 per head compared to $4.94 in non-poor regions). Donor earmarked funding is relatively more concentrated in the four poorest regions, but makes only a small difference to the overall pattern. Moreover, the pattern is not uniform. The Northern region, which is not only very poor but also has the worst overall performance on outputs, also in 2003 had the lowest per capita expenditure of any of the ten regions, while Upper East has the highest overall spending level. Figures for Greater Accra do not include the costs or the benefits of the teaching and specialist hospitals, and are therefore not directly comparable.

There is some evidence of high IGF collections and low spending on free services reducing outpatient attendance: all of the regions with IGF collections of more than the national average of $0.9 per capita had lower than average outpatient attendance, with the exception

of Brong Ahafo, where IGF is boosted by relatively high insurance coverage. Low IGF collection is associated with above average OPD attendance in Upper East and Ashanti, but not in the other poor regions where low spending, poor access, and lack of staff provide constraints to attendance.

Table 3.7 Regional Patterns of Expenditure

Region	Central	Northern	Upper East	Upper West	Poor regions	Ashanti	BA	Eastern	GAR	Volta	Western	Total
Per Capita Spending, US $												
GOG+HF	4.86	2.75	11.80	5.45	4.98	4.04	8.76	6.36	4.46	2.79	5.31	4.95
Earmarked	0.35	0.40	0.96	0.48	0.46	0.21	0.22	0.32	0.10	0.42	0.40	0.31
Sub-Total	5.21	3.15	12.76	5.93	5.44	4.25	8.98	6.67	4.57	3.21	5.70	5.26
IGF	1.03	0.07	0.61	0.32	0.49	0.76	1.19	1.31	1.42	1.27	1.04	0.90
Total Resources	6.24	3.22	13.37	6.25	5.93	5.01	10.17	7.98	5.99	4.48	6.74	6.16

Table 3.8 looks at expenditure by region in relation to the output achieved with that expenditure. The purpose of the analysis is to provoke follow up research into explaining the patterns we observe, research which should lead on to revealing lessons that can be used to strengthen performance.

Using the same weighted average of inpatient admissions and outpatient visits as a summary measure of output, the per capita output of the health system in the poorest regions as a whole is only slightly lower than the national average, but this disguises marked differences, with far higher than national average output in Upper East, and far lower output in Northern region, while the other two are close to the national average. The second row of the table looks at the average cost per service unit, by dividing total public and donor expenditure on health services in the region by the number of service units. This results in a radically different view of which regions achieve most with the resources they have. Northern, Ashanti, and Volta regions appear to achieve the most in terms of outputs from the below average resources made available to them. The implication for the Northern region is very clear – low achievement is the consequence of low public spending. The high level of output achieved by Upper East is shown to have required relatively high expenditure, probably reflecting the high cost of reaching poor populations in the remote Northern regions. The good output and outcome results achieved by Brong Ahafo have also been achieved at relatively high unit costs, perhaps reflecting to some extent the influence of insurance on provider behaviour. Of course, hospital admissions and OPD visits give no indication of the quality of the service offered (except in so far as people will make less use of services perceived to be poor), still less the impact on health.

Table 3.8: Output and Cost-Effectiveness by Region

Region	Central	Northern	Upper East	Upper West	Poor regions	Ashanti	BA	Eastern	GAR	Volta	Western	Total
Service Units p.c.	0.85	0.69	1.32	0.86	0.85	0.90	1.23	0.98	0.58	0.82	0.85	0.89
$ Cost per service unit	6.15	4.56	9.68	6.89	6.44	4.71	7.30	6.81	7.89	3.92	6.70	5.88
Rank (Best =1)	4	2	10	7		3	8	6	9	1	5	

We can gain a little more insight into these patterns by looking at staff productivity by region, as Table 3.9 attempts to do. This looks at the relationship between the outputs achieved and the Doctors and nurses available to achieve them. We also look at total PE budget in relation to output, as one way to capture the contribution of both medical and non-medical staff not included in the numbers of Doctors and nurses (medical assistants for example).

Once again, there may be particular explanations for the patterns observed that we are unaware of, and the main purpose of the exercise is to provoke questions as to why the patterns differ and what can be done to narrow the apparent differences between high productivity and low productivity regions.

We provide four measures of staff productivity by region: OPD per nurse, admissions per Doctor, 'service units' divided by total medical staff (proxied by Nurses and Doctors added together), and service units divided by the total PE budget. The average figures for the country, the country excluding GAR, and the poorest regions are provided at the top of the table. The body of the table compares each measure against an index in which the national average excluding GAR equals 100. Thus a value greater than 100 indicates higher than average value of the indicator, a value below 100 less than average. The last column comments on the results.

The most obvious point is that there appear to be enormous differences between regions in the productivity of staff. If we could understand those differences and raise the performance of the poorest towards that of the best performers, it could potentially lead to a very substantial increase in the output of the system without requiring massively higher budgets. The numbers we have produced are crude, but the discussion they might provoke can still be useful in revealing strategies for efficiency improvement.

It is interesting, and not unexpected, that the poorest regions have higher nurse: Doctor ratios than do better off regions. They presumably are able to substitute nurses for some functions that might be performed by Doctors in better-off regions, with for example a higher number of hospital admissions relative to the number of Doctors, but with more nurse support for each Doctor perhaps making this feasible. The overall output per staff member is significantly higher in the poorer regions. The higher nurse : doctor ratio is reflected in lower payroll cost per service unit in three of the poorest regions, but the very high output per staff member achieved in Upper East is reflected in very high staff costs. It would be interesting to explore the reasons for this, whether it is incentive payments to staff, or back-up staff to enable medical staff to be more productive.

3.3.5 Recommendations

- Inter-regional equity needs to be improved by increasing the non-wage recurrent budget share of the four poorest regions, from about 26% in the 2004 budget towards the GPRS target of 39%[20]. Particular attention needs to be given to increasing the budget of the Northern region, one of the poorest regions yet the one that receives least resources in per capita terms.
- There are huge differences between regions in the productivity of staff and in the output of services achieved for every Cedi that is spent. These differences cannot be adequately accounted for by factors such as the poverty or remoteness of the region. Similar differences exist within regions. The annual planning and review process needs to move beyond the existing indicators to include analysis of the reasons for those differences in cost-effectiveness and staff productivity, in order that weaker districts can benefit from lessons from the better performers. In preparing the POW for 2005, analysis needs to look at expenditure and output together.

[20] The Resource Allocation Proposal for the Ghana Health Sector prepared by PPMED GHS(undated, 2003).

Table 3.9: Indicators of Staff Productivity

Region	Nurse/Dr Ratio	OPD per Nurse	Admissions Per Dr	Service units/ total Drs & Nurses	Salary cost Per Service Unit ¢000s	Comment
National average	6	1446	518	2097	29	
National average excluding GAR	10	1508	935	2420	28	
Poor regions average	14	1382	1709	2641	30	Higher nurse/Dr ratio, higher output/staff member
		Index (National Average excluding GAR=100)				
Central	13	94	123	94	106	Average cost and output
Northern	19	73	295	110	78	High nurse/Dr ratio, high output relative to low payroll cost
UE	16	123	327	162	166	Highly productive medical staff, at high payroll cost
UW	10	97	117	103	117	
Ashanti	4	127	34	94	87	Few nurses, but good OPD and output relative to payroll (why? Other support staff?)
BAR	7	241	216	254	137	Highly productive staff, high payroll costs
Eastern	29	36	157	46	127	Not clear why high nurse numbers not reflected in higher output
GAR	3	78	5	41	158	Distorted by teaching/specialist hospitals
Volta	10	88	133	107	54	Average on most measures, but v low PE cost
Western	9	115	128	122	119	High unit cost but higher outputs

3.5 Changes to the Budget Process

3.5.1 Changing Donor Practices: The move towards Budget Support

Several donors are contemplating moving from sector support to health towards providing general budget support, leaving MOH to determine what percentage of funding to make available to the health sector, with the donor role limited to policy dialogue to influence MOF decisions. MOH would receive a larger share of its funds from MOF, and those funds would come via GOG channels.

General budget support has much to commend it in situations where the Government is seeking to use the budget process to make strategic choices, especially in the context of the GPRS objectives. In principle, it should be a welcome development that MOH has to argue for its budget with the central authorities, and subject to the discipline of a hard budget constraint. Unfortunately, our perception is that the budget process at present makes little impact on strategic choices between priorities, and has not in recent years succeeded in producing a budget that can be implemented, for the reasons of delay documented above. If donors nevertheless wish to move to GBS, we recommend that such a move should be preceded by:

- Ministry of Finance agreement to a timeframe for achieving the Abuja objective of a 15% share for the health sector, with immediate agreement to ensure that the HF funds shifted to budget support are reflected in a revised GOG resource envelope;
- Ministry of Finance agreement to the key changes in budget process discussed above that are required in order to avoid future delays, particularly the payment of item 2 in the same way as the service budget is currently paid;

- It would be good to also dialogue with MOH and MOF to designate key MOH programmes as priorities that will be given early releases and protected from in-year budget cuts.

3.5.2 Need versus Resource-Based Budgeting

In 2004, budgets were prepared on both a resource base and a needs base, as an attempt to persuade BMCs to think outside the box. A critical weakness of budget systems in Ghana is that the MTEF framework does not provide a realistic estimate of future resource availability but tends to be based on the previous year, encouraging a thoughtless incremental approach to the budget. The needs based budget attempted to move away from this, and in our regional visits we found examples of institutions using the additional flexibility to plan for new activities to support higher output from key programmes, e.g., pre-funding of exemptions by a district hospital, transport for increased outreach to inaccessible communities. The problem is to focus the increases that actually get funded on the high priority programmes. The proposed approach of identifying priority programmes for early releases and protection from expenditure cuts would be a potentially effective way to ensure that 'needs based' budgeting does not result in the funding of tertiary level wish-lists at the expense of primary level essentials.

Introduction

This chapter looks at institutional issues that affect performance. These include the non-government health services providers; the relationships between the MoH and other agencies, human resources and performance management. It also refers to the institutional aspects of health insurance, which is covered in more depth in the chapter on Poverty.

4.1 Non-Government Service Providers

The non-government health sector includes traditional practitioners; religious organisations – notably CHAG and the private-for-profit providers. Although the non-government organisations provide about half of all health services in Ghana and are expected to provide more, the POW 2003 is geared more towards the public service. The strategic objectives relevant to the non-government sector relate to the training of Traditional and Alternative Medicines Practitioners and Alternative Medicine Practice legislation and to a Strategic Initiative Fund. A Traditional & Alternative Medicines Council was established in 2003. Training has been provided to some T & AM practitioners and some training materials have been produced. The GHS was not consulted or involved in any of this training. It is recommended that there should be greater collaboration at district level in many aspects of T & AM. Where there is, it is a local initiative, e.g., a GHS psychiatrist is doing good work with traditional practitioners in mental health in Central Region.

In 2003 The Private Health Sector Policy prepared by the PPME Division of the MoH in collaboration with WHO was issued. It seeks to achieve the following objectives with the private sector:

1. To strengthen institutional capacity.
2. To promote and support human resource development.
3. To improve monitoring and technical support.
4. To improve data collection and management.
5. To promote resource mobilisation and increase public funding.
6. To strengthen regulation.
7. To strengthen partnership/collaboration and promote the private/pubic mix in national delivery at all levels.
8. To introduce intramural private practice.

As part of that policy, it was decided that a Strategic Initiative Fund should be created to provide funding for private providers with innovative ideas. To date, it has not been set up. The MoH has been consulting with stakeholders on the development of criteria for accessing a wide range of government support including the Strategic Initiative Fund. A guidance note is nearing completion and will be considered on 5th May 2004 at a meeting with stakeholders. It will provide guidance on the types of support that may be available (some of which are outside the Ministry of Health); the criteria for assessing bids and the processes to be followed. The intention is not only to inform providers about sources of support that are available but also to encourage activities that may "fill in the cracks" in current initiatives and programmes.

It is suggested that a team comprising representatives from the MoH and the GHS should review bids for monies from the Strategic Initiative Fund and other earmarked funds. This is important because the GHS has its priorities and some of the bids may contribute to, or conflict with, them.

In recognition of CHAG's major role in the provision of health services a Memorandum of Understanding between the MoH and CHAG was signed on 4th December 2003. It sets out the framework for collaboration but it is not a contract for services. CHAG recognises that service contracts will be entered into at District level with the GHS.

In the 2002 report it was noted that the MoH was exploring with the Ministry of Finance how the tax systems may be used to encourage providers to develop services in deprived areas. It does not appear that any progress has been made on this.

Many private providers are expressing concerns about the introduction of National Health Insurance. These concerns include the absence of clear guidelines on a number of policy issues (e.g., contracting, accreditation); timing and the need for resources for the operation of NHI systems that may well involve high transaction volumes and costs. It would seem that much closer collaboration is needed to develop an understanding of the provider issues and how they may be addressed but it is an area where the roles of the MoH and the GHS appear confused. The NHI Task Team appears to see its role as supporting the purchasers, leaving the providers to the GHS. However, the GHS is only dealing with its own provider facilities and the teaching hospitals and private providers appear to be ignored by both sides. This important issue is addressed in more detail under Health Insurance in Chapter 5.

4.2 Human Resources

Expected output:

- *New incentive schemes for health workers will be introduced*
- *Functional Community Health Nurses Training schools will be set up in every region.*
- *Hospital in-service training co-ordinators will be trained for all Teaching and regional hospitals.*

4.2.1 Incentive Schemes

A number of incentive measures for health workers have been introduced. With effect from 1 June 2004, HIPC funds will be used to pay a Deprived Area Incentive Allowance of between 20%-35% of basic gross pay to health professional and technical staff working in any of the 55 districts that have been designated as "deprived". The funds will be channelled through the District Assemblies. Modalities for disbursement and monitoring have been worked out and submitted to the Minister.

It appears that the GHS was not consulted about the designation of deprived areas and indeed, it has its own list of 52 some of which are not included in the 55. For those districts the DAIA will not apply and the GHS will have to find other solutions to attract/retrain staff.

A DFID-funded study in February 2002 of factors influencing the retention of health workers in deprived areas showed that the following were the most important:

1. Staff accommodation.
2. Water and sanitation
3. Electricity
4. Access to good schools and qualified teachers for children
5. Transport for work
6. Road access
7. Availability of working materials and equipment
8. Availability of good transport links to and from the district.

It is clear that while pay is important it is not the main factor. It is also clear that the GHS must work closely with the district assemblies and local communities on many of these issues.

In an effort to meet staff wishes on postings the GHS is planning to delegate recruitment of medical and other health professional staff to Regions and Districts. As a first step, job advertisements placed by the GHS invite candidates to express their first and second preferences on location and efforts are made to match these with service needs.

The GHS is also looking at the issue of part-time employment, which at present cannot be funded from the normal central government PE head. Experience elsewhere shows that there may well be a significant and under-utilised cohort of trained health workers who would like to work part time or flexibly and could help solve certain staffing problems.

A significant motivator for health workers is professional development. It is understood that the MoH may be thinking of clawing back training funds under its own management. This needs careful thought. The GHS as the main employer of health personnel is best placed to know how training funds could best be applied to motivate staff and meet the service needs of the people. They can also play an important part in performance review processes.

On a more general scale, the MoH is continuing with its policy dating back to 1997 of procuring saloons that eligible health workers may buy on a hire purchase basis. This year 415 vehicles have been acquired. Two thirds of the total are allocated to the regions, but only 24% of the total will go to the four poorest where incentives for staff are most needed. Consideration should be given to targeting future allocations towards staff categories and locations where incentives are most needed.

Similar hire purchase schemes are now being extended to motorbikes and bicycles. This will clearly be of benefit to equally important but lower paid staff especially needed in deprived areas.

A Housing Loan Scheme has been developed but no budget for start-up funding has been provided or sourced. The estimated sum needed is $400M based on 8,000 houses of between 2 – 4 bedrooms at an average cost of $50,000**.** It is hoped that it will function in 2005. This will not meet the need for staff accommodation at the workplace but it is thought that some staff would be more likely to accept a posting away from their home area if they know that ultimately they will have a home to return to. However, the cost is equal to more than two and a half times the annual health budget. Some of these costs will ultimately flow back to Government in loan repayments (though we are unclear if MOF have agreed to allow MoH to retain them as part of their budget), and the costs will not all be incurred immediately. Nevertheless, consideration must be given to finding more cost-effective means to meet these needs, and to targeting this benefit (perhaps making it conditional on a posting to a difficult location).

Other HR developments include:

a) Better pay through general public sector pay awards and restructuring within the public health service. Further proposals on pay are being discussed with professional groups.
b) A change to the post-basic training scheme for specialist doctors. W.e.f. September 2004 a large proportion of post-graduate training will be done in facilities outside teaching hospitals.
c) Pharmacy housemanships have been re-instituted to integrate newly qualified pharmacists into the health sector.
d) Involvement of District Assemblies in the nomination and sponsoring of students for training.
e) Development of staffing norms for the entire health sector. The MoH has done work on this and it understood that proposals are with the Minister. Meanwhile, the GHS is doing its own study. This is a clear example of poor collaboration between the MoH and the GHS.

f) The inauguration the Ghana College of Surgeons and Physicians in December 2003.
g) Reducing the time taken for payment of trainee allowances to 12 weeks rather than over a year in some cases. It is recommended that this function is delegated by the MOF to the MoH and the target for payment is reduced to 4 weeks.
h) Training of health care assistants to support nurses and technical staff. A 4 weeks training programme has been developed, which providers are delivering from 1 June 2004. 1200 new entrant staff will be trained in 2004. Funding for the training allowances and first year's salary is already earmarked from HIPC funds.
i) Increased support to private providers, HR; clinical & support staff; training; vehicles and equipment
j) Bonding of trainees. New procedures were introduced in October 2003 whereby the guarantor signs a bond in the presence of the student and the Government of Ghana.
k) Nursing fellowship programmes with overseas institutions. There are no training programmes within Ghana for specialist nursing, e.g., cancer, paediatrics, etc.

These activities are at different stages of development and it is too early to measure their effects. It is an impressive and commendable list but it is not yet clear that they meet the key objective of encouraging staff to work where there is the greatest need. It is understood that the MoH and the GHS are planning another (joint) survey of health workers in 2004.

4.2.2 Community Health Nurse Training Schools

CHNTSs are functioning in 8 of the 10 regions, with three further schools expected to open in 2004-2005.

In order to improve the status and career path of Community Health Nurses the basic training course is being redesigned from 2 years to 3 years. This is a pilot being tested in 2 schools w.e.f. October 2005 when between 80 -100 students will enrol. It will run in parallel with the existing 2 years courses meanwhile. If it succeeds then it will mean that nurses can stay within community nursing while following a professional development programme to diploma or degree level. In the past these ambitious and valuable nurses had to divert into clinical nursing and many were lost to community nursing forever.

4.2.3 Hospital In-Service Training Co-Coordinators

The GHS has been running training courses that have been attended by in-service co-ordinators from all teaching and regional hospitals and most districts.

4.2.4 Assessment

The design of incentives needs to take account of cost constraints given the problem that the growth of the PE budget has resulted in cuts in the real level of spending on service and administration budgets on which staff depend to be effective. Incentives need to be focused tightly on those categories of staff, and those locations where difficulties are being experienced, and provide the kinds of incentives most likely to be effective. To be worthwhile, they also need to be linked to better management of staff performance (see next section). As the 2002 study illustrated, not all of the incentives can or should be financial, since staff can also be motivated by the opportunity to do a rewarding job in a supportive environment that recognises their efforts.

4.2.5 Recommendations

- The staff in-service training budgets currently with the GHS should remain there.
- The Working Group looking into pay and conditions for health workers should continue to be supported.
- The payment of trainee allowances should be delegated to the MoH and the target for payment reduced to 4 weeks.

- MOH and GHS should collaborate closely on the 2004 worker incentives survey.
- Staffing norms that are being developed require input from those actually delivering care to patients/clients if they are to have any credibility. They should be seen as a guide with scope for interpretation taking local factors, (e.g., layout) into account.

4.3 Delivering Higher Performance from Health Sector Institutions

The key concern is that increased resources to the Health Sector have not been matched by significant improvement in the quality of services offered, or in the attainment of expected targets. This section reviews institutional performance in the context of a number of performance reviews undertaken over the past year, including:

- A functional Review of all Ministries, Departments and Agencies undertaken by the National Institutional Renewal Programme (NIRP)
- A review by the Ministry of Health into performance contracting
- Ghana Clinical Care Services Review, March 2004
- Appraisal of the Information, Monitoring and Evaluation (IME) System for the Health Sector (2004)

4.3.1 Clarity of Roles within the Sector

One of the issues raised from the functional review was the lack of clarity about the mandate of the MDAs. Particular conflicts had arisen over the scope of work and the responsibility of a number of institutions such as the MoH v GHS and the GHS v Teaching Hospitals.

This lack of clarity had led to significant 'conflict' over who is really responsible for what. The functional review process led to the clarification of the mandates of all the institutions in the sector highlighting the role, function and critical skill requirement. Suggestions were made to modify organisational structures to ensure the key functions required by an organisation to deliver its mandate effectively had been catered for.

There is no evidence that these have been reviewed by the MoH and have either been modified or implemented although it is understood that a review of Statutory Instruments is being conducted to identify what changes are needed to implement revised mandates.

Major areas of dysfunction have been identified, particularly between the MoH and the GHS, e.g., in policy and planning of health insurance or co-operation on human resource issues. In addition to the mandate issues, direct lateral communication at different levels is poor with everything having to be passed across at top level only. Rationale for this is unclear and it is a major constraint on the smooth co-ordination of the delivery of services in the sector.

4.3.2 Performance Management

One of the expected outputs from the POW 2003 is the reintroduction of the contractual arrangement system with BMCs, mission and private providers. Performance Contracting is seen as a means to focus all levels of the health system on delivering the key outputs from the POW, and as providing a framework against which performance can be monitored.

In preparation for this the MoH undertook a review into why the earlier attempt to introduce performance contracting in the sector had not succeeded. A number of reasons were identified:

1. Lack of leadership commitment
2. Unwillingness to be held accountable because of the lack of autonomy.
3. Unstructured approach to implementation
4. Absence of a performance management culture
5. No recognised in-built incentive system

6. No formal appointments
7. Inadequate and inconsistent/Untimely flow of resources

Many of the effects of not having good performance management systems were picked up in the recent reviews on clinical care and on the IME report. Deficiencies noted had to do with: attitudes of staff; lack of clarity about progression, and, based on the attainment of specific goals, quality of care issues.

Despite this, performance agreements are now being agreed with Directors at Regional and District level and are being regarded positively for setting priorities and agreeing targets. They are not being seen as devices to measure individual performance, as there are no rewards or sanctions.

If seen as part of the performance assessment framework, they can nevertheless be very effective tools for motivation if used by managers to recognise achievement and support future improvements. To perform this function effectively, they need to be supported by joint review processes that focus on understanding the reasons for the performance achieved and supporting strategies for improvement. They will fail if they lead to a 'blame culture' in which shortcomings are picked up by managers (or by MoH in relation to agency contracts) without a joint search for solutions.

It is important to ensure that performance agreements are followed up by effective systems of performance review. This applies at all levels – for instance, at national level it is important to clarify how recommendations from the annual reviews are followed up or who is accountable.

4.3.3 Recommendations

- The MoH should ensure that the outputs from the functional review are confirmed and agreed upon by each agency. Having agreed on the mandate this should be incorporated in the next performance agreements – together with the actions required to ensure that the agency is progressively improving its ability to deliver the mandate.
- Lateral communication between the MoH and the GHS should be encouraged.
- There should be a joint programme of change management for senior management of the MoH and the GHS working together with an independent trainer/facilitator. It is recognised that this has been suggested before but it has not been implemented and the problem remains, most notably in areas of human resources; capital investment; procurement and bio-medical engineering – all of which affect the delivery of services. Health partners should provide support for an initial facilitated workshop to launch this process.
- At every level, systems of performance review should be strengthened by identifying who is accountable for performance.
- The focus on targeting resources better to achieve greater impact and greater reduction in poverty-related inequalities should be reflected in the performance contracts that are being signed between MOH and Agencies and by GHS with BMC managers.

Chapter Five: Pro-poor Agenda in the Health Sector

During the late 1990s, the health sector in Ghana acknowledged that there were major inequalities in health care and health status indicators within the country. The second five-year PoW for 2002-2006 focuses the attention of the sector on these poverty-related issues by aiming at "Bridging the Inequalities Gap".[21]

This chapter discusses some aspects of the 2003 performance in relation to that objective, and prospects for improving performance during 2004 and the remainder of the 5-year PoW. The first part focuses on the broader issue of mainstreaming the pro-poor agenda in health and tracking the related achievements. The middle sections deal with strategies to enhance geographical access for the poor, including geographical targeting and CHPS, followed by strategies to improve financial access for the poor, including exemptions and health insurance. A final section makes some concluding comments and proposes some practical recommendations.

A key document for the review was the excellent and very thorough "Review of the Ghana Health Sector's Pro-poor Agenda", which was commissioned by the MoH as part of the 2003 annual review.[22] We will not attempt to reiterate all the well-considered analysis in that report, but we do emphasise that it should be very widely circulated, read and discussed by all the key stakeholders at all levels in the health sector.

5.1 Mainstreaming the pro-poor agenda in Health

5.1.1 Responsibilities for the pro-poor agenda

In order to bridge the inequalities in health services, the 5-year PoW has a principal focus on the four most deprived regions in the country - Northern, Upper East, Upper West and Central Regions[23]. These regions have chronic deprivation in both health status and in the distribution of health resources. Poverty-related focal areas in the 5 year POW include refining exemptions, development of prepayment mechanisms (District and National Health Insurance), implementing the Community Health Planning Services (CHPS), and targeted programmes (i.e., on malaria, HIV/AIDS, TB and guinea worm, including access to safe drinking water).

The 2003 Annual Plan of Work stated that the policy focus for 2003 would be to "ensure that resources and efforts are directed towards activities that will further enhance the ability of the poor to gain access to basic health services." It provided details of plans for expanding both geographical and financial access – see sub-chapters below.[24]

At the highest level, the MoH has participated in the GPRS and stated that it will adopt a pro-poor formula for allocating resources to implement the health component[25]. Indeed, there is evidence that efforts have been made in this regard. HIPC funds, which are availed on the basis of the GPRS, are clearly being allocated to the four most deprived regions. In 2003, with the support of HIPC funds, fee exemptions were introduced for institutional deliveries in the deprived regions. The HIPC funds are being targeted for: exemptions for maternal deliveries, support for the development of National Health Insurance (NHI), health centre

[21] MoH (2003) The second health sector 5 year programme of work 2002-2006. Partnerships for health: Bridging the inequalities gap. Accra, MoH.
[22] Bosu, W.K.; Laryea-Adjei, G.; and McIntyre, D. (2004) A Review of the Ghana Health Sector's Pro-poor Agenda: A key area review report for the annual health sector review 2003, MoH, March. Hereafter referred to in this review as the "Pro-Poor Review 04"
[23] Hereafter in this chapter, these four will be referred to as the 'four deprived regions'.
[24] The Ghana Health Sector Annual Programme of Work, 2003; Ministry of Health, January 2003
[25] Aide Mémoire Dec 03

rehabilitation and development of CHPS compounds, and district training facilities, especially for community health nurses and officers.

MoH and GHS responsibilities for pro-poor issues - There was no performance agreement between the GHS and the MoH for the 2003 period under review, so all parties relied on the discussion of responsibilities for the GHS and the MoH in the PoW 2003. Regarding pro-poor issues, the MoH was only tasked on two points - to provide the policy framework for health insurance through Mutual Health Organisations (MHOs), and to work on an incentive package for health workers, especially those to be deployed in deprived areas. The GHS was also tasked to work on health insurance (especially the practical side in development and implementation of schemes) and operating the incentive package for health workers to help ensure that postings are made to deprived areas. Other aspects of the pro-poor strategies were not assigned as specific responsibilities, which may have been a factor contributing to their lower profile, as will be discussed further below.

There is now a new performance agreement between the MoH and the GHS for 2004; this agreement stipulates that, "…pro-poor criteria for resource allocation (will be) developed. At least 80% of exemptions budget (will be) spent." However, there are no details on pro-poor criteria and no information about the amount in the budget for exemptions in this PA. There are also no comments about responsibilities vis-à-vis health insurance, CHPS and the equitable distribution of staff and services in order to address poverty and deprivation.[26] The PoW 2004 does, however, lay out responsibilities for health insurance (MoH/Local Govt/DA), CHPS (GHS/THs), and human resource development (MoH) and it assigns a budget for these activities.

MoH and CHAG responsibilities – there was no formal agreement between these bodies prior to late 2003. The new MoU[27] indicates that CHAG will "target service provision to the poor and the marginalised." Details include that CHAG will be open to new approaches to health financing, including health insurance. The MoH is expected to facilitate the equitable distribution of health professionals, including to CHAG institutions, without, however, clarifying whether this refers to the current geographical and service inequities by region or any other criteria. No other pro-poor agenda issues are specifically covered in the agreement.

Within the GHS – there were no performance agreements in 2003. For 2004, performance agreements have been developed for internal use in the GHS between different levels. The agreement between the GHS and Regional Directors of Health Services, and the cascaded similar agreements between Regional and District Directors show some attention to pro-poor issues in planning (MTEF activities) and monitoring (indicators). The MTEF activities address planning for increased access to health services for the poor at the level of the Regional Health Directorate (RHD)[28] and the District Health Administration (DHA), but there is no mention of these issues at the level of regional or district hospitals or the sub-districts. There is also no mention at any level of planning for exemptions; health insurance is mentioned for the RHD but no other levels; and CHPS is not mentioned specifically, though there is mention at the RHD and DHA levels of strengthening community and outreach services. The only level tasked with planning for the equitable distribution of services is the RHD.[29]

[26] 2004 Health Services Performance Agreement between The Minister of Health and The Chairman of the Ghana Health Service Council

[27] Memorandum of Understanding between the Ministry of Health and the Christian Health Association of Ghana; November 2003

[28] We note that the document says 'Regional Health Directorate' (RHD), but there are some officers in the GHS who assert that it should be 'Regional Health Administrations' (RHAs).

[29] Performance agreement between the Director-General GHS and Regional Directors of Health Services; Performance agreement between the Regional Director of Health Services and District Directors of Health Services, 2004

The conclusion is that pro-poor issues are not being effectively highlighted in the annual planning cycle, and that much of the pro-poor agenda has to depend on the unreliable circulation of many different documents emanating from many different offices rather than being signed up to by the responsible parties in coherent performance commitments. If the pro-poor agenda is truly one of the priorities of the sector, then it should be emphasised in the plans with strategies clearly spelt out at all levels. For example, what strategies will be adopted to ensure that those who need to be exempted (especially paupers) are actually being exempted?

5.1.2 Monitoring and poverty related indicators

The existing sector-wide indicators and their supporting indicators, as detailed in the annual PoW and the performance review guidelines, provide proxy or direct indicators for tracking some, but not all, aspects of the pro-poor agenda in health. The 2003 performance review guidelines include details of analyses to look at exemptions, health insurance, and CHPS.

Significantly less attention is given to other aspects of the pro-poor agenda. There is a single request for regional directors to highlight human resource development strategies to ensure equitable distribution, but there is no indicator for equity and no direct indicator on geographic access. There are also no operational definitions, e.g., for poverty, pro-poor, or equity. While the data is available, there is no request for a poverty-related analysis of disease patterns, e.g., any kind of disaggregated analysis of disease burden or service utilisation by population sub-groups, and geographical or financial access factors.[30]

These gaps in the system of monitoring mean that there is limited capacity to translate the rhetoric of 'pro-poor' into focused and measurable activities and results at any level. The following table suggests a few potential modifications to the current indicators, which could start as analysis strategies and might eventually be adapted as indicators for tracking pro-poor achievements. A much more extensive set of analyses and indicators is included in Annex 5.1.

Table 5.1: Examples of supplemental analyses from a pro-poor perspective

Pro-poor agenda	Current indicators 2003 & 2004[31]	Potential modifications to more clearly bring out pro-poor achievements (examples only – see Annex 5.1 for details)
Poverty and the poor	• No requirements about reporting on this issue	• Number (or proportion) of sub-districts that fall into core poor categories (using district criteria and poverty maps)
Geographical access and equity	• No sector-wide indicator on geographical access	• Proportion of the population living more than 8 kms (or more than one hour by locally available modes of travel) from a source of preventive/promotive health supplies (ITNs, condoms, FP supplies, IEC materials); linked to disaggregation by poor districts, and intra-district core poor areas
Poverty related diseases	• Malaria cases – total and <5yrs; institutional mortality <5yrs – sector, region, district, sub-district	• Comparison of the sub-district rates for each of the malaria indicators to intra-district poverty maps, i.e., disaggregation by core poor/poor/endowed areas of districts
Exemptions	• Number of patients receiving exemptions by category	• Number of patients whose health insurance (MHO) premiums are partially or completely paid by exemption funds, by category of patients (poor, under 5, etc.)
Health Insurance	• % of IGF coming from pre-payment and community insurance schemes	• Proportion of poverty related disease encounters that are covered by health insurance (based on top communicable diseases or top diseases of public health importance)

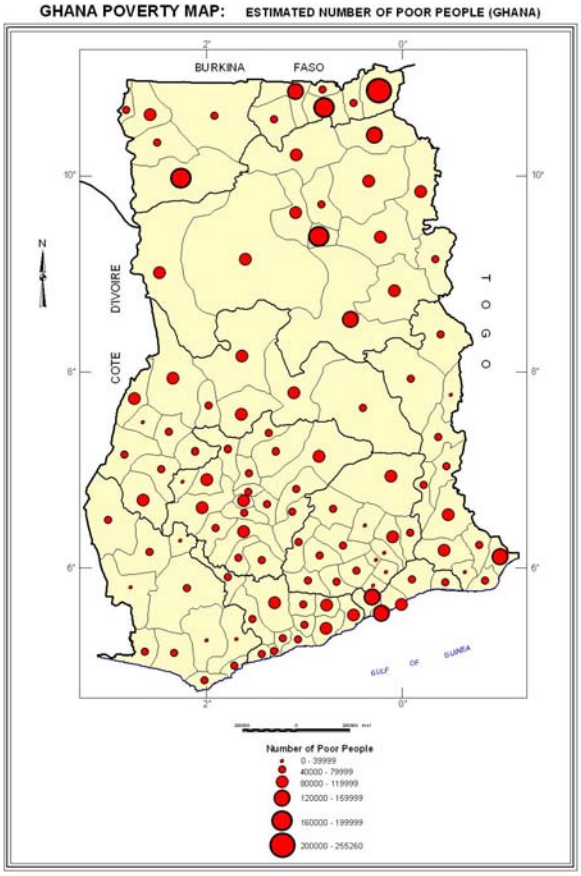
[30] GHS 2003 Performance Review Guidelines
[31] From: PoW 2003; Guidelines for performance review by BMCs 2003 PoW; PoW 2004; Performance agreements 2004 for MoH/GHS, GHS/RDHS, RDHS/DDHS; MoU MoH/CHAG

5.2 Geographical access

5.2.1 Targeting for geographical access and allocation of resources

Four main levels of geographically-linked population targeting can be identified: regional, district, intra-district and household or individual. At present, there is evidence of resource allocations based on regions, discussion of district level targeting, unstructured attempts at the sub-district level, and very little effort on identifying and targeting households or individuals.

Regional – As noted in many other reports, including the Pro-Poor Review 04, there is a regional concentration of poverty in the three northern regions (Northern, Upper East and Upper West) plus the Central region. Based on results and analyses of the CWIQ, GLSS, and GPRS, all of these regions have consistently and persistently had evidence of containing the greatest proportions of persons below the poverty line, the least access to resources, and the highest burden of poverty related diseases.

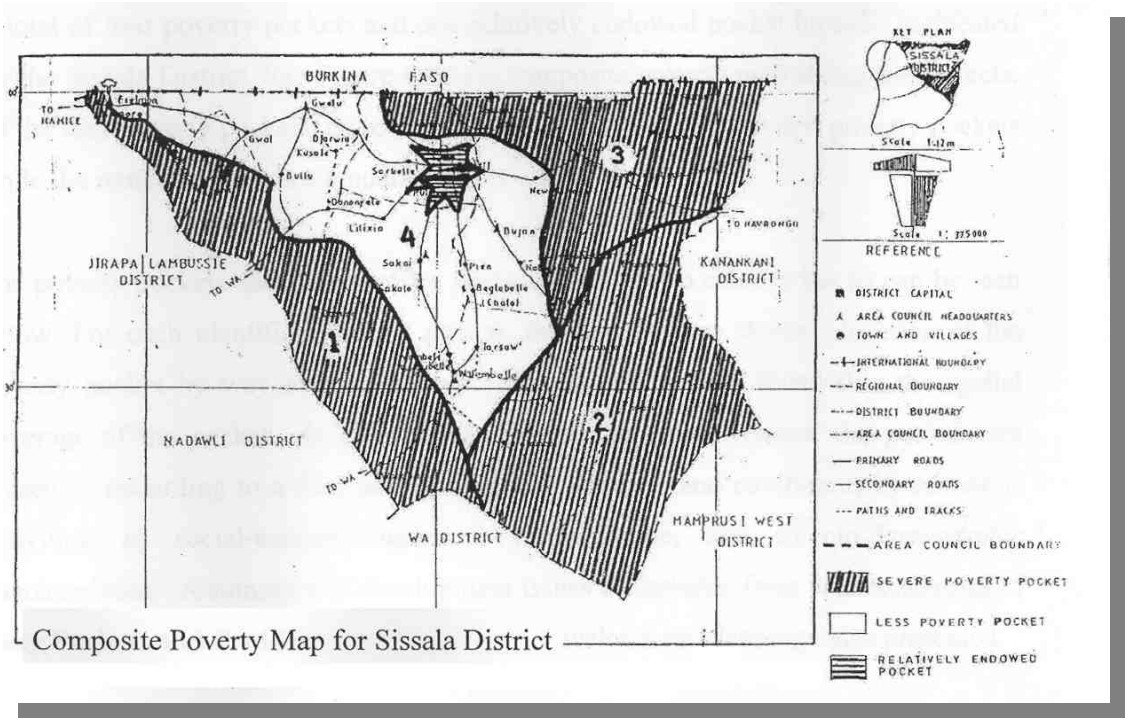


District – Work has been done during 2003 by the GSS as well as the NDPC and GHS in conjunction with the GPRS to deepen the disaggregation of national statistical data and identify the poorest districts around the country. This work has built on a widespread recognition that regions are not homogeneously poor (or affluent). It has yielded a set of 55 districts that are considered especially deprived[32]. Regions have been informed about this information, and some discuss how it applies in their region in the 2003 performance reviews. See district based map to the right (from the GSS).

Intra-district – the NDPC is now in process and will have completed work for all 110 districts by August on mapping of the intra-district areas that are 'core poor', 'poor' and 'endowed'. This exercise is blending qualitative data gathering and analysis of locally specific poverty indicators and conditions together with data from large-scale surveys (CWIQ, GLSS, Census). The groups producing the maps include local stakeholders: District Assembly, District Development Officer, and a DHMT representative in most cases. Interestingly, despite the fact that this project has been going on for close to a year, and the full set of maps for 110 districts is due to be completed by August, the review team has met only one person at regional or national level in the MoH or GHS who is aware of this resource – though there has been immediate and widespread enthusiasm for it when people have seen examples of the maps and documents that are being produced.[33] The resulting maps are of considerable value in assessing the relative deprivation and relevance of CHPS zones, outreach locations and future plans for health facilities. They also have great

[32] Note that this set of 'poor' districts is from the GSS, based on CWIQ, GLSS and census data.
[33] Contact person at NDPC Flagstaff House is Mr. Kodjo Mensah-Abrampa.

potential for linking community and district based planning to address high priority public health conditions. (See example below)



Individual persons and households – this is the most detailed level of identification for the poor, and obviously the most time consuming and difficult to do. In light of the coming national health insurance programme, this level of categorisation will be necessary and it is critical to work out a feasible and acceptable strategy for its implementation. There are constraints – being a 'pauper' is strongly stigmatised in Ghanaian society, especially in the rural areas, leading to reluctance to be identified, and certainly mandating that the procedure respect the confidentiality of individuals. Additionally, poverty is a dynamic state, and some people go in and out of poverty over time. If confidentiality can be assured, the secondary benefits of getting an 'indigent' classification, e.g., free or greatly subsidised health care, may lead to various efforts to manipulate the identification system for personal advantage.

The framework for the national health insurance programme describes a process that will rely on community perceptions and validation about who cannot pay. Once lists of such persons are created, they will be shared with a district health insurance scheme, which will have access to funds from a central pool that subsidise care for the indigent. Insurance scheme membership cards will be issued to the indigent families that entitle the holder to the same benefits as all other self-paying members.

Urban poverty – the issue of health and poverty in urban settings is not addressed in the seven regional reports available electronically to the review team. It has been covered as a comparative analysis in the Pro-Poor 04 study, drawing principally on the CWIQ data of 2003. Several key individuals interviewed during this review at HQ and regional level said that there has not been any special programme or activity related to urban poverty and health in any of the regions, including Greater Accra. There are, however, many problems with maldistribution of providers and service points in the urban areas that need to be rationalised for more efficient delivery of urban health care. In addition, there is a need for greater understanding of the links between poverty and health in urban areas. One review of urban poverty in Ghana has pointed out that, although the urban poor are closer to

providers, they tend to have a much narrower range of coping strategies and mutual assistance networks. As such, the cost and opportunity burden of an illness can more easily push an urban 'near-poor' person from their marginal status into deeply poor.[34]

5.2.2 Community-based Health Planning and Services initiative (CHPS)

The main contribution of CHPS to the pro-poor agenda of the health sector is in terms of addressing geographical inaccessibility. The CHPS programme is designed to bring health workers with sufficient training deeply into the community where they can provide focused health education, a limited range of at-home clinical services, and facilitate linkages to a referral system.

The PoW 2003 sector priorities include the following statement,

> *"Strengthening district, sub-district and community health planning and services as part of the 'close to client' system of health care delivery. This will involve the placement of CHOs particularly in deprived communities across the country to be supported by backstopping structures at the sub-district and district level."*

The 2003 output target was to establish 100 new CHPS compounds with an emphasis on deprived areas. By the end of 2003, there were 55 'completed' CHPS zones, i.e., settings that have been mobilised, have a residential compound, and have a CHO in place and working. This is an incremental increase of only 25 zones, though there is the possibility that some sites established in earlier years are no longer functional according to current criteria.

Selection and targeting – There is no unified strategy document as yet for the CHPS initiative[35]. This does reflect continuing creativity in a programme that is still evolving, but it is also a limitation. Locations for CHPS sites are (purportedly) agreed upon with the District Health Administration, District Assembly and community, with the understanding that they are targeted at 'deprived' areas/populations. The Social Investment Fund (GPRP, GTZ and Danida funding) has been investing in the capital development of CHPS sites in deprived areas through District Assemblies, based on poverty mapping and scrutiny of the DDHS to ensure that the site is congruent with future infrastructure plans of the DHA. USAID is also involved with a parallel system and different criteria for situating CHPS facilities. Of the 'functional' or 'completed' CHPS sites, there is a suggestion that the majority may be located in settings that are at least 8 kms from the nearest health facility, perhaps because this standard was promoted heavily in the beginning of the CHPS roll-out process.[36]

However, there is no good, systematic documentation and analysis of CHPS settings in most regions and districts. Based on interviews and limited observations in the field, the selection and development of CHPS sites is uneven, and the 'deprived' category is not systematically defined, either in geographic terms (e.g., distance to nearest static health facility), or any other aspects of deprivation, e.g., falling into a core poverty pocket, or a very high prevalence location for a behaviourally related disease or an easily treatable disease for which there have been barriers that have prevented access to services at a facility.

On the positive side, an extremely valuable resource for intra-district poverty maps has recently become available through the NDPC-GPRS, as noted in the previous sub-section on targeting for geographical access (see example above in geographic targeting).

Another drawback has been the on-going debate about whether CHPS should be an anti-poverty strategy and limited to 'deprived' districts, or whether it is the next revolution in

[34] Ashong, K. and Smith, D.R. (2001) Livelihoods of the poor in Ghana: further knowledge of livelihoods affected by urban transition, Kumasi, Ghana; A contextual review of Ghana-wide definitions and trends of poverty and the poor with those of peri-urban Kumasi. CEDEP for DFID

[35] GHS has prepared a preliminary draft policy, but it has not yet been widely circulated or received comments.

[36] Brong Ahafo region and Nkoranza district; needs to be confirmed from other sources

health care going beyond Primary Health Care to help Ghana reach the MDGs. The MoH discusses CHPS in terms of geographical targeting, and focuses on the four most deprived regions. Meanwhile, the GHS is not talking in terms of a regional focus for CHPS, and CHAG is not talking very clearly about CHPS at all. Current efforts to prepare and get consensus on a national CHPS strategy document should address these issues.

While the CHPS site selection is being guided (driven) by community desires in at least some locations, there is no systematic tracking of community contributions to CHPS settings, either in terms of selection, construction, mobilisation of trainees, volunteers, or recurrent maintenance and decision-making. This is a potential limitation for mobilising other communities and coping with their expectations about the scale of work and contributions involved.

Quality of care - The CHPS concept includes provision of care for a limited range of diseases that are met in the home during outreach activities, including illnesses of adults and not just for children. On the downside, absent a coherent strategy framework or guidelines, CHOs do not have a standard set of tasks nor a standard kit with a stock list that they are expected to use in the field. The range of services to be delivered by the CHO is not very clear as yet, e.g., a strong argument could be made for ensuring that all such officers have basic midwifery skills in the face of persistent maternal mortality. The role of the various levels in providing adequate support supervision to the CHOs is also unclear.

The scale of effort for the CHOs is still not resolved; there is confusion about the desired number of persons or households – some sources say a CHPS zone should have 1500 persons, i.e., about 300 or so households, and others say 5000 persons, about 900 households. This is an important consideration when some health planners expect a CHO to visit every household on a regular basis (e.g., at least once in a quarter) to deliver individualised health education, give support to child welfare and public health programmes, and do social marketing as well as home based clinical care. At 300 households, this is a manageable minimum of 3-4 households per day (plus travel time and other duties), but quite unrealistic at 900 households.

One key element in the original CHPS programme was the referral link between community-based caregiver and the sub-district. At present, however, this link appears to have disappeared from the criteria for a 'functional' CHPS site.

Summary – the CHPS is widely promoted, but equally widely interpreted in many different ways. It desperately needs to have a uniform set of well-articulated definitions, criteria, and activities, i.e., a consensual strategy document if not a policy. The guiding documents needs to be very clear about how the CHPS strategy will be addressing poverty and deprivation, rather than becoming yet another 'layer' in the health system.

5.3 Financial access

5.3.1 Exemptions and targeting

Exemptions - Specific exemption schemes are in place for reducing or removing the costs of 'cash and carry' to selected patients at the point of service, e.g., paupers are allowed to be exempted everywhere in the country, and all supervised deliveries are exempted in the four most deprived regions. There is some flexibility to respond to local perceptions about what conditions are to be exempted, e.g., allowing Upper West Region to reduce the age limit on exemptions for the elderly to 60 years in recognition that there are few persons over 70 (the national standard) and many persons in their 60s are overwhelmed by the costs of care.

Critically, in 2003 the exemptions have not been linked to intra-regional or intra-district targeting of core poor locations nor community level identification of paupers. Moreover, paupers are the least utilised of all the categories of exemptions, despite indications that 40% of the population are considered poor and 27% are deeply poor. These issues have been presented very cogently in two excellent reviews in late 2003.[37] The availability of intra-district poverty maps by mid-2004 should enable a much more focused approach in the future.

Although all patients arriving at a facility will be seen, those who are unable to pay may be discouraged from seeking treatment. In part, this is because self-reporting of pauper status is difficult in Ghana, where being a pauper is stigmatised. But another part is that many persons who could qualify are unaware of the exemption policies that affect them and they fear the costs of care. Costs for services and exemption options are not posted in health facilities, and there are also illegal additional charges in many areas. Poor persons fear humiliation and second-class treatment, such as having to wait longer to be seen, seeing less experienced staff, and receiving worse treatment, including fewer drugs and tests.

Service providers know that they face long delays in obtaining reimbursement for exemptions. When funds are tight, they have little incentive to target improved access for patients who will potentially further weaken their financial position, or to ensure that patients are aware of their rights to exemptions. Health workers are also reluctant to pursue exemption claims through all of the bureaucratic steps and delays; they fail to see any value in pressing for exemption monies that may never come rather than pressuring the client and his/her family for payment at the visit.

These disincentives to proper care for the poor need to be changed. In the longer term, membership of insurance schemes paid by Government will make the poor an attractive source of increased IGF and give facilities an incentive to serve them. In the near term, the same effect could be achieved through earmarking exemptions within the budget of facilities, but paid into their accounts up front, and accounted for retrospectively, possibly with release of the third quarter made dependent on financial reporting on the first quarter disbursement. Current accounting for exemptions is said to be not very rigorous, and the safeguards would need to be improved. The promise of release of further replenishment of funds paid up front would also need to be credible and quick, to encourage facilities to believe that funds voted in their budget will actually be paid.

Disease targeting - The MoH has advocated a package of essential services to address the leading causes of morbidity and mortality, with an emphasis on diseases associated with poverty. As discussed in the performance chapter of this report, firmly targeting all aspects of prevention and treatment of malaria would actually relieve the poor from their main illness burden. The national policy on ITNs does explicitly target women and children; and bednets are now tax-exempt as a strategy to reduce their cost. But there is much more that could be done by massive social marketing of malaria preventive behaviours, for example, selling subsidised ITNs by women's groups (as in the ACSD programme in Northern region) and by community health volunteers (as is being done in Tanzania). Everywhere the review team went, the demand for nets far exceeded supply. As another example, tuberculosis is one of the diseases that tend to affect the poor in greater proportion than the rich. The DOTS approach, however, is not pro-poor in that it is facility-based leaving the poor to find their own way to cope with physical and transport barriers to access.

Another serious criticism is that the various health programme managers and the health information system do not yet have any system to identify disaggregated differences in

[37] Exemption Policy Review Team (2003) Review of the Exemptions Policy; MoH/GHS/THs/CHAG, November. Also: Addai, E. (2003) Review of Exemption Policy; MoH-Partners Summit; December.

uptake, utilisation, or delivery of these key activities and services relative to poor populations. This is an issue that should be explored and experimented with in the 20 sentinel districts of the GHS/MoH information system.

5.3.2 Health insurance

Policies and programmes - There is widespread concern about the introduction of the National Health Insurance Scheme in all parts of the sector, including some units of the MoH itself. The concerns may be categorised as: a) those around policy and whether the scheme will indeed benefit the poor and deliver other objectives; and b) implementation.

So far, the guidance issued by the MoH has left many questions unanswered (e.g., whether drugs reimbursement will be based solely on the cost of generic drugs and whether the drugs list to be covered by the NHI will allow proprietary drugs or other variations from the national essential drugs list; plus concerns about accreditation). In such circumstances, rumour and assumptions proliferate. This generates anxiety and uncertainty among stakeholders, which in turn can be very de-motivating and damaging to morale.

Regional Health Insurance Co-ordinators are in place but their knowledge of health insurance varies; because of inadequate central guidance they are unable to answer many of the concerns of both purchasers and providers on the ground. Few written guidelines have been issued through expected channels and the MoH appears to believe that a strategy of disseminating information through the media is adequate.

On the purchaser side there is concern about the impact of NHI on the existing health insurance schemes; NHI is seen as a threat by many of these schemes and their stakeholders. Some fear that increasing license fees and lack of support for development are top-down methods of destroying the bottom-upwards development that has provided locally creative solutions up to this point. There are worries about the scale of operation that lies ahead and the resources available to cope with it. In Tano district, for example, the current scheme pays about 400 bills for in-patient treatment in a year. Out-patient figures for the district are about 94,000 per year, so even a fraction of insurance claims for those would be overwhelming and unmanageable without more manpower and better business and information systems. The use of block contracts initially would be crucial. Although it is understood that some technical and financial support may be available, there is widespread ignorance of what it is or how to access it, or when.

On the provider side, it would appear that the MoH has assumed that the providers will deal with the implementation issues themselves; there has been no MoH initiative to identify and scope the resources needed to support an insurance billing system. The demands that will be made on providers are immense. They will need more staff; computerised systems to capture and link patient activity and billing data and training in how to use them. They will need hardware and good communication networks. In many cases they will need office space. There should be some form of diagnostic coding that appears to be lacking now. They will need rules on exemptions and procedures for managing them speedily and sympathetically. It is a complex and large-scale on-going function that needs to be managed efficiently if NHI is to work and not become discredited from the outset.

The GHS has recognised the difficulty of rolling out the NHIS and commendably has written its Response to the NHI Act in the form of a strategic framework for action. It has formed its own Task Team with sub-groups and is developing operational plans. It anticipates that block contracts based on average costs may be appropriate for 3-5 years for district services until computerised management systems are fully functioning. However, the GHS is only dealing with its own providers. It appears that the private providers and the teaching

hospitals have had no guidance or support from the MoH and are being left to look after themselves.

The National Health Insurance Council has been set up, replacing the former MoH NHI Task Team, and the new members have been identified; of these, there is no member selected as a pro-poor representative. The current head of the MoH Task Team will be moving to become the acting Executive Director of the Council. The NHI Council becomes a new player in national health insurance and it would be wise to ensure that from the outset there is a shared understanding of role and responsibilities and each major player – thus reducing the potential for conflict and mismanagement. The MoH will continue to have responsibility for health insurance policy but it is not entirely clear how it intends to carry out that function, especially now that the 'Task Team' appears to have ended its tenure with the appointment of the NHIC.

Health insurance and access for the poor – The NHIS is aimed at replacing cash and carry payments and a portion of the present exemptions with a pre-payment system. It is not expected to cover the full cost of health services for the sector but aims to meet about 20% of the total. The NHIS plans to incorporate the exemptions categories, including paupers, as subsidised clients[38]. A preliminary experiment with this strategy has been underway in the Dangme West district, Greater Accra Region, with support from the ILO[39]. Although there is no formal report of the study as yet, this experiment has been testing various financial and social components and reveals some important lessons that have application to the national programme.

The Dangme West scheme has tested community recruitment of paupers into the programme, using a system of community-based identification of who is unable to pay. This strategy is similar to the one articulated in the NHIS framework, and is linked to a card system for scheme members. One important lesson is that the cards do NOT identify who is a pauper on the card, thereby avoiding the risk of discrimination. Information about pauper status is held only at the scheme headquarters and to outward appearances seen by the public or the care providers, all card-carrying members are equal.

The Dangme West test has been done in a deprived district, but this was only a first test. This scheme (including both self-pay and subsidised clients) covered only 8% of the population. It will be crucial to test the feasibility and sustainability of achieving fuller coverage before rolling out these preliminary experiences as national policies or guidelines. The 20 sentinel districts would provide a very good platform for the next level of testing since they already have skilled data managers in place, and 6 of the districts already have Mutual Health Organisations in operation.

Other elements that have been tested by the Dangme West scheme in order to make the system relevant for paupers are related to cost control. These include a ceiling on hospitalisation (currently ¢400,000) and a standard flat fee for all outpatient visits of ¢7,000 regardless of diagnosis or treatment. Both of these strategies address a critical potential problem in the national health insurance rollout of changes in provider behaviour that result in increased expenses. There is already evidence from Brong Ahafo where there are a number of insurance schemes that providers caring for insured patients are more likely to use proprietary drugs than generics, order more diagnostic tests, and allow longer hospital stays.

According to interviews and documents available to the review team, up to date, only the Dangme West health insurance scheme has implemented a pro-poor system for registering

[38] Policy Framework for the Establishment of Health Insurance in Ghana (October 2002), MoH
[39] Dangme West Health Insurance Scheme, Annual Report of the Second Insurance Year, 2001-2002

and subsidising paupers, though two other schemes are beginning the process of community identification of indigents and paupers with Danida support. All of the many other schemes around the country are based on ability to pay. There is already fear by stakeholders that the current exemption reimbursement situation will persist in the case of insurance subsidies, i.e., slow, late releases instead of early and regular releases. Although the Dangme West scheme has relied principally on earmarked donor funds for their subsidy money, they have also done some important experimenting with turning exemption funds into partial premium payments, e.g., for the aged and for children under 5. This approach allows the exemption money to be used up front rather than coming as a reimbursement, a feature that will be essential for the financial health of the schemes.[40]

For the national scheme, the definition of the poor who will have their premiums paid or heavily subsidised needs to be drawn broadly, and will probably need to cover upwards of 10% of the population. There is a particular risk that health insurance will otherwise further increase the existing inequality of access to services. Insurance will draw Government resources into meeting the increased demand of those who are covered by the scheme, who will increase their utilisation of health services. If the definition of the poor who qualify for subsidy is drawn too narrowly, the effect of the increase in demand from those who are willing and able to pay will be to squeeze out the poor. Those who are not covered because they are not eligible to have their premiums paid will find that the budgets available for the de facto free or deferred payment services to which they currently have some access will be further squeezed as providers give preference to meeting the demands of the insured patients.

Many Mutual Health Organisations or local Community Health Insurance initiatives are only covering inpatient care, in part because that is the bigger and more distressing financial risk burden for their clients so it gets prioritised during local development of the schemes. The Dangme West scheme, however, has been able to extend their support to outpatient visits and even community based care, e.g., from CHOs. A key factor in this capacity is reducing overhead costs by shifting from reimbursing fee for service claims to a system of paying only a flat fee per visit, based on fee rates prepared by a combination of cost analysis and consultation with providers.

Geographical access factors – The present insurance schemes are largely hospital facility oriented and tend to have a geographical distribution of clientele focused around the hospital (or urban areas where the hospital is located). There is insufficient discussion as yet about how the national insurance scheme can address geographical inequities, especially in the absence of any supplemental transport and communications systems for their members.

Empowerment issues – Health insurance schemes, and their boards/committees seem to be gaining strength as consumer advocates, developing a stronger sense of ownership and participation than health unit management committees or other top-down organised groups, possibly related to changing the nature of client-provider/patron relationships. They are able to be more assertive and challenging about quality of care and rights to care, also about managing costs of care.[41] Meantime, there is likely to be resistance to change by providers in response to consumer pressures, but the strength of this resistance does not seem to have been well-articulated or assessed in the insurance literature to date.

The current insurance schemes are targeting people with the ability to pay, most of whom are better educated and more likely to be empowered in voicing their opinions in their local scheme. It is unclear at this point whether the poor are going to be drawn into the national

[40] Irene Agyepong, RDHS GAR, former DDHS Dangme West. She will be sending us an electronic copy of a memo about how this procedure is done.
[41] BAR insurance technical group, Nkoranza health scheme

scheme at a time and in a way that empowers their voice for significant design decisions, e.g., the local package of services to be covered, or even in terms of a poverty oriented spokesperson on the Health Insurance Commission at national level.

National Health Insurance has become a political topic, which is a strong factor influencing the extremely rapid rollout process. On the one hand, this may be bringing the benefits of health insurance to much larger numbers of people more rapidly, but many technical persons in the health sector also see it as being too rapid for adequate testing and reflection. Promotional efforts addressing various aspects of national health insurance have already caused negative impacts on existing health insurance schemes, raising confusion and causing declines in enrolment. They are also creating communication gaps between the centralised top-down rollout process versus the bottom-up creativity of the existing schemes that have gradually come into existence over the past few years.[42]

Summary – There are very high risks for an excessively rapid top-down approach to implementing a brand new national health insurance programme. There has already been a high failure rate among local MHOs, and internationally there is a lack of successful examples for the approach being rolled out in Ghana. The MoH and the health sector in general therefore need to take every precaution to maximise the chances of successful outcome.

5.4 Recommendations

Mainstreaming and responsibilities for pro-poor agenda

- Highlight the full pro-poor agenda in the annual planning cycle, i.e., ensure that the MTEF process (or needs based budgeting) addresses identification and targeting of the poor, including both geographical, financial and condition specific (service/disease) related targeting. To the extent possible, this effort should include operational definition of some key terms (i.e., pauper, indigent, core poor) in ways that facilitate planning while still accommodating local variations. [Reinforces POW 2004 plans]

Monitoring and poverty related indicators

- Develop and test a limited set of additional indicators and analyses that will be more effective in capturing and portraying the achievements of the health sector toward the pro-poor agenda. The testing should be done in collaboration with the 20 sentinel districts, which include both deprived and endowed districts. For the medium term, focus on how the results of these analyses and indicators can be used to guide the annual plans of districts and regions for better pro-poor planning. In the long term, use the results of this testing process in contributing to the sector-wide indicators to be used in the next 5-year sector-wide programme. [Goes further than 2004 plans]

Targeting for geographical access and allocation of resources

- Pursue obtaining electronic and hard copies of intra-district poverty maps from the NDPC in time for the next annual planning cycle, and circulate them very widely in the districts, regions, and headquarters so that the planning for 2005 can become highly focussed on addressing intra-district pockets of poverty.
- The DHA should review the pro-poor aspects of the annual district health sector plan with the District Assembly and its planning department for relevance to their information and plans, including how to make best use of funds that are earmarked or available for health priorities. Document the results of this review, and include a

[42] There are now 120 schemes distributed among 108 districts.

summary of it in the annual performance report for the district. In support of this district level of targeted planning, it will be beneficial if the GHS headquarters reviews the pro-poor aspects of their annual plan with the NDPC/GPRP in order to ensure that co-ordinated messages about pro-poor health priorities are delivered through both the health and local government sectors.

- Carry out a situation analysis and scoping study of urban poverty and health, with the specific objective of gathering adequate information to develop a plan for rationalising urban health care delivery. [All go beyond POW 2004 plans]

Community-based Health Planning and Services initiative (CHPS)

- Urgently complete the consultative and review process to reach consensus on a standard definition for CHPS, standard components and criteria for assessment. Include prescriptions about standard activities to take place during the first year of operation, in particular, developing a household based card file for all families in the zone; preparing participatory maps for the location of all communities in the zone, and for all households in each community; and developing a functional referral and feedback system.
- Carry out a qualitative and quantitative cost-benefit study of the CHPS approach, including a careful comparison to other best practices around the country that are delivering services to deprived populations. [All of these go beyond POW 2004 plans]

Exemptions and targeting based on financial access

- Improve targeting of the poor – in the short term, DHAs and district assemblies to explore how to link the local application of pauper exempting to intra-district targeting of core poor locations (e.g., via the NDPC-GPRP mapping and CHPS zone planning) plus community level identification of paupers (e.g., as per the strategies in the Dangme West ILO-supported health insurance scheme or the experiments underway in Nkwanta and elsewhere with Danida support). In the medium and long term, as per the review of exemptions policy, conduct further costing analysis of exemptions; operational research on identifying the poor, both in rural and urban settings; exempt diseases of public health importance, and work toward recruiting and subsidising the poor within the national health insurance scheme. [Goes further than 2004 plans]

Health insurance

- Rollout - The introduction of NHI should be seen as a major project that cannot be handled part-time or as a sub-section within a directorate of the MoH. There should be a properly resourced limited-life Project with a Project Team that includes representatives of stakeholders from the MOH; the GHS; the Teaching Hospitals; CHAG; and other private providers; District Assemblies and mutual health organisations. The Project Team should be supported with technical assistance. A project plan should be produced with a critical path and milestones. There should be a high-level strategic project committee chaired by the MOH, which should include the NHIC, GHS, Teaching Hospitals, CHAG and other major stakeholders.
- Pro-poor – The National Health Insurance Council should further develop detailed plans for how to identify and incorporate the poor in the health insurance scheme, and pre-test these arrangements in at least two different district MHOs in at least two different regions, one of which should be one of the highly deprived regions/districts. The pretest should go beyond just identification to also include testing the financial subsidy vs exemption arrangements and tracking the effects of incorporating the poor for the various stakeholders – impoverished clients, paying clients/MHO members, health care providers, MHO administration, District Assembly and District Health Administration. Based on the pre-testing, the Council should produce clear strategies, guidelines and training materials to: a) support culturally sensitive

identification and recruitment of the poor, while maintaining flexibility for local definitions of extreme poverty, and b) clarify the system for subsidy payment for indigent clients/members, including timing, as well as sanctions and recourse for delayed releases/payments. At the highest level, there should be a poverty representative on the National Health Insurance Council, e.g., a member coming from the NDPC or a Civil Society Organisation that is a well-informed advocate for the poor. [All go beyond POW 2004 plans]

The recommendations from each chapter of the report are brought together in the following matrix table. For ease of tracking the subsequent implementation of those that are accepted, we have set them out using a matrix that can be adapted for tracking progress by adding columns similar to the ones in the policy matrix that was prepared for the June 2003 and December 2003 Aide Mémoires.

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
Chapter 1: Overview of the Report					
	Complex recommendations of a range of good reports require systematic follow-up	➢ Ensure follow up for the recommendations of this report that are accepted by assigning clear responsibility for them, and reporting back to partner group meetings using the policy matrix table developed in June 2003.	PPME MOH	X	XXX
Chapter 2: Sector performance 2003 PoW					
Overall Performance	There appears to be little technical and content related discussion and feed-back on the basis of reports submitted by districts and regions	➢ National & Regional managers should define more specifically the main priorities for each programme and provide regular, targeted supervision and feedback to regions and districts (also through feedback on reports that have been produced).	GHS/HQ and RHMT: All dept heads national and regional	X	XXX
Data management and IME	There are serious problems with health data capture, reliability and completeness at national level which can impact negatively on performance assessment and use for decision making.	➢ MOH set up a task team to facilitate setting up a Data Repository within MOH and Agency Information service Units as recommended in the IME report.	MOH-GHS/HQ	XXX	X
Target setting	Some targets may be unrealistic in the light of 2003 performance.	➢ Discuss targets and performances between the MOH and the agencies in order to arrive at a common understanding of what is feasible to achieve with the available resources.	MOH and GHS/HQ	X	XXX
Clinical Care & Hospital Services	A comprehensive study on the Clinical Care performance has revealed strengths and weaknesses that need to be studied and decided upon by senior management. OPD per capita figures remained stable over the last three years, while hospital admission rates increased.	➢ GHS/MOH is to constitute a task-team composed of managers from various institutions to study the recommendations from the Clinical Care study and report to GHS/MOH for gradual implementation. ➢ The following suggestions need special attention: All larger hospitals should start a Primary Facility close to their entrance and the expansion of the PPRHAA experiences.	MOH-GHS/HQ and Medical Superintendents of major hospitals	XXX	X
Public Health Programmes	Except ANC, the RCH output indicators from CHIM show some improvement over the past three years. However, indicators on measles, HIV/AIDS sero prevalence and Guinea Worm are stable or worsened. Malaria indicators show little improvement and ITN use is still very low across the country.	➢ More detailed priority setting and better targeted supervision and feedback – as has been stated already earlier – are the most important measures that GHS should take urgently. ➢ RBM should focus on massive distribution of low-cost ITNs in particular in deprived regions.	GHS/HQ Programme Managers and Regional BMC heads.	X	XXX

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
Regional Performances	Regional reports are bulky and do not address recommendations of the previous year.	➢ Regional Reports should become more focussed, shorter and aim at managing the region itself as well as informing headquarters on their achievements.	GHS/HQ and Regional Directors.	--	XXX
Previous Recommendations	Many of the recommendations made since POW 2001 have been addressed either explicitly or implicitly by MOH/GHS, especially as they relate to the sector wide indicators.	➢ Carry forward the outstanding but important recommendations that relate to inclusion of patient satisfaction surveys results in the SWAp indicators, Maternal Mortality study and a more prominent focus on TB control.	GHS/HQ and Director PH and Director Clinical Care	XXX	X
Chapter 3: Resource allocation and management					
Level of Expenditure on Health	GOG spends modestly on health by international standards. Insurance will provoke increased demand for Government spending in addition to insurance costs.	➢ The recommendation of the 2002 review to maintain pressure for increasing the health share of GOG funds to reach the Abuja declaration of 15% is endorsed. This can be done by submission of resource requirements for scaling up implementation of health service programmes to cabinet.	CD MOH/ Budget Director MFEP	X	XXX
Regional equity of budgets.	Per capita Government health expenditure (GOG plus Health Fund) is only marginally higher in the poorest regions ($4.98 per head compared to $4.94 in non-poor regions). The Northern region had the lowest per capita expenditure of any of the ten regions.	➢ Improve inter-regional equity by increasing the non-wage recurrent budget share of the four poorest regions, from about 26% in the 2004 budget towards the GPRS target of 39% . Particular attention needs to be given to increasing the budget of the Northern region.	PPME & MOF	X	XXX
	Decline of real non-recurrent spending, especially at district level.	➢ Increase the non-salary recurrent budget substantially in real terms in 2005, with the share of the districts increased to reach the 42% target share. This will require restraint in other areas of spending in order to limit the future share of resources taken by personal emoluments and investment	PPME, MOH	X	XXX
	To address the delays in release of funds to the Ministry of Health	➢ It is recommended that MoH should negotiate and agree with its partners, including GoG, specific budget release dates that must be met unless a written explanation is provided as to why a scheduled release can not be made. This will ensure that funds are received in time for disbursement to BMCs.	FC, MOH; Bank of Ghana.	X	XXX
	Delayed adjustments to BMC budgets to reflect new budget ceilings cause delays and underspending, especially for districts.	➢ MOH and its agencies should decide on priority service delivery levels and programmes that must be shielded in the event of marginal cuts in budget releases. This will reduce the delay in re-prioritising disbursements when budgetary releases are less than programmed.	PPME MOH, PPME GHS		
	GOG administration budget uses Treasury system and is frequently delayed and therefore underspent.	➢ MOH should seriously negotiate with MOFEP to have its GOG Administration budget released in the way the Service budget is released.	FC, MOH with MOFEP		

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
	Lack of budget predictability contributes to poor spending decisions.	➢ A disbursement plan for disbursement to BMCs should be agreed and communicated to all agencies of the ministry and its partners during the first quarter of each year. Any expected changes to this plan during the year should also be communicated.	FC, MOH		
	High transaction costs in terms of man-hours spent issuing cheques and traveling cost between BMCs, regions and HQ.	➢ MOH should consider transferring disbursements to BMC bank accounts to reduce the lead time between issue of cheques at HQ and clearing of cheques at BMCs.	FC, MOH		
	Expenditure by CMS cannot be allocated to the appropriate level benefiting from the expenditure.	➢ The accounting system at the CMS should also be improved to provide information on transactions with BMCs. This will facilitate accounting for centrally procured items distributed through the CMS system.	FC MOH with CMS		
	Limited internal audit capacity to address problems in financial management.	➢ MOH and Donors should consider providing earmarked funds to support development of the technical capacity of the internal audit units of the ministry headquarters and its agencies. This support should include training and skills development, joint audits and logistics.	FC, MOH and donor partners		
	There are huge differences in cost-effectiveness and staff productivity between regions. Better indicators of relative cost-effectiveness are needed to understand the differences and inform management action to secure improved performance.	➢ MOH and donor partners should develop and use indicators of cost-effectiveness and staff productivity to reveal differences in cost-effectiveness and staff productivity between regions and districts, and to inform performance assessments and progress reviews.	PPME MOH & PPME GHS		
Resource Allocation and management	Inability to routinely report on sub-district level expenditure	➢ Explore how expenditure by the sub-district can be tracked at present and the scope for doing so in future using the BPEMS coding.	FC MOH	X	
General Budget Support (GBS)	Conditions needed to ensure that the move to GBS does not worsen the financial position of the health sector.	➢ MFEP agreement to the key changes in budget process required to avoid future delays, particularly payment of item 2 in the same way as the service budget is currently paid; ➢ Ensure MOFEP & MOH designate key MOH programmes as priorities that will be given early releases and protected from in-year budget cuts. ➢ MOFEP agreement to a timeframe for achieving the Abuja objective of a 15% share for the health sector, with immediate agreement to ensure that the HF funds shifted to budget support are reflected in a revised GOG resource envelope;	Health Fund partners with MFEP and MOH.		X
Chapter 4: Health sector institutions					

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
		➢ The in-service staff training budgets currently with the GHS should remain there.	MOH/GHS		
		➢ The Working Group looking into pay and conditions for health workers should continue to be supported.	MOH/GHS		
	Long delays in trainee payments.	➢ The payment of trainee allowances should be delegated to the MOH and the target for payment reduced to 4 weeks.	MFEP/MOH		
		➢ There should be close collaboration of the 2004 survey on worker incentives between the MOH and the GHS.	MOH/GHS		
	Poor co-ordination on staffing norms.	➢ The development of staffing norms in healthcare cannot be done with any credibility without input from those actually delivering care to patients/clients. Staffing norms should be seen as a guide only and are for local interpretation taking local factors, (e.g., layout) into account.	MOH/GHS		
	Continuing uncertainty over responsibilities of MOH and health sector agencies leading to poor working relationships and low achievement.	➢ The MOH should ensure that the outputs from the functional review are confirmed and agreed upon by each agency. Having agreed on the mandate this should be incorporated in the next performance agreements – together with the actions required to ensure that the agency is progressively improving its ability to deliver the mandate.	MOH		
	Major problems of poor communication.	➢ Lateral communication between the MOH and the GHS should be encouraged.	MOH/GHS		
		➢ There should be a joint programme of change management for senior management of the MOH and the GHS working together with an independent trainer/facilitator. Donors should be approached to fund initial facilitated workshop.	MOH & Agencies, including GHS, NHIC, Partners		
		➢ At every level, identifying who is accountable for performance, ensuring constructive review and feedback should strengthen systems of performance review.	MOH/Agencies		
Chapter 5: Poverty and the pro-poor agenda in the health sector					
Mainstreaming and responsibilities for pro-poor agenda	Lack of clear identification and targeting of the poor.	➢ Highlight the full pro-poor agenda in annual planning cycle, i.e., ensure that the MTEF process (or needs based budgeting) addresses identification and targeting of the poor, including both geographical, financial and condition specific service /disease related targeting. [Reinforces POW 2004 plans]	MOH & Agencies		
Monitoring and poverty related	Present sector wide indicators do not capture plans or achievements in tackling poverty and inequality.	➢ Develop and test a limited set of additional indicators and analyses that will be more effective in capturing and portraying	MOH & Agencies		

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
indicators		the achievements of the health sector toward the pro-poor agenda. The testing should be done in collaboration with the 20 sentinel districts, which include both deprived and endowed districts. For the medium term, focus on how the results of these analyses and indicators can be used to guide the annual plans of districts and regions for better pro-poor planning. In the long term, use the results of this testing process in contributing to the sector-wide indicators to be used in the next 5 year sector-wide programme. [Goes further than 2004 plans]			
Targeting for geographical access and allocation of resources	Availability of useful poverty maps not yet widely known to the health sector.	➢ Pursue obtaining electronic and hard copies of intra-district poverty maps from the NDPC in time for the next annual planning cycle, and circulate them very widely in the districts, regions, and headquarters so that the planning for 2005 can become highly focused on addressing intra-district pockets of poverty.	PPME MOH		
	Potential to improve poverty reduction effectiveness and availability of additional funding would benefit from closer coordination with DAs.	➢ The DHA should review the pro-poor aspects of the annual district health sector plan with the District Assembly and its planning department for relevance to their information and plans, including how to make best use of funds that are earmarked or available for health priorities. Document the results of this review, and include a summary of it in the annual performance report for the district.	GHS		
	POW concern with urban poverty not reflected in practical measures.	➢ Carry out a situation analysis and scoping study of urban poverty and health, with the specific objective of gathering adequate information to develop a plan for rationalising urban health care delivery. [All go beyond POW 2004 plans]	MOH & GHS		
Community-based Health Planning and Services initiative (CHPS)	Competing visions of the objectives and scope of CHPS.	➢ Urgently complete the consultative and review process to reach consensus on a standard definition for CHPS, standard components and criteria for assessment. Include prescriptions about standard activities to take place during the first year of operation, in particular, developing a household based card file for all families in the zone; preparing participatory maps for the location of all communities in the zone, and for all households in each community; and developing a functional referral and feedback system.	GHS		
	Risks that CHPS may result in a further expensive service	➢ Carry out a qualitative and quantitative cost-benefit study of	Joint MOH/GHS		

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
	delivery level, may not be equally applicable in all areas.	the CHPS approach, including a careful comparison to other best practices around the country that are delivering services to deprived populations. [All of these go beyond POW 2004 plans]			
Exemptions and targeting based on financial access	Low access by the poor, including exemptions.	➢ Improve targeting of the poor – in the short term, DHAs and district assemblies to explore how to link the local application of pauper exempting to intra-district targeting of core poor locations (e.g., via the NDPC-GPRP mapping and CHPS zone planning) plus community level identification of paupers (e.g., as per the strategies in the Dangme West ILO-supported health insurance scheme or the experiments underway in Nkwanta and elsewhere with Danida support). In the medium and long term, as per the review of exemptions policy, conduct further costing analysis of exemptions; operational research on identifying the poor, both in rural and urban settings; exempt diseases of public health importance, and work toward recruiting and subsidising the poor within the national health insurance scheme. [Goes further than 2004 plans]	Joint MOH & GHS		
Health insurance	Health insurance is a major management challenge.	➢ Rollout - The introduction of NHI should be seen as a major project that cannot be handled part-time or as a sub-section within a directorate of the MoH. There should be a properly resourced limited-life Project with a Project Team that includes representatives of stakeholders from the MOH; the GHS; teaching hospitals;CHAG and other private providers; District Assemblies and mutual health organisations. The Project Team should be supported with technical assistance. A project plan should be produced with a critical path and milestones. There should be a high level strategic project committee chaired by the MOH, which should include all significant stakeholders.	MOH lead, Partners help finance		
	Need to develop effective mechanisms for providing access to the poor.	➢ Pro-poor – The National Health Insurance Council should further develop detailed plans for how to identify and incorporate the poor in the health insurance scheme, and pre-test these arrangements in at least two different district MHOs in at least two different regions, one of which should be one of the highly deprived regions/districts. The pretest should go beyond just identification to also include testing the financial	NHIC		

Subject/Area	Conclusions	Recommendations	Ownership	POW 2004	POW 2005
		subsidy vs exemption arrangements and tracking the effects of incorporating the poor for the various stakeholders – impoverished clients, paying clients/MHO members, health care providers, MHO administration, District Assembly and District Health Administration. Based on the pre-testing, the Council should produce clear strategies, guidelines and training materials to: a) support culturally sensitive identification and recruitment of the poor, and b) clarify the system for subsidy payment for indigent clients/members, including timing, as well as sanctions and recourse for delayed releases/payments. At the highest level, there should be a poverty representative on the National Health Insurance Council, e.g., a member coming from the NDPC or a Civil Society Organisation that is a well-informed advocate for the poor. [All go beyond POW 2004 plans]			
	Insurance will draw Government resources into meeting the increased demand of those who are covered by the scheme, who will increase their utilisation of health services. If the definition of the poor who qualify for subsidy is drawn too narrowly, the effect of the increase in demand from those who are willing and able to pay will be to squeeze out the poor. Those who are not covered because they are not eligible to have their premiums paid will find that the budgets available for the de facto free or deferred payment services to which they currently have some access will be further squeezed as providers give preference to meeting the demands of the insured patients.	➢ The definition of the poor who will have their premiums paid or heavily subsidised needs to be drawn broadly, and will probably need to cover upwards of 10% of the population.	MOH with MFEP		

Annex 1: People met during the review

MoH, HQ

Addai, Eddie..... Head, Monitoring and Evaluation Unit, PPME
Afriyie, Hon Kweku..... Minister of Health
Ahmed, Kofi ..... Chief Medical Officer
Akor, Sam ..... Director, Programme Planning, Monitoring and Evaluation
Alissah, Odile..... Assistant Planning Officer
Antwi-Boasiako, Y. ..... Director, Human Resources for Health Development
Dakpallah, George ..... Head, Policy Planning and Budgeting Unit, PPME
Owusu-Agyei, S. ..... Chief Director
Owusu-Ansah, E. ..... Head, Capital Planning Unit

Ghana Health Service, HQ

Adams, Isaac ..... Head, Information, Monitoring and Evaluation Unit
Addo, Adokwei..... National AIDS Control Programme Manager
Adjei, Sam..... Deputy Director General
Akosa, B. ..... Director General, GHS
Amofah, George ..... Director, Public Health, GHS
Antwi Agyei, Nana K.O. ..... National EPI Programme Manager
Bannerman, Cynthia ..... Quality Assurance Coordinator, Clinical Care
Bart-Plange, Constance..... National Malaria Control Programme manager
Bonsu, Frank..... National TB Programme Manger
Nyonator, Frank ..... Director, Programme Planning, Monitoring and Evaluation
Osei, Dan..... Head, Budget Unit
Sagoe, Ken ..... Director Human Resources Division
Seddoh, A.T. ..... Head, Policy and Health Strategy Development

CHAG

Adjei, Elizabeth ..... Personal Asst
Boateng, Bismark Ohusu..... JCT Officer
Kankye, Philip ..... Executive Secretary
Surnye, Henry..... Programmes Coordinator

School of Public Health, University of Ghana, Legon

Ahmad, Omar..... Head, Dept. of Epidemiology and Biostatistics

Korle Bu Teaching Hospital

Chris. N. Narty ..... Director of Administration, Korle-Bu Teaching Hospital

Ministry of Finance and Economic Planning

S.B Nyantekye ..... Director of Budget

National Development Planning Commission

Farhat, Angela Brown ..... Programme Co-ordinator, National Development Planning Commission
Mensah-Abrampa, Kodjo ..... Monitoring and Evaluation Specialist, GPRP/SIF

Ghana AIDS Commission

Ani, Sylvia. ..... Ghana AIDS Commission

Others in Accra

Aning, Sam ..... Policy Analyst, Office of the President
Annang, David Quaye..... Policy Analyst, Office of the President
Kwarko, K.A., Jnr. ..... Secretary, Society for Private Medical and Dental Practitioners

Greater Accra Regional Health Directorate

Agyepong, Irene Akua ..... Regional Director of Health Services

Brong Ahafo Regional Health Directorate

Akanzinge, Philip ..... Regional Health Insurance Co-ordinator
Anwah, Richard Yaw..... Regional Surveillance Officer
Bonsu, George ..... Senior Medical Officer, Public Health (SMOPH)
Braimah, Madam Alice..... DDNS
Dadzie, Mustapha..... Regional Pharmacist
Grueb, Andreas ..... GTZ Advisor
Ibrahim bin Mohammed Regional Director, BA Region
Issa, Ibrahim ..... Dep. Chief Health Service Admin
Oduno, C.Y. ..... Regional Accountant
Sifah, Tweneboah Kofi..... Regional Health Information Officer
Sopiimeh, William ..... Regional Health Educator

Tano District

Ashante, Nana ..... Insurance Scheme Manager, Tano District
Boampong, Joseph..... Revenue Collector, Bechem Govt. District Hospital
Boateng, Daniel ..... National Service attachment, Tana Insurance Scheme
Narty, Divine ..... Hospital Administrator, Bechem Govt. Hospital
Offei, Mr. ..... District Director, Tano Health District
Ziblim, Issahalku ..... Accountant, Becham Govt. District Hospital

Sunyani District

Opare, David A. ..... District Director of Health Services
Opoku, Dora..... Medical Assistant I/C, Chiraa Health Centre

Nkoranza District

Amobea, Agnes ..... Accountant, Nkoranza Health Scheme
Basoah, Joseph Ababio..... District Finance Officer, Nkoranza DA
Boateng, U. Amafi..... DHMT member
Brobbey, Opoku ..... Scheme Manager, Nkoranza Health Scheme
Dozie, A.T. ..... District Co-ordinating Director, Nkoranza DA
Henneh, Richard Kwasi ..... District Director of Health Services
Madana, Sampson ..... District Planning Officer, Nkoranza DA
Mensah, James Opoku ..... District Engineer, Nkoranza DA
Sarpong, G. M..... Board Chairman, Nkoranza Health Scheme
Twumasi, Kwame Ampofo .... District Chief Executive, Nkoranza DA

Upper West Regional Health Administration

Abdulai, Ibrahim..... HRM, RHD
Alhassan, Rebecca..... Assistant Training Coordinator
Asamoah-Bediako, K. ..... PHSA, Regional Hospital

Bayaa, Smith..... RMLT
Bezagrebere, Lawrence J..... Regional Accountant
Boye, Kwame..... RSO
Duorinuu, Jacob P ..... DDPS (Retired)
Firina, Jonas ..... Procurement Officer
Gyader, E.N. ..... Medical Director, Regional Hospital
Gyimah, Peter Ekow ..... Senior Pharmacist
Karim, Williams ..... Principal Accountant
Kunko, Charles ..... Special Assistant RECU/RTU
Lartey, S. Amakye..... RHSA, RHA
Loggah, Faith S..... DDNS, Regional Hospital
Mornah, Dominic..... Chief Records Supervisor
Mumuni, Jacob..... Transport Officer
Ola, Amao M. ..... Regional Internal Auditor
Owusu-Ansah, Yaw ..... Regional Information/Statistician
Saan, Mary..... Senior Pharmacist, Regional Hospital
Yayemain, Daniel..... Senior Medical Officer (PH)
Yerj, Esther ..... Secretary, Regional Director

Nadowli Health Administration

Angsomwine, Florence ..... PHN
Anyaakuu, Bernadette ..... PNO
Bokuma, Melany ..... Ag. DDHS
Mornah, Perpetua D..... DDNS

Jirapa-Lambussie Health Administration

Ashima, Alphonse..... Senior Executive Officer
Bening, Sulemana B.B. ..... Accountant
Beworenwin, Gaspard..... Storekeeper
Danlara, Grace..... Nutrition Officer
Kuuzagr, Roland ..... DCO
Mahamood, Fakeih ..... SAO
Mwaamaal, Theodorah ..... DPN
Samani, Clement ..... DCO
Tente, Henry ..... DDCO

Health partners

Ankrah, Victor ..... Programme Officer, UNICEF
Awittor, Evelyn ..... World Bank
Baldwin, Sandy ..... Health Advisor, DfID
Dzikunu, Helen ..... Programme officer, Danida, HSSO
George, Melville..... World Health Organisation
Laryea-Adjei, George..... Programme Officer, UNICEF
Thorup, Hanne..... Chief Technical Advisor, Danida, HSSO
Van der Horst, Jan ..... Royal Netherlands Embassy
Walters, Paul..... Economic Adviser, DFID

Annex 1.1 Review of previous recommendations

Annex Table 1.01: Status of previous recommendations

Recommendation/requirement/objective formulated by MoH	Source of information	Status/comments
Recommendations: Strategy and review		
Revise the Medium Term Health Strategy:	• AM, July 2002, AM Dec 02	Not pursued.
Summit: • MoH and partners identified areas of improvement in the format and timing of annual POW, submission of background information • The chief director should assign responsibilities for carrying forward the different action points	• AM, Dec 02, p.1,2 • AM, June 03, p.10	Dec 03 AM: Draft POW 2004 criticised for poor consultation, lack of costing, weak reflection of priorities in budget allocations. Policy matrix used to follow up Aide Mémoire, PPME requesting status reports from Directors for reporting back.
CMA: • Review the CMA to formalise responsibilities for action and to take account of the new budget support trend and the attendant shift of control towards the MoF	• Review'02,	Yet to be followed up.
Business meetings: • MoH should ensure that regular meetings are held with the health partners, with mutually agreed agendas and clear steps on carrying out agreements reached • The quarterly business meetings will be reorganised to, among other things, discuss implementation of the CMA and progress against the Aide Memoir	• Review '02, p.77 • AM, June 03, p.2	Business meeting held in September '03 discussed progress against Aide Mémoire. Policy Matrix for follow-up from July 2003.
MoH – partner relationship • Minister of health should identify key representatives be personally responsible for informal means of enhancing relationships between key stakeholders • Partners need to recognise the need for MoH to position itself	• Review '02, p.78 • Review '02, p.78	Problems of communication remain endemic in the system, despite some good examples of better practice that are dependent on individual initiative.
Review and review process • Review process should be started well in advance; attention given to content-matters, logistics and secretarial support • All important documents and data should be made available to the review team • Important to ensure availability of key staff of MoH, GHS and THBs at the time of the review • The steering committee should ensure that the terms of reference are completed early to allow for the fielding of experts for the review • The MoH will coordinate all sectoral review exercises (p.19) • The MoH will be responsible for ensuring relevant sector-wide information on the performance of the health sector is available (p.19) • Reports of future reviews should be made available on time	• Review '01, p.84 • Review '01, p.84,87 • Review '01, p.84 • AM, Dec 02, p.10 • POW 2003, p.19 • POW 2003, p.19 • AM, June '03, p.10	• The committee was established in March '03. TORs and list of possible consultants was prepared by a small voluntary group- very late for getting consultants for April/May. • 2004 review benefited from extensive internal review process, but data on sector-wide performance had to be compiled by the consultants themselves, regional review reports available late.
Review of recommendations on performance 2001-2003		
Sector-wide indicators: From input towards output/outcome and decisions • Focus of the sector assessment should shift from inputs and process towards measuring outputs and outcomes. The sector wide indicators should reflect this. • Regular surveys should be used to measure outcome indicators • Funding should be sought to conduct an Immunisation coverage survey as soon as possible. • GHS will establish a framework by which BMC will collect and analyze information for decision making	• Review '01, p. 6 • Review 01, p.6,10,85 • AM, June '03 • POW 03, p.21, p.5	*Current SWAp indicators reflect both process and output. They also take GPRS and MDG into account *This is in place through Ghana DHS. Findings have been reported. (- MMR) *Survey proposal developed and implemented. Framework of SWAp Indicators is available in all BMC. However, few comments and decisions are made on the basis of that

		information (IME report).
Sector-wide indicators – getting valid and reliable information: • Means of interpretation of the Sector-wide indicators should be clearly defined • All districts should be able to measure most of the indicators by using the routine health information systems • Before publishing 'final' data, MOH should ensure regions' and programme managers' agreement with data • Efforts to establish the baseline should start immediately and be completed by the next summit. • National targets for sector-wide indicators should be established by the next summit. Steps should be taken to establish consistency between POW and GPRS targets. • Guidelines for reporting on the sector-wide indicators should be completed and circulated for use in the 2002 Review • MoH will be responsible for defining and establishing a framework by which all executing agencies and partners will collect, analyze and report information • A data adjustment meeting should be held by the end of August to provide reference for the reported performance levels	• Review '01, p. 6 • Review '01, p. 6 • Review '01, p.10,84 • AM, July 02, p.9 • AM, July 02, p.9 • AM, Dec. 02, p.10 • POW 03, p.19 • AM, June 03, p.5	No follow-up so far This is now in place in all the districts Generally not in place. This complicates the process interpretation of the data Baseline has been developed and is available (2001) Targets have been established by MOH and GHS but they are generally not in agreement (IME Annex 4) June '03: Guidelines for reporting completed and circulated for use in 2002 Review, but unclear. November '03: Guidelines have been developed even though not circulated to partners. November '03: Preliminary report on data adjustment is available.
Sector-wide indicators: Specific indicators and analysis • OPD-visits are important to include from the for-profit private sector • Analysis of sector-performance should be presented as much as possible by gender desegregation • Use total recurrent expenditure per capita by region/district to measure geographical service concentration. MICK	• Review '01, p.10,85 • AM, July 02, p.9 • Review 02, p.5	The reports do not show a clear desegregation of data between the various agencies and Private Sector. Private sector data are often absent. Not visible in the aggregated data sheet, but possible to obtain for some of the indicators in the original reports This is currently reported by districts or regions
Sector-wide indicators and efficiency: • The composition of the Sector-wide indicators should allow for an analysis of the relation between inputs, outputs and outcomes. • Each hospital should measure efficiency (output) indicators and these should be included in the list of sector-wide indicators • Indicators on workload may be defined and added to the list • Re-introduce the average cost per patient-day in the set of sector-wide indicators • Work on developing BMC specific indicators and accompanying guidelines should be completed by the next summit.	• Review '01, p.6 • Review '01, p.11,85 • Review '01, p.11,85 • Review '01, p.11,85	*The current format of the SWAp indicators in principle allow for such an analysis, if the data re reliable and complete. In few reports the reflection was made. Most hospitals do provide efficiency indicators, and these are used in the SWAp tables. Not yet included, but valuable suggestion Not yet included, but valuable suggestion Nov.'02: A task team is working on BMC-specific indicators. POW II indicators have been reviewed in relation to GPRS (IME annex 4).
Sector-wide indicators and resource shifts (MICK) • An indicator should be defined to better reflect shift of resources to PHC services at sub-district and grassroots level • % Recurrent and capital expenditure by level, region and by source should be included as an indicator. • The relative distribution of expenditure between line items must be closely monitored to ensure that non-salary expenditure is not squeezed out.	• Review '01, p.11,85 • POW 03, p.36 • Review 02, p.34	Such an indicator has not yet been developed. Such an indicator has not yet been developed Such an indicator has not yet been developed
Quality assurance and improvement: • Patient satisfaction surveys should be standardised implemented • Hospitals should increase proportion of maternal deaths reviewed. • Observation and documentation of HIV/AIDS care should be encouraged to improve quality	• Review 01, p.87 • Review 01, p.87 • Review 01, p.87 • POW 03, p.12	*These surveys are done in most regions but are not reflected in the SWAp format. *Reported proportions are high, but decisions and outcomes of the audits are not reported.

• Wide dissemination of the Patient Charter of ethics • A system of grading and accreditation of hospitals developed and implemented • Information on service and drug charges should be made available to consumers	• POW 03, p.12 • AM, June 03, p.8	Not clear to what extent this has been followed up (vague recommendation) The Charter is widely available *Currently being undertaken by GHS *Process started, tool being pretested,system not yet established *Not yet in place
HIV/AIDS and STIs • M&E of HIV/AIDS policies must be built in to undertake corrective actions as well as for the next cycle of planning • The protocol on ART should be widely circulated • Need for stricter control of the use of ARV-drugs and the proposal of stricter control of sale of such drugs should be discussed, agreed on and enforced • Cost of ART to be included in resource envelope and agreed proportions of expenditures on different levels and between regions to be maintained • Strategy to intensify STI treatment for high risk groups should be put in place • MoH will inform partners as to policy for ART distribution and access by next summit. MoH should ensure they provide the required TA on access to ART. • MOH will finalize the regulation of ART through Food & Drugs Board and present a proposal at the next summit • MoH will inform partners as to the concrete arrangements for local production of ART • Strategy of reducing mother to child transmission (PMTCT) will be initiated with the introduction of ART for HIV positive pregnant women	• Review 01, p.88 • AM, July 02, p.3 • AM, July 02, p.3 AM, July 02, p. 3 • AM, July 02, p.3 • AM, Dec 02, p.4 • AM, Dec 02, p.4 • AM, Dec 02, p.4 • POW 03, p.6	No follow-up (unclear recommendation?) Nov. '02: The protocol has been finalized, but not yet widely circulated . Nov. '02: Cost of ARV has been included in resource envelope Nov '02: Programmes are in place and will be scaled up. The follow-up on this is unclear to us June '03: Progress on Food & Drug Board's proposal not known June '03: Negotiation for local production is ongoing ART and PMTCT have started in some locations.
Tuberculoses: • Need for high prominence and focus on TB control activities, implementation and monitoring at all levels. • Planning and budgeting guidelines should ensure effective implementation of TB control activities. Lower levels should be sufficiently supported in monitoring and supervision. • A review of the TB programme will be undertaken to ensure improvement in management at district level and more involvement of the private sector. The TB drug treatment regime will also be reviewed. • TB diagnostic centres set up in every district and control activities visibly reflected in budgets at district level • Scale up the DOTS strategy by promoting role of CHOs in case identification and case holding. • Organise the private sector in TB control	• AM, July 02, p.3 • AM, Dec 02, p.5 • POW 03, p.7, 8 • POW 03, p.7, 8 • Review 02, p.14	Nov. '02: Periodic shortage of TB drugs. TB still not given the required attention. June '03: "GHS Policies and priorities '03-'05" give high priority to TB including supervision of patient management, education, counselling, defaulter tracing. Parts of the TB programme have been reviewed (Drug Mgmt, Global Fund) and a new Manual is being prepared. No new TB Diagnostic Centres have been set up and activities are not reflected in regional/district budgets No clear information on this is available from CHPS Under Global Fund, initiatives for collaboration with private sector has started
Malaria: • Need to promote use of ITMs in public health institutions to protect patients and promote use to general public • Promotion of use of pre-packed anti-malaria drugs should be encouraged • Efforts should be made to complete the review of the anti-malaria drug policy • Malaria: Improve IEC activities to promote proper home based care • Malaria: Need to pay more attention to vector control. • Capacity at regional level to advocate and monitor district activities on malaria must be strengthened.	• AM, July 02, p.4 • AM, July 02, p.4 • AM, Dec 02, p.6 • POW 03, p. 7 • Review 02, p. 12 • Review 02, p. 12	*Nov. '03: ITNs are commercially available in all regions. MoH distributes donated 85.000 ITNs to <5 and pregnant women at subsidized prices. *Pre-packed malaria drug available in drug stores but not in CMS *June '03: The anti-malaria drug policy has not been completed, but the technical team for malaria treatment in Ghana has proposed combinations of Artesunate + Amodiaquine and Co-artemesine. *Radio programmes, manuals all started. Not information available in annual report; still to be addressed

Mental health • The meeting requested that indicators for monitoring the programme activities should be identified • A framework for integrating mental health should be developed and discussed at the next summit • A revised programme road map of activities for 2003 is to be completed by Feb.	• AM, Dec. 02, p.5 • AM, Dec. 02, p.5 • AM, Dec. 02, p.5	No indicators have been developed June '03: Framework for mental health at primary level has been developed. The document is silent on secondary and tertiary care. No roadmap of activities has been completed
Guinea Worm: • Specially designed programmes targeting the 3 most heavily affected regions should be mounted • Effort should be made country wide to discover infection niches and morbidity maps must be drawn to guide surveillance • Initiate plans to provide 25% of endemic communities with portable water	• Review 01, p.88 • Review 01, p.88 • POW 03, p. 7	Special programme in place, but in need of more support from local DA See Presentation Technical Review. Current status unclear Coordination with Water authorities and DA planned
Reproductive and Child health (RCH): • IMCI will be scaled up, access to essential obstetric care in every district will be improved, and all district hospitals will provide adolescent friendly services	• POW 03, p. 8	IMCI programme is expanded to all regions, EOC seems not systematically addressed and adolescent friendly services have just started. Regional reports do not show meaningful progress.
EPI: • Various activities will be undertaken to strengthen efficiency in vaccine use and planning	• POW 03, p. 9	Recommendation is very vague.
Emergency services: • 24 hour emergency care in metropolitan areas will be expanded • Emergency service delivery in hospitals will be strengthened by equipping accidents and emergency/casualty units • Ambulance services will be piloted in two regions	• POW 03, p. 9 • POW 03, p. 9 • POW 03, p. 9	This is theoretically available in all hospitals. Regional reports do not reflect implementation of this recommendation Ambulance Services have been piloted in Central and Ashanti Regions. Outcome unknown to RT.
Traditional medicine: • It is planned that Alternative Medicine law and policies would be completed and a training programme initiated.	• POW 03, p. 10	A Traditional medicine policy has been drafted but no training has taken place so far.
Malaria: • Need to promote use of ITMs in public health institution to protect patients and promote use to general public • Promotion of use of pre-packed anti-malaria drugs should be encouraged • Efforts should be made to complete the review of the anti-malaria drug policy • Malaria control activities will focus on the promotion of use of ITMs. • Improve institutional management of malaria by promoting pre-packed anti-malaria drugs • Malaria: Improve IEC activities to promote proper home based care • Review anti-malaria drug policy • Need for higher profile of the Roll Back Malaria Programme (RBM). • Malaria: Need to pay more attention to vector control. • Capacity at regional level to advocate and monitor district activities on malaria must be strengthened.	• AM, July 02, p.4 • AM, July 02, p.4 • AM, Dec 02, p.6 • POW 03, p. 7 • POW 03, p. 7 • POW 03, p. 7 • POW 03, p. 7 • Review 02, p. 12 • Review 02, p. 12 • Review 02, p. 12	• Nov. '03: ITNs are commercially available in all regions. MoH distributes donated ITNs to <5 and pregnant women. Pre-packed malaria drug available in drug stores but not in MoH medical stores • June '03: The anti-malaria drug policy has not been completed, but the technical team for malaria treatment in Ghana has proposed to combinations of anti-malaria drugs (Artesunate + Amodiaquine and Co-artem)
Mental health • The meeting requested that indicators for monitoring the programme activities should be identified • A framework for integrating mental health should be developed and discussed at the next summit • A revised programme road map of activities for 2003 is to be completed by Feb. 2003.	• AM, Dec. 02, p.5 • AM, Dec. 02, p.5 • AM, Dec. 02, p.5	• No indicator has been developed • June '03: framework for mental health at primary level in place. The document is silent on secondary and tertiary care. • No roadmap of activities has been completed

Recommendations: Resource allocation and management		
GOG allocation to health: • Donor partner pressure for meeting agreed budget targets.		See Chapter 3.
Resource allocation: • Allocation within MoH needs to be reviewed to incorporate more relevant factors based on districts rather than regions • MoH needs to ensure that GPRS target of increasing the proportion of funding going to the four deprived regions is reflected in the allocation of resources • MOH/GHS should explore possibility of engaging TA to address resource allocation process to reflect deprivation and performance • Planning and budgeting systems for decentralised resource utilisation will be strengthened • Interagency resource allocation criteria will be developed • To ensure that targets of increased spending on the district and below level are achieved, steps must be taken to ensure that these levels receive priority in early fund disbursement • It should be investigated why regional level and above are able to access funds earlier and to a greater extend than the district and lower levels. • There must be a clear policy of prioritising districts and sub-districts Providing district BMC with better information on disbursements, revised budgets and cash flows is a priority • Steps should be taken to improve financing and cash flow at the service delivery points	• Various reviews and AMs.	• Good paper on resource allocation for 2004, but serious inequity in 2003, districts lost out to regions. • FC made available as part of 2003 Review, and pursued recommendations for improvements to financial management (Chapter 3).
Resource envelope • Budget should be based on a complete and comprehensive resource envelope reflecting GoG, donor, earmarked and HIPC funds (requirement for timely partner funding to health account)	• AM, Dec. 02, p. 11	• June '03: This has happened
Financial statements • Explore simplified financial reporting to avoid disbursement delays.	•	• Q3 2003 FR only one month late. Simplified format not pursued.
Audit and control systems • Internal audit must address both financial and operating aspects of the sector • Management must ensure that all audit recommendations are addressed and penalties imposed for failure to address lapses • Audit: Theft, embezzlement, depletion of drug funds and other financial irregularities must be detected on timely basis • Monitoring of internal control systems especially with IGF will be strengthened	• Review 01, p.85 • Review 01, p.85 • Review 01, p.86 • POW 03, p. 15	Followed up by FC in current review.
Strategic Initiative Fund: • The proposal on the Strategic Initiative Fund should be finalised and presented for discussion • It was agreed that this fund would provide a mechanism for funding innovations in public and private sectors. The Committee put in place to develop criteria for accessing resources needs to be revamped and reconstituted. The reconstituted committee should be put in place and re-examine the framework for managing the fund • Increased attention to operationalising the Strategic Initiative Fund to support innovations.	• AM, July 02, p. 5 • AM, Dec. 02, p. 7 • POW 03, p. 5	• Being pursued but not yet established.
Collaboration with Local Government/DAs/ local communities • Need for a manual for guiding collaboration with Local Government/DAs • MoH will advocate for an inter-ministerial committee to be formed to advise on issues related to the collaboration with Local Government/DAs	• AM, Dec 02, p.3 • AM, Dec 02, p.4	• June '03: A draft manual on collaboration with DAs has been developed. • June '03: Inter-ministerial Committee on macro-economics in

• Guidelines for working with DAs will be established • MoH should seek support for earmarking of some district level HIPC funds to meet health sector objectives • MoH will review the scope of application of the HIPC funds to cover other areas incl. exemptions and malnutrition and take these proposals to relevant authorities	• POW 03, p.16 • POW 03, p.16 • POW 03 • Review 02, p.32,73	health has been formed • Significant earmarking of HIPC for health in 2004
Recommendations: Health Sector Institutions		
Act 525 • A technical team should be put in place as soon as possible the manage implementation of Act 525. • Necessary for MoH to clarify roles in procurement. So far there have been conflicting opinions. Whatever is preferred care should be taken that GHS and other executing agencies have a clear say (in priority setting) • The meeting endorsed the recommendation of a roundtable conference of the MoH, GHS and THBs. • GoG will as a matter of priority clarify roles and responsibilities for capital planning and management • The need for a change management group was highlighted. • ACT 525 and other legislation need to be reviewed and revised to eliminate ambiguities over roles and functions	Various reviews and AMs	See Chapter 4.
Regulation • The regulatory environment must be revamped by strengthening regulatory bodies and establishing new ones where appropriate • Legal instruments of all regulatory bodies will be reviewed. 3 new regional offices for Food and Drugs Board will be established. A laboratory for Food and Drugs Board established • Each regulatory will develop a business plan • The sector's regulation is probably best contracted out to an independent agency with a mandate to protect consumers' interests.	• Review '01, p.84 • POW 03, p.13 • POW 03, p.21 • Review 02, p.70	Not researched by the team.
Collaboration with private sector including CHAG • Recommended that the MoU be reviewed, adapted and signed as soon as possible • The finalisation and signing of MoU between MoH and CHAG is expected soon • An assessment of output for the support provided to the CHAG institutions from GoG and other sources should be undertaken • Improve the capacity of the Private Sector Unit in relation to its mandate • Mainstream the collaboration with the private sector at all levels • Strategic Fund to be use as entry point for the institutionalisation of the involvement of the private sector • Specific activities will include contracting relationships with all partners in health • Develop guidelines for contractual agreements with private sector providers • Seek necessary authorisation for ensuring access to government fund by private sector providers • GHS responsible for establishing modalities for engaging the private sector • Performance hearings should be re-formatted to involve the DA and the private sector as well as	• Review 01, p.84 • AM, July 02, p.6 • AM, July 02, p.6 • AM, July 02, p.6 • AM, July 02, p.6 • POW 03, p.5 • POW 03, p.16 • POW 03, p.16 • POW 03, p.19 • POW 03, p.21	• CHAG MOU signed Nov 2003. • Private Health Sector Policy has been completed. • Nov. '03: MoU with CHAG signed • Nov. '03: Private Sector Strategic Plan not completed

ensure the consumer perspective better • Develop strategic plan to operationalise the Private Health Sector Policy • MoH will define a contracting framework to enable contracts between agencies and private practitioners • MoH should create a forum to regularly engage the private sector at all levels	• AM, June 03, p.5 • AM, June 03, p.7 • AM, June 03, p.7 • AM, June 03, p.7 • AM, June 03, p.7	
Hospitals Strategy: • Review incentives of consumers as to inappropriate use of facilities • Proceed with studies mentioned in Hospital strategy • Hospitals: Set up an effective referral system • Conduct a development strategy for Accra • Adapt a clear hospital strategy, which involves maximum utilisation of existing infrastructure • Completion and dissemination of hospital strategy to be undertaken	• Review 02, p.21 • Review 02, p.21 • Review 02, p.21 • Review 02, p.21 • Review 02, p.21 • AM, June 03, p.7	• Nov. 03: Hospital strategy has been circulated to partners
Procurement • Analysis should be undertaken on the quality of procurement incl. priority setting • Strengthen institutional capacity for procurement implementation and monitoring. Implement a training plan in procurement consistent with POW • The procurement plan will be reviewed to include items by item and by level. Should be completed by end of January 2003 • A final Procurement Plan for 2003 is a requirement for timely disbursement of partner funding to the Health Account • The health sector procurement policy will be reviewed. • Framework for procurement planning will be developed for agencies. • Procurement training for procurement officers will be continued • Revise capacity development document to include all health staff with procurement responsibility. • Train the rest of BMCs on procurement and logistics. Include basic logistics practices in in-service training. • Disseminate 2nd ed. of Procurement Procedures Manual • Extend capacity building to cover health facility staff. • Examine and rationalise all units undertaking procurement in light of roles, responsibilities and interrelationship • Continue with recruitment of procurement agent • Procurement planning, management and finance should work closely together to produce a plan within national priorities, budget and within a realistic time span	• Review 01, p. 87 • AM, July 02, p. 8 • AM, Dec. 02, p. 8 • AM, Dec. 02, p. 11 • POW 03, p. 15 • POW 03, p. 15 • POW 03, p. 15 • Review 02, p. 44 • Review 02, p. 44 • Review 02, p. 44 • Review 02, p. 44 • Review 02, p. 44 • Review 02, p. 45 • Review 02, p. 46	• Nov.'02: A procurement audit report Oct. '02 identified weaknesses, some of which MoH has addressed • June '03: A procurement plan has been submitted which generally follows the requirements. However, the plan was well above the resource envelope. A revised version is awaited.
Central Medical Stores • The issue of deciding upon the future status of CMS should be included again on the agenda for Health Summit July '02. Key issue are clear and decision-making is urgently needed. • Appointment of management team to implement improving operations of CMS should be completed and reported at next summit • The meeting was informed that a paper recommending franchising arrangements on the CMS is currently being considered by the Cabinet. Progress will be reported at the next summit • Management of CMS will be reorganised	• Review 01, p. 87 • AM, July 02, p. 8 • AM, Dec. 02, p. 8 • POW 03, p. 15	• Nov. '03: A new Management Board for CMS established. Appointment of a new manager is underway. • June '03: Information on franchising is not yet available

• CMS price mark ups should be uniform across the country. • CMS's capability to forecast their requirements needs to be strengthened to increase commodities procured under ICB	• Review 02, p. • Review 02, p. 49	• Nov. '03: The committee will meet very soon to revise the pricing structur
Drugs: • Serious attention should be given to prescriber behaviour. ICB drugs should have a mark up to bring retail prices below national market prices. • Non-value added activities should be avoided to reduce mark ups. • Undertake commodity market analysis • Contraceptives should be integrated to the drug supply chain • Performance indicators need to be defined • Review the pricing policy to cover health commodities and services. • Recommended prise system should be introduced and supported by a strong monitoring system. • The MoH should step up advocacy on reduction of tariffs on health commodities	• Review 02, p. 49 • Review 02, p. 49 • Review 02, p. 49 • Review 02, p. 51 • Review 02, p. 52 • AM, June 03, p. 8 • AM, June 03, p. 8 • AM, June 03, p. 8	Not pursued in 2003 review.
Donor-coordination in supply: • Donor-coordination in supply should be optimised • The procurement plan to include procurement under earmarked funds	• Review 01, p. 87 • AM, Dec. 02, p. 8	Not pursued in 2003 review.
Capital procurement: • Ensure vehicles are allocated to facilities first. A fund for spare parts should be established. Capacity building should be pro-active. • Allocate as of immediate effect: 10 ambulances, 25 MCs, 6 boats and bicycles, which are deteriorating at a rapid rate.	• Review 02, • Review 02,	Not pursued in 2003 review.
Capital Investment Plan (CIP): • The next 5 year Plan should include measures to improve storage conditions. Training programmes should include health management training for (sub-) district staff on simple management techniques including stores management, stock keeping, etc. • Proper prioritisation and costing of the CIP taking into consideration existing policies and plans for transport and equipment and the priority given to the lower levels in POW II and GPRS should be finalised by mid July • Capital requirements of CHPS need to be incorporated in the plan • Establishing and expanding Regional Community Health Nursing Training Schools should be captured in the CIP • It was evident that there was need for more consultations to enable the Capital Plan to be finalised and accepted. The Capital Plan should be reconciled and completed by the end of January 2003 • A final Capital Plan for POW II and 2003 is a requirement for timely disbursement of partner funding to the Health Account • The focus of the health sector will be expansion of training institutions, CHPS, staff accommodation, establishment of model facilities, trauma centres, GHS building and rehabilitation/upgrading of health facilities (p.17) • The CIP will be implemented depending on availability of funds • Essential to link capital plans of DAs with health sector investment strategy.	• Review 01, p. 87 • AM, July 02, p. 7 • AM, July 02, p. 8 • AM, Dec. 02, p. 9 • AM, Dec. 02, p. 8 • AM, Dec. 02, p. 11 • POW 03, p. 17 • POW 03, p. 18 • Review 02, p. 35 • Review 02, p. 35 • Review 02, p. 35	• Nov.'02: Several draft CIPs have been circulated, none of these are considered finalized by all partners. A phased process has been agreed with MoH for the work on the plan to be finalized mid December '02. • June '03: Construction of CHPS compounds has been captured in CIP '03. Funding have not yet been received • June '03: Considerable progress has been made in improving capital planning for the sector. An overall investment plan '02-'06 has been prepared. • Nov. '03: MOH has decided that the rehabilitation shall be the responsibility of the ministry. A consultant is expected to be appointed and MoH will be requested for funding

• Project start up costs (HR and systems) should be incorporated into capital plan. • Need improved mechanisms of accounting for recurrent implications of capital costs • The capital works on the Tamale Regional Hospital to be reprioritised and captured in the investment plan. • An allocation will be made from Health Fund to cater for minor repairs this year	• AM, June 03, p. 9 • AM, June 03, p. 9	• Generally, capital investment has run ahead of non-salary recurrent budget, lack of rigorous prioritisation.
Recommendations: Human resources		
HR strategic plan/strategies • A draft human resource development strategic plan was presented and discussed. Further consultations with stakeholders should be held. TA is required. • Costed incentives including CHPS should included in the HR plan • The HR strategy needs to address the anticipated constraints more clearly, which may include re-prioritising the most deprived areas for CHPS coverage • Ghana may need to train "non-tradable" cadres (with wider scope) to sustain services • Essential that MoH HR strategic plans estimate impact of private sector and wastage • Agency HR plans must be better coordinated with MoH strategic objectives • Need for National HR forum • MoH to hold a forum on strategies for improving the human resource for health	• AM, July 02, p. 7 • AM, July 02, p. 7 • Review 02, p. 59 • Review 02, p. 59 • Review 02, p. 60 • Review 02, p. 60 • Review 02, p. 61 • AM, June 03, p. 9	• Nov.'02: A HR development plan has been drafted. To be discussed at a workshop ultimo November 02 • See CH 4 for detailed discussion.
Health workers' incentives • Need for a revolution of thinking about human resource indicators. Staff's accommodation, water/electricity supply, transport to work will bring to light some of the hidden issues of human resources, staff retention and staff redistribution • The conclusion on the incentive package should be reflected in the '03 budget • Operationalising the health worker incentive scheme for the placement of health workers in deprived areas will receive increased attention. • Improving health worker performance by incentives for improved performance • Conducting regular medical surveillance for health workers • Clarify the policy for an incentive package, which include vehicles at high purchase as it can also act as an un-incentive (p.48) • A thorough review of ADHA and distributional incentives is needed (p.59)	• Review 01, p. 86 • AM, Dec. 02, p. 9 • POW 03, p. 5, 14 • POW 03, p. 13 • POW 03, p. 13 • Review 02, p. 48 • Review 02, p. 59	See Chapter 4 discussion. • June '03: The incentive package which was part of the HR plan for 2003 has not been included in the '03-budget due to stalled negotiations on salary.
Performance contracts • Performance hearing system should be institutionalised as the basis for introducing performance monitoring and contractual agreements with BMCs • Broaden the scope of the contractual arrangement system to include BMCs in the public sector; missions and private will receive increased attention. • System for contractual arrangements will be made operational • Inter and intra agency performance based modalities of management e.g., performance contracts should be re-introduced	• AM, July 02, p. 7 • POW 03, p. 5 • POW 03, p. 14 • AM, June 03, p. 5	See Chapter 4. • Nov. '03: A phased approach is envisaged. In 2004 MoH will contract with agencies and CHAG followed by the agencies contracting with sub-units in subsequent years
Allocation of HR: • Staff numbers should be adjusted to match demand as well as need, and not be only based on staffing norms for different types of facility (p.6) • Priority should be given to redistributing staff between regions rather than redistribute smaller	• Review 02, p. 6 • Review 02, p. 34	• Nov. '03: Plans for retention and relocation of staff to most deprived areas is still with cabinet. Decentralisation of item 1 within GHS has been proposed by WB/PRSC mission, not

budgets for item 2 and 3 (p.34)		agreed.
Training of HR • Need for closer monitoring and to link the in-service-training programme to HR resource database • Strengthening in-service capacity in hospitals by organising training for hospital in-service coordinators as well as provision of basic equipment • Training of more professional health staff to address HR shortages and CHPS • Proposal to initiate Tele-health to be followed up as a strategy to train more personnel	• AM, Dec. 02, p. 9 • POW 03, p. 13 • POW 03, p. 13 • AM, June 03, p. 9	• June '03: The vision of MoH is to achieve equity in IST. The IST information system links HR database and IST. But poor reporting is a problem.
Management • Support the continued development of Business Plans by larger facility managers • Management of salary budget should be decentralised • Clear job descriptions should be defined, focus on outputs and deadlines and support peoples work • HR managers should compile BMC staff databases • BMC accreditation should be reviewed and extended to staff and staff budget management.	• Review 02, p. 21 • Review 02, p. 61 • Review 02, p. 73	BMC accreditation has been reviewed.
Recommendations: Poverty		
CHPS: • 100 new compounds will be established with emphasis on the deprived areas • CHPS should be used when it adds efficiency. • Effects on other services should be assessed and adjustment in supply made. • Implementation should follow the defined systematic steps. • It should be scaled at a pace the community can absorb and development through the local government system might increase sustainability. • District teams must rethink what determines consumption of health services and develop plans for health services that reflect the behaviour and needs of consumers. • CHPS programme should be integrated with district plans and programmes. • Proper involvement of communities is an important pre-condition for the effectiveness of CHPS. • Rationalisation of existing health system, facilities, infrastructure and staff should be made prior to establishment of CHPS. • Dialogue with Ministry of Local Government should be established to solicit more involvement of DAs A strategic framework for development of CHPS and Nurses Training Schools should be prepared by the next summit	• POW 03, p.10 • Review 02, p.24 • Review 02, p.24 • Review 02, p.24 • Review 02, p.24 • Review 02, p.24 • AM, June 03, p.6 • AM, June 03, p.6 • AM, June 03, p.6 • AM, June 03, p.6	• November '03: 104 out of 110 districts have initiated action on CHPS. Implementation limited by funding, logistics and manpower. Development of national framework for implementation ahs been initiated but progress has been slow. Task teams have been established: Service delivery, planning/procurement, linkages and M&E. Funding mainly used for Training Schools
Exemptions: • Steps to be taken to enter into dialogue with partners to clarify the implementation roadmap and funding implications • The exemptions policy should be reviewed and a clear roadmap for its improvement developed and implemented. • The exemptions budget should be reviewed to include all known funding sources and any identified gap to be brought up for discussion at the next summit • The exemption policy will be reviewed to focus on poor and vulnerable • Primary beneficiaries of exemptions should be the poor	• AM, July 02, p. 5 • AM, Dec. 02, p. 8 • AM, Dec. 02, p. 8 • POW 03, p. 15 • Review 02, p. 36	See Chapter 5.

• There should be a process of pre-identification of the poor. Process should be undertaken by local committees • Adequate resources for exemptions should be made available and equitable allocated between geographical areas. • It is critical that the existing fee exemption reimbursement channel (through GHS headquarter to regions to facilities) is improved • Clear information on systems should be widely disseminated (p.36) • A working group involving field staff and partners to be established to review studies and pro-posals already put forward and present a clear roadmap for implementation, costing of various alternatives and assessing impact on resource distribution.	• Review 02, p. 36 • Review 02, p. 36 • Review 02, p. 36 • Review 02, p. 36 • AM, June 03, p. 4	• Nov. '03: A working group has been established to review the entire exemption policy. Two good reviews undertaken (See Chapter 5). • Funds for free deliveries disbursed to DAs in 4 deprived regions. No established structure for GHS to access funds.
National Health Insurance (NHIS): • Government must focus on public employees and economically disadvantaged • Steps to be taken to enter into dialogue with partners to clarify the implementation roadmap and funding implications • The MoH should ensure a wider involvement in the discussions and policy development process • Accelerating implementation of the health insurance and mutual health organisation schemes • 45 new District-wide Mutual Health Organisations will be established across the country • Primary beneficiaries of subsidies for HI should be the poor • Adequate resources for insurance contribution subsidies should be made available and equitable allocated between geographical areas • Clear information on systems should be widely disseminated • Proceed with prudence. Devote significant HR to NHIC/NHIF. Design a package that is attractive to formal sector. Define benefit package based on financial modelling. Provide more support for existing CHIs. Jumpstart further CHIs. Capitalise on CHI experience. Ensure that NHIP is pro-poor • MoH to ensure that all stakeholders are engaged in further dialogue on the process. • A meeting for all stakeholders should be held be the end of July to discuss the pending HI Bill. A further meeting should be held following legislation to elaborate the legislative instrument and implementation issues	• Review 01, p. 86 • AM, July 02, p. 5 • AM, Dec. 02, p. 8 • POW 03, p. 5 • POW 03, p. 12 • Review 02, p. 36 • Review 02, p. 36 • Review 02, p. 36 • Review 02, p. 37 • AM, June 03, p. 3 AM, June 03, p. 3	See Chapter 5. • Nov. '02: No steps have been taken to enter into dialogue with partners • June '03: A wider involvement has not taken place. • Nov. '03: A stakeholders meeting was held in July. A number of concerns were raised. The bill was passed into law 26th August 2003

Annex 2.01

Annex Table 2.01: SWAP Indicators by region and against targets, Ghana 2003

		Indicators 2003 by Region	WR	CR	GAR	VR	ER	AR	BAR	NR	UWR	UER	National Perf	MOH target	MOH Target	GHS Targets
Reports		HARD COPY received	YES		YES	YES		YES	YES	YES	YES	YES	2003	2003	2004	2004
		ELECTRONIC copy received	YES	YES		YES		YES		YES	YES	YES				
Profile		Total population/1000	2,115	1,696	3,306	1,730	2,106	3,994	1,354	1,970	950	606	21,102			
		Districts	11	12	5	12	15	18	13	13	5	6	110			
		Health Facilities	286	148	285	261	300	388	231	140	78	59	2173			
		Doctors	59	44	543	51	62	299	33	26	29	12	1207			
		Nurses	549	585	1376	498	1787	1290	238	484	300	192	8122			
		Beds	1442	1268	561	2169	2331	2128	1433	1011	672	700	13715			
		OPD Attendance	951,750	831,040	1,619,940	657,400	968,760	2,476,280	866,560	531,900	437,000	357,540	10,551,000			
		Nurse/OPD patients ratio	1734	1421	1177	1320	542	1920	3641	1099	1457	1862	1299			
		Admissions	70801	50497	24574	63214	91149	94309	66709	69060	31736	36725	598774			
Access	1	Population Doctor ratio	35853	38554	6089	33791	33930	13370	41596	76080	32786	50541	17489	20,500	20,500	
	2	Population Nurse ratio	3874	2900	2403	3475	1179	3096	5700	4070	3169	3159	2598	1,800	1,800	
	3	Outpatient visit per capita	0.45	0.49	0.49	0.38	0.46	0.62	0.64	0.27	0.46	0.59	0.5	0.55	0.6	0.55
	4b	Hospital admission rate/1000pop	36.9	32.9	22.8	38.2	45.2	38	34.2	37.7	50.5	41.1	35.9	36	38	38
	5	Total number of CHPS Zones Started		89		70						-				
	6	Total number of CHPS zones Completed	2	9	0	10	9	0	0	0	4	21	55		400	160
Quality	7	% of maternal audits to maternal deaths	89	84	100	78		89	73.8	89	100	100	85	20	35	70
	8	Under five malaria case fatality rate	0.4			3.5		2.8	11	0	2.7	2.4	3.67	1.5	1.2	1.2
	9	% tracer drug availability	95		89	98		92	91	0	98	92.2%	93	85	90	80
Efficiency	10	HIV seroprevalence (Regional Mean, Nat Median)	4.2	5.4	4.3	2.9	6.1	4.7	4	2.1	2.2	3.5	3.6	3.8	3	
	11	Tuberculosis cure rate (2002 Cohort analysis)	41.6	47	65	72	47.0	59	63	26	20	41	53.8	50	65	55

	12	Guinea worm cases	28	0	3	1511	37	45	492	5999	152	23	8290	< 1000	800	< 3000
	13	AFP non polio rate	1.1	1	1.4	1.5	2.1	1.1	1.2	0.8	0.6	2.2	1.3	3	3.5	3.5
	14	Contraceptive Prevalence Rate	14	26	22	27	34	14	36.0	16	36	19	22.6	25	28	25
	15	% ANC coverage	93.4	102.5	80.9	86.2	94.6	83.6	97.1	102.7	88.7	100.2	91.2	99	99	90
	16	% PNC coverage	37.3	69.7	47.3	57.9	62.8	58.1	54.1	62.1	75.8	50.1	55.8		55	
	17	% Supervised deliveries	46.2	67	49.3	48.9	50.6	56.2	55.9	39.2	67.3	44.9	51.9	55	80	58
	18	Bed occupancy rate	55.9	61	98	49.1	55.1	64	60	59	48	47	64.1	70	65	70
	19	EPI coverage DPT3	88	83	62	67	81	66	81	85	87	83	76	80	100	87
	20	EPI coverage Measles	87	81	66	68	93	70	86	92	88	84	79	85	100	85
financial	21	Total budget allocated/Bil	83.1	50.7	98.7	44.3	74.7	91.5	178.6	120.9	205.2	44.5	1,336.3	8%	12.9%	
	22	Total GOG recurrent budget/bil	29.5	20.9	41.5	10.5	36.0	43.4	31.4	14.5	13.2	18.3	831.2	12%	14.0%	
	23	Total Health Fund/bil	11.3	11.7	9.8	10.1	13.8	16.1	11.1	11.8	6.9	9.6	240.1	50%	45%	
	24	Total IGF/bil	20.6	16.1	43.8	21.1	24.6	28.7	14.7	2.1	3.2	4.4	242.0	5%	10%	
	25	Total amount spent on exemptions/bil	3.1	2.0	3.6	2.6	0.3	3.3	1.4	1.4	1.9	2.3	22.9	5%	6%	50
Health status	26	Infant mortality rate	18.6						120	91	180	10	NA			
	27	Under five mortality rate	32.9						30	37	43.5	25	NA			
	28	Institutional Maternal Mortality ratio	210	159		256		196	200	240	100	248	220			
	29	% U-5years who are malnourished	23.5					3.4	5.1	104	25.8	8.4		23	22	
	Total expected indicators		29	29	29	29	29	29	29	29	29	29				
	Total indicators satisfied		26	23	17	21		25	24	21	23	29				
	% Total indicators satisfied		89.7	79.3	58.6	72.4	0.0	86.2	82.8	72.4	79.3	100.0				

Annex 2.02

Annex Table 2.02: National trends of GHS/DHS indicators, 1993-2003

	DHS			Other Sources					
	1993	1998	2003	1998	1999	2000	2001	2002	2003
Background									
Population (thousands)				18,449	18,868	18,912	19,434	19,973	20,529
OPD attendance/1000				7195	7170	8510	9523	9787	10265
Access									
Population to doctor ratio							22811	22193	17489
Population to nurse ratio							2043	2080	2598
OPD attendance/Capita				0.39	0.38	0.45	0.49	0.49	0.5
Hospital admission rate/1000pop				27.5	29.7	34.9	34.9	34.1	35.9
Total number of CHPS Zones Started						118	525	900	1199
Total number of CHPS zones Completed						19	19	39	55
Efficiency									
Median HIV seroprevalence (Median Women 15-49)				3.4	2.4	2.3	2.9	3.4	3.6
TB cure rate (Cohort analysis of previous yr)				43.8	49.3	44.9	48.9	53.8	
TB Defaulter rate(Cohort analysis of previous yr)									
Guinea worm (cases)						7420	4739	5611	8290
Contraceptive Prevalence rate	10	13	18.7	14.5	13.7	11.6	20.3	21	22.6
ANC coverage	86	87	92	94.7	92.1	96.4	93.5	93.7	91.2
PNC coverage				40.8		46.3	52.9	53.6	55.8
Supervised delivery	44	44	47	44.1	46.4	50.2	49.2	52.6	51.9
Bed occupancy rate						58.9	64.7	65.5	64.1
DPT3 Coverage	62	67	76.4	68	73	84	76.3	77.9	76
Measles coverage	64	61	83.2	67	71	84	82.4	83.7	79
Health Status Outcomes									
IMR/1000 livebirths	74.7	61	64			58.2	57	55	NA
<5MR total country	132.8	110	111		101	112.1	108	100	NA
Children <5 yrs underweight (Wt/A)	27.4	24.9			24.9				
Instituitional MMR/100,000Lbs							214	204	204.5
Financial									
% GOG Budget spent on Health system								7.6	9.5
% GOG recurrent budget spent forHealth								10.5	12

Annex 2.03

Annex Table 2.03: Comparison GHS/DHS Output data for Ghana,

		Regions										National Performance
		WR	CR	GAR	VR	ER	AR	BAR	NR	UWR	UER	
ANC Registrants	GHS 2003	93.4	102.5	80.9	86.2	94.6	83.6	97.1	102.7	88.7	100.2	91.2
	DHS 2003	94.9	94.7	96.3	89.5	91.8	94.2	95.7	82.8	91	85.5	91.9
SD (Skilled attendant)	GHS 2003	46.2	67	49.3	48.9	50.6	56.2	55.9	39.2	67.3	44.9	51.9
	DHS 2003	38.6	38.4	81.4	45	46.5	59.9	58.4	18.3	33.3	27.8	47.1
FP (CPR)	GHS 2003	14	26	22	27	34	14	36.0	16	36	19	22.6
	DHS 2003	17.7	13.2	26	19.3	21.5	21	24.8	7.7	19.5	9.7	18.7
DPT-3 (PENTA)	GHS 2003	88	83	62	67	81	66	81	85	87	83	76
	DHS 2003	78.9	87.9	57.6	81.1	77	82.4	85.3	62.2	75.5	77.8	76.4
MEASLES	GHS 2003	87	81	66	68	93	70	86	92	88	84	79
	DHS 2003	76.4	86.5	87.8	89.4	79.1	82.2	87.1	76	79.5	91.2	83.2
<5yrs sleeping under ITN	DHS 2003	1.0	0.7	1.1	2.2	0.3	1.2	2.1	7.2	20.7	1.9	3.5
TB Case Detection Rate/2003	GHS 2003	79	81	61	70	76	58	34	19	32	35	59
TB Cure Rate(2002 Cohort)	GHS 2003	41.6	47	65	72	47.0	59	63	26	20	41	53.8
% Tracer drugs availability	GHS 2003	95		89	98		92	91	0	98	92.2%	93
Drugs per prescription	GHS 2003	NA		3.4	NA		NA	NA	3.4	3.1	NA	
% prescriptions with antibiotics	GHS 2003	NA		42	NA		NA	NA	37.2	44.8	NA	
% prescriptions with diagnosis	GHS 2003	NA		90	NA		NA	NA	98	94.5	NA	
Average cost per prescription	GHS 2003	NA		NA	NA		NA	NA	NA	6130	NA	
HIV VCT Centres	GHS 2003	0	0	16	0	4	4	2	0	0	0	26
PMTCT sites	GHS 2003	0	0	6	0	5	6	0	0	0	2	19
HIV Sentinel sites	GHS 2003	3	3	4	3	3	3	3	2	3	3	30

Annex 2.04

Annex Table 2.04: Analysis of the Regional Performance Reports (2002-2003)

Regions	Have Swap performance indicators been included against targets? (1)	Have specific recommendations of last year (2002) been addressed specifically? (2)	Have policy initiatives been presented and analysed (QA, RBM, IMCI, 3-delays, IDSR, NHI) (3)	Are new local initiatives/challenges by districts and regions been highlighted? (4)	Has financial information (budget against expenditure) been included and analysed? (5)	Have pro-poor activities been highlighted and supported (CHPS, NHI, Exemption)? (6)	Have Performance Guidelines suggested by GHS been followed? (7)	Comments
Ashanti	Yes	Yes, but vague	Partial	No	Partial	No	86.2	Report weak because very little analysis and reflection on the data. Most is just description. Looks like PoW 2004. Log frame+ Unclear what did they do with the district comparison? OPD/IPD increased. Was there increase in IGF? YES (p.42)
Brong Ahafo	Partial	No	Partial	No	Yes	No	82.8	1. No targets 2. No recommendations made 3. IDSR well mentioned. IMCI mentioned and not much That were IMCI p19. So is CHPS p35. MHO implementation matrix and issues available p37 4. No systematic presentation of initiatives 5. Source and BMC data presented and analysed p55-56 6. Not visible
Central R	Partial	No	Partial	Partial	Partial	Yes	79.3	1. No targets 2. Issues of concern at beginning of year (end 2002) were not touched. 3. QA, IMCI, RBM not presented 4. CHPS and NHI p56 5. No analysis p69. 6. CHPS and NHI presented p56
Eastern								
Greater Accra	Yes	No	Partial	No	Yes	Partial	58.6	1. Excellent review though no targets p11-14 2. No evidence that the 2003 priorities are drawn from 2002 (2002 Report unavailable) 3. IDSR well presented. Also QA, p36 CHPS P47 and MHO P49 4. Not well outlined and how to address them 5. p134-153 6. MHO p49. Reference Table 32 on CHPS not available
Northern R*	Partial	Partial	No	No	No	No	72.4	Very poor report. They need help CHPS is at 'budding stage' (zero finalised) PH is really very weak (see CSM, TB, Malaria). OPD seriously low (0,27); No actions proposed on any of the downward indicators

Regions	Have Swap performance indicators been included against targets? (1)	Have specific recommendations of last year (2002) been addressed specifically? (2)	Have policy initiatives been presented and analysed (QA, RBM, IMCI, 3-delays, IDSR, NHI) (3)	Are new local initiatives/challenges by districts and regions been highlighted? (4)	Has financial information (budget against expenditure) been included and analysed? (5)	Have pro-poor activities been highlighted and supported (CHPS, NHI, Exemption)? (6)	Have Performance Guidelines suggested by GHS been followed? (7)	Comments
Upper East*	Yes	No	Yes	Partial	Yes	Partial	100	3. RBM, CHPs, NHI, ACSD well presented p23, 65 5. Well presented p100-108 6. CHPS, exemption and NHI but targeting unclear. Only UER satisfied all requirements (Median 82.8%)
Upper West*	Yes	Partial	Yes	Yes	Yes	Yes	79.3	Upper West: IGF funds doubled from 3,6 to 6,4 B. Programme Funds also from 3,1 to 5,3 B. Reason for OPD down? Sometimes little link between findings presented in the report and the actions taken to improve the situation.
Volta	Partial	No	No	Partial	Yes	Partial	72.4	1. No targets p4 2. No evidence that the priorities are drawn from 2002 recommendations (2002 report not available) 3. Presentation follows the Regional BMC categories (clinical, PH, support service) 4. p62 5. Trend analysis of amts by source pix,88-104 6. CHPS were presented p62
Western	Partial	Partial	Yes	Yes	No	Partial	89	1. Some priority indicators mentioned and justification for interventions stated.p22. No targets set. 2. Outlook for 2003 (in p60 of 2002 report) is largely different from that outlined in 2003 report p23 3. IDSR, World bank supported C-IMCI in 10 comms. in Sefwi Wiawso and status of MHOs implementation well presented pp82,90,101 4. p82, 91 5. Annex 6. p91,

Notes:

- There are variations in the formats used. Only 3 regions used formats consistent with the one given to the reviewers (UER, ASH, BA).
- Problem of clarity of measurement e,g. GAR admission rate is admission/capita; supervised deliveries seem to be provided for skilled attendant.
- There are differences in sequencing and use of software.
- General absence of data requirements on CHPS: may be a problem with clarity of requirement

Annex 2.05

Annex Table 2.05: Review of District/Regional Performances (through observer team report, March 2004)

Regions	District Strengths	District Weaknesses
Western	• Format of review well prepared. • Responsibles of BMC all attended; • Emergency Care is important innovation	• Financial matters and overarching issues not addressed; • Lack of consensus on indicator definitions; • Little discussions on exemptions and NHIF • Late release of funds is major constraint
Greater Accra	• No report available in the Observer Team Report of March 2004.	•
Volta	• All but one district participated together with various other stakeholders • Improved EPI and RH performance (denominator?); • Voucher system for ITN piloted. • Drug availability is good • Outreach programmes (Eye Care) operational; • IGF is most reliable source of funding!! • Increased intake of students, but low pass-rate; • Regional Indicators of SWAp available (p.38)	• Formats provided but not always followed • Many data presented but difficult to grasp; • Guinea Worm and Yaws numbers are increased; • TB also on the increase; • Utilisation is low, but IGF increases, higher fees; • Support for clinical care services is weak. • Huge amounts of un-refunded exemption bills • Flow of funds is reduced delayed and irregular • Staff: inadequate numbers and misdistribution;
Eastern	• Review included many other actors and activities, including PoW 2004; • Many other partners and NGO's participated (GES, PI, Red Cross and others); • Intersectoral collaboration is striving; • Region presented its own Performance Review; • Talking instead of Power point; Prizes!!	• TB programme performs poorly (defaulters); • High Maternal Mortality (poor referrals; communication); high abortion rate; • Role of GHS in the implementation of NHIS remains unclear; Responsibilities of GHS vs Nurse Training School remain unclear; • Distrust in District Health Insurance Scheme
Ashanti	• All 18 districts participated with 2 representatives, but NGO's, CBO's and MDA did not turn up. • Most districts presented innovative activities; • Client surveys are being done to assess quality of care provided. • Staffing in most districts inadequate and delays in getting clearance from MOH to recruit new staff. • Intersectoral collaboration was clearly indicated in the district presentations	• It is impossible to assess whether health in the districts is improving or deteriorating. • Exemptions and origin of funds (from DA, GOG, DPF) are not presented. No information on Cash flow from GOG/DPF or on budget allocation vs disbursement; • There is no standardised format for the presentations; Little focus on targets and achievements. No standard indicators
Brong Ahafo	• All regional and district managers attended (+ training school) but no private sector or NGO's; • FP attendance increased, while EPI, HIV/AIDS, Guinea Worm have all got worse.	• Guidelines should include targets vs performance gaps and discuss constraints; • No clear targets (and indicators) defined; • CHPS has shifted to training CHO and construction within Sunyani Regional Capital. • Reports are often delayed/poor data quality;

Regions	District Strengths	District Weaknesses
	• Drug availability is good (95%); • Health Insurance is increasing but many problems remain (premiums, package)	• Shortage of professional staff is major concern • Inflow of GOG + DPF money only in 3rd Trimester (July)
Central*	• Not only all 12 districts participated but also the hospitals, University of Cape Coast, Catholic Church and Community Health Training school. • It is the impression that exemptions increase access to supervised deliveries.	• Causes for high Maternal Mortality are mainly institutional and thus can be effectively addressed (Few Caesarean operations, no blood transfusion, few transport and communication systems). • Cash flow (DPF) is a problem. IGF revenues have increased (higher fees)
Northern R*	• While all DHMT participated, DA were absent. Donors and NGO also presented; • Accelerated interventions of IMCI, EPI, Vit A and Trachoma control; • Output indicators were presented sometimes with data from 2001 and 2002 for comparison; Most indicators of SWAp were captured. • Data on Cash flow and expenditure control were presented; • Good relations with DA; • 188 CHPS defined, 41 started and 0 completed; • CHAG participates actively	• Timeliness of routine reporting was poor; • TB Case detection dropped, but defaulter tracing improved (community DOTS); Guinea Worm cases increased; OPD cases dropped, despite reimbursement of exemptions • Accuracy of population figures is problem in many of the output indicators; • HRM is problem (high attrition and mal-distribution) • IGF used for top-up of salary of MOH staff; • GOG and DPF Funds came late (only in third trimester)
Upper East*	• One regional, six district presentations. Partners were present; • Uniformity and coherence had improved; • Peer review and Best Practice is taking place; • Financial reporting and reporting on exemptions comprehensive (paupers are not reported); • There are varied views on usefulness CHPS; • Quality of data is diverse: inputs are well reported but outputs/outcome less.	• Guidelines not adhered to (data, analysis, completeness and accuracy); cleaning of data still needed. • Overall performance has not improved compared to 2002 (indicators decreased), • Delay of funds is one of the major causes; • CHAG stopped exemptions due to lack of reimbursement. • Audits of Maternal death do not lead to decisions to prevent similar cases
Upper West*	• All 5 districts (and other BMC) participated and worked in groups on various topics to verify wrong data and arrive at a consensus. • Drug supply stable and adequate	• TB prevalence still high and Meningitis despite immunisation; • Budget releases late (July); • Insufficient feedback to districts on their performance

* = One of the four most deprived regions in the country

Appendix 3.1

Annex Table 3.01: Timing of receipts and disbursements - GoG & Health Fund

	Date expected	Date recvd/disb	Lag time (months)	Date expected	Date recvd/disb	Lag time (months)
Qtr 1	GOG			HF		
Item 3	15-01-03	26-08-03	7			
Danida				01-01-03	02-06-03	5
DfID				01-01-03	06-06-03	5
EU				01-01-03	-	
Netherland				01-01-03	-	
World Bank				01-01-03	-	
Disburse to BMCs	15-01-03	21-08-03	7	01-01-03	20-04-03	4
Qtr 2	GOG			HF		
Item 3	01-04-03	26-08-03	5			
Danida				01-04-03	10-06-03	2
DfID				01-04-03	06-06-03	2
EU				01-04-03		
Netherland				01-04-03		
World Bank				01-04-03		
Disburse to BMCs	01-04-03	21-08-03	5	01-04-03	01-07-03	3
Qtr 3	GOG				HF	
Item 3	01-07-03	09-12-03	5			
Danida				01-07-03	23-08-03	2
DfID				01-07-03	-	
EU				01-07-03	-	
Netherland				01-07-03	24-07-03	1
World Bank				01-07-03	22-08-03	2
Disburse to BMCs	01-07-03	10-12-03	5	01-07-03	10-09-03	2
Qtr 4	GOG				HF	
Item 3	01-10-03	23-02-04	5			
Danida				01-10-03	29-01-04	4
DfID				01-10-03	18-11-03	2
EU				01-10-03	24-12-03	3
Netherland				01-10-03	-	
World Bank				01-10-03	-	
Disburse to BMCs	01-10-03	15-04-04	7	01-10-03	05-11-03	1
Average release lag			6			3
Average disbursement lag			6			3

Appendix 3.2

Annex Table 3.02: Disbursement processes of IGF, Earmarked Funds, Health Fund and GOG funds

Steps	Disbursement process of Internally Generated Fund	Responsibilities	Comments
1.	Prepare and approve Budget	BMC management	Only reliable source of funding, which makes exemptions unpopular- unless they can be budgeted, earmarked, and paid in advance.
2.	Collect Revenue	BMC management	
3.	Bank Collections Intact/Gross	BMC management	
4.	Raise LPO & PV to access funds	BMC management	

Annex Table 3.03: Disbursement process – by steps and budget items for GoG funds

Num.	Steps (details)	Responsibilities
Disbursement process of Item 1 (Personnel Emoluments)		
1.	Issue Provisional/Budget Estimates & General warrant[43]	MOFEP
2.	Prepare Cash Plan	MOH (HQ)
3.	Apply for quarterly Cash Limit	MOH (HQ)
4.	Release Cash Limit and General Warrant (Items 1 & 2)	MOFEP
5.	Lodge Copy of General Warrant with Health Treasury (Accra)	MOH (HQ)
6.	Prepare Sub-Warrants for Agencies	MOH (HQ)
7.	Lodge Copy of Agency Sub-Warrants with Health Treasury (Accra)	MOH (HQ)
8.	Prepare Sub-Warrants for RHAs	GHS (HQ)
9.	Lodge Copy of RHA Sub-Warrants with Health Treasury (Accra)	GHS (HQ)
10.	Certify & Pass Sub-Warrants	H/Treasury
11.	Collect Certified RHA & Subvented Org. Sub Warrants from H\Treasury	MOH (HQ) & GHS (HQ)
12.	Send Certified Sub-Warrants to RHAs & Sub Organization	MOH (HQ) & GHS (HQ)
13.	Lodge RHA Sub-Warrants with Regional Treasury	RHAs
14.	Prepare Sub-Sub Warrants for BMCs	RHAs
15.	Lodge BMC Sub-Sub Warrants with Regional Treasury	RHAs
16.	Certify & Pass Sub-Sub Warrants for BMCs	R/Treasury
17.	Collect Certified BMC Sub-Sub Warrants From Regional Treasury	RHAs
18.	Send Certified Sub-Sub-Warrants to BMCs	RHAs
19.	Lodge Certified BMC Sub-Sub Warrants with Servicing Treasury	MOH (HQ), GHS (HQ), RHAs & BMC
20.	Apply to CAGD HQ for Expenditure Authorization	H/Treasury, RHAs & D/Treasury
21.	Issue EA to Servicing Treasury	CAGD (HQ)
22.	Transfer Funds to Employee Accounts	CAGD (HQ)
Disbursement process of Item 2 (Administrative Expenses)		
1	Issue Provisional/Budget Estimates & General warrant	MOFEP
2	Prepare Cash Plan	MOH (HQ)
3	Apply for quarterly Cash Limit	MOH (HQ)
4	Release Cash Limit and General Warrant (Items 1 & 2)	MOFEP
5	Lodge Copy of General Warrant with Health Treasury (Accra)	MOH (HQ)
6	Prepare Sub-Warrants for Agencies	MOH (HQ)
7	Lodge Copy of Agency Sub-Warrants with Health Treasury (Accra)	MOH (HQ)
8	Prepare Sub-Warrants for RHAs	GHS (HQ)
9	Lodge Copy of RHA Sub-Warrants with Health Treasury (Accra)	GHS (HQ)
10	Certify & Pass Sub-Warrants	H/Treasury
11	Collect Certified RHA & Subvented Org. Sub Warrants From H\Treasury	MOH (HQ) & GHS (HQ)
12	Send Certified Sub-Warrants to RHAs & Sub Organization	MOH (HQ) & GHS (HQ)
13	Lodge RHA Sub-Warrants with Regional Treasury	RHAs
14	Prepare Sub-Sub Warrants for BMCs	RHAs
15	Lodge BMC Sub-Sub Warrants with Regional Treasury	RHAs
16	Certify & Pass Sub-Sub Warrants for BMCs	R/Treasury
17	Collect Certified BMC Sub-Sub Warrants From Regional Treasury	RHAs
18	Send Certified Sub-Sub-Warrants to BMCs	RHAs
19	Lodge Certified BMC Sub-Sub Warrants with Servicing Treasury	MOH (HQ), GHS (HQ), RHAs & BMC
20	Apply to CAGD HQ for Expenditure Authorization	H/Treasury, RHAs & D/Treasury
21	Issue EA to Servicing Treasury	CAGD (HQ)
22	Transfer Funds to MOH Operational Account	CAGD (HQ)

[43] Few problems getting PEs paid, some problems with payroll management.

23	Raise LPO & PV to access funds	MOH (HQ), GHS (HQ), RHAs & BMC
Disbursement process of Item 3 (Service Expenses)		
1.	Issue Provisional/Budget Estimates & General warrant	MOFEP
2.	Prepare Cash Plan	MOH (HQ)
3.	Apply for quarterly Cash Limit	MOH (HQ)
4.	Prepare Expenditure & Activity Initiation Form	MOH (HQ)
5.	Request Release of Service Funds with Exp & Activity Initiation Form	MOH (HQ)
6.	Issue Specific Warrant to MOH	MOFEP
7.	Prepare Disbursement Schedule	MOH (HQ)
8.	Request RHAs to submit Expenditure & Activity Initiation Form to HQ	GHS (HQ)
9.	Request BMCs to submit Expenditure & Activity Initiation Form to RHAs	RHAs
10.	Submit Expenditure & Activity Initiation Forms to RHA	BMC
11.	Submit Expenditure & Activity Initiation Forms to HQ	RHAs
12.	Send Specific Warrant to CAGD for Expenditure Authorization	MOH (HQ)
13.	Issue Expenditure Authorization to MOH	CAGD (HQ)
14.	Prepare Payment Voucher to Health Treasury for Release of Funds	MOH (HQ)
15.	Issue Cheque to MOH	H/Treasury
16.	Credit MOH Account at BOG	BOG
17.	Write Cheques for BMCs	MOH (HQ)
18.	Inform HQ, THS & RHA cheques ready	MOH-HQ
19.	Collect Cheques from HQ	RHAs
20.	Collect Cheques from RHAs	BMC
21.	Lodge Cheques with Banks	BMC
22.	Clear cheques for BMCs	BOG
23.	Raise LPO & PV to access funds	BMC
Disbursement process of Item 4 (Investment Expenses)		
1.	Issue Provisional/Budget Estimates & General warrant	MOFEP
2.	Prepare Cash Plan	MOH (HQ)
3.	Apply for quarterly Cash Limit	MOH (HQ)
4.	Apply for Commencement Certificate	MOH (HQ)
5.	Issue Commencement Certificate	MOFEP
6.	Contractor undertakes works	Contractor
7.	Consultant raises Works Certificate	Consultant
8.	User Endorses Works Certificate	RHAs
9.	Regional Minister Endorses Works Certificate	Regional Minister
10.	Submit Endorsed Certificate to HQ	RHAs
11.	Register Endorsed Certificate at HQ and Submit for Approval	GHS (HQ)
12.	Forward Endorsed Certificates with Expend. & Activ. Init. Form to MoFEP	MOH (HQ)
13.	Issue Specific Warrant for Expenditure Authorization	MOFEP
14.	Issue Expenditure Authorization	CAGD (HQ)
15.	Prepare Payment Voucher	GHS (HQ)
16.	Submit Payment Voucher to Health Treasury for Endorsement	GHS (HQ)
17.	Endorse Voucher for Payment	Health Treasury
18.	Submit Voucher to Ministries Treasury for Payment	GHS (HQ)
19.	Issue Cheque for payment to Contractor	Ministries Treasury
20.	Collect Cheque From Ministries Treasury	MOH-HQ
21.	Register Cheque	GHS (HQ)
22.	Issue Cheque to Contractor	GHS (HQ)

Annex Table 3.04: Disbursement process – by steps and budget items for non-GoG funds

Num.	Steps (details)	Responsibilities
Disbursement process of Health Fund		
1.	Request Disbursement	MOH (HQ)
2.	Disburse to Health Account[44]	Donors
3.	Prepare Disbursement Schedule[45]	MOH (HQ) & GHS (HQ)
4.	Prepare US dollar to Ghanaian Cedi Transfer Letter	MOH (HQ)
5.	Sign US dollar to Ghanaian Cedi Transfer Letter	MOH (HQ) & CAGD (HQ)
6.	Debit $ accounts & Credit ¢ Account	BOG
7.	Prepare payment vouchers	MOH (HQ)
8.	Write Cheques	MOH (HQ)
9.	Inform HQ, THS & RHA cheques ready	MOH (HQ)
10.	Collect Cheques from HQ	RHAs
11.	Collect Cheques from RHA	BMC
12.	Lodge cheques in BMC bank accounts	BMC
13.	Clear Cheques	BOG
14.	Raise LPO & PV to access funds	BMC
Disbursement process of Earmarked Fund		
1.	Request Disbursement	MOH (HQ)
2.	Disburse to Aid Pool Account	Donors
3.	Advise MOH/GHS of disbursement	Donors
4.	Prepare payment vouchers	MOH (HQ) & GHS (HQ)
5.	Write Cheques	MOH (HQ) & GHS (HQ)
6.	Inform HQ, THS & RHA cheques ready	MOH (HQ)
7.	Collect Cheques from HQ	RHAs
8.	Lodge cheques in RHA bank accounts	RHAs
9.	Clear Cheques	Bank
10.	Collect Cheques from RHA	BMC
11.	Lodge cheques in BMC bank accounts	BMC
12.	Clear Cheques	Bank
13.	Raise LPO & PV to access funds	BMC

[44] Give notice of dates.
[45] Cash forcast now acceptable to WB for triggering disbursement.

Annex 5.1: Monitoring the pro-poor agenda

Annex Table 5.01: Supplemental analyses and indicators for monitoring the pro-poor agenda

Pro-poor agenda	Current indicators 2003 & 2004[46]	Potential modifications to more clearly bring out pro-poor achievements	Possible source	Utility
Poverty and the poor	• No requirements about reporting on this issue	• Proportions of the population that are poor (using national criteria) • Number (or proportion) of sub-districts that fall into core poor categories (using district or regional criteria)	• Based on information from national surveys, e.g., GLSS, CWIQ • Based on maps produced by District Assemblies with NDPC support and DHMT participation	• Assessing relative need, for allocation of resources • Enabling disaggregation of relative contribution by poor areas to utilisation and service uptake, burden of disease, and equity of distribution of staff, services
Geographical access and equity	• No sector-wide indicator on geographical access • % of population within 8 km of static or outreach points. (RDHS/DDHS performance agreement) • Population per doctor, population per nurse (sector, region, district) • Specialist outreach services from tertiary, secondary and district hospital by region [see CHPS below regarding community resident nurses] • % recurrent and capital expenditure by sector, region, district, and by source [discussed in chapter on finance]	• Proportion of the population living more than 8 kms (or more than one hour by locally available modes of travel) from a health facility (and not served by a CHO) – alternatively, the proportion living more than this distance/time from a source of preventive/promotive health supplies (ITNs, condoms, FP supplies, IEC materials); linked to to disaggregation by poor districts, and intra-district core poor areas • Proportion of staff posts filled (and staff at post) based on staffing norms for public health/outreach and clinical service provision, particularly if this can be linked to disaggregation by poor districts, and intra-district core poor areas • Proportion of patients treated during specialist outreach services that qualify as paupers (and are exempted from payment) [Note – the existing equity indicators are biased toward clinical services, and do not allow sufficient focus on needs of the poor]	• National surveys (DHS, CWIQ), district assembly and DHA records and poverty/population maps (from NDPC). It would also be possible to use mapping of distances with motorcycle odometer (as per Ashanti) or GPS/GIS (as per Navrongo) • District and regional records, linked to poverty rankings of locations	• Assessing geographical coverage – the first option assumes a health facility that has a basic package of preventive, promotive and curative services; the second option would assess coverage of social marketing for health promotion • Assessing equity of staff distribution [limitation – would require some modification of current staffing norms that emphasise clinical services]
CHPS	• Number of community resident nurses (sector, region, district, sub-district)	• Number (and proportion for the regional/national aggregates) of CHPS sites that meet standard criteria for providing service to deprived areas (e.g., geographical	• DHA and district assembly records, maps	• Assessing accomplishments in directing services to deprived areas

[46] From: PoW 2003; Guidelines for performance review by BMCs 2003 PoW; PoW 2004; Performance agreements 2004 for MoH/GHS, GHS/RDHS, RDHS/DDHS; MoU MoH/CHAG

Pro-poor agenda	Current indicators 2003 & 2004[46]	Potential modifications to more clearly bring out pro-poor achievements	Possible source	Utility
	• Number of cases seen and treated by CHOs, • Number of CHPS zones completed by region and district, • Number of CHPS zones started by district	distance from other static health facilities, location in District Assembly/NDPC documented core poor area, provision of essential services including skilled midwifery) • Number of sub-districts (or area councils?) that qualify for CHPS based on standard criteria for deprivation but have no services in place, i.e., whether the compound is 'started' or not, the community and its households are not receiving the CHPS package of preventive, promotive and curative services [Note – the existing indicator is not very useful in its present form; the suggestions here would be for eventually replacing the existing indicators]		
Urban poverty	• No requirements about reporting on this issue	• Proportion of persons ill in the previous two weeks who used an accredited facility (for at least part of their care), disaggregated for urban/peri-urban and rural districts • Could be linked with a follow-up question (for those who attended – amount paid out of pocket; for those who did not attend – why not)	• Survey (CWIQ, also possibly done as a supplemental or 'piggy back' question with the annual district EPI survey in all districts	• Community based assessment of utilisation • Rapid assessment of costs for care (which is a greater issue than geographical access in urban areas), and barriers to care
Poverty related diseases and targeted programmes	• Malaria cases – total and <5yrs; institutional mortality <5yrs – sector, region, district, sub-district • Guinea worm cases – sector, region, district, sub-district • Institutional maternal mortality – sector, region, district, sub-district • ANC, PNC, deliveries by skilled attendants – sector, region, district, and sub-district	• ITN coverage by district, sub-district and compared to malaria cases (as per work being done in NR and UER with the ACSD) • Numbers of malaria cases treated in homes by qualified personnel (CHOs, trained volunteers?); eventually with disaggregation by core poor/poor/endowed areas of districts • Proportion of households/population with access to safe water year-round within 30 minutes round trip. • Comparison of the sub-district maps for rates on each of the indicators in the existing set to intra-district poverty maps • Community-based maternal mortality rates (e.g., by sisterhood method) [Note – these could be done as supplemental analyses, building on the present indicators/analysis]	• Survey (CWIQ, also possibly done as a supplemental or 'piggy back' question with the annual district EPI survey in all districts • Sub-district records (assuming CHO records kept separately) • CWIQ, DHS, piggy back question in EPI survey, or using continuously updated community mapping at SD/CHPS zone level • Poverty maps from NDPC and other sources • Survey (CWIQ, also possibly done as a supplemental or 'piggy back' question with the annual district EPI survey in all districts (if statistically sound)	• Being able to compare the most effective public health measure for malaria prevention with outcomes (at least institutional rates) • Assessing outreach service delivery to the poor • Assessing status of the primary public health measure for GW prevention • Assessing health status and outcomes for the poor – are we really reaching them effectively? • Validation of institutional MMRs

Pro-poor agenda	Current indicators 2003 & 2004[46]	Potential modifications to more clearly bring out pro-poor achievements	Possible source	Utility
Exemptions	• Number of patients receiving exemptions by category, • Amount spent on exemptions by category (including a category of 'poor' or 'pauper'), • Amount spent by institution (sub-district, hospital)	• Number of patients whose health insurance (MHO) premiums are partially or completely paid by exemption funds • Amount of exemption funds contributed to (paid to) insurance funds for coverage of exemption qualified patients (especially paupers) [Note – these could be done as supplemental analyses, building on the present indicators/analysis]	• Enrolment and financial records of MHOs • Financial records of RHDs, DHAs and District Assemblies (possibly also donors who earmark funds)	• Tracking coverage for the poor during the transition from exemption for cash and carry to exemption support within health insurance
Health Insurance	• % of IGF coming from pre-payment and community insurance schemes	• Proportion of the population enrolled in local or district wide health insurance schemes (MHOs) • Number of paupers (core poor) covered by the schemes • Proportion of poverty related disease encounters that are covered by health insurance (based on top communicable diseases or top diseases of public health importance) [Note – the present indicator may be useful for financial purposes, but is not useful for pro-poor analysis. The suggestions above would therefore be additional to the existing indicator]	• Enrolment data of functioning schemes that meet standard criteria for MHOs • District assembly records or registers (after developing pauper identification system) • Service records	• Tracking achievements of the health insurance initiative from the local level upwards • Ensuring that the poor are being targeted for improved access to health services • Assess effectiveness of pro-poor strategies in addressing the diseases of poverty

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