Final Thematic Paper
on
Health Sector

(Thematic Paper no. 3)

Joint Evaluation of the Ghana – Denmark Development Co-operation from 1990 to 2006

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Table of contents

Table of contents i
List of tables iv
List of figures v
List of acronyms vi
SUMMARY 1
1 INTRODUCTION 1
2 FRAMEWORK OF SUPPORT TO THE SECTOR 1
2.1 Government's sectoral policies 1
2.1.1 Ghana Vision 2020 1
2.1.2 Ghana poverty reduction strategy (GPRS) 2
2.1.3 Health sector policies 2
2.2 2.2. Sector-Wide Approach in Ghana (SWAp) 4
2.3 Trends of sector-wide performance Programme indicators POW II 2002 – 2006 (Baseline 2001) 5
2.4 Health Fund and its working Mechanisms 7
2.5 Government funding of the health sector 8
2.6 Danida's sectoral policies 9
2.6.1 Sexual and reproductive health and rights strategy 11
2.6.2 HIV/AIDs policy 11
3 NARRATIVES OF THE PROGRAMMES 1990-1998 12
3.1 Description of major programmes and projects 12
3.2 Assessment of relevance, efficiency, effectiveness, impact and sustainability – mainly based on existing documentation 14
3.3 Lessons learnt 14
4 THE PROGRAMMES 1998-2008 15
4.1 HSPS Phase II (1998-2002) 15
4.2 HSPS Phase III (2003-2007) 17
4.3 Support HIV/AIDs national strategy framework II (NSF II) 19
4.4 Disbursements by Danida between 1994 and 2006 19
5 SECTORAL EVALUATION QUESTIONS 22
5.1 Question 1: To what extent is Danida support to health linked to, aligned with and accountable in relation to Ghana's health policies, plans and sector strategies, harmonised with other DPs, and predictable? 22
5.1.1 Danida support refers to and is conceived in support of national development objectives and strategies 22
5.1.2 Alignment 22
5.1.2.1 Improved alignment of Danish assistance on national priorities 22
5.1.2.2 Strengthened capacity by co-ordinated support 22
5.1.2.3 Increased use of country procurement systems 23
5.1.2.4 Increased use of country public financial management systems 23

5.1.2.5 Increased predictability ... 24
5.1.3 Harmonisation ... 24
5.1.3.1 Use of common arrangements or procedures ... 24
5.1.3.2 Encouraged shared and increased analysis ... 25
5.1.4 Predictability of disbursement improved ... 25
5.1.5 Conclusions ... 27
5.2 Question 2: How appropriate was the choice of regions of Danish assistance to the sector (if applicable)? ... 27
5.2.1 Quality and comprehensiveness of choice of regions and sectors ... 27
5.2.2 Consideration of up-scaling potential in regional and (sub-)sectoral choice (replicability) ... 28
5.2.3 Conclusions ... 28
5.3 Question 3: To what extent has Danida support to the health sector enhanced the performance of health service delivery (quality of services) since 1994? ... 28
5.3.1 Improved Reproductive Health Services ... 29
5.3.2 Supervised delivery ... 29
5.3.3 Infant and under-five mortality ... 30
5.3.4 Performance in selected health indicators in deprived regions *versus* the national average ... 31
5.3.5 Quality of care ... 32
5.3.6 Utilisation of health services ... 33
5.3.7 Effective maintenance systems ... 33
5.3.8 Participation of the private sector in health service delivery ... 35
5.3.9 Decentralisation has built the capacity and increased participation of district and sub-districts in the planning, management and evaluation of health services ... 36
5.3.10 Summary ... 37
5.4 Question 4: To what extent has Danida support contributed to improved access to health services, especially for the poor and vulnerable? ... 38
5.4.1 Exemption mechanism in place for those who can not afford to pay for certain services ... 38
5.4.2 Increased existence and application of provisions to ensure protection of vulnerable groups from financial risks, e.g. health insurance schemes ... 39
5.4.3 Conclusions ... 42
5.5 Question 5: To what extent has Danida support to PHC training institutions contributed to improved quality of health services to the population? ... 43
5.5.1 Availability and performance of human resources (trained CHNs) ... 43
5.5.2 Availability and quality of HLM ... 44
5.5.3 Improvement in infrastructure of the four cadres of PHC workers at Kintampo Rural Health Training School ... 45
5.5.4 Evidence of infrastructural developments at the CHN and CHNM Training Schools ... 45

5.6 Question 6: To what extent has Danish assistance contributed to the development of organisational and institutional capacity in the health sector and sustained improved performance of these in Ghana? 46
5.6.1 Consideration, by Danida, of capacity-building issues in health sector policy dialogue 46
5.6.2 Relative (strategic) importance given to capacity-building measures in individual programmes and sectors 47
5.6.3 Satisfaction of trainees of all kinds with the capacity-building measures 47
5.6.4 Relevance of capacity-building measures to in-country needs 48
5.6.5 Level of retention of staff trained 48
5.6.6 Progress in administrative and institutional reforms that aim at improved service delivery for the clients 49
5.6.7 Conclusions 49
5.7 Question 7: How appropriate were the aid modalities / support and funding methods used by Danish assistance in the health sector? 50
5.7.1 Assessment of modalities applied by Danish assistance by Ghanaian government, Civil Society and other partners 50
5.7.2 Appropriateness of combination of modalities to national policy and institutional context 50
5.8 Question 8: To what extent were cross-cutting issues and priority themes duly considered in Danish assistance to the health sector? 51
5.8.1 Gender as a cross-cutting issue 51
5.8.1.1 Increased gender mainstreaming into programme support and project activities 51
5.8.1.2 Increased targeting of women, children and vulnerable groups as direct or indirect targets (beneficiaries) of Danida programmes and project 51
5.8.1.3 Increased level of women's participation in decision-making on Danish supported programmes and projects as well as in grassroots community levels 51
5.8.1.4 Improved levels of the socio-economic status of women, men, children and the vulnerable due to Danish Assistance 52
5.8.1.5 Conclusions 52
5.8.2 Environment as a cross-cutting issue 52
5.8.3 Good governance as a cross-cutting issue 53
5.8.4 Human rights and democracy as cross-cutting issues 54
5.8.4.1 Consideration of issues of promoting human rights and democracy issues when designing the interventions, especially regarding promotion of (local) participation in decision-making, i.e. through Civil Society 54
5.8.4.2 Increased mainstreaming of human rights and democracy issues into programme support and project activities 54
5.8.4.3 Conclusions 55
5.8.5 Private sector as a priority theme 55
5.8.6 HIV/AIDs as a priority theme 56
6 SUMMARY ASSESSMENT, RELATED TO THE DAC CRITERIA 57

7 OVERALL CONCLUSIONS AND RECOMMENDATIONS 60
7.1 Overall conclusions of the assessment 60
8 ANNEXES 63
8.1 Persons met 63
8.2 Bibliography (major documents) 66
8.3 Summary of Danida support to the UWR 71
8.3.1 Organisation and management (O&M) 71
8.3.2 Quality of care 74
8.3.3 Infrastructure development 75
8.3.4 Community participation and women empowerment 76
8.3.5 Utilisation of health services 76
8.3.6 Supervised delivery 77
8.3.7 Effective maintenance systems e.g. construction of new and rehabilitation of old facilities and transport have been put in place 78

List of tables

Table 1: Trend of sector-wide performance Programme indicators POW II 2002 – 2006 (Baseline 2001) 5
Table 2: Sector-wide financial indicators by Year, 2001-2006 8
Table 3: Percentage share of health sector funding, by source, 2002-2006 9
Table 4: Summary of health projects supported by Danida during Phase I, 1994-97 13
Table 5: Danida support to the health sector between 1994 and 1997: Summary assessment 14
Table 6: Summary of health projects (1998-2002) 16
Table 7: Budget for Danida Support to the health sector programme 2003 - 2006 (DKKm) 24
Table 8: Assessment of relevance and impact of choice of regions and (sub-)sectors 28
Table 9: Trends in performance of Reproductive Health Service 29
Table 10: Proportion of births attended by skilled health personal 30
Table 11: Development of basic health indicators in Ghana 1993 - 2006 30
Table 12: Proportion of 1 year olds immunised against Measles, 1998-2006 31
Table 13: Performance in deprived regions versus national average 2003 - 2004 32
Table 14: Outpatients admissions by region, 2001-2006 33
Table 15: Danida support to EMU: Programme budget against disbursement, 1999-2006 34
Table 16: Danida earmarked support to strengthening district and sub-districts: Programme budget against disbursement, 1999-2006 37
Table 17: Summary of DAC-criteria assessment of Danida support to improving health sector performance 37
Table 18: Danida earmarked support to access to health services, budget versus disbursement, 1999-2006 39
Table 19: Regional distribution of the proportion of the population registered under the NHIS, 2005-2006 41

Table 20: NHIS registration coverage by category of registrants, 2005 - 2006 41
Table 21: Summary of DAC-criteria assessment of Danida support towards ensuring protection of vulnerable groups from financial risks 42
Table 22: Annual student intake of six CHNT schools supported by Danida, 1998-2006 44
Table 23: Annual enrolment of six Danida supported CHNT by training Institute and sex, 1998-2006 44
Table 24: Kintampo Rural Health Training School: Admissions by Year and Sex 45
Table 25: Summary of DAC-criteria assessment of the contribution of Danida support to PCH training institutions towards improved quality of health services to the population 46
Table 26: Brain Drain in Ghana by cadres having left the country, 1998-2003 48
Table 27: Beneficiaries of Danida Fellowship by gender and current status (in post or not in post), 1999-2007 49
Table 28: Summary of DAC-criteria assessment of the contribution of Danish assistance to the development of organisational and institutional capacity in the health sector and sustained improved performance of these in Ghana 49
Table 29: Summary of relevance and effectiveness 55
Table 30: Summary assessment of Danida support to the health sector related to DAC criteria 57
Table 31: Age classification of transport vehicles in health in UWR 73
Table 32: OPD Attendance in UWR by districts, 2000-2006 77
Table 33: Ante natal coverage in UWR by district, 2000-2006 77
Table 34: Number of supervised deliveries by district, UWR from 2003 to 2005 78
Table 35: Coverage of FP acceptors in UWR by district, 2001-2006 78
Table 36: Danida support to EMU: Programme budget against disbursement, 1999-2006 79

List of figures

Figure 1: Health sector support, 1994-1997 (impact diagram) 13
Figure 2: Health sector support, 1998-2002 (impact diagram) 16
Figure 3: Summary expenditures of Danish support and year, 1998-2002 17
Figure 4: Health sector support, 2003-2007 (impact diagram) 18
Figure 5: Expenditures by year during HSPS III 19
Figure 6: Denmark-Ghana development co-operation: Summary of Danish expenditures to the health sector and year, 1994-2006s 20
Figure 7: Comparison of summary expenditures of the three health support phases (HSSP I (1994-98); HSPS II (1998-2002); and HSPS III (2003-2006) 20
Figure 8: Trends in the nutritional status of children in Ghana, 1008 - 2006 31

List of acronyms

ADA	Additional Duty Allowance
AIDs	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASR	Annual Sector Reviews
BMC	Budget Management Centres
CHAG	Christian Health Association of Ghana (CHAG)
CHC	Community Health Committees
CHPS	Community-based Health Planning and Services
CHO	Community Health Officer
CHN	Community Health Nurse
CHNTS	Community Health Nursing Training School
CMA	Common Management Agreement
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisations
DA	District Assembly
Danida	Danish International Development Agency
DFID	Department for International Development Co-operation
DHMT	District Health Management Team
DISHOP	District Health Operation Programme Support
DP	Development Partner
DKK	Danish Kroner
DO	Desk Officer
EC	European Commission
ECOWAS	Economic Community of West African States
EQ	Evaluation Question
EDP	Essential Drug programme
EIA	Environmental Impact Assessment
EMU	Estate Management Unit
ENRECA	Enhanced Research Capacity Programme
EPA	Environmental Protection Agency
EPI	Expanded Programme for Immunisation
EVAL	Danida's Evaluation Department
EU	European Union
GAC	Ghana AIDs Commission
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GHS	Ghana Health Service
GIS	Geographic Information System
GLSS	Ghana Living Standard Survey
GNI	Gross National Income
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
GTZ	German Technical Co-operation
GRMA	Ghana Registered Midwives Association
GSMFI	Ghana Social Marketing Foundation International
HDI	Human Development Index
HF	Health Fund

HIPC	Highly Indebted Poor Countries
HIV/AIDs	Human immunodeficiency virus/Acquired immune deficiency syndrome
HIRD	High Impact Rapid Delivery
HLM	Health Learning Materials
HR	Human Rights
HS	Health Sector
HSSO	Health Sector Support Office
HSPS	Health Sector Support Programme
HSR	Health Sector Reform
ICPD	International Conference on Population and Development
ICPD-POA	International Conference on Population and Development-Programme of Action
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JICA	Japan International Co-operation Agency
JPP	Joint Procurement Programme
KATH	Komfo Anokye Teaching Hospital
LI	Legislative Instrument
MD	Managing Director
MDA	Ministries Departments and Agencies
MCP	Mixed Credit Programme
MDBS	Multi Donor Budget Support
MDG	Millennium Development Goals
MFA	Ministry of Foreign Affairs
MICS	Multiple Indicator Core Survey
MoFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOWAC	Ministry of Women and Children's Affairs
MPBS	Maintenance Programming and Budgeting System
MTEF	Medium-Term Expenditure Framework
MTHS	Medium Term Health Strategy
MTS	Midwifery Training Schools
NCS	National Catholic Secretariat
NDPC	National Development Planning Commission
NGO	Non Governmental Organisation
NHIS	National Health Insurance Scheme
NPEP	National Polio Eradication Program
NSF	National Strategy Framework
NTC	Nursing Training College
NTCP	National Tuberculosis Control Program
ODA	Overseas Development Assistance
OECD/DAC	Organisation for Economic Co-operation and Development
PFM	Performance Financial management
PHC	Primary Health Care
PIU	Project Implementation Unit
PNC	Postnatal Care
POW	Programme of Work

PPM	Planned Maintenance Management
PPME	Policy Programme Monitoring and Evaluation
PRSP	Poverty Reduction Strategy Paper
PSU	Private Sector Unit
RDE	Royal Danish Embassy
RG	Reference Group
RNE	Royal Netherlands Embassy
SBS	Sector Budget Support
SDHMT	Sub-District Health Management Team
SPS	Sector Programme Support
SRHR	Sexual Reproductive Health Rights
SRN	State Registered Nurse
SWAp	Sector Wide Approach
TA	Technical Assistance
TOR	Terms of Reference
TP	Thematic Paper
U5MR	Under-5 Mortality Rate
USD	United States Dollar
UN	United Nations
UNAIDs	The Joint United Nations Programme on HIV/AIDs
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session
UN MDGs	United Nations Millennium Development Goals
USAID	United State Agency for International Development
UWR	Upper West Region
WB	World Bank
WDR	World Development Resources
WHO	World Health Organisation

Summary

During the period of the evaluation (1994-2006), Danida provided support for the implementation of three major programmes in the health sector (Health Sector Support Programmes I to III - HSSP). The direct project support adopted during Phase I (1994-97) shifted to a sector-wide approach (SWAp) in subsequent phases. An estimated 66% to 75% of Danida support to the sector was channelled through the health account for the implementation of the Ghanaian Medium Term Health Strategy / Programme of Work (MTHS/POWs). Earmarked funds ensured sustainability of ongoing Danida activities, helped maintain some visibility and secured funding for areas of crucial importance to the success of the POW II, but at the risk of being sidelined. Danida support in the health sector was directed to the implementation of the sectoral policies and strategies, development of health systems, infrastructural development, as well as capacity building, with a major focus on the poor and vulnerable.

In addition to the programmes under the three phases, Danida also provided a 10-year support to the Noguchi Memorial Institute of the University of Ghana in 1993 on “Enhancement of Research Capacity” (ENRECA) in developing countries initiated in 1989. The total budget of DKK 22m was disbursed. Support (DKK 9.970m) was earmarked to support five of the seven intervention areas of the HIV/AIDs NSF II, including support to six ministries to mainstream HIV/AIDs into their sectoral plans.

As part of its support to child health interventions, Danida provided an amount of DKK 9,669,043 in 2004 to support the National Polio Eradication Programme (NPEP).

Overall, a total amount of DKK 793,614,841 has been spent on the three phases of the sector programme (amount excludes expenditure on ENRECA and earmarked for HIV/AIDs) as at the end of 2006, with one year still left of programme implementation. Under HSSP I, the programme overspent its budget by 8.2%. The total support for Phase II amounted to DKK 225m, out of which about 93.3% was utilised at the end of the programme. Of the total programme budget of DKK 340m, HSPS III had disbursed 88% (DKK 300,613,546) as at the end of December 2006.

Danida support to the sector has been **relevant** and consistent with the national and sectoral policies and strategies of the country and addresses priority health needs (capacity building, access to health care, improved health status and primary health care). In principle, the **effectiveness** of Danida’s contribution through the SWAp can only be measured through the assessment of the entire health sector performance, though some level of attribution can be made. Generally, Danida earmarked support to the sector has been effective in contributing to the introduction of innovations and the building of systems to improve the quality of care. Some of these innovations include the creation of Quality Assurance Teams, introduction of maternal mortality audits and institution of clients’ satisfaction surveys at the facility levels. Danida investments in **capacity building**, health infrastructural development, including construction and rehabilitation of health facilities and Public Health Care (PHC) Training Institutions, strengthening of districts and sub-districts and the establishment and development of the Estate Management Unit (EMU) have been highly effective. The support of fellowships for postgraduate courses outside the country has contributed to the achievement of programme objectives.

One of the striking features of the sector during the period under evaluation is the increase in the budget allocation to health, from 8.7% of government recurrent expenditure in 2001 to 18% in 2006, which is higher than the Abuja Declaration suggests. Unfortunately, most of the increase in funding has been allocated to increases in salaries (personnel emoluments).

During the period covered by the evaluation, the sector adopted the SWAp and developed a sector-wide monitoring system with harmonized indicators, which provided a good basis for improved **efficiency**. Predictability of fund flow to the sector, coupled with flexibility in the disbursement mechanism through the Health Fund, allows for efficient implementation of programme activities. However, inadequate investment in service delivery of the health sector by the GoG is affecting efficiency.

Impact: The overall performance of the sector using the sector-wide indicators provides a mixed picture. Indicators on specific programmes such as ANC, PNC, utilisation rates, HIV and AIDs and nutrition showed positive trends. However, there have been recent concerns about other important health outcomes over the period, e.g. infant and under-5 mortality, which have either stagnated and/or retrogressed. Though health status depends not only on health sector achievements, the sector has been thoroughly examined in an attempt to explain the unsatisfactory performance. An independent review carried out in 2006 concluded that the challenges in the sector primarily relate to the budget, the way it is managed, the workforce and its level of motivation.

The ratios of doctors to nurses to population have declined in recent years reflecting the high reputation of Ghana's clinicians abroad and the difficulties in retaining doctors in the country. The "brain drain" of Ghanaian health staff thus continues to be one of the major constraints to improving health outcomes. The problem is aggravated by the distribution of human resources, which is skewed towards urban areas and often not allocated according to actual work load.

The **sustainability** of Danida support was an identified risk which has proven justified in some few instances. Some of the promising systems put in place, especially in the Upper West Region (UWR) during Phases I & II, could not be sustained. There are, however, instances where systems developed in other regions with Danida support have been replicated either at the national level or in some regions.

Cross-cutting issues: Cross-cutting issues such as HIV/AIDs, environment, gender and good governance are relevant to the health sector, and have been mainstreamed into the support.

Coherence, co-ordination, complementarity: Danida's support to the sector is fully coherent with higher level policies such as Ghana Vision 2020 and GPRS I and II, as well as with the health sector polices such as the MHTS and POWs. Donor co-ordination in the sector improved over the period and Danida has been a major player in this regard. Donor co-ordination in the health sector, which had been non-existent during HSSP I, improved during the early implementation of SWAp under POW I, but deteriorated in the early 2000s. There are indications now that sector dialogue and co-ordination have started to improve and it is hoped that this will be maintained. The shift from project support to SWAp in 1997 has contributed to ensuring harmonisation and improving dialogue.

Danida has also made conscious efforts to strengthen and harmonise sector dialogue, including dialogue and co-ordination on the side of the development partners (DPs) as donor sector lead in 2005/2006. There have been marked improvements regarding harmonisation of procedures, the use of national systems and the alignment of programmes over the period.

Issues of procedures, administration and management: Danida support has been flexible, predictable, holistic and consistent in terms of procedures, administration and management of the health sector programmes. The programme documents and the Common Management Agreements (CMA) clearly spelt out these procedural and managerial issues.

Global Assessment: In all, Danida support to the health sector in Ghana from 1994-2006 has been highly relevant to the goals and objectives of national and sector policies and programmes.

Danida has contributed to in several ways to some of the major changes in the sector. These changes include institutional reforms and development of a vision for health service delivery policies and procedures that aimed to shift service delivery to the district level, introduction of far-reaching fiscal and management decentralisation concept[1], and the introduction of the National Health Insurance Scheme (NHIS). Other major changes of significance that have been introduced in the sector include the creation of Quality Assurance Teams, maternal audits and client satisfaction surveys at facility levels, as well as the strengthening of primary health care delivery. The MoH, with support from its DPs is implementing the High Impact Rapid Delivery (HIRD) to address three of the MDG indicators, which has received support from donor partners including Danida. During the same period, the MoH pioneered the SWAp approach, harmonised programmes in the sector and enjoyed flexibility in funding from its partners. During the period, the Ministry assumed the leadership role of the sector and thereby initiated and led its own sector programmes. Dialogue among DPs and MoH, which had improved considerably in the early part of SWAp and then deteriorated in the early 2000, is now showing renewed signs of improvement. A common funding mechanism has been adopted for all donor partners. Per capita funding for the sector has increased from USD 6.3 in 2001 to USD 25.4 in 2006. Similarly, the GoG increased the proportion of government recurrent expenditure on health to 18% in 2006, exceeding the Abuja declaration.

Conclusions and recommendations: In conclusion, Danida support to the health sector has contributed to an increased access to health services, to improved quality and efficiency of health service delivery and to strengthened district capacity to plan, budget and monitor programme implementation. The support has also assisted the MoH to build health systems in the sector, which has contributed to improved service quality and efficiency. Danida's continued support to the sector is still relevant as it would contribute to achieving the goals of the health sector policies and programmes. The evaluation recommends:

- Danida should continue to support capacity development efforts in the sector as within the current aid modality, especially short- and long-term TAs, external post-graduate programmes and implementation of the NHIS.
- Government should increase and ensure improved efficiency in central government funding for services, especially at the district level. *Danida and other DPs could use the policy dialogue to discuss with government the setting aside of a certain proportion of the health sector budget for service provision, especially at the district level.*
- Government and DPs should take immediate measures to address the stagnation and/or worsening situation of selected health outcomes to ensure that the country meets her MDG targets.
- Government should institute and sustain incentive packages for PHC professionals to stem the sector's "brain drain". Government, with support from DPs should address the lack of career development for certain categories of health professionals, such as PHC providers. In this context, the MoH's Human Resources Development

[1] Budget Management Centres (BMC) are cost centres with responsibility to manage and spend an allocated budget from the government specific to their activities. It is a concept designated to health administrations, hospitals, training and research institutions, etc. This is part of the health sector plans towards total financial decentralisation and a more efficient and transparent financial management system in the sector. The BMC concept is a step towards ensuring ownership of plans developed by each health institution as well as ensuring that institutions accept full responsibility for managing and accounting for resources provided for the plans developed at that level or unit.

Unit should facilitate implementation of the new approach to HRH planning, development and management that it has developed.

1 Introduction

The main purpose of the Joint Evaluation of the Ghana-Denmark Development Co-operation from 1990-2006 is to evaluate achievements against the overall development objectives as formulated in various development strategy documents, including the development strategy presented by Ghana in Paris in June 1993; the Ghana Vision 2020; the Ghana Poverty Reduction Strategy from 2002; the Interim Poverty Reduction Strategy (2000-02); the Ghana Growth and Poverty Reduction Strategy (September 2005); the Danish Strategy 'Partnership 2000'; and the country strategies for collaboration between Ghana and Denmark published in 1993, 1998 and 2004. The efforts and achievements have been assessed against the contemporary context and standards prevailing at the time when the key decisions were taken.

While the evaluation has covered the entire period from 1990 to 2006, the main emphasis has been on lessons learned from 1998 (second country strategy for collaboration between Ghana and Denmark) to the present day. Particular attention has also been paid to the lessons learned from implementation of the most recent country strategy (2004-2008).

In line with the up-dated Danida Evaluation Guidelines (MFA, Danida 2006a), the evaluation was carried out to generate knowledge and accountability information about developments interventions in Ghana and contribute to the improvement of development co-operation through collation, analysis and dissemination of experience. In addition, the evaluation is intended to provide parliamentarians and the general public in Ghana and Denmark (as well as other interested parties) with professional documentation on the objectives and results of development co-operation.

Based on the TOR and the tender submitted by Particip, the contract concluded proposed a number of thematic papers (TPs) to be prepared as building blocks for the synthesis report. These papers will be circulated and discussed with relevant stakeholders. They will also be annexed to the synthesis report. However, these papers should not be considered as merely or mostly background papers but as essential pillars of the overall evaluation, focusing on specific issues that arose from first discussions and document analysis.

This thematic paper discusses the health sector and the support of Danish assistance to the sector from 1994 to 2006, and focuses on both project and programme support (Details of Danida support to the UWR is attached as an appendix). The assessment relied on existing project documents and field interviews conducted in August and September 2007 of key stakeholders in the health sector of Ghana, including officials from the Ministry of Health (MoH), Ghana Health Service (GHS) at national, regional and district levels, Christian Council of Ghana (CHAG), Royal Danish Embassy (RDE), Health Sector Support Office (HSSO), former project staff and staff of selected District Health Schemes.

2 Framework of support to the sector

2.1 Government's sectoral policies

2.1.1 Ghana Vision 2020

In 1996, Ghana developed a long-term vision for growth and development known as "Vision 2020", that envisaged the country moving from low-income to middle-income status by 2020. The Vision 2020 document defines the nation's areas for priority attention in the medium to long term as:

- maximising the healthy and productive life of Ghanaians;
- fair distribution of the benefits of development;
- attainment of a national economic growth rate of 8%;

- reduction of the population growth from 3% to 2.75%;
- the promotion of science and improved technology as tools for growth and development.

The overall objective of national health policy in the “Vision 2020” document was to “improve the health status of all Ghanaians”. The specific health objectives of Vision 2020 were:

- significant reduction in infant, child and maternal mortality rates;
- effective control of risk factors that expose individuals to major communicable diseases;
- increased access to health services, especially in rural areas;
- establishment of a health system effectively reoriented towards delivery of public health services;
- effective and efficient management of the health systems strengthened.

2.1.2 Ghana poverty reduction strategy (GPRS)

The GPRS I (2003-2005) and GPRS II (2006-2009) were developed as the national policy documents after the Ghana Vision 2020 to address and guide national poverty reduction efforts focusing on economic growth through agricultural development and rural income generation. Unlike previous programmes and plans, the GPRS is linked to annual budgets to address implementation lapses during previous national programmes and plans. The policies and programmes in the GPRS articulate the strategic plans of Ministries, Department and Agencies.

The main objectives are ensuring macro-economic stability for accelerated growth, increasing production and gainful employment, facilitating direct support of human development and provision of basic services, and expanding special programmes to support vulnerable groups and enhancing good governance. The GPRS outlines the following key objectives:

- bridge equity gap in access to quality health and nutrition services;
- ensure sustainable financing arrangements that protect the poor;
- enhance efficiency of service delivery.

2.1.3 Health sector policies

Supplementing the overall national development polices or programmes are sector-specific policies and programmes. The health sector policies are derived from the national development policies and programmes. In 1997 Ghana produced a coherent strategic framework and plan for achieving health sector goals laid out in *Ghana Vision 2020*. A Medium-Term Health Strategy (MTHS) prepared in 1996 (and later updated in 1999), specifies five key objectives:

- increasing access to health care;
- improving the quality of health care;
- improving the efficiency of delivery of care and avoiding waste;
- fostering closer ***collaboration and partnership*** between the health sector and communities, other sectors and private providers, including NGOs; *and*
- ***increased overall resources*** in the health sector**,** and more and better management of *financing* for health care delivery *(MOH, 1999)*.

A five-year Programme of Work (POW) was prepared to provide a framework for the financing and implementation of the MTHS for the period 1997-2001 and was based on a sector-wide approach (SWAp).

Box1: First health sector five-year programme of work – POW I: 1997-2001

Policy Goal: To improve the health status of all Ghanaians
Objectives
Increased geographical and financial *access* to basic services
Better *quality* of care in all health facilities and during outreach
Improved *efficiency* in the health sector
Closer collaboration and *partnership* between the health sector and communities, other sectors and private providers, both allopathic and traditional
Increased overall *resources* in the health sector, equitably and efficiently distributed.
Strategies
To strengthen primary health services (district health services)
To re-orient secondary and tertiary services delivery to support primary health services
To develop and implement a programme to train adequate numbers of new health teams to provide and manage these services
To improve capacity for policy analysis, performance monitoring and evaluation, and regulation of service delivery by health professionals
To strengthen central support systems for human resources, logistics and supplies, and management of financial and health information
To promote private sector involvement in the delivery of health services
To strengthen inter-sectoral collaboration.

Source: Ministry of Health, 1996

In 2001 Ghana's health performance was reviewed, nearly at the end of the first Five Year Programme of Work (POW I). Box 2 below provides insights into the lessons learnt from the implementation of the POW I.

Box 2 Lessons learned from POW I

Performance: The overall health status of Ghanaians has improved, but the gains have been slow and unequal. Utilisation has remained constant; some public health services have increased outputs.
Persisting constraints have been as follows:

- financial barriers to access services have remained
- targeting of the poor and vulnerable has not been optimal
- the delivery system has not been responsive to beneficiaries
- potential of inter-sectoral work and contribution from NGOs has remained untapped
- building blocks of organisational reform are in place, but progress to achieve the expected efficiencies has not been realised
- human resource strategies resulted in only marginal staff increases; addressing low salaries remains a dilemma
- while budgetary targets were achieved, per capita expenditures remained low and the allocation inequitable

Source: Reflections on the First Five Year Health Sector POW, 1997-2001

A second 5-year Programme of Work (POW II) (2002-2006) – "Partnership for Health: Bridging the inequalities gap" was developed to guide the sector for the next five years. The POW II built on the gains made during the POW I and applied lessons learnt from findings to develop new solutions. The POW II is also an integral part of the GPRS and recognises that improving the health status of the poor is crucial for reducing poverty, given that ill-health is both a consequence and cause of poverty. The policy and strategy guidelines to achieve obtain the objective of the POW II is captured in the Medium Term Health Strategy (MOH, Nov 2001).

The most important programme outcomes and impact targets set in the POW II for the end of 2006 include:

- HIV/AIDs prevalence rate reduced to 2.6%
- Reduced infant mortality rate from 57 to 50 deaths per 1,000 live births

- Reduced under 5 mortality rate from 108 to 95 per 1,000 live births
- Reduced maternal mortality from 214 to 150 per 100,000 live births
- Maintain life expectancy at 58 years
- TB cure rate improved from 43% to 60%
- Improved TB case detection rate
- Increase use of insecticide Treated Nets (ITN) from 10% to 56%
- Reduced the fatality rate of malaria cases for <5s
- Increase supervised deliveries from 44% to 50%
- Increase CPR from 14% to 40%

The preparation of the strategic framework and five-year POW in the mid-1990s coincided with a new paradigm shift towards a SWAp. The MoH opted for a sector-wide approach for the implementation of this POW. Both the process and outcome of the strategic planning convinced the Ghanaian authorities that the POW goals would best be served by moving towards a more coherent and co-ordinated collaboration with its partners that would address the issues and constraints the country was facing at the time.

2.2 2.2. Sector-Wide Approach in Ghana (SWAp)

Ghana's evolution towards a SWAp has been a long, dynamic and incremental process, spanning more than 10 years. The SWAp is a shift from vertical project strategy support to a more coherent and co-ordinated effort to overcome the deficiencies of projects. The ultimate goal of SWAp is to promote the equitable, sustainable and efficient use of all available national and external resources.

The health sector relationship with donors under SWAp has undergone considerable change from project-type approaches (with donors in control) to a government-led-and-controlled approach. Evidence from the performance of the past 9 years from 1997 to 2006 indicates that some gains have been made in this partnership. Although gains in the sector were modest (note targets) the partnership has gained considerable success in policy dialogue (until recently), joint performance assessment of the sector, co-ordination of activities to reduce duplication of effort, improved financial management and procurement and general planning for the health sector.

These successes were attained through biannual joint summits of MoH and donors, monthly donor meetings and joint quarterly business meetings between MoH and donors and the joint programme of work.

The development of SWAp II was a joint exercise between the MoH and donors and the aim was to consolidate the gains of SWAp I through bridging the inequality gaps between the north and south and urban and rural.

The SWAp started to change the dynamics of the Danida's dialogue with Government and with other development partners; and it has supported other critical components of a SWAp, most notably the discussion and drafting of common management arrangements, the preparation of the MTHS and PoW I and the holding of Summit Meetings. Technical and financial support provided by development partners in support of PoW I and II implementation culminated in the building of sector management capacity and revolutionised the way Ghana and its partners act and interact in support of health sector development goals.

Under PoW I Government assumed a leadership position in the management of the sector. The PoW has become the framework for mobilising and catalysing the technical and financial support of partners. Under the first PoW systems and processes were implemented and refined that facilitated the documentation and joint review of sector performance of the previous year and the preparation, review and approval of plans and budgets for the subsequent year. Government systems and capacities have been developed at

central, regional and district levels, especially in the areas of procurement and financial management. Reliance on these systems has enabled the consolidated management of the public budget and pooled funding, particularly in the areas of procurement and financial management. The certification of BMCs has facilitated the decentralisation of sector planning, budgeting, financing, financial management, and monitoring. Under PoW II 2002-2007 experience was gained and refinements to the SWAp process continued.

Notwithstanding these successes, some capacity-building objectives of the SWAp process were not wholly achieved under the two SWAp operations supporting PoW I and II. For example, the established partnerships for the health sector do not yet include the active participation of Civil Society in sector reviews and planning and the formula for allocation of resources across regions and districts is not yet sufficiently developed to ensure equity as well as to reflect the different costs of doing business in different environments. A sound public expenditure framework is missing, making it difficult to ensure efficient and equitable use of funding. Various systems that have been developed (planning, financial management, procurement, performance monitoring) are not synergistic, thus undermining sector management capacity. The monitoring of process, output and outcomes is not linked with inputs and activities. Since the creation of GHS in 1996 no real progress has been achieved in ensuring a sound institutional framework for health by rendering MoH and GHS fully operational; in addressing human resources issues systematically; or in developing and implementing a functional performance management system that would define and monitor accountability for results.

2.3 Trends of sector-wide performance Programme indicators POW II 2002 – 2006 (Baseline 2001)

Table 1below provides the performance of sector-wide programme indicators for the POW II, using 2001 as the base year. Further analysis and write-up on the programme indicators are present in later sections of this report

Table 1: Trend of sector-wide performance Programme indicators POW II 2002 – 2006 (Baseline 2001)

Indicators	***Baseline 2001***	***Performance 2002***	***Performance 2003***	***Performance 2004***	***Performance 2005***	***Performance 2006***
Objective: Improved Health Status						
Infant Mortality Rate	57	55	64	NA		71
Under Five Mortality Rate	108	100	111	NA		111
Maternal Mortality Ratio	214 ('93)	204	187	NA		
% Under 5 who are malnourished (Wt/A)	25	NA	22.1	29.9		N/A
HIV sero-prevalence among pregnant women	2.9	3.4	3.6	3.1	2.7	2.9

Indicators	Baseline 2001	Performance 2002	Performance 2003	Performance 2004	Performance 2005	Performance 2006
Objective: Improved Service Outputs and Health Service Performance						
Performance of Clinical Care (Coverage and Quality)						
Outpatient visit per capita	0.49	0.49	0.50	0.52	0.53	0.52
Hospital admission rate/1000 pop	34.9	34.1	35.9	34.5	36.5	32.6
Bed Occupancy Rate	64.7	65.5	64.1	63.0	58.4	50.9
Tuberculosis Cure Rate	47.9	55.1	61.0	-		
TB case Detection Rate	61	59	58	56	N/A	67.6
Under-five Malaria Case Fatality Rate	1.7	1.9	3.7	2.8	2.4	2.1
No. of specialised outreach services carried out	N/A	158	175	145	164	170
Performance of Reproductive Health Services (Coverage and Quality)						
% FP Acceptors (CPR)	20.3	21	22.6	24.3	22.6	26.8
% ANC Coverage	93.5	93.7	91.2	89.2	88.7	88.4
% PNC Coverage	52.9	53.6	55.8	53.3	52.7	55.9
% Supervised Deliveries	49.2	-	51.9	53.4	54.1	44.5
% Maternal Audits to Maternal Death	<10	67	85	70.5	75.6	52.0
Performance of Preventive Services and Surveillance						
EPI Coverage – DPT 3	76.3	77.9	76	75	85	84.2
EPI Coverage – Measles	82.4	83.7	79	78	83	85.1
AFP non Polio Rate	2.8	2.3	1.4	1.5	1.68	1.55
Objective: Improved Level and Distribution Health Resources						
Human Resources						
Population to Doctor ratio	22,811	22,193	17,489	17,615	10,380	10,700
Population to Nurse ratio	2,043	2,080	2,598	1,513	1,578	1,587
Health Infrastructure						
CHPS Zones completed (functional CHPS Zones)	19	39	55	84	N/A	N/A

Source: Compiled from MOH, Annual Sector Reviews, 2005 and 2006

Box 3: Achievements and Challenges of SWAp under POW I & II (1998-2006)

Increase – as agreed - of the proportion of government funding going to health from 8.7% in 1997 to 11% in 2000. In 2006, the proportion was 18%, exceeding the Abuja target

Larger allocation to District level: there has been significant inflows of funds to district levels although the exact increase is rather difficult to assess owing to changing accounting practices over the same period

Outcome/impact: During POW I there were improvements in a number of indicators[2], e.g. immunisation levels, while during POW II the results were not so positive.

Planning and Budgeting: Planning and budgeting has been strengthened as increased authority in financial management and programme planning has been given to Budget and Management Centres (BMCs). Planning formats conform to a uniform national MTEF. Planning guidelines now emphasise key output areas. However, districts plans have yet to be integrated into the plans of the political administration at district level, the District Assembly. In addition, earmarked funding is not included in the BMC plans and budgets.

Financial management: Informed financial management accounting procedures have been developed and implemented. Danida was key to this for many years by financing a consultancy that worked on the system. But this ended somewhat unfortunately in a conflict and a complicated shift to another system. A joint audit (an audit company contracted to assist the auditor general) audits all funds, whether government or DP basket funding[3], and therefore improves transparency on the totality of funding, not just DP funds. What has never been successful, despite being a clear priority of the SWAp, was timely disbursement to BMCs, a factor that clearly undermined effectiveness.

Procurement: The Health sector has made substantial progress in the development of procurement capacity and the standardisation of procurement procedures. A procurement unit has been established at the GHS.

Capital planning: The whole SWAp almost collapsed before it had even started, when DPs found out that huge and unreasonable investments in sophisticated regional hospitals had been planned and contracts awarded in 1996. The issue was resolved by MoH committing itself to better future capital investment planning/criteria; but capital investment has continued to be a very contentious problem in Ghana[4], and a few years into HSPS II Danida withdrew DKK13m owing to breach of agreement regarding the procedures pertaining to capital investments (1998).

Review process: The institutionalisation of an annual independent technical review and two Health Summits a year (review meetings – one in the spring to review the preceding year's progress, and one in the fall to agree on the coming year's plans and budgets) has improved the analytical framework for the sector. The role of the Summits quickly evolved from being very donor-centred to becoming more a forum for Ghanaian stakeholders, although mainly government[5]. The quality of sector dialogue has varied considerably over time.

Frequent changes of Ministers: The SWAp is an innovation and consequently, the process to introducing it requires extensive policy dialogue and preparation. It requires the highest political commitment in order to be successful. Unfortunately, the frequent changes of Ministers of Health and the departure of senior and experience staff from the Ministry to either GHS or to international jobs delayed the implementation of some key programmes. For example, the contracting of services to the Mission sector and the split between the Ministry and its agencies was delayed on account of this.

2.4 Health Fund and its working Mechanisms

Since 1997 the MoH has worked closely with its partners in unifying its sources of funding into "one basket". The sector budget support has since been channelled through the Health Account or the Donor Pooled Funds through which health partners channel their contributions to the MoH in support of the agreed PoW. Funds from this account are available for all non-wage categories of expenditure and these include civil works, goods and services, drugs, vehicles, operating costs, training and consultancies as long as they conform to the approved annual budget and work programme and to spending procedures.

[2] See e.g. the Appraisal Report for HSPS III.

The contribution of HF as a proportion of total health sector funding, which increased from 18% in 1997 to 26% in 1999 has since decreased to 8% in 2006 (Table 3).

Danida support to the health account as a proportion of the total disbursement to the sector has increased from 43% in 1999 to 75% in 2006, the remaining being earmarked. Danida support under this component has been efficient in terms of disbursement, for by 31st December 2006 about 88% of HSPS III funds had been disbursed.

In general, the government and many partners including Danida considered the giving of sector support through the health account as having been very successful. Danida's contributions to the HF, together with those of other donors, have contributed to the development of government policies, strengthening of the health reforms and building of institutional reforms. Because of its innovative nature, the Ghana sector programme was subjected to additional scrutiny beyond annual technical reviews by the Danish Auditor General in 1999/2000. The thorough assessment concluded that the preconditions for giving sector programme support had been and still were being fulfilled. The Auditor pointed out a number of shortcomings, but did not substantially criticise the overall design of the programme. The Parliament's Elect State Auditors/Public Accounts Committee in their comments implicitly concluded that the HSPS II widely fulfilled the necessary requirements for Danish Sector Programme Support. The shortcomings identified have been addressed. Audit procedures include an internal as well as external audit.

2.5 Government funding of the health sector

Government spending on the health sector as shown in Table 2more than doubled between 2001 and 2006, exceeding the Abuja target by about 3%. The proportion of GoG budget allocated to health is calculated as the total allocation to health and includes donor, IGF, and statutory funds. The proportion of GoG recurrent funds allocated to health has increased steadily over the period and stabilised at 14% in 2005 and 2006. The increase is attributed mainly to the wage bill. The proportion of recurrent GoG health expenditure on non-salary items has since 2002 fallen below the 2001 value. Table 1further reveals that the proportion of expenditure at district level and below remain at the level. Exemption funding on the other hand increased from 3.6% in 2001 to 8% in 2005 as a result of the implementation of the maternal exemptions policy at national level. In 2006 exemption funding fell due mainly to the scaling up of the NHIS. In all, total health sector spending has increased consistently from US$6.3 per capita in 2001 to US$25.4 in 2006. It is expected that *per capita* spending will increase further if NHIS expenditures reflect fully in the MOH account.

Table 2: Sector-wide financial indicators by Year, 2001-2006

Indicators	***2001***	***2002***	***2003***	***2004***	***2005***	***2006***
% GOG Budget spent on health	8.7	9.3	9.1	8.2	15	18
% GOG recurrent budget spent on health (all items)	10.2	11.5	11.2	11.9	14.5	14
% of GOG recurrent health spending on non-salary items (2&3)	8.1	5.9	6.9	5.4	6.6	7
% spending on district and below (items 2 & 3)	NA	40.9	35.4	37.9	36	40
% earmarked/total donor fund	62.3	32.8	39.5	26.3	40	61
% recurrent funds on exemptions	3.6	NA	NA	NA	8	2.2
Total health sector spending per capita USD	6.3	8.1	10.5	13.5	19	25.4

Table 3 presents the percentage share of health sector funding by source from 1997 to 2006. GoG contributions to health funding increased from 43% in 1997 to 53% in 2006, but

the level is still below that of 1998 and 2000. However, when IGF, HIPC and NHIS sources are added to the direct government budgetary allocation, the trend shows an increasing share of government funding to the sector. This is an indication of increased resources from the government but as noted earlier a greater proportion of the funds is spent on salaries. The importance of the health account as a funding source has declined over the years and might continue doing so, as the importance of other funding sources increases. As Table 3 illustrates, the share of donor HF of health sector funding has varied over the period, from 18% in 1997, 26 % in 1999, 20% in 2000 and 22% in 2001 back down to 8% in 2006. Financial credits and project funding have reduced their share of health funding over the reporting period. Overall, public finance sources, comprising GoG, HIPC and NHIS contribute about 63% to the sector funding. IGF remains an important component of health sector funding but the proportion has declined from 14% to 12% and it is expected to decline further with the gradual abolition of the “cash and carry” system.

Table 3: Percentage share of health sector funding, by source, 2002-2006

Shares	***GOG***	***Donor HF***	***IGF***	***HIPC***	***NHIS***	***Financial Credits***	***Project Funding***
1997	43	18	8	0	0	31	NA
1998	55	15	9	0	0	21	NA
1999	54	26	12	0	0	8	NA
2000	55	20	12	0	0	5	NA
2001	49	22	14	0	0	2	NA
2002	49	19	14	0	0	10	8
2003	47	13	13	4	0	9	14
2004	40	24	12	6	0	11	7
2005	43	15	12	0	0	15	14
2006	53	8	12	5	9	8	0

Source: 1. MOH, Annual Sector Reviews, 2005 Financial and 2006; *Danida, (2002): HSPS Phase III, Final Draft Programme Support Document*

2.6 Danida’s sectoral policies

The overriding objective of Danish development policy over recent years has been support for partner countries’ efforts to reduce poverty. The Act on International Development Co-operation (MFA, 2002a) outlines the objective of Denmark’s ODA to developing countries to promote economic growth and contribute to social progress and political independence through co-operation with governments and public authorities in these countries, in accordance with the aims and principles of the United Nations Charter (Source: Review of the Development co-operation policies and programmes of Denmark, June, 2007).

Danish development assistance is aimed at helping the poor by investing in human development and promoting sustainable development through poverty-oriented economic growth. Women’s participation, environment and human rights as well as HIV and AIDs are important cross-cutting issues for Danish development assistance. Denmark also supports continue progress in democratisation. A fundamental principle of Danish assistance is delivery of effective and efficient assistance through strategic results-oriented interventions through sector support. Danish development aid is primarily channelled to a selected group of “partner countries” that demonstrate commitment and ability to effectively promote long-term sustainable development. Countries that qualify for assistance are those challenged by severe poverty constraints, while concurrently committed to confronting these challenges by way of preparing and implementing long-term national strategies for poverty reduction and showing commitment to consolidation of democracy and respect for human rights.

The main aim of Danida's health sector policy for the developing countries is to improve the health status of the population, especially for the most vulnerable and poorest sections. Specific emphasis is placed on women and children. The importance of health systems and the provision of good quality service is stressed in order to increase the utilisation of basic health services. In addition, individual, household and community control over their own health should be strengthened, through enhanced participation in the planning and provision of health services and more appropriate health-related behaviour. A more comprehensive approach to sexual and reproductive health and rights, also highlighted in the Cairo meeting, has been emphasised.

Denmark endorsed the Primary Health Care (PHC) approach adopted at the Alma-Ata conference in 1978. It subscribed to the main principles of equity, community involvement, focus on prevention, appropriate technology and a multi-sectoral approach. Danida was instrumental in operationalising the principles and elements of PHC in the 1990, and focused on primary and public health essential services and on developing the health systems to provide them. Danida pioneered the new concept of Essential Drug programme (EDP) and placed emphasis on the principles of equity and the utilisation of health services by poor and vulnerable groups. It advocated community participation and stimulated community-based health care by supporting the training of community health workers and construction of community health centres.

The first half of the 1990s was a period of rapid change in Danida's support to health. Danida was one of the first donors to recognise that project- and provision-based assistance often led to fragmentation and was unable to tackle the organisation and management of health systems. Consequently, Danida began to focus more on comprehensive health system projects, particularly on initiatives relating to district health systems. At the same time, it remained focused on public health and specific emerging health problems.

Most of Danida's support to health was managed through projects, as elaborated in the Danida documents "Project Guidelines, Appraisal and Planning" (1985) and Guidelines for project Preparation (1992). Danida reoriented its bilateral aid by advocating a move from project assistance towards a more sectoral approach and adopted SWAp (Sector-wide Approach) as its main modality in 1994 (although this had been spearheaded in the health sector in the beginning of the 1990s). Danida played a key role in furthering the SWAp approach internationally and co-hosted with the World Bank the first conference on the issue in Copenhagen in 1997, and also co-sponsored with the European Commission, WHO and DFID the first guide on SWAp.

Box 4: Health policy areas (Danida's health sector guidelines from 1995)

<table>
<tr><td>(Essential) Health services
Child health
Sexual and reproductive health and rights
Immunisation
Essential drugs
AIDs
Health Systems
Health financing
Health planning and management
Health manpower development
Health research</td><td>Community Development
Health education
Safe water supply and sanitation
Gender perspectives and empowerment of women
Nutrition
Health infrastructure and Equipment</td></tr>
</table>

The international policy emphasis on essential services (including reproductive health) and Health Sector Reform (HSR) as reflected in WDR 1993 and several global conferences substantially influenced Danida's health policies during the 1990s. Danida invested considerable time and effort in adapting to these conditions by formulating new policy frameworks. Danida's health sector guidelines from 1995 outlined the policies and strategies in

the health sector for the latter half of the 1990s (Box 4). It is also important to note that Danida has been very supportive of building health systems internationally, and at country level.

2.6.1 Sexual and reproductive health and rights strategy

Danida has a well-elaborated strategy for “Promotion of Sexual and Reproductive Rights”. The strategy clearly defines the policy framework within which Danida provides support for reproductive health and rights in the developing countries and further identifies four priority thematic areas of support. The strategy states the firm commitment of Danida to promoting sexual and reproductive health rights (SRHR), and recognises sexual and reproductive health as a human right, essential to good health and human development. It further states that people should have the right to take their own decisions about their sexual and reproductive lives and should have the means to do so. This includes access to reproductive health services and information and to safe and legal abortion. The strategy notes that support to SRHR will help stimulate development and reduce poverty, at both individual and macro-economic levels.

Danida’s policy, support and co-operation in the field of population is informed by the Programme of Action (PoA) adopted by the International Conference on Population and Development (ICPD) held in Cairo in 1994, and the additional goals and indicators adopted at the Special Session of the UN Genera Assembly in 1999 (ICPS+5). Full implementation of the ICPD PoA and ICPD+5 is central to the achievement of the Millennium Development Goals (MDGs) and thus poverty reduction, which underpinned Danish development assistance.

The overall goal of the Danish strategy is to contribute to the ICPD goal of universal access to sexual and reproductive health and rights, including for youth. With the MDGs as the common framework for poverty reduction and the driving force for international development, the focus of Danida support will be to contribute towards achieving MDG3, MDG5 and MDG6. The strategy recommends actions for Danish support and co-operation at international and country levels, as well as strategic actions for Danish efforts within four thematic areas, namely:

- promoting gender equality and empowerment of women;
- improving sexual and reproductive health;
- young people’s access to information and services; *and*
- linking the response to HIV/AIDs with sexual and reproductive health and rights

2.6.2 HIV/AIDs policy

Danida was among the first countries to launch a Plan of Action for international assistance to fight HIV/AIDs in 2001. Prior to this, Danish efforts in HIV/AIDs had been guided by specific strategy papers and consisted of support for projects and components in the sector programme support. The Plan of Action was informed by “Partnership 2000”, which identifies HIV/AIDs as one of the priority areas for Danida development assistance.

In 2004, the Danish Parliament discussed and confirmed its strong support to Denmark continue support for the fight against HIV/AIDs. Following this Parliamentary support, the 2001 Plan of Action was reviewed in 2004 and it was concluded that Denmark’s support for the fight against HIV/AIDs through sector programme support was increasing steadily and that some progress had been made in supporting women and orphans. A new strategy for Denmark’s support to the International fight against HIV/AIDs was subsequently developed in 2004 entitled “Strategy for Denmark’s Support to the International Fight against HIV/AIDs”. The strategy addresses Denmark’s support to the fight against

HIV/AIDs in developing countries, such as bilateral support mainly allocated to the 15 so-called Programme Countries and the multilateral assistance to international organisations.

The new HIV/AIDs strategy remains a strategic priority in Denmark's development co-operation. Based on the priorities for Danish development co-operation on 2005-2008, "Security, growth – development", Denmark commits herself to strengthening efforts to fight HIV/AIDs, with special focus on Africa South of the Sahara. Accordingly, the goal of the new strategy is to "*strengthen and focus Denmark's contribution towards reaching the internationally agreed HIV and AIDs targets through its bilateral development co-operation as well as its contribution to the multilateral efforts".* Danish support contributes to a wide variety of interventions ranging from prevention to treatment and care.

3 Narratives of the programmes 1990-1998

3.1 Description of major programmes and projects

The Danish support to the health sector in Ghana started with the Ghana-Denmark Health Sector Support Programme in 1994-1997 with a total budget of DKK 171m and spent DKK 185.11m, representing an 8.2% expenditure over-run (Pre-Study, May 2007). The overall objective of the support was to contribute to improving the health status of the population of Ghana. During this phase Danida provided direct project support to the following three critical areas:

- broad-based (sector) support to Upper West Region, with focus on improving access to and quality of health services: The medium term objective of the support was to achieve 'a functional health system able to deliver accessible and quality care effectively and continuously to the population of Upper West even after the withdrawal of earmarked support from Danida';
- support to the development of a National Tuberculosis Control Programme; *and*
- support to Primary Health Care Training Institutions to educate more competent community health nurses and midwives relevant for the primary health care service delivery (see also Figure. 1)

Danida complemented its health sector programme support by providing a specific project grant of DKK 25m in 1996 for the establishment of the Estate Management Unit (EMU). The aim of the support to EMU was to develop the capacity of the Ghana Health Service (GHS) in the areas of health estate management and building maintenance. Prior to this, the GHS (then MoH) had relied on services provided by the then Ministry of Works for rehabilitation of buildings and preventive maintenance. The support to the EMU became a regular programme component in 2001 and is due to be phased out at the end 2007.

As part of a programme of Enhancement of Research Capacity (ENRECA) in developing countries, initiated in 1989, Danida funded the Noguchi Memorial Institute of the University of Ghana to implement a Malaria Research Programme. The ENRECA research project covered a wide range of subjects within the health and other sectors. The project in Ghana was implemented for a period of 10 years (1993-2003) with a total budget of DKK 22m (DKK 22.05m was spent).

Implementation of the programme during this phase was managed by a steering unit headed by a Danida Chief Health Advisor who also participated in the policy dialogue and the development of a sector-wide approach to health and health sector support co-operation.

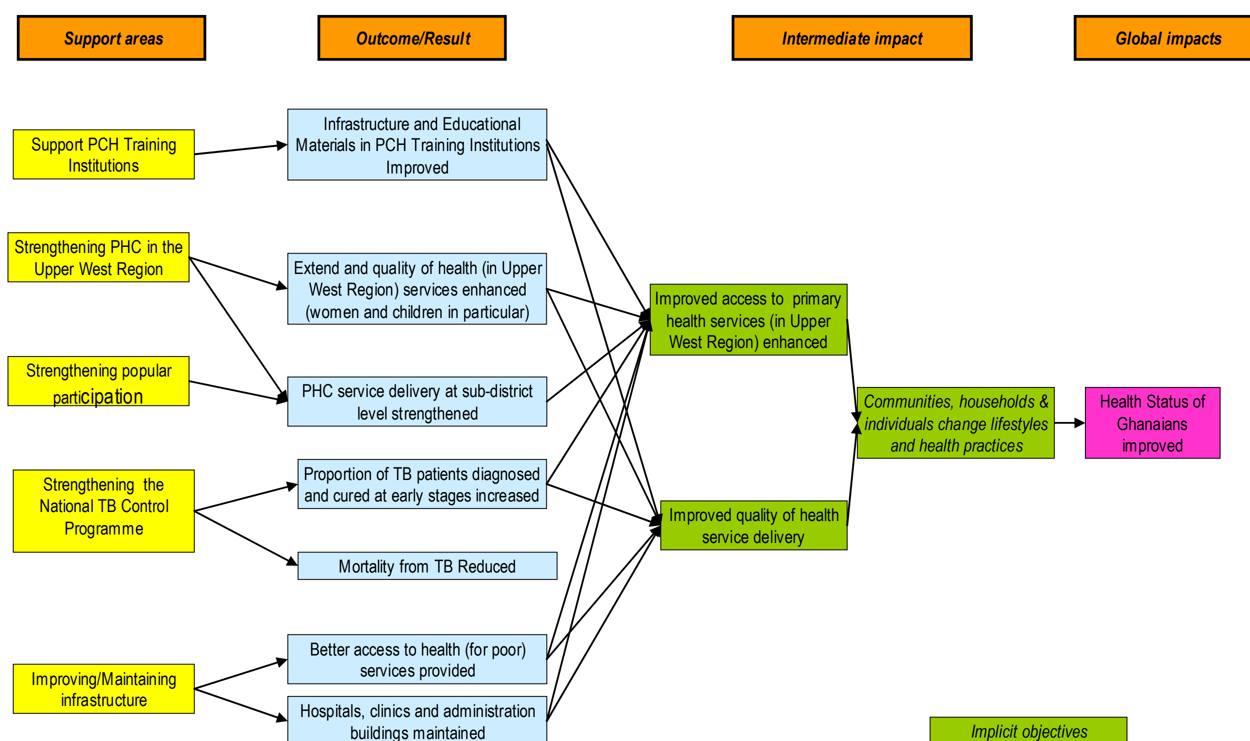
During this phase, the MoH largely felt that it was not sufficiently in control of projects in the sector and saw a need for streamlining the many different and parallel donor project procedures for planning, implementation and reporting. Table 4is a summary of health projects supported by Danida under HSSP I.

Table 4: Summary of health projects supported by Danida during Phase I, 1994-97

Project Title	***Duration***	***Amount (DKK)***
Primary Health Care Training Institutions	1994-1997	53.5m
Primary Health care in the Upper West Region	1994-1997	65.2m
National Tuberculosis Control Programme	1994-1997	31.4m
HSSP Steering Unit (for the management of the programme)	1994-1997	5.9m
Health Estate and Building Maintenance Project	1997-2000	18.8m

The following Figure 1 below describes the intervention logic of the support during this phase.

Figure 1: Health sector support, 1994-1997 (impact diagram)



3.2 Assessment of relevance, efficiency, effectiveness, impact and sustainability – mainly based on existing documentation

Table 5: Danida support to the health sector between 1994 and 1997: Summary assessment

Criterion	**Assessment**
Relevance	The intervention areas during this phase addressed the critical needs of the health sector at the time; UWR, the most deprived in the country lacked basic health facilities and delivery of health services was the poorest in the country. Expansion in infrastructural base of the PHC Training institutions addressed access to primary health services and also inequalities in health service delivery. Similarly, the support to the strengthening of the National Tuberculosis Programme was highly relevant because the area had not received the requisite support for a very long time.
Effectiveness	A review of the appraisal of Phase I, Sector Programme Support (1998) and the status report on stocktaking revealed that all the components supported by Danida achieved their objectives.
Efficiency	The strength of the HSSP during this phase was its relative fast and effective implementation in most of the components, including good quality work and low prices of construction. The budget for the phase was overspent by 8.2% (DKK 171m against DKK 185.11m). The numerous capacity-building interventions for health staff, particularly in UWR and the introduction of quality assurance, increased efficiency in the sector during the period.
Impact	Infrastructure improved considerably at both the PHC training institutions and this resulted in increased enrolment and quality of teaching and standard of learning. Elsewhere the expansion of infrastructure in UWR increased access to health services by the poor and vulnerable in the region.
Sustainability	Lack of sustainability was an identified risk which has been confirmed. Most of the promising systems put in place during the period could not be sustained. It must be noted, however, that some of these systems have been replicated at national level, e.g. community health committees, quality assurance, scheduled drugs, transport, etc. Some of the vehicles and infrastructure that were either renovated or constructed could not be maintained.
Cross-cutting Issues	Gender issues were mentioned and mainstreamed into the support to UWR through community participation and women empowerment activities. The women empowerment component implemented by CEDEP was a success as soft loans were given to women groups. This empowered the women economically and made it easier for them to access health services without being heavily dependent on their husbands to go to hospital when the need arose. Efforts were also made to target women for training programmes.

3.3 Lessons learnt

The main objective of the health sector support during this phase was to improve the health status of the population. A number of systems were developed to facilitate access to quality and efficient health delivery in the country particularly in the UWR; some of these new systems have been replicated at national level: transport and equipment maintenance system; quality assurance; referral systems with radio linked to all facilities and regional hospitals; procurement and drug scheduled delivery.

Like other donor funded programmes during the period, the MoH largely felt that it had not been sufficiently in control because of the vertical nature of the programmes and had seen the need for streamlining the many different and parallel donor project procedures for planning, implementation and reporting, including HSPS I.

4 The programmes 1998-2008

4.1 HSPS Phase II (1998-2002)

The objective for Danida's sector support to the health sector during this period was in line with the objective of the POW I. One of the lessons learnt during Phase I was that there was lack of coherence and co-ordination in health sector support. To address this gap, the MoH, in consultations with the main donors, including Danida, developed a sector wide approach for the development of the sector and for integrating aid within the sector. A Medium Term Health Strategy (MTHS) and a five year Programme of Work (POW I) were therefore formulated and adopted by government. Danida participated actively in this work with a view to changing its modality of support to health sector programme support. This was in line with the Danish Strategy for Development Policy "Towards the Year 2000", adopted in 1994. The aid modality for Danida support to the health sector consisted of sector budget support (66%) and earmarked funds. The sector support was channelled through the Health Fund (HF) and managed by the MoH for implementation of the five broad areas of activity of the POW.

A noticeable shift during this phase was the move from project support to programme support, addressing the whole sector and relying extensively on policy dialogue.

The Phase II support was guided by the Ministry of Health 5-Year Programme of Work (1997-2001) and the Common Management Arrangements (for procurement, financial management, planning, performance monitoring and reporting) developed by the Ministry of Health in close consultation with the main development partners, including Danida, within the framework of the government's medium term health strategy. The overall objective of the support during this phase was to improve the health status of Ghanaians, recognising that the many factors outside the health sector contribute to health. Figure 3, illustrating the intervention logic, captures the intended impact of Danida support to the health sector during this period.

The total support for Phase II was DKK 225m, out of which about 93.3% (DKK210.1m – Pre-study assessment) was utilised at the end of the programme.

The earmarked funds were used to support the following components:

- continue support to the health sector in UWR
- health estate and building management
- private sector development
- improving access to health care
- strengthening districts and sub-district capacity; *and*
- increased collaboration with the private sector

The justification for Danida's continued support for earmarking, in spite of the SWAP includes the following:

- maintaining visibility and a more clearly demarcated role for Danida in a situation where this advanced form of sector programme support is still a new experience;
- securing funding for areas of crucial importance to the success of the POW, but which are difficult or are at risk of being sidelined Continue support to the health sector in UWR;
- ensuring sustainability of ongoing Danida funded activities for which political commitment for a long-term involvement had been given;
- health estate and building management;
- focus on gender issues;

Figure 2: Health sector support, 1998-2002 (impact diagram)

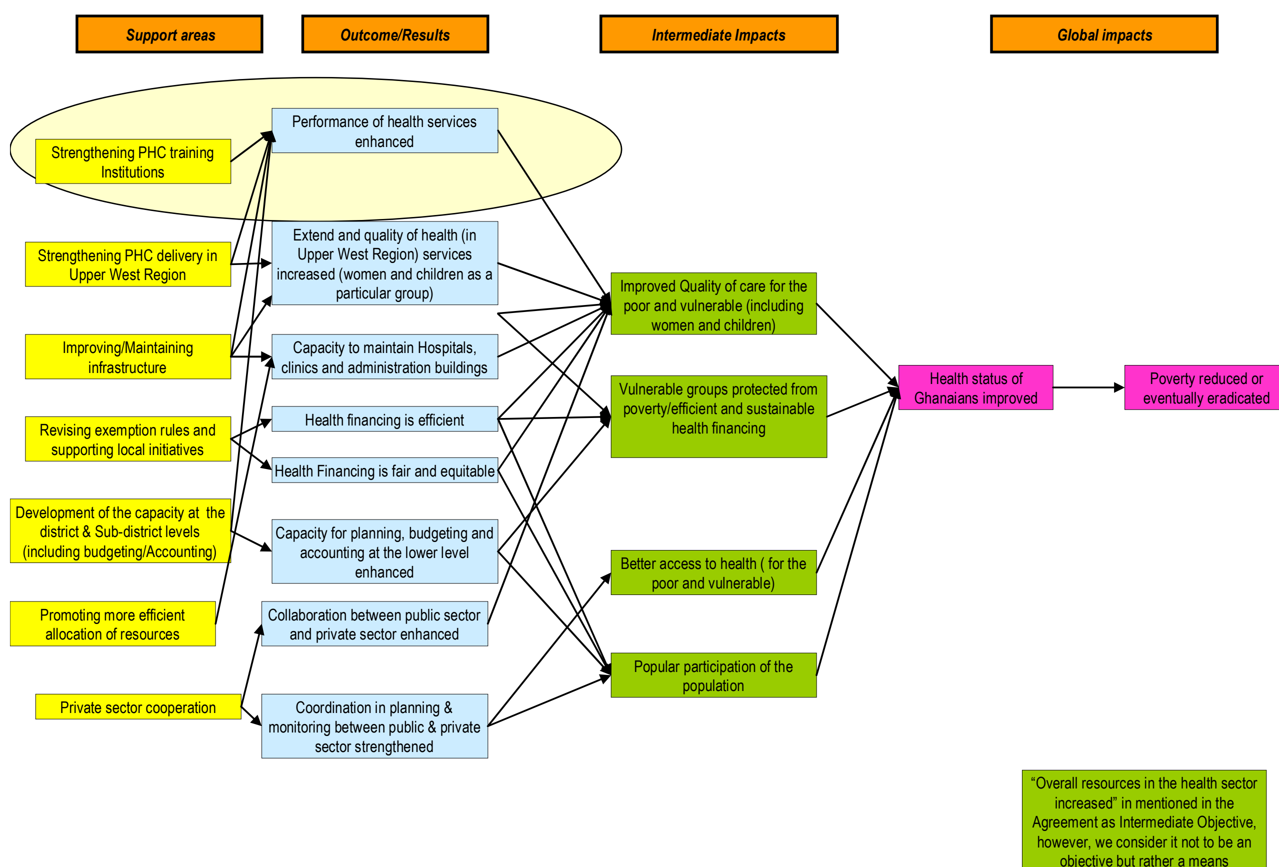


Table 6 presents the supported components, sub-components and the financial support budgeted by Danida to the health sector during the strategic period under review.

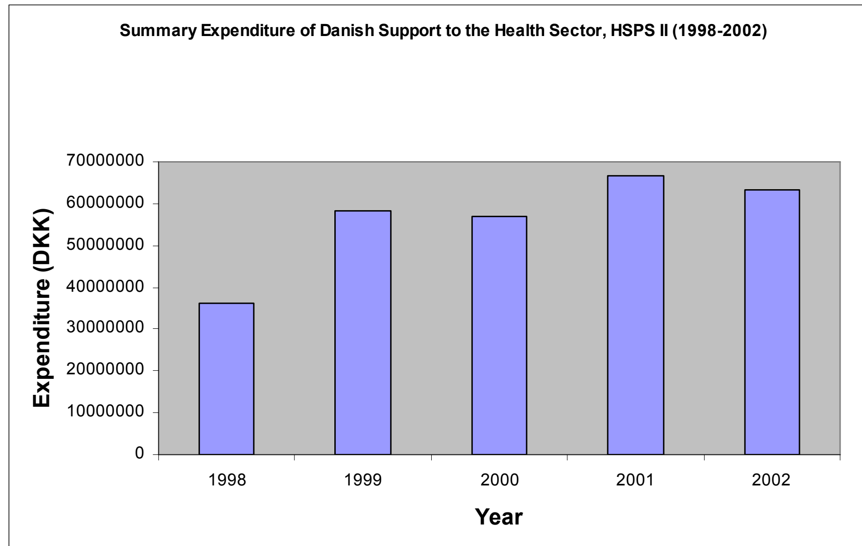
Table 6: Summary of health projects (1998-2002)

Areas of Support	***Period***	***Budget (DKKm)***
Budgetary Support to the Ministry of Health	1997 – 1999	25
Health Sector Programme Support – Phase II, comprising:	1998 – 2002	225
MoH 5-Year Programme of Work	1998 – 2002	148.7
Strengthening District and Sub-district Capacity	1998 – 2002	16.2
Increased collaboration with Private Sector	1998 – 2002	10
Improving Access to Health Care for the Poor	1998 – 2002	10
Health Estate and Building Maintenance	2000 – 2002	6.4
Danida Health Sector Support Office	1998 – 2002	12.1
Upper-West Region	1998 – 2002	14.7
Health Estate and Building Maintenance Project	1997 -2000	18.8

Source: RDE, 2002 (Country Assistance Strategy Assessment Part II

Figure 3 below further provides expenditure by year between 1998 and 2002. Expenditure pattern reveals that expenditure increased annually except in 2000 and 2002 when disbursements fell slightly below the preceding year's expenditures.

Figure 3: Summary expenditures of Danish support and year, 1998-2002



Source: Pre-Study Report, 2007

4.2 HSPS Phase III (2003-2007)

The HSPS III covers the period 2003-2007 with a total budget of DKK 340m (DKK 275.7m had been spent at the time of pre-assessment study, i.e. early 2007). The Phase III support was expected to extend one year beyond the POW II (2002-2006). It was conceived and implemented in line with the Ministry of Health's Medium Term Health Strategy and the Second Five-Year Programme of Work (POW II 2020-06). Although the support during this phase focused on the same strategic objectives of POW I, the POW II emphasised more strongly the importance of reducing inequalities in health outcomes (poor/rich, rural/urban, and across regions). Therefore a number of observations and lessons from implementation of the first POW guided the strategic focus of the second POW.

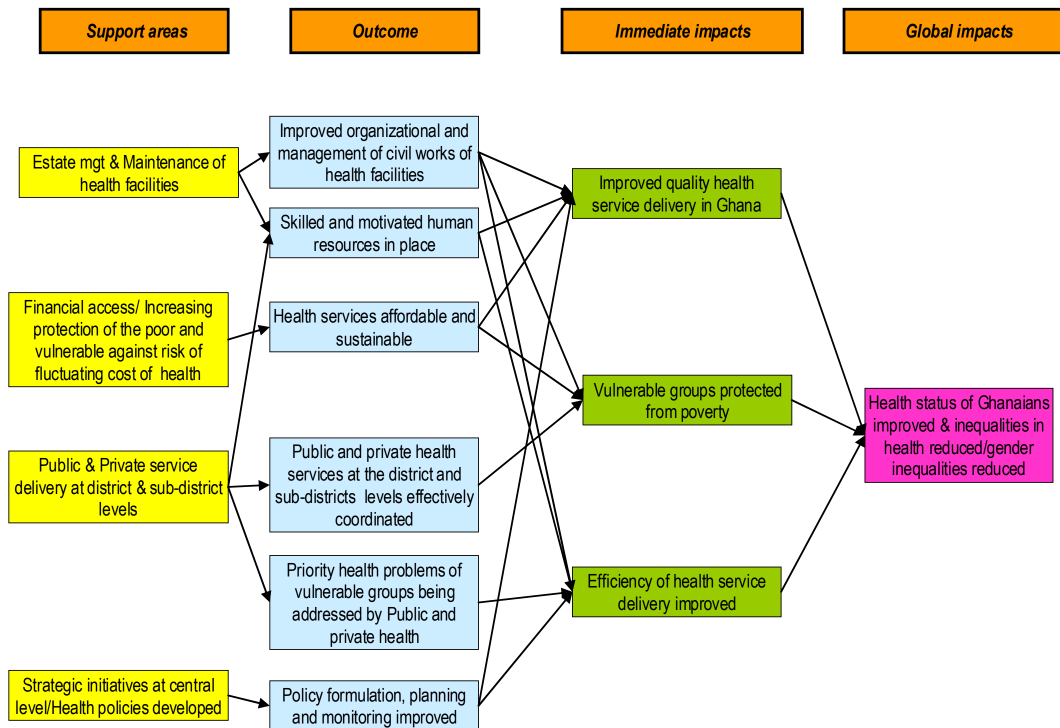
The overall objective of the support during this phase was to improve the overall health status of Ghanaians and reduce inequalities in their health outcomes. The key intermediate objectives of the programme include the following:

- improve quality of health delivery
- increase access to health services
- improve efficiency of health service delivery
- foster partnership in improving health
- improve financing of the health sector

During this phase, Danida continued with the same aid modality of support to the health sector consisting of sector support *via* SWAp through the HF (75%) and earmarked funds. The Health Fund (HF) is managed by the MoH for the implementation of the strategy areas of activities of the POW II.

The following figure summarises the envisaged outcomes and impacts of HSSP III.

Figure 4: Health sector support, 2003-2007 (impact diagram)

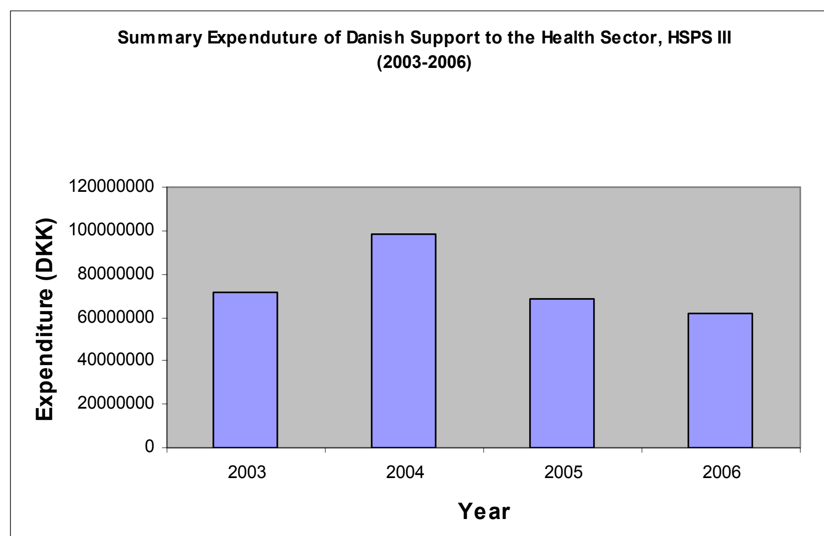


The HSPS III consisted of approximately 75% budget support to the POW, through contributions to the Health Fund along with contributions from other donor partners. In order to ensure the sustainability of ongoing Danida activities and to secure funding for areas of crucial importance to the success of the POW II but at risk of being sidelined, about 25% of the Phase III support was earmarked for the following critical areas:

- improved health estate management and planning;
- improved access to health care, with a focus on the poor, and on issues addressing exemptions and health insurance;
- strengthening public and private service delivery at district and sub-district level, including focus on HIV/AIDs and gender; *and*
- strengthening strategic initiatives at central level in capacity-building for policy and planning in both public and private sectors, financial management and regulations

Figure 4 presents expenditures by year during HSPS III. The data excludes expenditures for 2007. It shows that expenditures peaked in 2004, the second year of implementation of the programme, but experienced a decline in 2005 and 2006.

Figure 5: Expenditures by year during HSPS III



Source: Source: Pre-Study Report, 2007

4.3 Support HIV/AIDs national strategy framework II (NSF II)

Danida provides support to the implementation of the National Strategic Framework II for HIV and AIDs in Ghana. In 2005, Danida signed an agreement with the Government of Ghana to support the 2006 Programme of work with an amount of DKK 9.975m. The objectives of the programme were those of the NSF II, which include the following:

- reduce the new infection among vulnerable groups and the general population;
- mitigate the impact of the epidemic on the health and socio-economic systems as well as on infected and affected persons; *and*
- promote healthy lifestyles, especially in the area of sexual and reproductive health.

The support was earmarked to activities in five of the seven intervention areas of the NSF II, namely policy, advocacy and enabling environment; co-ordination and management of the decentralised multi-sectoral response; mitigating economic, socio-cultural and legal impacts; communication on prevention and behaviour change; and treatment, care and support. The support is channelled through the Ghana AIDs Commission (GAC).

The Danish support to HIV/AIDs in Ghana was informed by an HIV/AIDs Situation Analysis carried out by the Embassy in 2001, the Danida HIV/AIDs Action Plan, and the Ghana National HIV/AIDs Strategic Framework. The focus of the support was to mainstream HIV/AIDs-related activities into existing sector programmes, focusing on information and prevention.

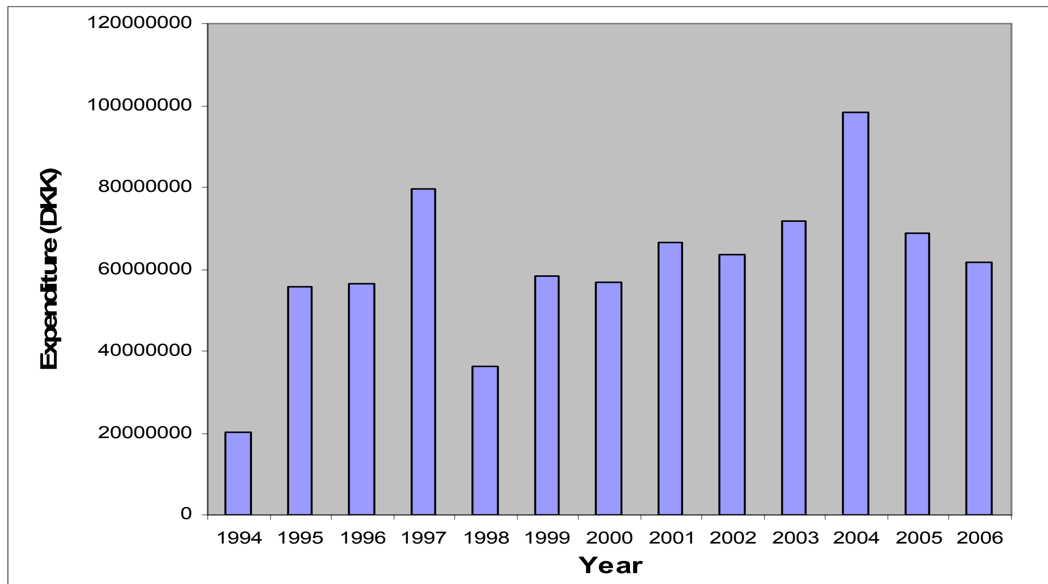
In addition, the Embassy has played an active role in participating in the UNAIDs Theme Group, the UN Extended Theme Group and other joint HIV/AIDs fora over the years. Together with DFID and USAID, the Embassy contributed to joint review of the national HIV/AIDs response in the country.

As part of its support to child health interventions, Danida provided an amount of DKK 9,67m in 2004 to support the National Polio Eradication Programme.

4.4 Disbursements by Danida between 1994 and 2006

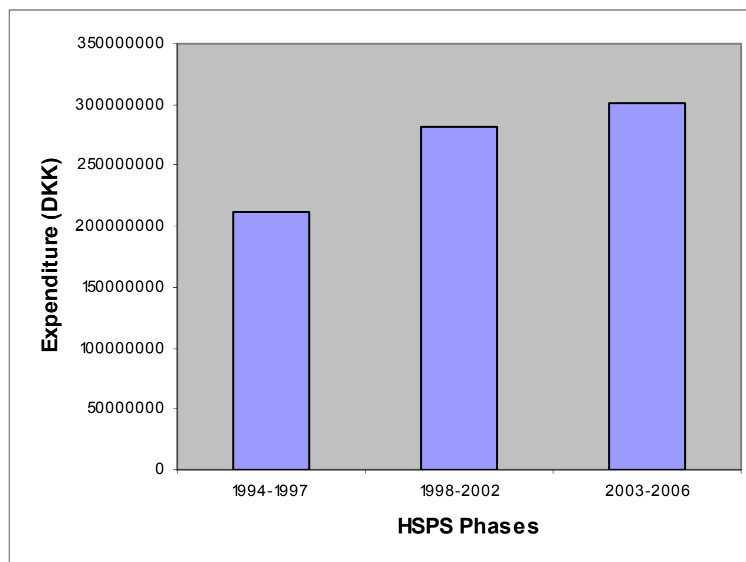
A total amount of **DKK 793.6m** was disbursed by Danida to the health sector under the three HSPSs. The figure below presents disbursement by Danida to the health sector from 1994-2006.

Figure 6: Denmark-Ghana development co-operation: Summary of Danish expenditures to the health sector and year, 1994-2006s



The Figure 7 below further presents a comparison of Danida expenditures by the three phases of the programme. The data reveals that Danida disbursements increased in each programme funding phase.

Figure 7: Comparison of summary expenditures of the three health support phases (HSSP I (1994-98); HSPS II (1998-2002); and HSPS III (2003-2006)



Danida subscribed to the use of common implementation arrangements for the public sector, regardless of the source of funding, except for some of the earmarked funds and for procurement of TA. The sector support has therefore been implemented mostly through the regular channels of Government. The MoH remained responsible for policy, monitoring, co-ordination of donors and inter-sectoral agencies, and public financing for health services, whereas GHS has been the executing agency since its establishment. Danida further subscribed to the common arrangements for planning and budgeting, and for implementation, including procurement of civil works, goods and TAs, and for financial management (disbursement and management of funds, accounting and audit, and reporting on

progress). This is in line with the CMA. The HSSO provides technical support and co-ordination for the RDE.

In addition to the funds provided to the three phases, Danida funded a 10-year support to the Noguchi Memorial Institute of the University of Ghana in 1993 on “Enhancement of Research Capacity” (ENRECA) in developing countries initiated in 1989. A total budget of DKK 22m was disbursed (DKK 22.05m). Support totalling DKK 9.970m was also ear-marked to support five of the seven intervention areas of the HIV/AIDs NSF II, including support to six Ministries to mainstream HIV/AID into their sectoral plans.

5 Sectoral Evaluation Questions

5.1 Question 1: To what extent is Danida support to health linked to, aligned with and accountable in relation to Ghana's health policies, plans and sector strategies, harmonised with other DPs, and predictable?

5.1.1 Danida support refers to and is conceived in support of national development objectives and strategies

Danida support to the health sector in Ghana is fully in line with Ghana's overall policy development (GoG, 1995a), the MTHS (MoH, 1995a), and the POW I & II (MoH, 1996, 2001) as well as the National Strategic Framework for HIV and AIDs. The overall strategy of Danida, Partnership 2000, including the specific concerns regarding access to adequate health care for the poor and for women, as well as the Danida strategy for support to the health sector, is also in accordance with the analysis, priorities, strategies and activities contained in the MTHS and the POWs as well as the Vision 2020 and GPRS I and II. Furthermore, Danida development assistance is in line with the sector programme support strategy contained in the POW.

5.1.2 Alignment

5.1.2.1 Improved alignment of Danish assistance on national priorities

Danida's support to the health sector has improved its alignment with national policies, shifting from project support during the first phase to sector budget support. It must be noted that Denmark has been an advocate of a sector approach for over a decade. The funding arrangement in Ghana, through the health account, was until recently also the modality chosen by a majority of the key health sector donors such as DFID, the World Bank, the EC and the Royal Netherlands Embassy. Support to the Christian Health Association of Ghana (CHAG) is not duplicating other efforts and it is addressing an agreed need. Support for the fight against HIV/AIDs is co-ordinated with donors under the M-SHAP facility.

The MoH and its development partners have committed themselves to using a single, unified set of indicators to monitor activities in the health sector, including HIV and AIDs, to which Danida has subscribed. The objective of this arrangement is to harmonise the indicators to monitor and evaluate systems used for the Global Fund, UNGASS, the GPRS, the Health SWAp, and the GAC-led national response.

Though there was little alignment during the first phase of Danida support, which may be attributed to the fact that the sector had not developed coherent programmes with implementable strategies and activities, subsequent support has been aligned on national and sectoral development policies and programmes.

5.1.2.2 Strengthened capacity by co-ordinated support

The Health Sector Support Office (HSSO) was established as a PIU to provide effective co-ordinated support for implementation of HSPS. The office was established after extensive discussions with the Ministry showed that the MoH did not like the TA within the MoH, except EMU. The office has had long-term TA from Denmark posted to it. In addition to the TA, the office has very strong and competent Ghanaian technical staff who collaborate with the TA. In recent years, the role of HSSO is focused more on technical support whilst the Embassy disburses directly to the EMU and the Health Fund. Interviews with both government officials and donors confirmed the technical strength of Danida in the health sector and attributed this in part to the HSSO. MoH, CHAG and donor partners regularly

use the services of the HSSO and they acknowledge the technical competence of the office.

The capacity of the Ghanaian health sector has been enhanced through support to organisation and management of the sector and its decentralisation. In addition, technical support provided for financial management, transport, EMU and further support for post-graduate training and for development of policies and improved systems have contributed to capacity-building in the sector. As noted through reviews of programme documents and field work, financial reporting in the sector has improved immensely at all levels. In addition, the capacity of districts, particularly in UWR to plan and prepare budgets, has improved over the years. Of the eight District Directors of health services in the UWR, for instance, only one has not benefited from a Danida-supported post-graduate programme outside the country.

Overall, Danida has provided technical support through the HSSO in support of the implementation of PoW I and II, culminating in the building of health sector management capacity; Danida support influenced to some extent the way the sector and its partners act and interact in support of the sector's development goals. The support has also improved the capacity of the sector in quality care assurance, maintaining effective transport systems, procurement and scheduled drug delivery.

5.1.2.3 Increased use of country procurement systems

Except for international consultancy services which are procured according to international procedures, all other procurement of goods, works and local consultancy services is aligned with national procedures. Through the POW, Government systems and capacities have been developed at central, regional and district levels, especially in the areas of procurement and financial management. *Procurement* capacity has been strengthened with the establishment of a procurement unit within the MOH and GHS and the development of a Procurement and Procedures Manual and of standard bidding documents as well as the introduction of procurement audit as part of the SWAp. Reliance on these systems facilitated consolidated management of the public budget and pooled funding, particularly in the areas of procurement and financial management. Danida has contributed significantly to the development of these systems. The CMA I and II provide a general framework for the implementation of the First and Second Health Sector POWs, which include guidelines for procurement of goods, civil works and consultancy services.

5.1.2.4 Increased use of country public financial management systems

Danida has had long experience (since HSPS II) with channelling funds through the Health Fund, using exclusively government public sector procedures.

Over time, from 1998, about 66%-75% of Danida support to the health sector has been channelled through the health fund or the SWAp, and disbursed through the public sector financial procedures.

The functioning of public financial procedures has been assessed in connection with Denmark joining the MDBS. There are concerns about the negative impact of delays in disbursements to the districts, particularly in the first half of the year. The field interviews confirmed documentary reviews of delays and administrative bottlenecks in funding disbursements: government funds to district and sub-district levels, and reimbursements of NHIS claims to service providers (facilities), are expected to effectively impact on effectiveness and efficiency. However there have in general been major strides in improving public financial management systems. There is a need to strengthen the control systems at the lower level and internal audit at all levels

5.1.2.5 Increased predictability

The shift from project support to sector-wide budget support has ensured a high degree of predictability of funding for the health sector. In general the health sector has enjoyed very high predictability of programmed disbursement for both the sector budget support and earmarked funds from Danida. Table 7 shows that, on average, about 83% of the cumulated budget for the period 2003-2006 were disbursed at the end of 2006. It further shows that disbursement to the health account was 100% whilst disbursement of earmarked funds for improving access exceeded the budget by 5%. Disbursements to all other earmarked items, except reviews, were more than 80% of budget.

The general view among stakeholders during the field work was that Danida is a reliable partner in the health sector.

Table 7: Budget for Danida Support to the health sector programme 2003 - 2006 (DKKm)

Earmarked Funds	*2006 Budget*	*2006 Expenditure*	*% Spent*	*Accumulated Budget 2003-2006*	*Cumulative Expenditure at the end of 2006*	*% spent*
Budget Support to POW III	40,000	40,212	101	189,925	190,382	100
Estate Management Unit	2,200	2,177	99	16,795	15,437	92
Reviews	904	904	100	14,523	2,944	20
Improving Access	1,650	1,977	120	16,245	17,083	105
Strengthening Districts	5,500	3,646	66	19,120	15,945	83
Central Level Initiatives	2,500	1,480	59	10,334	8,399	81
Danida HSSO	3,471	2,231	64	11,659	9,617	82
Total HSPS III	**56,225**	**52,627**	**94**	**278,601**	**259,806**	**83**

Source: HSSO 2006 Annual Report

5.1.3 Harmonisation

5.1.3.1 Use of common arrangements or procedures

Danida has demonstrated flexibility in use of common arrangements, the use of which predates and goes beyond the recent EC Code of Conduct on Complementarity and Division of Labour in Development Policy.

The funding arrangement through SWAp is the modality chosen by a number of key health sector donors, including the Royal Netherlands Embassy (RNE) and DFID. The World Bank and the EU that used to be part of this modality have since 2006 shifted to MDBS. Danida plans to shift to SBS, beginning with implementation of the new Country Programme in 2008. At the time of the mission, the Royal Netherlands Embassy was representing DFID on health issues through a partnership arrangement.

The MoH and its development partners, including Danida, have committed themselves to using a single, unified set of indicators to monitor activities in the health sector, including HIV and AIDs. This arrangement is in line with efforts to harmonise procedures in the sector.

A review of Annual Sector Reviews (ASRs) and interviews suggested that donor coordination is well developed and that Danida support complements other donor support. There are monthly health partner meetings chaired by the Ministry of Health. Health summits are held twice a year to address issues of concern relating to the sector.

In spite of the foregoing, some vertical and fragmented projects are still ongoing, for example those linked to Global Funds, project-oriented UN-agencies, and non-aligned do-

nors such as JICA and USAID within the health sector, which is a problem that needs to be addressed.

Overall, the general perception of donors of Danida is positive; many see Danida as a strong, active, constructive, dependable partner in promoting harmonisation and pro-poor advocacy. However, it was also noted that there were a few instances where Danida had taken unilateral decisions such as exercising the fall-back position option with government in 1998 and 2006 after the latter had failed to adhere to the tenets of the agreement.

5.1.3.2 Encouraged shared and increased analysis

Danida has a history of shared analytical work and reviews in Ghana. Danida undertook some joint health monitoring missions in the northern Ghana with UNICEF, and also jointly funded the Multiple Indicator Core Survey (MICS), with UNICEF. The MoH, undertakes joint MoH/Donor Monitoring in accordance with the CMA but this is done under persistent pressure from Danida as noted by the 2006 HSSO Annual Report.

Overall, some considerable progress has been made in shared analysis in the areas of joint annual external performance assessments of the health sector, intensive and regular policy dialogue, co-ordination of activities, improved financial management and procurement and general planning for the health sector.

5.1.4 Predictability of disbursement improved

Sector budget support is disbursed by the Danish Embassy quarterly into the USD account used for the Health Fund or in accordance with the CMA I and II. In general, the amount disbursed is in equal proportion of the annual allocation for the four quarters if not otherwise agreed. To facilitate disbursement of funds, MoH prepares for the Embassy quarterly cash flow statements, indicating the required timing of the next quarter’s disbursement. Disbursement of funds to the MoH has been timely as agreed with government, except where there has been non-performance or non-adherence to the agreement on the part of government. Sector Dialogue

Dialogue in the health sector has evolved from non-dialogue during the first phase (1994-97), which was marked by multiple, unco-ordinated projects and characterized by donor decision-making and micro-management. During this period mutual trust and dialogue were fragmented and dominated by donors. The HSPS II phase coincided with the SWAp during which period there was improved frank, balanced and productive dialogue between the MoH and donors. The MoH assumed the leadership role of the sector and owned the sector programmes. The MoH had the ability to utilise the dialogue to further positive change in the system, e.g. more funds going to the primary level and more control over big hospital investments.

It was clear from the reviews and the interviews that there had been some challenges in the dialogue since 2002 but the situation has improved since the appointment of the new Director-General. The shift in aid modality to MDBS/SBS by some donors in the sector and the lost of senior and pioneer members of MoH to GHS and international organizations as well as non-adherence of government to agreements between MoH and DPs might have weakened the dialogue.

In recent years, Denmark has made a conscious effort to strengthen and harmonise sector dialogue, including dialogue and co-ordination on the development partner side as a donor sector lead in 2005/6. Emphasis is also being made on assisting in improving overall planning and budgeting.

The following are some experiences in sector dialogue during the period under evaluation:

- The initial phase was blessed by very able and very strong visionary leadership that had an ability to utilise the DP side to further positive change in the system, e.g.

more funds going to the primary level and more control over big hospital investments. The DP worked cordially with, and listened to, the government side.

- In the early part of the dialogue, the DP side focused on a few important issues, not least the proportion of funds allocated from the GoG to health and the proportion going to the district level. This, combined with the same intentions of key decision makers in the MoH, resulted in the achievement of the agreed targets of 11% of GoG funds going to health and >40% of all funds going to the district level.
- The period from early 2001 was marred by insufficient dialogue and mounting tensions, with Danida at the forefront in voicing criticism, particularly focusing on the inadequate handling of pro-poor issues. The biggest conflict was the insufficient funding of exemptions, partly due to the government's fear that exemptions would be a disincentive for people to enrol in the NHIS. The near break-down of a Summit in 2005, Danida not signing the Aid Memoire (2006) and the subsequent temporarily Danida withdrawal from the Health Fund (HF) marked a culmination. Prior to this, Danida had exercised a similar option in 1998, after government had failed to adhere to agreements with DPs. A factor contributing to the problems was the diminishing technical presence of DPs in the sector and the shift of focus from the SWAp/sector level to MDBS/general level, leaving Danida rather alone in its opposition and dialogue.
- Much less successful was the control over capital investments, an area dominated by politics and economic interests, and at one point in 1998, and again in 2006, the government's clear breach of agreement resulted in Danida's temporary withdrawal from the HF.
- The introduction of a Procurement Audit was quite important. Actually, when the first such audit was done, the findings were so negative, that some DPs, e.g. the EU, considered leaving the HF. Danida, however, was very clear, that if DPs ran away each time negative findings were made, there would be no way the benefits of the SWAp could be reaped. The government side also felt that that if it was to take very serious actions based on negative findings, the government's incentive to introduce increased transparency would be reduced. Senior management in Danida agreed that if clear plans and prospects were there to rectify badly functioning systems, it could accept such findings.
- The full implementation of GHS and the start of NHIS marked a troublesome time for the collaboration and policy dialogue. There were also a succession of new staff in charge at MoH, and the DP side was weakened by DFID withdrawing their technical presence (and eventually entering into silent partnership run by the Dutch). Danida was left as the only HF DP with strong technical presence, and found itself fighting loosing battles on all fronts, having not enough capacity itself and no strong support from other DPs. The only aspect positive about the situation was the well-functioning Health sector Support Office (HSSO). The conflicts between Danida and the MoH culminated with Danida's temporary withdrawal from HF and its refusal to sign the Summit Aide Memoire (2006). There was virtually no support from other DPs except for some mumbling of agreement that it was important to be more pro-poor.
- The Embassy managed to make the justifiable but nevertheless rather complex Danish position clear and understood:
    - Danida could not co-finance a budget without a proper foundation;
    - Danidawithdrew temporarily;

- o Danida allocated the money directly to pro-poor initiatives (e.g. HIRD), as it recognised the huge unmet funding needs and did not wish to harm the poor by totally withdrawing.

5.1.5 Conclusions

Danida support to the health sector has been highly relevant and consistent with the health priorities of the sector. Denmark supports the principle of ownership and has put the principle into practice in the health sector of Ghana, based on the country strategies for poverty reduction. The principle of ownership is also reflected in the country strategy process. The earmarked support has been strategically channelled to critical areas that would have received little support from the pooled funds, but critical in making an impact on health outcomes. Danida has played a key role in to strengthening and harmonising sector dialogue, including dialogue and co-ordination on the development partner side and was the donor sector lead in 2005/2006.

Donor co-ordination since the implementation of the POW noticeably improved during POW I but suffered some setbacks during the last couple of years. The sector co-ordination is led by MoH. In principle most donors accept the POW as the overall framework and participate in GoG-donor meetings, and many have signed the Memorandum of Understanding (MoU). Furthermore, there is strong inter-agency co-operation and considerable openness and exchange of information between the main donors and the government. The SWAp has ensured predictability of funding. Disbursement of earmarked Danida funds to the sector has been timely. The Common Management Agreement I and II (CMA I&II) provides a framework for guiding the relationship between the Ministry and donor partners in the implementation of activities in the sector for the benefit of the poor and vulnerable.

5.2 Question 2: How appropriate was the choice of regions of Danish assistance to the sector (if applicable)?

5.2.1 Quality and comprehensiveness of choice of regions and sectors

Although the evaluation did not find documentary evidence on the processes and criteria used by Danida in selecting UWR for support during Phase I, there is no doubt that the selection of UWR by Danida was informed by the level of poverty and deprivation of the region. Available data from GLSS, GDHS and the National Population and Housing censuses reveal that UWR is the least developed region in the country and has some of the poorest health outcome indicators and the highest proportion of persons living in poverty.

The choice of the four regions (Northern, Upper East, Upper West and Central) for support for exemptions, and community health insurance schemes during Phase II and III, were informed by the MTHS and POWs. The three northern regions and Central Region have been targeted for exemptions, risk sharing and maternal and child health (HIRD) interventions during the third phase of the programme. The selection of these regions is influenced by the pro-poor policy of Danida and the fact that the three northern regions represent the poorest in the country.

The long-term objective of Danida support to these regions was to achieve ‘improved health status of the population in the regions. The support was intended to impact positively on access to health service delivery, empowerment of women and their participation, and ultimately contribute to the reduction in health-related poverty.

In addition to the pool funding, the selection of certain critical areas for support such as exemptions, insurance schemes and HIRD was informed by analysis of poverty dimensions and trends in the country. The selection of these areas may be attributed to Danida’s pro-poor policy and its desire to impact positively on the reduction of poverty in the coun-

try. The support of earmarked areas was also to ensure sustainability of ongoing Danida activities and to secure funding for areas of crucial importance to the success of the POW I and II but at risk of being sidelined.

Overall, the selection of regions and component areas was fully justified and takes into account the priority health needs of the country as reflected in the national and sector policies and programmes.

Unfortunately, there is not much documentary evidence that greater stakeholder participation occurred during the first phase in the selection of the support areas and regions, but this did not affect equity and access very much. In subsequent support, there is evidence of the ministry's active participation, while Civil Society Organisations (CSOs) and NGOs are believed to have participated in the development of the GPRS and MHTS. The extent of the involvement of these groups is not well documented. Involvement of NGOs, CSOs, private-for-profit organisations and the wider society in the selection process would have enriched the programme.

5.2.2 Consideration of up-scaling potential in regional and (sub-)sectoral choice (replicability)

Danida is acknowledged by both government and donors as being very supportive of innovative ideas. Danida has supported implementation of effective systems such as quality assurance, procurement, transport, scheduled drug delivery, mutual health insurance and maintenance. Some of these innovative systems have been replicated in some regions and at national levels. In the Eastern region, for example, ongoing implementation of **"community decision systems"** in the Birim North district is a replication of the **"health committees"** concept implemented in the UWR. Danida has also supported strategic initiatives at central levels such as strengthening the regulation of the health sector, improving the financial management and strengthening the overall policy development and planning capacity of MoH.

Overall, some Danida's innovative approaches and demonstrated successes in some interventions have led to a scaling-up a good number of these successes or a spreading of them across the country or in national systems and policies.

5.2.3 Conclusions

Table 8: Assessment of relevance and impact of choice of regions and (sub-)sectors

Criterion	***Assessment***
Relevance	Danida's choice of regions was highly relevant and targeted the poorest regions and the most vulnerable groups, for example women. The support for exemption, risk-sharing and HIRD activities as well as support for the development of innovative systems were all relevant.
Impact	The impact of Danish support to the health sector in Ghana has been substantial; through, for instance, construction and renovation of more physical infrastructure, it has contributed to increased geographic access to health services; increased access to health services by the poor through exemptions and health insurance; and improved quality and efficiency of health services. The exemption support has saved many poor and vulnerable women who would not have received care had it not been for the contribution of Danida interventions in this area. In addition, utilisation of health services has witnessed substantial increases. Impact on some health outcomes, for example infant, under-5 and maternal mortality, has been positive.

5.3 Question 3: To what extent has Danida support to the health sector enhanced the performance of health service delivery (quality of services) since 1994?

The answers to this question are provided by analysing the changes in the following criteria over time:

- improved reproductive health services
- supervised delivery
- infant and under-five mortality
- performance in selected health indicators in deprived regions versus national average
- quality of care
- utilisation of health services
- effective maintenance systems
- increased active participation of the private sector in health service delivery
- decentralisation, in building up the capacity and increased participation of district and sub-districts in the planning, management and evaluation of health services

5.3.1 Improved Reproductive Health Services

MDG5 seeks to improve maternal health and reduce by 75%, between 1990 and 2015, the maternal mortality ratio (MMR). The proportion of births attended by skilled health personnel is the second indicator for MDG. In order to reduce maternal mortality as indicated, government and development partners have invested in promoting institutional delivery facilities in health centres for normal deliveries, making them more acceptable to women and ensuring basic obstetric care services, improved health-centre-to-hospital referral, and improved quality of clinical care in hospitals. Government has also made efforts to target the poorest and most disadvantaged in society for provision of better services.. Table 8 provides a summary of the trends in key service output and sector-wide indicators relevant to maternal mortality reduction.

Table 9: Trends in performance of Reproductive Health Service

Indicator	***1997***	***1998***	***1999***	***2000***	***2001***	***2002***	***2003***	***2004***	***2005***	***2006***
% ANC	85.2	87.5	86.4	99.1	93.6	93.7	91.2	89.2	88.7	88.4
% PNC	34.3	37.7	43.1	46.3	52.9	53.6	55.0	53.3	55.0	55.9
% maternal death audited	NA	NA	NA	NA	60.0	84.0	85.0	55.9	89.6	52.7

Source: MOH

Overall, trends in performance at service output level are not encouraging. Although antenatal coverage is high, there was only a 3.2% increase in coverage between 1997 and 2006, although between 2000 and 2003 coverage was above 90%. Levels of post-natal care are not very high; the level in 2006 is about 56%. However, the trend sho shows consistent increases over the reporting period. Trends in the proportion of maternal deaths audited have not been consistent; the percentage of maternal deaths audited increased from 60% in 2001 to 84% and 85% in 2002 and 2003 and reached its highest level of 89.6% in 2005, but this dropped to about 53% in 2006. Maternal death audits are used to determine the cause of maternal deaths and also provide more information to explain trends in institutional maternal mortality, and thus to identify and explain what is going wrong, and where, in the health system.

5.3.2 Supervised delivery

Supervised deliveries attended by skilled health professional are a measure of addressing maternal health. The MoH and GHS have implemented activities aimed at increasing supervised deliveries by skilled health professionals in all health facilities in the country. Available statistics on supervised delivery (Table 9) show that the proportion of births at-

tended by health professionals showed an appreciable increase in 2002 (74%) and 2003 (75%) from previous levels. Subsequently, the proportion of births attended by skilled health professionals decreased. The regional statistics show the same pattern as the national pattern, except for Central, Eastern, and Western regions which recorded some increases in 2006, though the levels are still low. The introduction of exemption policies for free deliveries might have contributed to increases in the proportion of births attended by skilled health workers between 1998 and 2003 at national level. Delays in releases of government funds for service activities and the introduction of the NHIS from 2004 might have contributed to the observed non-performance in supervised delivery. The downward trend in 2006 may be attributed to the series of strikes by health workers during the year.

Fee exemption for delivery care has had an effect on utilisation of health facilities, and therefore on skilled health personnel. The health insurance scheme is expected to have a similar effect, although it is too early to assess the impact.

Table 10: Proportion of births attended by skilled health personal

Region	1998	1999	2000	2001	2002	2003	2004	2005	2006
Ashanti	50.5	53.6	64.1	61.7	79.6	80.3	56.2	41.7	40.8
Brong Ahafo	52.8	58.6	64.3	55.1	74.6	72.2	57.8	50.3	47.4
Central	29.3	34.4	37.7	35.6	79.6	83.8	76.3	54.3	74.0
Eastern	39.3	27.6	54.3	56.1	73.3	67.5	47.3	39.1	40.3
Greater Accra	49.7	40.3	50.2	50.9	103.4	92.7	46.2	45.6	61.4
Northern	26.4	32.0	41.1	40.1	50.0	54.1	48.2	30.0	26.3
Upper East	24.3	26.2	42.2	41.6	68.0	74.8	71.2	40.7	39.5
Upper West	47.9	49.0	68.0	63.4	110.0	99.9	71.2	28.3	26.7
Volta	31.6	36.5	39.0	40.7	59.5	72.6	39.7	36.5	35.4
Western	44.5	30.7	51.2	50.7	62.3	63.4	46.2	26.4	34.8
National	**40.8**	**43.5**	**51.6**	**50.4**	**74.7**	**75.0**	**53.4**	**40.3**	**44.5**

Source: MOH/GHS

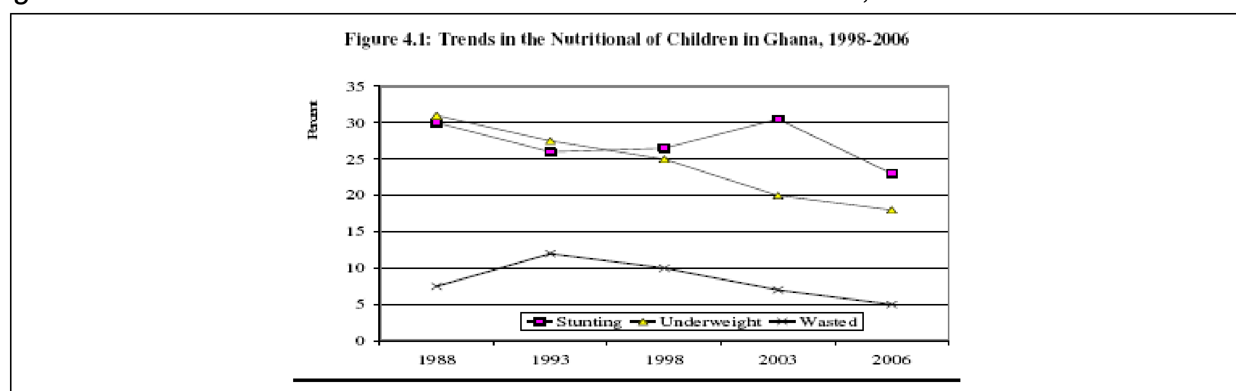
5.3.3 Infant and under-five mortality

The table above presents trends in infant and under-five mortality in Ghana between 1993 and 2006. The data shows that Ghana made strides in improving infant mortality rates between 1993 and 2003 but that the situation worsened in 2006. Under-five mortality rates, however, show no significant changes over the period under consideration. On the other hand, the proportion of under-fives reported as malnourished dropped by about 11 percentage points between 1993 and 2006, indicating an improvement. A major factor in the stagnation of infant and under-5 mortality performance is a shortcoming in budget execution leading to inefficiency at operational level. Another likely reason for the stagnation of infant and under-five mortality rates may be the increasingly dysfunctional exemption system, leaving poor children unable to access health services.

Table 11: Development of basic health indicators in Ghana 1993 - 2006

Indicators	1993 DHS	1998 DHS	2003 DHS	2006 MICS
Infant mortality rate per 1000 live births	66	57	54	71
Under five mortality rate per 1000	119	108	111	111
Under five who are malnourished (underweight)	27%	25%	22%	18%
Source: GDHS, 1993-2003: Multiple Indicator Cluster Survey (MICS), 2006				

Figure 8: Trends in the nutritional status of children in Ghana, 1008 - 2006



Source: Extracted from NDPC 2006 APR

Table 12presents the proportion of 1-year-olds immunised against measles over an eight-year period. Generally there has been an improvement in coverage of 1-year-olds immunised against measles at national level. Regional coverage also shows that all the regions have made progress in coverage, except Volta region where coverage is below 70%. Intensive immunisation education and awareness creation activities may have contributed to the high coverage.

Table 12: Proportion of 1 year olds immunised against Measles, 1998-2006

Region	1998	1999	2000	2001	2002	2003	2004	2005	2006
Ashanti	60.8	57.0	68.7	83.9	77.0	70.0	68.0	79.0	73.7
Brong Ahafo	63.1	68.0	102.0	91.1	87.0	86.0	87.0	89.0	99.4
Central	72.9	62.0	79.0	80.5	83.5	81.0	83.0	85.0	89.0
Eastern	61.9	57.0	87.9	84.7	91.6	93.0	86.0	92.0	93.8
Greater Accra	68.5	60.0	65.8	70.0	75.6	66.0	63.0	67.0	65.9
Northern	89.3	96.0	100.6	90.0	106.4	92.0	94.0	96.0	112.4
Upper East	64.4	73.0	95.7	77.0	93.3	84.0	88.0	85.0	95.8
Upper West	74.3	64.0	90.2	90.9	89.7	88.0	92.0	78.0	101.1
Volta	53.1	49.0	68.3	71.7	65.3	68.0	70.0	69.0	71.0
Western	72.6	68.0	89.2	92.1	86.8	87.0	86.0	80.0	90.3
National	67.4	71.0	81.5	82.4	83.8	79.0	78.0	81.0	85.1

Source: MOH/GHS

5.3.4 Performance in selected health indicators in deprived regions *versus* the national average

Government, through the GPRS, is making efforts to address the health problems of the four most deprived regions of Ghana, namely UWR, UER, Northern and Central regions. The performance of these regions between 2003 and 2004 has been presented in the table below. The evidence shows an overall improvement in the performance in the four regions in selected health indicators during the period under review, except in a few areas such as TB control and ANC. Northern Region, as observed in 2003, remained the weakest performer. CR, NR, and UER made little progress in PNC and FP. UWR recorded a good improvement in all these areas. Supervised delivery in the four deprived regions improved considerably, notably in UER; NR however performed below the national average despite the fee delivery package.

Table 13: Performance in deprived regions versus national average 2003 - 2004

IND	INDICATORS	CR 2003	CR 2004	NR 2003	NR 2004	UWR 2003	UWR 2004	UER 2003	UER 2004	National 2003	National 2004
Service	% Under 5 who are malnourished (Wt/A)	?	31.6	?	48.8	?	34.1	?	31.7	?	29.9
	HIV sero prevalence among pregnant women	5.4	NA	2.1	NA	2.2	NA	3.5	NA	3.6	NA
	Tuberculosis Cure Rate (%)	47	46.3	NR	65	NR	52	41	59.6	53.8	61
	% Supervised Delivery	67	76.3	39.2	48.2	67.3	71.2	44.9	71.2	51.9	53.4
	% FP Acceptors (CPR)	26	33.6	16	16.7	36	44.6	19	20.2	22.6	24.3
	% ANC Coverage	102.5	107	102.7	110.4	88.7	94.7	100.2	102	91.2	89.2
	% PNC Coverage	69.7	70.4	62.1	62.9	75.8	94.1	50.1	48.4	55.8	52.3
	EPI Coverage – DPT 3	83	84	85	93	87	89	83	86	76	75
Access	Population to Doctor ratio	38,.5	23,4	76,0	58,1	32,7	30,8	50,5	30,0	17,4	17,6
	Population to Nurse ratio	2900	1695	4070	2941	3169	1786	3159	1408	2598	1513
	Hospital admission rate/1000 population	32.9	33.6	37.7	21.8	50.5	63.9	41.1	41.1	35.9	34.5
Quality	% Maternal Audits to Maternal Death	84	100	60	0	100	100	100	93.5	85	70.5
	Maternal Deaths (Institutional)	159	-	240	-	-	248	248		220	-
	Under-five Malaria Case Fatality Rate	NA	2.1	NA	3.4	2.7	2.4	2.4	2.5	3.6	2.8
Efficiency	AFP Non-Polio Rate	1.00	1.00	0.80	1.70	0.60	2.2	2.2	2.00	1.43	1.52
	Bed Occupancy Rate	61	67.3	59	51.9	48	47	47	53.4	64.1	63.0

Source: Extracted from MOH, Review of POW 2004, Report of the External Review Team, April 2005

Access to professional (nursing) staff witnessed improvements between 2003 and 2004 in the four deprived regions. The population per doctor ratio also decreased considerably in the three of the deprived regions but stabled in UWR. There is, however, some uncertainty regarding comparability of the data between the two years, owing to definitional differences (e.g. 2004 figures include private physicians).

5.3.5 Quality of care

Improving the quality of health services has been one of the main objectives of government in recent years and has therefore developed systems to improve and monitor the quality of services. Awareness creation interventions have been put in place to inculcate into health service providers the essence of quality of care. Investment in the establishment of quality assurance teams, in increases in supervision, training and development of guidelines for the practice of quality assurance, and in monitoring systems, have contributed to quality of care at facility level. Peer review mechanisms and maternal death audits have also been instituted at all levels as part of quality of care practice.

Patient satisfaction surveys have been instituted at the facility level by MoH and GHS, conducted twice a year to gauge the quality of care of clients. Unfortunately, these surveys have not been implemented regularly because of the heavy load on the service providers and also of lack of capacity. Discussions with community members and health staff revealed that people are more satisfied with the quality of care now than before.

5.3.6 Utilisation of health services

Average OPD admissions have shown steady increases from 1998 to 2005, with only a slight downward trend in 2006 which may be attributed to strikes by health workers seeking better condition of service during the year, which led to the closing down of public health facilities for weeks (Table 12). A similar pattern is observed in the regional statistics over the same period, except the Central, Brong Ahafo and Western Regions which recorded consistent increases throughout the period.

Trends in National OPD per capital show steady increases from 1998 to 2005 and only declined in 2006. The decline in OPD per capita in 2006 may be attributed to the national strike actions embarked upon by health workers during the year. Geographical access to health services has increased through improved and expanded health infrastructure and provision of health services closer to the people through Community-based health planning systems (CHPS).The increased utilisation of health services in the country could also be attributed to the investment in the health sector by government and development partners to ensure availability of health services to the people.

Table 14: Outpatients admissions by region, 2001-2006

Region	1998	1999	2000	2001	2002	2003	2004	2005	2006
Western	57,217	53,944	61,472	67,737	71,949	78,984	84,908	85,407	85,446
Central	30,336	43,392	49,169	52,999	54,871	55,820	59,611	63,932	67,628
Gr. Accra	74,475	58,205	76,956	91,009	88,299	76,606	81,874	98,561	92,890
Volta	51,625	51,894	56,329	57,081	63,844	66,241	68,144	70,000	69,919
Eastern	58,681	65,108	71,106	87,163	90,329	99,469	82,859	100,222	91,578
Ashanti	88,465	97,654	108,441	107,029	133,495	150,209	153,891	158,436	147,223
Brong Ahafo	46,373	45,447	64,735	65,211	62,531	67,009	67,931	77,798	81,607
Northern	40,279	43,561	58,856	67,323	69,801	74,733	72,368	67,063	60,547
Upper East	31,104	33,900	34,483	35,382	38,910	39,164	41,695	42,971	41,166
Upper West	13,774	19,679	24,887	28,580	31,846	30,656	32,157	36,047	29,716
National	492,329	512,784	606,434	659,514	705,875	738,891	745,438	800,437	767,720
National (OPD/Capita	0.38	0.40	0.45	0.49	0.49	0.50	0.52	0.54	0.52

Source: MOH/HIMS(GHS)

5.3.7 Effective maintenance systems

In 1995 the MoH (the EMU is now under GHS following the separation) made a request to Danida to provide support to build capacity in capital assets management. This decision of MoH was informed by the need for the ministry to take over the responsibility for managing all health estates from the then Ministry of Works and Housing.

The initial support for the EMU covered the establishment of two sections: the Capital Project Management and Planned Preventive Maintenance (PPM). In 2000, however, a new Capital Planning section was added as a third section in an effort to strengthen capacity in the health sector for planning capital investments according to set national policies, strategies and guidelines.

The table below provides a summary of budget, disbursement and percentage of Danida budget disbursed to the EMU between 1999 and 2006. In general budget implementation has been striking: a total grant of DKK 26.8m was budgeted for the EMU with DKK 29.1m actually spent, that is 108.3% of the budget.

Table 15: Danida support to EMU: Programme budget against disbursement, 1999-2006

Year	*Budget for programme (DKK)*	*Disbursement (DKK)*	*Disbursement (%)*
1999	3.000.000	4.186.599	139,6%
2000	3.000.000	4.715.962	157,2%
2001	999.803	1.339.662	134,0%
2002	254.959	258.945	101,6%
2003	5.854.000	4.853.494	82,9%
2004	5.449.434	5.445.019	99,9%
2005	6.075.678	6.075.678	100,0%
2006	2.181.641	2.177.046	99,8%
Total	**26.815.515**	**29.052.405**	108,3%

The immediate objective of the EMU support was to design and build-up a hospital based maintenance system over a three-year period covering all Government Health Estates, making use of existing structures and procedures, resulting in lower overall building running costs and an improved working environment.

The various sections of the EMU have made tremendous strides since their establishment. For instance, the PPM has trained staff, distributed tools, and raised awareness among users of the importance of maintenance. On the other hand, with the establishment of the Capital Management Section, an architect and a quantity surveyor has been appointed. Regional Estate Officers have been trained and deployed to all regions, including the appointment of Regional Estate Officers for the Regional Hospitals. Capacity has also been established to manage and monitor capital projects more effectively.

In a nutshell, Danish support to the EMU has ensured improved access, quality and cost-effectiveness of health care through the provision of more efficient and effective management of physical facilities. The current vision is one of improved functional and technical standards at health facilities in both rural and urban areas. The main outputs for the preventive maintenance programme are the building of technical, managerial and logistical capacity, creation of awareness of preventive maintenance, promotion of community participation and development of policies and guidelines.

The Planned Preventive Maintenance Section has put in place a maintenance system in all regions. Estate managers and maintenance persons have been adequately trained, and provided with tools (tool kit box) to carry out their assignment effectively. Manuals and guidelines have been developed and tool kits distributed.

The findings of the completion report on the Phase I of EMU show a fair representation of women in the employment of EMU, against the background that this profession is perceived as a male-dominated field. Of the estate managers, about 25% were reported to be women at the end of the first phase of the project. Among the maintenance staff in the districts, there are about equal numbers of men and women. The situation has not changed much during the second phase of EMU implementation..

Some of the constraints of the EMU include the following:

- resignation to of about 13% (6 out of 47) of trained personnel to seek improved prospects outside the country;
- lack of funding for maintenance works;
- lack of clear co-ordinated institutional responsibility for capital planning by MoH/GHS for overall implementation of capital projects; *and*
- lack of clear procedures and institutional responsibility for capital planning.

The major issue, however, is how to sustain the operations of the unit after termination of Danida funding. During the 10-year of EMU, Danida alone funded the operations of the Unit, with government paying for salaries. The evaluation team is rather optimistic that the mechanisms being put in place by the unit, if fully implemented, will ensure the optimal functioning of EMU. Some of the expected measures include the following:

- budgetary allocation from central government; since its establishment, government has not provided funding to the unit for its operations, except salaries;
- setting up a Technical Consultancy Services unit to provide consultancy services to GHS and others for a token fee; the consultant will offer services providing technical information and design to the GHS, CHAG and private health practitioners;
- sale of tender documents will also generate some revenue

5.3.8 Participation of the private sector in health service delivery

The contribution of the private sector to health service delivery in Ghana is quite substantial; almost half of all visits to health facilities take place within the private sector. Not-for-profit providers are estimated to cover about 40% of the health needs of the population, mainly in rural areas. With such large private sector activity, it is essential that mechanisms are developed to secure the private sector's support for the overall health policy objectives and that the combined effort of the public and private sectors is cost-effective. In spite of the contribution of the private sector to the overall health sector in the country, the*re has been continued failure on the part of the MoH to promote and exploit the full participation of the private and non-governmental sectors in health service delivery.* Private sector activities are still not taken fully into account in the planning of government services or in the monitoring of health services performance.

Christian Health Association of Ghana (CHAG)

The CHAG is a grant-assisted association of the MoH. The salaries of key health staff of CHAG are paid by the Ministry. CHAG is an umbrella association of Christian Health Associations in Ghana, founded in 1967. The aim of CHAG is to foster closer partnership between church-related health services and the MoH in order to promote competent total health care for the people. Its mission is “to provide holistic spiritual and physical health services in fulfilment of Christ's ministry to people of all races, colours, and religions and social/economic status”. CHAG had a membership of 152 health institutions in 2006. The institutions comprise hospitals, primary health care facilities and health-related personnel training centres in the country. Together, CHAG members provide care for an estimated 35-40% of the population, mainly in the underserved rural areas, making CHAG the second highest provider of health care in Ghana, following the MoH.

During HSPS III Danida provided financial and logistic support to CHAG for the development and implementation of a five-year strategic plan, the main purpose being to build the institutional capacity of the CHAG Secretariat. The Danida support covered review and development of CHAG strategies, structures, and systems, particularly at the central level where the organisation is very weak. Through that support the advocacy skills of CHAG have been strengthened and thereby CHAG has been able to solicit funding from more donor partners and has also signed a Memorandum of Understanding (MOU) with the MoH. This memorandum sets out the principles for the working together of the two institutions, including government support to CHAG in terms of human resources, payment of health workers' salaries and access to health insurance.

The Private Sector Unit (PSU)

The Private Sector Unit (PSU) of the MoH has the responsibility for co-ordinating the private health sector in Ghana. Danida has supported the capacity building efforts of the unit.

The capacity of the PSU is still weak and this is has been worsened by inadequate corporate policy and insufficient staffing to undertake its co-ordination role. The mid-term review of three components of Danida support revealed that there are no effective links with the regulatory bodies of MoH that worked successfully with NGOs and private enterprises. It recommended clear lines of authority and accountability on the functions and responsibilities of the PSU in relation to the regulatory bodies. This evaluation supports this finding as a way of strengthening the PSU to enable it to co-ordinate effectively the private sector participants in the health sector.

On the whole, Danida support to CHAG has been effective. On the other hand, support has not been very successful for the other private sector players, for example GRMA and the Ghana Private and Dental Practitioners Association (GPDPA). Danida support to GRMA and GPDPA was in the form of capacity-building with emphasis on training. GRMA's and GPDPA's preference was for supply of equipment to strengthen members' facilities..

5.3.9 Decentralisation has built the capacity and increased participation of district and sub-districts in the planning, management and evaluation of health services

In the last couple of decades Ghana has placed much emphasis on strengthening the districts as fairly independent entities including their capacity to undertake the task of developing the districts. Some of the milestones included the establishment of DHMTs in the 1970s, strengthening the District Health Systems Initiative in 1988, and increased financial autonomy to the DHMTs in 1995.

With the introduction in the health sector of the Budget Management Centres (BMC) concept and the Performance Contract, combined with an increased and comprehensive budget-frame, the autonomy of the district, as well as the sub-district, is in the process of being further increased and this is expected to improve efficiency in administration at district level.

It was expected that the process of general decentralisation to district level, e.g. the Local Government Act of 1988, would influence the development of administrative capacity at the level. Unfortunately, the legal inconsistency between the GHS Act and the Local Government Act has negatively affected the achievements of decentralisation.

In addition to its contribution to the health fund, Danida has provided earmarked support to the districts to help improve management at that level including financial management, undertake operational research, provide quality assurance and foster collaboration between public and private participants in the health sector. A mid-term assessment of the three earmarked components (November 2001) revealed that the support was relevant and a worthy investment, with many impressive achievements; and it recommended continuation of support for the component. Danida's support was aimed at helping District Managers and service providers to use available resources efficiently to improve coverage and quality of health services. Districts and sub-districts were helped to improve quality assurance, improve financial management and strengthen health information management. Other support included strengthening of general management and improvements in service delivery at community level through bringing services closer to the communities.

Some of the achievements include the training of all district health teams in the District Health Operation Programme Support (DISHOP). Linkages were also strengthened with DAs. District health accountants were provided with training in financial management and appraisal of BMCs. This skill-building contributed to improved reporting and financial analysis, which resulted in improved efficiency in health service delivery. The CHPS strategy was expanded to ten districts and quality assurance manuals, guides and educational materials were developed. Quality assurance teams were also established in district hospi-

tals. Under operational research, regional level training was provided to facilitate operational research, planning, co-ordination and support from regional level to district.

The GPRS emphasises district/sub-district/community-based quality care as an essential strategy for reaching the majority of the poor and has set targets for proportion of expenditure reaching the districts which however have never been met. Furthermore, the district level is an important convergence point for planning, implementation and supervision for many of the key principles emphasised by POW. This sub-component of Danida support was established to support the POWs with the objectives of strengthening district capacity to improve the coverage and quality of health care and providing it in an effective and efficient manner. This assistance, although modest in total investment, has focused on facilitating some of the key management and clinical delivery needs of districts and sub-districts, helping develop their management teams and encouraging greater collaboration and co-ordination within and beyond the health sector.

Table 13 provides a summary of programme budget and disbursement from 1999 to 2006. In all, the programme budget was over-spent by about 25%. The over-expenditures could be explained by the fact that the initial planning might not have accurately anticipated the total resource requirement for the support.

Table 16: Danida earmarked support to strengthening district and sub-districts: Programme budget against disbursement, 1999-2006

Year	***Budget for programme (DKK)***	***Disbursement (DKK)***	***Disbursement (%)***
1999	0.08m	4.63m	565.2
2000	1.07m	3.57m	332.7
2001	6.18m	6.31m	102.0
2002	5.55m	5.87m	105.8
2003	3.24m	3.24m	100.0
2004	4.09m	4.09m	100.0
2005	4.19m	4.19m	100.0
2006	5.16m	5.16m	100.0
Total	**29.59m**	**37.06m**	

Source: Danida, Pre-Evaluation Study

5.3.10 Summary

Table 17: Summary of DAC-criteria assessment of Danida support to improving health sector performance

Criterion	***Assessment***
Relevance	Danida support is relevant and in line with government's overall and sectoral policy of enhancing the performance of the health sector and contributed to achieving some of the United Nation's Millennium Development Goals.
Effectiveness	The performance was mixed; whereas there was improved performance in some health indicators, in other areas there was either no improvement or a decline in performance.
Impact	Generally, the impact of Danida support has contributed to improved performance of health outcomes in the sector e.g. IMR and under-5 mortality rates, though there has been recent concern about recent stagnation or a downward trend in some of these outcomes. Utilization of health services, ANC and PNC coverage as well as OPD per capital have improved during the reporting period. Improvements have been made in the planning and budgeting processes.
Sustainability	Some of the innovative interventions supported by Danida risk not being sustainable, par-

Criterion	Assessment
	ticularly some of the health systems developed. Maintenance of infrastructure, whether constructed or rehabilitated, has not been maintained owing to improper management and inadequate funding.
Cross-cutting Issues	Gender and environmental issues have been addressed. Capacity-building for women through training was impressive; an equal number of men and women received fellowships to pursue short-and long-term programmes in foreign schools, mainly in Denmark. The number of women in decision-making positions, particularly in UWR, improved during the reporting period; 75% of District Health Directors are women. On environment, the EMU has designed environmentally-friendly incinerators for the disposal of hospital waste.

5.4 Question 4: To what extent has Danida support contributed to improved access to health services, especially for the poor and vulnerable?

From the first phase of Danida support (HSSP I) to the health sector up to the current phase (HSPS II), access to quality health services has been one of the areas of support. This question therefore covers the various dimensions of access, that is geographical or physical access, exemption, and risk-sharing mechanisms.

At the national level, interventions by government in the construction of health facilities, training of more health professionals, improved referrals systems, introduction of the CHPS compound concept, and intensification of outreach programmes have all worked together to improve and bring health services closer to the population.

The expansion of community health services and the support of priority health interventions have improved availability of services. Under PoW II considerable progress been made to date in extending the Community-based Health Planning and Services Strategy (increasing from 19 compounds in 2001 to the target of 400 in 2006). However, under-financing of district health services and the failure to reimburse district facilities for exemptions have put facilities in dire financial difficulty and compromised the regularity of these services, as well as their accessibility to the poor.

Overall, Danida support was highly relevant and effective and has contributed to addressing a fundamental equity issue of access to health services. Through the intervention, more facilities were built, constructed or renovated and vehicles provided for outreach services. Equipment such as solar panels and solar fridges as well as TP communication have been provided for the facility and thereby making the facilities more efficient and accessible to the population who are in need of health services. The sustainability will depend on the commitment of the MOH and GHS to provide resources to maintain the facilities, equipment and resources for outreach activities.

5.4.1 Exemption mechanism in place for those who can not afford to pay for certain services

In 1997 the Government put in place an exemption policy to ensure that vulnerable people have access to health services without paying up-front. However this policy, which would have increased access to poor people including pregnant women, has had only partial success in lifting financial barriers to health services utilisation. There have been insufficient funds to allow for eligible women and the poor to take full advantage of available services. Available data indicate significant increases in exemptions for pregnant women using antenatal services (from 2.6bn cedis in 1997 to 3.5bn cedis in 2000), persons over 70 years (from 0.7bn cedis in 1997 to 1.3bn cedis in 2000), and children under 5 (from 54m cedis in 1998 to 3.0bn cedis excluding Greater Accra Region, in 2000). High utilisation of antenatal services by all vulnerable groups is a likely outcome of such increases. Exemptions for poor children remained virtually unchanged (at 0.4bn). It has also been documented that budgets for exemptions amounted to far less than actual exemptions, to the extent that the Northern Region, which performed very well in making exemptions avail-

able to clients, received a total of 1bn cedis to cover for exemptions in 2000, whereas total claims for that year amounted to 2.2bn cedis. Danida financed the difference for that particular year. Danida further disbursed an amount of ₵1.644m to the UWR in 2006 to offset outstanding exemption bills for 2005-06. Regional and district level staff observed that there have been some difficulties in honouring the exemption policy when they are not reimbursed for these costs. Table 16presents a summary of Danida support to access of health services (exemptions and risk-sharing), excluding contribution to the HF.

Table 18: Danida earmarked support to access to health services, budget versus disbursement, 1999-2006

Year	***Budget for Programme (DKKm)***	***Disbursement (DKKm)***	***Disbursement in %***
1999	0m	1.17	-
2000	0.74	5.22	708.8
2001	4.53	4.54	100.1
2002	2.82	3.36	125.3
2003	3.70	3.69	100.0
2004	5.85	5.84	100.0
2005	6.08	6.08	100.0
2006	2.01	2.01	100.0
	25.73	**31.91**	

The health summit of May/June 2003 agreed on some key steps for improving exemption. These issues include the efficiency with which the policy is being implemented, in particular the process of reimbursement to service delivery points; the growing demand on the exemptions fund; and the need to ensure appropriate targeting to contain cost and cover the poor. The problem of lack of involvement of the District Assemblies was also raised as a district concern. During the evaluation concerns were raised by Regional and District Health staff as well as health facilities (BMC) about the volume of non-reimbursed arrears and the effect on this of continuing provision of service for exempted patients (no exemption since 2004).

Exemption funding increased but was still inadequate; reimbursements of health facilities were either delayed or were not paid. Initial lack of clear guidelines on how to identify the poor might have contributed to the slow pace of implementation of the policy and the difficulty in determining ahead what the budget would be. It is expected the NHIS will assume the role of protecting the poor because the NHIS Act makes provision for indigents to access free services. However, it will take some time for the majority of the poor who are expected to benefit under the scheme to be covered by the NHIS, given the proportion of the indigent population covered currently. There is a need to sustain protection of the poor through exemptions, as efforts are made to bring them under the NHIS. There is also a need for clear guidelines on definitions and criteria to ensure that those in need of the services actually have access to them.

5.4.2 Increased existence and application of provisions to ensure protection of vulnerable groups from financial risks, e.g. health insurance schemes

A financial protection system cushions the impact of the poor and vulnerable from the high cost of “Cash and Carry systems” and makes access to health facilities less difficult. In its situation analysis of the health of the nation, the first Health Sector Five Year Programme of Work, 1996 (POW I) identified major challenges constraining improved health status in the medium term, namely: geographical access, access to basic services, financial ac-

cess, inadequate service quality, inadequate funding of health services, inefficient allocation of resources and weak intersectoral linkages

Furthermore, the second Five Year Programme of Work, 2002 – 2006 (POW II), which is an integral part of the Ghana Poverty Reduction Strategy (GPRS) recognises improvement in the health of the poor as crucial for reducing poverty. Therefore, one of the priority issues is to ensure "sustainable financing arrangements that protect the poor". Improving financial access is therefore vital in the key POW II areas of intervention. The purpose is to ensure that financial barriers do not prevent access to health services and to develop community prepayment schemes and health insurance plans to replace cash-and-carry systems in both the formal and informal sectors.

The NHIS Act 659 of 2003 provides for the establishment of a National Health Insurance Scheme (HIS) with the main objective of removing financial barriers which limit access to health care and nutritional services, particularly by the poor and vulnerable sections of the population. The introduction of the NHIS was viewed by DPs as a high-risk intervention both technically (very complicated) and financially (an ILO assessment was that it would go bankrupt in a few years). The DPs, including Danida, dragged their feet and were generally sidelined in this key development of the sector. Danida initially was of the opinion that a better option would have been a focus on community-based schemes and a slower but possibly more sustainable model for moving towards universal insurance coverage. Danida later acknowledged that it could not continue its quiet opposition to the government's policy and changed its strategy to support for the NHIS.

Since the passing of the NHIS Act, Danida has provided varied support to enable most of the districts to build their capacity to manage their schemes. Danida support also covers refinement of the criteria for the selection of indigent and poor people from the communities for support by the schemes. Currently, the Community Health Committees (CHCs) and opinion leaders in the communities of the catchment areas of the schemes are dependent on the schemes to identify indigents in their respective communities. Mechanisms for identification include the use of the criteria set by the CHCs. The list of identified indigents, when submitted to the Scheme, is reviewed by the District Social Welfare Department and the Scheme to ensure that the identified people satisfy the criteria. In most cases the indigents identified have met the criteria.

The schemes have collaborated with the District Assemblies to ensure sustainability of the schemes. The DAs are strongly represented on the Boards of the district schemes. Some of the DAs have provided the schemes with office accommodation (e.g. Kintampo North and Tamale), and other logistics for community outreach activities, and have actively participated in the scheme's community outreach activities. The level of district assembly involvement in the district schemes visited is encouraging and if further promoted could ensure the sustainability of the schemes.

Awareness of the insurance scheme at district level has been very high and is reflected in the steady increases in the proportions of the population who have now registered with schemes in the past two years. Available data from 2005 and 2006 show that national coverage of the scheme increased from 22% in 2005 to 38% in 2006, coverage increasing further to 47% in 2007. The following table depicts regional distribution of the proportion of the population who have registered under the scheme. It shows that Brong Ahafo region has the highest proportion registering followed by Ashanti, Central and Northern in that order. UWR recorded the least proportion of its population enrolling in the scheme and this may be explained by the high level of poverty in the region and the inability of most people to afford the payment of the premium. Encouraging, however, is that all the regions recorded increases in coverage between 2005 and 2006. It is worthy of note that retention rates of registrants of the scheme were quite high in the schemes visited during the field work.

Table 19: Regional distribution of the proportion of the population registered under the NHIS, 2005-2006

Region	Estimated population (million)	% of population registered in 2005	% of population registered in 2006
Upper West	0.96	7.85	30.00
Upper East	0.56	10.73	32.00
Northern	1.79	18.73	40.00
Brong Ahafo	1.97	30.14	61.00
Ashanti	3.92	28.14	44.00
Western	2.04	21.34	35.00
Central	1.69	22.42	44.00
Gt. Accra	3.58	17.02	19.00
Eastern	2.27	18.31	37.00
Volta	1.64	28.06	36.00
Total Country	**20.42**	**22.00**	**38.00**

Source: Extracted from NDPC 2006 APR

Table 22 below further presents NHIS registration coverage by category of registrants in 2005 and 2006. It shows that the proportion of indigents covered by the scheme in 2006 was less than 2%, but higher than was estimated in the Act. There is a need to accelerate the process of registering the indigent or poor. Otherwise, the good intentions of the policy would be defeated and the hope of the scheme replacing the exemption policy would be dashed.

Table 20: NHIS registration coverage by category of registrants, 2005 - 2006

Category	2005 Registrants			2006 Registrants		
	No.	As % of Reg.	As % of Pop.	No.	As % of Reg.	As % of Pop.
Total Registered	4.40m		22	7.67m		38
Total Membership	3.22m	73	16	6.14m	79.9	30.0
Informal sector	0.62m	14	1	1.41m	18.4	6.9
SSNIT contributions	0.47m	11	2	0.77m	10.0	3.8
Categories of exempted persons						
SSNIT pensioners	0.04m	1	0	0.11m	1.4	0.5
Children under 18 years	1.75m	40	9	3.07m	40.0	15.0
Aged: 70 and over	0.27m	6	1	0.54m	7.0	2.6
Indigents	0.08m	2	0	0.14m	1.8	1.8
Total Exempt	3.22m	59	13	4.62m	60.0	23.0
Total ID Card Bearers	**1.39m**	**43**	**7**	**3.95m**	**51.4**	**19.3**

Source: Extracted from NDPC Annual Progress Report, 2006

The roll-out of the District schemes faces some technical implementation challenges. Issuing of ID cards to members who have paid has been delayed in some places but this is being addressed. The situation is, however, better in districts that have received support from Danida in the form of scanners and digital cameras which have facilitated the issuing of the cards. Other challenges being encountered by the Schemes include delays in reimbursing service providers, some conflicts in claims with service providers over bills, understaffing and inadequate logistics. Some of these problems are being addressed through decentralisation of the National Council to ensure prompt processing of claims by districts. At district level arbitration committees have been established to address claims issues

quickly. The Council has also provided a pick-up each to each district to facilitate community outreach activities. While this is laudable, there is a need for additional means of transport to facilitate outreach activities.

5.4.3 Conclusions

Danida, one of the government's main health partners, has been supporting programmes that aim at increasing access to health services, especially for the poor and vulnerable. Danida's support has covered pre-paid health financing schemes and exemptions. This support has not only been great in financial terms but crucial and timely in the operations of the schemes. Most of the existing schemes prior to the establishment of NHIS were weak, financially and structurally, and Danida has helped them address some of these teething problems in order for them to "find their feet". It can be said that Danida has contributed immensely towards the successful uptake of the NHIS.

Coverage of the NHIS in the three years since its implementation has been encouraging. As an infant programme, there are bound to be some challenges but it is the ability of the scheme managers to identify quickly the difficulties and gaps and take immediately the necessary corrective measures that will ensure the success and sustainability of the programme. Danida's support to the scheme has contributed tremendously to its success. Danida is perceived as the "mother" of the schemes; it has provided the manual for the schemes, and training, capacity-building and technical assistance to their implementation.

Table 21: Summary of DAC-criteria assessment of Danida support towards ensuring protection of vulnerable groups from financial risks

Criterion	***Assessment***
Relevance	The first Health Sector Five Year Programme of Work, 1996 (POWI) in its situation analysis of the health of the nation, identified several challenges and weaknesses as constraints to improving health status in the medium term. These relate to geographical access, access to basic services, financial access, service quality, funding of health services, and allocation of resources. Again, the second Five Year Programme of Work, 2002 – 2006 (POWII), which is an integral part of the Ghana Poverty Reduction Strategy (GPRS) recognises that improving the health of the poor is crucial to reducing poverty. Therefore, one of its priority issues is to ensure "sustainable financing arrangements that protect the poor". Danida support is highly relevant. The interventions and pioneer works of Danida including the development of manual have been of immense help to the NHIS. The technical support by Danida has also been relevant.
Effectiveness	Danida support to access to health services through the provision of health infrastructures, exemptions and the health insurance scheme has been effective. It has helped to build the capacity of PHC services and the insurance schemes. However, it is too early to assess the effectiveness of the National Health Insurance Scheme. There are reported teething problems, but like all new programmes it is the ability to quickly identify the weaknesses and gaps and take the necessary corrective measures to address them that will ensure the success of the scheme. Generally, implementation of the exemption policy has not been as effective as it should have been owing mainly to inadequate funding and lack of clear guidelines for identifying the poor. However, Danida support in this area has been effective
Efficiency	Disbursement of funds from the NHIS Council to the schemes for payment of service providers (BMCs) has been slow. Some schemes, especially those in urban areas, have their own providers of facilities and services. For instance, there are reported cases where some service providers had temporarily suspended services to scheme card-bearing holders because of non-payment by the schemes. This situation if not addressed can have serious consequences on the relationship between certain service providers and schemes. Devolution of powers from the national council to lower levels in the processing and payment of claims to regions and districts will help address the problem. Reimbursements of facilities for exemptions have been delayed and in some cases payments have not been made for several years.

Criterion	Assessment
Impact	Extensive awareness has been created in the communities of the health insurance scheme and this has resulted in the steady increases in enrolment over the past two years. It is estimated that 36% of the population registered with the scheme in 2006 and coverage now stands at 47% (September 2007). OPD attendance at facilities has also increased sharply across the country and there are reported cases of pressure on the facilities.

5.5 Question 5: To what extent has Danida support to PHC training institutions contributed to improved quality of health services to the population?

This question is very much interlinked with question 3. This section therefore provides some additional elements that contribute to assessing the changes in the quality of health services delivered, focusing on primary health care.

Provision of health services requires a varied set of conditions to be in place, including essential services through an accessible network of providers, with the right mix of staff, respect for patient rights, and so on. Supporting PHC training institutions with health learning materials, training of tutors and improved infrastructure ensures that health providers of the right calibre in that category are produced, with the right attitude to work. During Phase I of Denmark-Ghana health sector support, the support to the PHC training Institutions was identified as a major intervention where Danida could impact on health service delivery in Ghana, particularly primary health care that targets the poor and rural communities. During this phase, six training PHC training institutions were supported with rehabilitation and provision of health learning materials. The six supported institutions included Akim Oda, Ho, Hohoe, Tamale, Winneba and the Rural Health Auxiliary Training School at Kintampo (RHTS). The Jirapa Training Health Centre was included for rehabilitation in the earmarked support to UWR during Phase II. The support provided by Danida covered infrastructural developments, revision of the curricula for community health nursing schools to make them more responsive to the needs of the Ghana's primary health care needs, provision of HLM and teaching equipment to enhance teaching and learning including projectors, text books and teaching aids; provision of transport for training and outreach activities; and sponsorship of three tutors for post-graduate courses.

5.5.1 Availability and performance of human resources (trained CHNs)

The Government's current policy is to ensure that all the ten Regions of Ghana have at least one Community Health Nursing Training School to cater for the immediate health needs of the people in the regions and to address the brain drain of medical doctors and nurses. In 2003, the Jirapa and Tamale Nursing Training Colleges (NTCs) introduced CHN to the existing SRN and MTS programmes. According to the GHS 2006 annual report, there are currently eight CHNT schools established in eight regions.

Expansion in staff accommodation has contributed to increasing the tutorship population of the schools to some extent; however, staff accommodation is still a major problem.

Danida's support was to complement government policy. Through Danida support, the infrastructure of the supported training institutions has considerably improved and expanded and this has contributed to increases in student intake by the CHNT and MTS. Tables 21 and 22 below show student intake by six of the supported institutions. Table 6 shows the aggregated enrolment of the six supported PHC training institutions from 1998-2006, whilst Table 22 presents enrolments into the six schools by sex for the same period. Available data from six supported training institutions reveals that there were more than five-fold increases in yearly admissions between 1998 and 2006 from 297 to 1,554 (Table 21). A total of 6,848 community health nurses and midwives have been enrolled by the six Danida supported CHNT schools since 1998, and more women (5,161) than men (1,687) have been trained in the schools since 1998. However, available data shows that the annual in-

take of men has been increasing over the years. The high enrolment of women and girls may be explained by the fact that traditionally nursing is regarded as a female-dominated profession. The increased enrolment will fulfil the government's policy of focusing on primary health care delivery in the country. Danida support has contributed to increasing expansion of infrastructure such as classrooms, dormitories, library facilities and staff bungalows..

Table 22: Annual student intake of six CHNT schools supported by Danida, 1998-2006

Year	All Facilities		
	Male	Female	Total
1998	57	240	297
1999	94	270	364
2000	49	376	425
2001	108	508	616
2002	161	473	634
2003	234	535	769
2004	225	745	970
2005	345	874	1219
2006	414	1140	1554
Total	**1687**	**5161**	**6848**

Source: Enrolment records of Tamale, Jirapa, Kintampo, Akim Oda, Ho and Winneba CHNT Schools

Table 23: Annual enrolment of six Danida supported CHNT by training Institute and sex, 1998-2006

Year	Tamale CHNTS			*Jirapa			Oda			Ho			Navrongo			Winneba		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1998	0	0	0	0	31	31	0	95	95	0	42	42	0	0	0	0	61	61
1990	0	0	0	0	47	47	0	105	105	0	43	43	0	0	0	0	63	63
2000	0	77	77	0	45	45	0	120	120	0	40	40	0	0	0	0	77	77
2001	1	93	94	4	38	42	3	150	153	2	88	90	0	0	0	0	104	104
2002	6	89	95	5	45	50	11	163	174	12	58	70	15	30	45	10	93	103
2003	9	54	63	23	78	101	17	154	171	7	81	88	18	21	39	4	116	120
2004	14	128	142	32	91	123	16	156	172	34	167	201	13	47	60	14	148	162
2005	13	132	145	26	111	137	23	201	224	40	179	219	23	76	99	14	173	187
2006	20	124	144	27	181	208	37	300	337	33	166	199	39	95	134	6	230	236
Total	**63**	**697**	**760**	117	667	**784**	107	1444	**1551**	128	864	**992**	108	269	**377**	48	1065	**1113**

Source: Enrolment records of Tamale, Jirapa, Kintampo, Akim Oda, Ho and Winneba CHNT Schools
**Jirapa cover CHNs, SRNs and Midwifery*

5.5.2 Availability and quality of HLM

The objective of the support was to contribute to improving teaching and learning in the supported CHNTS in the country. The curriculum of the CHN was revised to make it more relevant and responsive to the emerging primary health care needs of the country. Teaching and learning aids such as projectors, demonstration models and text books were supplied to the schools. Some of the HLM materials were observed during the field mission. However, it was noted that some had broken down whilst others have become obsolete and were not functioning properly. The support was, however, highly relevant and has contributed to making teaching and learning more efficient. The HLM component was effective

in achieving its objective of improving teaching and learning as well as contributing to the quality of the products of the schools. Increased enrolment may be attributed in part to Danida's expansion work in the schools by. The increased enrolment is likely to impact on government efforts to improve and increase access to primary health care. The sustainability of the support for HLM is low: some of the projectors provided to the schools had either broken down or the bulbs had broken without being replaced because of inadequate resources to maintain them.

5.5.3 Improvement in infrastructure of the four cadres of PHC workers at Kintampo Rural Health Training School

The Kintampo Rural Health Training School (RHIS) at Kintampo specialises in the training of certain cadres of health workers under MoH for primary health care service delivery. Different cadres of health personnel are trained, among them being community health nurses. It is the only institution in the country that trains Medical Assistants. At the RHIS at Kintampo for instance, a dormitory has been named after Danida in recognition of the latter's contribution to the development of the school. Support was also provided to the school to develop practical sites outside Kintampo for students' practical work. Support was also given to student supervisors to ensure effective supervision. Three tutors of the school received fellowships to pursue post-graduate programmes outside the country while the rest of the tutors received training in participatory learning approaches.

The support to the infrastructural development of the school was relevant. In addition to the annual increases in the student intake of the schools, three new programmes or cadres have been introduced since 2003. These programmes include Post Basic Community Oral Health, Direct Medical Assistant and Technical Officer (Oral Health). They have been designed to address specific primary health care needs of the country and were made possible partly due to expansion of infrastructure in the schools. Student admission has increased very sharply from 68 a year in 1998 to 428 in 2006 while the tutor population increased from 7 to 30 during the same period (Table 23).

Table 24: Kintampo Rural Health Training School: Admissions by Year and Sex

YEAR	MALE	FEMALE	TOTAL
1998	57	11	68
1999	94	12	106
2000	49	17	66
2001	98	35	133
2002	117	25	117
2003	174	52	226
2004	115	55	170
2005	229	78	307
2006	291	139	428

Source: RHTS, Kintampo, September 2007

5.5.4 Evidence of infrastructural developments at the CHN and CHNM Training Schools

Information was gathered on all the Danida supported Community Health Nursing (CHN) and Community Heath Nursing and Midwifery (CHNM) training institutions, except Hohoe. Three of the schools were visited during the mission. Evidence of improvement in infrastructure exists in all the institutions, included dormitories, classrooms, dining halls, store rooms, libraries, laboratories and tutors' bungalows. Other infrastructural support concerned provision of water and sewerage systems, fencing of the schools and improve-

ments to the general appearance of the school compounds. In addition, all schools were provided with a minibus to facilitate outreach and student field work. Support was also provided to the school to develop practical sites for students' practical work. The support to the infrastructural development of the CHNTS was significantly relevant as the expanded infrastructures contributed to increases in student intake of the various schools as mentioned under section 5.4.1. It also created an enabling environment for teaching and learning,

In general, the Danida support was relevant and timely in addressing the huge problems of the schools. At Kintampo for instance it was reported that Danida support had been massive. . Almost "all the structures were in deplorable condition, they (Danida) pulled them down and put up these magnificent edifices. We are very appreciative of Danida; they are generous and honest with their support….it has been comprehensive. We have responded to this generosity by naming the biggest dormitory after Danida". At Jirapa, "Danida" has even become a household name for changing the landscape of the NTS in the community because Danida has provided them with a "London in remote area", referring to the infrastructural development and improvements to the appearance of the school.

Expansion in staff accommodation has contributed to increasing the tutorship population of the schools to some extent, and staff accommodation is still a major problem.

Table 25: Summary of DAC-criteria assessment of the contribution of Danida support to PCH training institutions towards improved quality of health services to the population

Criterion	***Assessment***
Relevance	The support to the PHC training institutions was highly relevant to the priority health needs of the sector.
Effectiveness	All the supported components were effective in achieving their objective of improving infrastructure and teaching and learning as well as contributing to quality of the products of the schools.
Efficiency	Construction works were delayed due to the lengthy bidding process. However, disbursement of funds for implementation of the project was adequate and on time.
Impact	Danida support has contributed to making teaching and learning more efficient. Expansion in infrastructure has impacted on enrolment and staffing of the school, although provision of more bungalows for tutors remain a major priority.
Sustainability	Some of the HLM materials have not been maintained owing to funding problems. Again, some of the renovated infrastructure has not been maintained properly and there is the danger that there may be a reversion to the deplorable situation prior to the intervention
Cross-cutting Issues	More women students are admitted than men but gradually the male population is increasing. There are more female tutors than male tutors

5.6 Question 6: To what extent has Danish assistance contributed to the development of organisational and institutional capacity in the health sector and sustained improved performance of these in Ghana?

Capacity-building here refers to the provision of training to enhance knowledge and skills as well as provision of requisite hospital equipments, transportation and infrastructural development for the health sector. Danida has provided tremendous support to capacity-building in the health sector covering all the phases of its support. This section reviews the capacity-building assistance that Danida has given to the health sector.

5.6.1 Consideration, by Danida, of capacity-building issues in health sector policy dialogue

Review of documents reveals that issues of capacity-building are frequently discussed during dialogue with the MoH. Capacity-building has taken the form of training, equipment, in-

frastructural development and provision of short and long-term technical assistance. The HSSO has had long term technical assistance and a permanent health advisor. Long-term TAs have been recruited to help address some of the most pressing needs, within fields with particularly low capacity and insufficiently covered by other DPs' support. For example, TAs have been provided to the EMU since it establishment. A Transport Advisor was also attached to the Transport Unit of UWR. Other capacity-building assistance discussed during the dialogue included provision of post-graduate fellowships for health staff to attend either short courses or Masters Programme in International health. Although one donor indicated that capacity-building assistance has not always been welcomed by government, the general view was that MoH has been receptive to this assistance. This support has enhanced the capacity of the health sector to deliver quality health service to the people.

5.6.2 Relative (strategic) importance given to capacity-building measures in individual programmes and sectors

Danida's Country Strategy 2004-2008 states that 'Denmark will seek to promote capacity development in the relevant institutions through the thematic programme for good governance and human rights'. Danida attaches great importance to the provision of holistic support for capacity-building in individual programmes and sectors and this is reflected in the programme documents. Danida's capacity-building support has been relevant and effective. Strategic areas that have received support in the form of TA include the EMU, transport and financial management.

As part of efforts to reduce the cost of overseas training and ensure that more staff are trained, the new strategic direction of the HR unit of the MoH since last year is to place more emphasis on in-country training. This is expected to reduce costs but at the same time increase the number of staff trained. In 2006, therefore, there was a massive shift from foreign-based fellowships to locally- based fellowships. The 2006 annual report of the Human Resource Division of MoH indicates that only 10 of the 661 fellowship awardees in 2006 had foreign-based fellowship, a 77% increase over 2005. This was achieved basically because access to fellowships has been streamlined as a result of strict adherence to recommendations made by the central fellowships committee.

5.6.3 Satisfaction of trainees of all kinds with the capacity-building measures

Career structure for technical and non-technical staff exist at the Ministry; but there is no plan to ensure that the skills and knowledge acquired by trainees are immediately and effectively tapped. Satisfaction of trainees, particularly those supported by Danida is generally good as regards the technical content of the course. However, generally, most trainees on their return from training programmes become frustrated because they are unable to apply their acquired skills and knowledge immediately. Movement of trained staff away from the position for which they were trained is common, thus frustrating institutional capacity-building efforts. However, interaction with staff supported by Danida to undertake post-graduate courses revealed that most of them had been placed in responsible positions. In the UWR, for instance, seven of such beneficiaries are District Directors of Health Services, one is the Regional Co-ordinator of the National Health Insurance Scheme in the region and another is the acting Regional Training Officer. One of the beneficiaries in the Eastern Region resumed his position as the District Manager of a mutual health insurance scheme on his return from a post-graduate course in South Africa. Interaction with some of these trainees revealed that the training courses had been very useful and that they are applying the knowledge and skills to their present job.

The HR Division of the MoH has developed job descriptions for all sector agency established posts and a new strategy document has also been developed. This move is an indi-

cation of the need to streamline capacity-building measures to make training more useful and beneficial to both the trainees and MoH.

5.6.4 Relevance of capacity-building measures to in-country needs

Fellowships provided by Danida for either long- or short-term courses outside the country were highly relevant to the in-country needs of the health sector. Most of the courses held at the University of Copenhagen focused on International Health and address the health problems of developing countries. Other courses included health economics which was attended by staff managing the health insurance schemes at district and regional levels.

Both short-term and long-term TAs in financial management, transport and support to the EMU have been relevant

5.6.5 Level of retention of staff trained

In the MoH and GHS generally, there is evidence of a high attrition rate of health staff, particularly medical doctors and nurses. A majority of the health workers in Ghana migrate abroad because of poor working conditions and salaries, whilst others migrate to secure better accommodation and better prospects for promotion (MoH, 2007). Internal migration of health staff also exists between rural and urban areas and between regions, owing mainly to poor working conditions in the sending areas. At national level, the brain drain has affected the capacity of the country to improve its human resource base to meet the increasing health needs of the population. Table illustrates the number of cadres leaving the shores of Ghana by year between 1998 and 2003.

Table 26: Brain Drain in Ghana by cadres having left the country, 1998-2003

Cadres	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*
Doctors	61	72	52	62	105	117
Nurses	161	215	207	235	246	252
Pharmacists	53	49	24	58	84	95
Allied staff	6	9	16	14	0	N/A

Source: MOH, 2005 (Review of POW 2004: Report of External Review Team)

It must also be noted that a lack of career structure within community nursing compels ambitious nurses with no alternative to undertaking general nursing training and leaving the community nursing field altogether. Although this movement is within the country's borders, it hampers government efforts to strengthen primary health care in the country.

The government has recognised the threat of the brain drain of all kinds and has instituted incentive measures to stem the flow. These incentive packages, which include the following, have yielded some positive results since 2006:

- enhanced condition of service
- car hire purchase
- institution of post-graduate programmes in-country
- housing loans, etc.

Although there is a generally a high rate of attrition of health staff in the country, evidence from records of Danida-supported trained health staff reveals that the retention rate is quite high among this category of trainees. Of the 20 health staff trained in UWR, 70% were still in post in the region and 20% had been transferred to other regions within GHS. Only 10% had been lost to the GHS due either to death or to a desire to seek better opportunities (see following table).

Table 27: Beneficiaries of Danida Fellowship by gender and current status (in post or not in post), 1999-2007

Danida Fellowship between 1999-2007				
		In Post (%)		
Sex	No. Trained	GHS (Region)	GHS (Elsewhere)	Not in Post
Male	10	6	3	1
Female	10	8	1	1
Total	20	14	4	2
%age Distribution of beneficiaries of Danida support and current status				
Sex	No. Trained	GHS (Region)	GHS (Elsewhere)	Not in Post
Male	50	60	30	10
Female	50	80	10	10
Total	100	70	20	10
N	20	14	4	2

5.6.6 Progress in administrative and institutional reforms that aim at improved service delivery for the clients

In 1996 the Ghana Health Service (GHS) was established under Act 525 as an autonomous executive agency responsible for health service delivery through the public health system. The reform articulated in Ghana's MTHS and grounded in the national constitution called for separation of policy and regulatory aspects from service delivery functions. Implementation of the reform has been plagued by a number of issues, including lack of clarity of roles and responsibilities and complementarities between MoH and GHS; duplication of services between the two agencies; the weak capacity of MoH after most senior staff left this agency to join the GHS and were replaced with less experienced staff; and the failure to review or adopt the legislative instrument to implement Act 525. While these issues were repeatedly raised in summit (and other) meetings and documented in progress reports, they have persisted until recently. This has caused some confusion and inefficiencies in health sector operations, especially at national level. The MoH has signed a MoU with the CHAG but has failed to expand its service capacity through the development of contractual arrangements with other NGOs or the private-for-profit sector.

In November, 2006 the MoH launched its National Health Policy to guide the country's health programmes until 2015. The new health policy "Creating wealthy through health" falls within the overall priorities as outlined in GPRS II and has been designed within the national vision of attaining middle-income status by 2015

Incentives packages exist to honour performing health staff during the annual assemblies.

5.6.7 Conclusions

Table 28: Summary of DAC-criteria assessment of the contribution of Danish assistance to the development of organisational and institutional capacity in the health sector and sustained improved performance of these in Ghana

Criterion	***Assessment***
Relevance	Danida capacity-building support has been very relevant to the capacity needs of the sector. Provision of fellowships for post-graduate studies and of TA to areas of the sector with the most pressing needs, including financial management, EMU and transport has been highly relevant.
Effectiveness	The capacity-building has been effective in achieving its objectives. Although there is massive brain drain of health professionals trained with taxpayers money, retention rates of beneficiaries of Danida-supported external training have been quite high. In the UWR for instance, 7 of the 8 District Directors of Health services have benefited

Criterion	Assessment
	from Danida fellowships.
Impact	Support has impacted positively on improved capacity of the sector which has been translated into enhanced performance in the sector. This is reflected in increased utilisation of health services and improvement in some key health outcomes.
Sustainability	Sustainability of capacity-building hinges mainly on availability of funds, especially GoG resource allocation for health service delivery
Cross-cutting Issues	Gender has been one of the major consideration in capacity-building and training. Equal numbers of women and men received fellowships for post-graduate training in foreign countries.
Coherence, co-ordination, complementarity	Donor co-ordination or harmonisation in capacity-building is weak. DPs provide a mix of support including TA, study tours, equipment, and short and long term external training under either their own arrangements or in consultation with the MoH.

5.7 Question 7: How appropriate were the aid modalities / support and funding methods used by Danish assistance in the health sector?

5.7.1 Assessment of modalities applied by Danish assistance by Ghanaian government, Civil Society and other partners

Generally, aid modalities are perceived by both the MoH (and GHS) and donor partners as effective with good predictability and high flexibility. The sector-wide budget support gives MoH the flexibility to channel funds to underserved areas. The earmarked support allows support for innovative ideas. A particular strength of the Danida support is its ability to provide opportunities for the testing and assessing new ways of doing things. The evaluation encountered important initiatives that might not have taken place without the flexibility of Danida support.

Overall interviewees were positive and very satisfied with Danish sector aid modalities, especially when compared with some other sector donors, but noted that the application of the pull-back clause in its agreement with the Government in 2006 was not helpful and had been done without much consultation with partners. However, it is the view of the evaluation team that the position taken by Danida was right and legitimate; the government had signed an agreement with Danida and each party had committed itself to the tenets of the agreement. Evidence gathered indicated that Danida did send the money to MoH but not through the health account. Rather, it sent it through the appropriate government channels to districts in the four poorest regions for HIRD activities. Part of the funds was also used to defray outstanding exemptions bills in UWR

5.7.2 Appropriateness of combination of modalities to national policy and institutional context

The application of mixed aid modalities by Danida to national policy and institutional context is perceived as appropriate to the sector. Whereas support to the health account through SWAp gives the Ministry the flexibility to apply funds as appropriate to priority areas of the sector, earmarked funds ensure sustainability in areas of crucial importance to the success of the POW but otherwise at risk of being sidelined.

Overall, the funding and aid modality has been relevant, effective and efficient in its application and has been to the advantage of the interventions.

5.8 Question 8: To what extent were cross-cutting issues and priority themes duly considered in Danish assistance to the health sector?

5.8.1 Gender as a cross-cutting issue

5.8.1.1 Increased gender mainstreaming into programme support and project activities

Danida support has contributed to increasing mainstreaming of gender into the health sector programmes. Danida has supported the MoH in developing a gender policy "Promoting Gender Equity and Health", and gender training of staff and policy makers as well as being instrumental in the establishment of a Gender Desk at the Ministry of Health. Through Danida support a team has been set up to facilitate the mainstreaming and implementation of the policy POW "Partnership for Health, Bridging the Inequalities Gap". The overall programme has a strong focus on improving reproductive health and the main development targets include reduction of maternal mortality ratios, increase family planning acceptors, and increasing ANC and PNC coverage.

On gender, the completion report on support to estate management and planning found an encouraging level of women's representation in employment at the EMU. Of the estate managers, about 25% were reported to be women at the end of the first phase of the project. Among the maintenance staff in the districts, roughly equal numbers of men and women are represented. The situation has not changed much in the second phase of implementation of EMU. The discussions during the field work indicated that women tend not to stay in their jobs in the regions for long, especially when their spouses go on transfers.

5.8.1.2 Increased targeting of women, children and vulnerable groups as direct or indirect targets (beneficiaries) of Danida programmes and project

Increasingly Danida targets women for scholarships to pursue further studies outside the country. Analysis of data on beneficiaries of Danida-supported external fellowships shows that half of them were women. Danida interventions in exemptions and HIRD were geared to improving maternal and child health. Pregnant women and children in the four poorest regions benefited from these interventions. During the implementation of the HSPS in the UWR, one of the programme components was community participation in health. Women were particularly encouraged to participate and an economic empowerment component for women was factored into the programme. The programme enabled women to be provided with soft loans for their economic activities.

5.8.1.3 Increased level of women's participation in decision-making on Danish supported programmes and projects as well as in grassroots community levels

Women participation in decision-making in the health administration of the UWR is quite high and satisfactory. As already observed, the region was a major beneficiary of Danida support. Currently 75% of the eight District Directors of Health in the region are women. All the women Directors except one have benefited from a postgraduate fellowship from Danida. The current Acting Regional Training Officer is a woman and a beneficiary of the post-graduate course in Denmark. All but one of the six Principals of the CHNT schools supported by Danida are women.

In general, the participation of women in decision-making in Danida-funded projects in UWR is quite satisfactory. Unfortunately, representation of women on boards and management of District Health Insurance Schemes is negligible. Of the seven District Schemes visited, one had two women on a six-member management team and two others had one woman member each. The trend is the same in representation on boards; there were a maximum of two women on all the boards of the schemes visited. The community health

committees also had fewer women serving on the committees. It is explained that the low representation of women is due to the difficulty in identifying women willing to serve on the committees. It is the view of the evaluation that efforts should be made to encourage more women participation in the governance of the district health insurance schemes.

5.8.1.4 Improved levels of the socio-economic status of women, men, children and the vulnerable due to Danish Assistance

Information on direct impact of Danida assistance on the socio-economic status of women, children and the vulnerable was not available. However, it could be deduced from some of the interventions that there is potential for the interventions to improve the status of these groups. First, the socio-economic status of the District Health Directors could be said to have improved. Second, the soft loans to some women in the UWR were aimed at improving their socio-economic status and the status of the women beneficiaries could be said to have improved, all other things being equal. Similarly, and as noted earlier, the exemptions for the northern region and the HIRD activities were meant mostly to assist women and other vulnerable groups and help improved their socio-economic status.

5.8.1.5 Conclusions

Gender mainstreaming into sector programmes has been relevant as it addresses an important issue in the GPRS and the health sector PoW. The support has aimed at involving more women in decision-making, improving the socio-economic status of women and access to health services for women and the vulnerable. The Danida support has been effective in some degree.

5.8.2 Environment as a cross-cutting issue

The EIA regulations of Ghana make it mandatory under the environmental assessment Regulations LI 1652 of 1999 for all plans for major construction work to include an environmental impact assessment to determine the possible impact of the construction activities on the environment and the people, including the vulnerable, and the mitigation measures that needed to be put in place. Construction of hospitals and health related facilities falls within the category that requires environmental impact assessment before construction works take off. The Ministry complies with the national regulations and ensures that environmental assessments are conducted on all construction works. Danida recognises and supports the implementation of the Environmental Action Plan being implemented by the Environmental Protection Agency (EPA).

It must also be noted that the preventive maintenance policy of the MoH has contributed to better environment and increased awareness of cross-infection and health hazards through education and development of manuals and guidelines. Training programmes of the EMU include one on how to sort waste at points of source, collection and disposal. To address the hospital waste problems of the health facilities, the EMU has designed more cost-effective and environmentally-friendly incinerators and provided guidelines for the incineration of hospital waste at all levels. Five of the incinerators have been piloted with funding from EMU whilst the EPI has funded construction of 150 across the country.

In view of the recognition by MoH that co-ordination of environmental waste management and sanitation generally is more effective at district level, the EMU has actively collaborated with the Ministry of Local Government and Rural Development and built up the capacity of their staff in waste management. Furthermore, the MoH has established partnerships between many entities involved in environmental health and management, under the umbrella of a more capable Local Government System. These efforts are designed to ensure that appropriate measures are taken to safeguard the environment.

5.8.3 Good governance as a cross-cutting issue

The MoH has overall responsibility for the stewardship of the entire health sector and for ensuring equity and efficiency in sector activities. It exercises this function by providing overall policy direction, institutional development, co-ordination of the activities of agencies, partners and stakeholders involved in health and ensuring performance and accountability within the sector. In addition, the MoH co-ordinates planning, resource mobilisation, budget execution, human resource development and overall monitoring and evaluation of health sector performance. The thrust of MoH, therefore, is to promote achievement of results through good governance; efficient, equitable and transparent mobilisation; efficient allocation and utilisation of resources; and ensuring better harmonisation and alignment of activities and investments by stakeholders in health.

Danida has supported some efforts to engage more meaningfully the participation of communities in health sector governance. This includes support to workshops on community participation and mobilisation as well as support for training activities in the lead CHPS districts in community entry and participation. In addition, during the support to UWR Danida supported an inter-sectoral “health forum”, which provided a platform for different stakeholders, including the media, to discuss health issues. The support included publication of a newsletter on health matters. Further support has been extended to the training of Board members of the district health insurance schemes. Danida support for community participation addresses one of the POW priority areas which requires empowerment of households and communities and establishment of community linkages. However, due to lack of capacity and inadequate time and effort on the part of the MoH to engage communities in health sector governance, as well as to conflicts in communities, linkages between the health sector and communities in policy formulation and implementation are weak, and bureaucrats and professionals still dominate the policy development process within the health sector, which is not healthy for good governance.

The current governance arrangements in the health sector in Ghana were influenced by Article 190, sub-section 1 of the Constitution, which classifies the Health Service as one of the public services of Ghana, and Act 525 which establishes the Ghana Health Service and Teaching Hospital Boards as semi-autonomous organisations. Under Act 525, there are mechanisms for some involvement of Civil Society and communities as advocates for the needs of the poor and vulnerable in health policy formulation and implementation[6].

The Ghana Health Service under the MoH has responsibility for implementing approved national policies for health delivery, increasing access to improved health services, and prudent management of the resources available for provision of health services. In accordance with Act 525, MoH and GHS has decentralised health services within the MoH through the BMC and the performance contract system; and facilitated the establishment of regional and district health committees and involvement of local communities and users. The MoH has functional relationships with, and is partly accountable to, the decentralised political authorities. Act 525 provides for the establishment of Regional Health and District Health Committees, with representation from the Ministry of Health, the Regional Co-ordinating Council, DAs, traditional authority, and other residents in the region and districts, including a woman. The Health Committees are responsible for advising the Regional Director of Health Services on policies related to health in the region.

Governance in the context of the delivery of healthcare has been defined to mean that health needs should constitute the basis of any healthcare delivery system and should be designed to improve access to health services. Thus the process of deciding on the level

[6] Republic of Ghana, Ghana Health Service and Teaching Hospitals Act, Act 525, 1996, p. 10-14

and distribution of health services, access to health services, use of services, institutional arrangements for managing the services, and mechanisms for the delivery of such services, should be the preserve not only of health professionals but also of clients and a wide range of interest groups and stakeholders including Civil Society. However, the present arrangement has been more one of consultation and participation than of real transparency and ownership by the public of health sector programmes and activities.

Public and financial accountability measures have been instituted by MoH including systems for planning, budgeting, accounting, procurement, reporting and reporting. Danida has supported the ministry in putting in place these systems and building the capacity of the ministries to operate them. In 2003,Government introduced three laws (Financial Administration, Procurement and Internal Audit Laws) which in combination aim at establishing a strong framework for PFM and accountability. Activities related to an improved PFM system have to a large extent focused on MoFEP. A number of assessments of Ghana's PFM performance have been made: CFAA in 2001 and in 2004; External Review of Public Ghana Public Financial Management Performance using PEFA methodology in 2006; and an assessment of the procurement system in 2007, using the OED-DAC methodology. Notwithstanding all that, there is still much to be done if the generally positive trend in public financial management is to continue to improve, not least at district level.

Danida support to health is expected to be governed by these public and financial accountabilities, which have been clearly set out in the programme documents, in agreements with government and in the CMAs.

5.8.4 Human rights and democracy as cross-cutting issues

As noted in the earlier section, the policies and programmes of the country and MoH recognise the need to improve and increase access to health services to the population irrespective of gender, location, ethnic background or status in society. Provision of access to health services should not discriminate. Danida has supported expansion of services to the most deprived areas in the country and further supports interventions on access to health services, which target the poor and vulnerable.

5.8.4.1 Consideration of issues of promoting human rights and democracy issues when designing the interventions, especially regarding promotion of (local) participation in decision-making, i.e. through Civil Society

Fora for participation in decision-making by Civil Society groups have been identified. The MoH engages Civil Society groups and NGOs such as the Coalition for Health to deliberate on matters of health. It was evident however, that the level of involvement of these groups in decision-making is limited and there is more room for improvement. In the UWR, Danida supported the setting-up of an inter-sectoral health forum where stakeholders in health discussed health issues. The then Regional Editor for Graphic, now the MD of Graphic Communication Ltd, was sent on a course in health outside the country to enable him edit a magazine, which was the mouthpiece of the forum.

5.8.4.2 Increased mainstreaming of human rights and democracy issues into programme support and project activities

Public participation in decision-making in health is limited. Efforts are being made by the GHS to forge inter-sectoral collaboration with MDAs at all levels. MDAs are therefore invited to participate in regional planning and review meetings. Similarly, Civil Society groups and MDAs participate in the health forum organised by the MoH. However, it has been observed through documentary reviews that because of the high level of technical engagement in the forum the Civil Society groups may not be able to make the necessary contributions.

The Ministry has published policies that protect the rights of the clients such as Reproductive Health protocols and standards and the Patient's Charter.

5.8.4.3 Conclusions

Table 29: Summary of relevance and effectiveness

Criterion	***Assessment***
Relevance	Danida sector support to mainstreaming cross-cutting issues such as gender, environment, promotion of human rights and good governance is relevant. However, there is room to strengthen the mainstreaming in terms of concrete support to ensure the realisation of the mainstreaming of these cross-cutting issues in all facets of the health sector programmes.
Effectiveness	The effectiveness of Danida support is mixed. With the exception of gender, and to a rather larger extent good governance, the other cross-cutting issues are not explicitly addressed in the programme document. This makes it difficult to conduct a meaningful assessment of the effectiveness of the support by Danida for these cross-cutting issues

5.8.5 Private sector as a priority theme

Danida support has targeted the private sector, including implementation of health sector programme support. CEDEP was partnered to implement the community participation and women empowerment component of the support to UWR region. In addition, two well-established NGOs were given responsibility for implementing key components of the Danida-supported programme. The National Catholic Secretariat (NCS) was helped to manage and implement the re-equipment of three mission hospitals in the Northern, Upper West and Upper East Regions. The Planned Parenthood Association of Ghana (PPAG) also received support for managing and implementing the refurbishing of 26 of its clinics and the expansion of its community-based distribution activities. An additional amount of 220,000 SDR was designated for grant financing for the re-equipment of other missionary hospitals in the Northern, Upper West and Upper East Regions. Ghana Social Marketing Foundation International (GSMFI) were supported by Danida in promoting contraceptive uptake among the population with emphasis on social marketing.

The CHAG, GRMA and Ghana Private Medical Practitioners Association have been engaged in Danida support as part of the implementation of the HSPS III.

- Increased economic activity in private sector enterprises due to Danish Assistance

Danida supported construction activities, including health facilities and health training institutions were contracted out to private sector enterprises. It is envisaged that the massive construction activities over the construction period stimulated economic activity in the private sector enterprises. In addition, prior to the establishment of the NHIS, Danida supported new and existing community mutual insurance schemes across the country, particularly in the three northern regions, Brong Ahafo and Eastern Regions. These schemes were private initiatives which might have contributed to increasing economic activity in the sector. However, the increased economic activities did not benefit the private sector health service providers.

- Increased employment in private enterprises in the sector due to Danish Assistance

Although information is not available on the numbers of people employed, either directly or indirectly, the constructional activities supported by Danida as noted above might have created employment avenues for sand contractors, masons, carpenters, and other labourers to work on the building projects. As part of the support to CHAG to strengthen its Secretariat, Danida supported the recruitment of three new management members to join the Secretariat management team.

- Private enterprises increasingly taking part in dialogue with government, in institutional development and in influencing local decision-making

Private sector engagement with government is weak. However, through the Danida support to CHAG the Secretariat has been strengthened to conduct constructive dialogue with government. CHAG has made strides in building relations with the MoH. Like other private sector actors, CHAG is an active participant at the health summit. CHAG's advocacy was effective in having MoU signed between them and MoH and also in having funding of staff remuneration maintained.

Overall, Danida support for implementation of certain programme activities generated economic activities mostly for non-health private sector enterprises. Only CHAG and the community mutual health insurance directly benefited from increased economic activities generated by Danida-supported activities.

5.8.6 HIV/AIDs as a priority theme

The Danish HIV/AIDs portfolio has included some strategically important interventions, and the Danish participation in the policy dialogue on the national HIV/AIDs response, including that in the health sector, is respected and appreciated by both national and external players. This is not to say that more Danish funds allocated to this area could not have been spent productively. Identifying limited but innovative initiatives taken by relevant national institutions and well co-ordinated with other activities should remain the core of the Danish response, in addition to the support given to the health sector and continued and broadened mainstreaming of HIV/AIDs into the other sector programmes. Should a basket-funding arrangement materialise, as presently envisaged, this would be a welcome approach to ensuring that the Danish contribution supported national leadership and co-ordination of the response.

Danida supports the mainstreaming of HIV and AIDs into sectoral plans and has provided funding to six ministries. These ministries were to mainstream HIV and AIDs into their interventions, focusing on prevention and control activities. These Ministries are Manpower, Health, Transport, MOE, MOFA and MOWAC. The support was channelled through the GAC. Unfortunately, Health and Transport could not access the offer and the GAC did not offer an explanation as to why the ministries could not utilise the funds.

In addition to the support to the six ministries to mainstream HIV/AIDs into their sectoral plans, Danida support to the health sector is based on a basket funding arrangement as already explained in previous sections. Together with other core donors, Danida provides funding for MoH's National Programme of Work through a Common Fund. Approximately 75% of the Danish support is basket funding. MoH determines the precise allocation of funds to the various priority areas, in line with national policy. HIV/AIDs is one of the most important health priorities for the MoH, which is responsible for the majority of HIV/AIDs treatment and care and related activities undertaken in Ghana. Danida earmarked funding for district capacity-building support, includes integration of HIV/AIDs into community-based CHPS programmes in deprived areas.

Apart from the HSPS, the Decentralisation Component of the Good Governance Programme includes funds disbursed as non-earmarked support for general budgets. This relates to the development budgets of a number of District Assemblies, which however may be assumed to include only negligible funding of HIV/AIDs-related activities. The Districts would rather fund implementation of such activities from recurrent budgets, which are not co-funded by Danida.

Overall, Danida support to mainstreaming HIV/AIDs into the sectoral plans of ministries is relevant and conforms to the goals and objectives of the NFS II. The support targets five of the seven intervention areas of the NSF II, namely policy, advocacy and an enabling environment; co-ordination and management of the decentralised multi-sectoral response; mitigation of economic, socio-cultural and legal impacts; communications on prevention and behaviour change; and treatment, care and support.

6 Summary assessment, related to the DAC criteria

Table 30: Summary assessment of Danida support to the health sector related to DAC criteria

Criterion	***Assessment***
Relevance	Danida project support during HSSP I (1994-97) targeting strengthening of PHC training institutions, PHC service delivery in UWR and the NTCP was very relevant as it focused on some of the critical health areas at the time. HSPS I was also highly relevant –to the goals and objectives of the Ghana Vision 2020 and the MTHS and POW I (1997-2001). During the period of implementation, Danida aid modality shifted from project support to SWAp, and about 66% of the support was channelled into the health account for the implementation of the POW. Earmarked funds were relevant because it enabled Danida to ensure sustainability of ongoing Danida activities, and to secure funding for areas of crucial importance to the success of the POW II but otherwise at risk of being sidelined, and maintain some visibility. Again, HSPS III was critically relevant – it supported the second Five Year Programme of Work, 2002 – 2006 (POWII), which is an integral part of the Ghana Poverty Reduction Strategy (GPRS). The GPRS and POW II recognise that improving the health of the poor is crucial to reducing poverty. Investment in sustainable financing arrangements for the poor, quality improvements, the efficiency and financing of the health sector, and fostering of partnerships in health, were all useful investments. Hence, POWII recognises improving financial access as vital in its key areas of intervention. Danida's choice of regions for earmarked support and HIRD interventions was highly relevant to targeting poverty in the three poorest regions. The choice of the four northern regions and Central region appears to have been based more on the level of poverty and health outcomes in these regions. The attention to and investment in EMU was highly justified. Support to capacity-building was relevant as was investment in cross-cutting issues such as gender, HIV/AIDs, environment, and governance. However, mainstreaming of environment and governance issues into programmes was not very pronounced, in contrast with gender – In general, Danida's sector support programme has been relevant to the health sector policies, plans and strategies such as the MTHS and POW. It is also in harmony and alignment with the programmes of other sector donors and is highly predictable.
Effectiveness	Danida support to HSSP I was very effective and achieved its objective of developing health and PCH training school infrastructures. There were a few delays in construction work but that did not affect the other achievements of Danida's support. Specifically, the following interventions were effective and achieved both the short- and long-term objectives of the intervention during Phase I: • construction of classroom block, students' and tutors' accommodation, provision of HLM and of school bus; • construction of health facilities in UWR (indeed 43 facilities were constructed as against the 23 planned; provision of equipment, including hospital equipment, transportation, a maintenance centre for servicing of vehicles and equipment, and solar panels and fridges and TP communication facilities, was very effective); • organisation and management in the UWR, which was very effective; • quality assurance and scheduled drug delivery; *and* • establishment of the National Tuberculosis Control programme Donor co-ordination and harmonisation during the period was not effective due to the vertical nature of projects The combination of aid modality applied during HSPS II and III was very effective. The SWAp was more flexible and predictable and enabled MOH to plan ahead. On the other hand, the earmarked funds were also highly effective. Danida support to capacity-building in the sector was effective. The support to the EMU, systems building, district strengthening and innovations was all highly effective. The support for exemption was strong, but implementation was characterised by implementation difficulties, except for the fairly short direct support from Danida to exemptions in the four deprived regions. Equally effective was the support for risk-sharing arrangements and

Criterion	Assessment
	fellowships for postgraduate courses outside the country. However, support to central level initiatives and the private sector (with the exception of CHAG) was slow in achieving the set objective. Interventions in connection with decentralisation have been effective but this effectiveness is threatened by resource constraints, human and financial . The effectiveness of Danida support to gender mainstreaming is mixed. However, in the UWR there are more women in decision-making at the district level. Overall, most Danida-supported components were effective. The targets for most of the SWAp performance indicators did not meet the targets although there was evidence of consistent improvements.
Efficiency	Disbursement of funds from Danida to MoH for implementation of agreed activities was very efficient. Analysis of project budget and disbursement show that disbursement rates were very high. However, there were delays in disbursements of funds from MoH to district level. Efficiency in service delivery therefore seems low, as financial resources reach the districts and sub-districts only to a limited extent, creating poor working condition in many facilities. Infrastructural works such as construction and renovations of new and old health facilities, bungalows and student accommodation, and classrooms for PHC training schools were efficiently undertaken. Work on the general appearance of sites and provision of sewerage facilities and solar panels was efficiently executed. Generally, Danida support for the sector is viewed as highly efficient. The development of a sector-wide monitoring system with harmonised indicators provides a good basis for improved efficiency. Flexibility in the disbursement mechanism allows more efficient implementation of projects. Lastly, support for capacity-building and training was provided as an integral part of Danida interventions, ensuring high efficiency.
Impact	Investment in the construction of health facilities, exemptions and risk-sharing has improved both geographic and financial access to health services for women and the vulnerable. Support to EMU has also been substantial. The impact of Danish support to the health sector in Ghana has been substantial; in UWR region, for instance, construction and renovation of more physical infrastructure has contributed to increased geographical access to health services; increased access to health services by the poor through exemptions and health insurance; and improved quality and efficiency of health services. Utilisation of health services has increased substantially. Impact on some health outcomes over the period, for example infant, under-five and maternal mortality has been positive. However, looking at the impact indicators over the last five years, the 2003 GDHS and 2006 MICS findings show stagnation and generally worsened U5MR and IMR levels with only Upper East Region demonstrating a consistent reduction. Expansion of cost-effective interventions are known to contribute to important mortality reduction and this might be the case in Upper East Region (UER). However such findings may need in-depth analysis to establish the real underlying factors which for now appear to relate to a combination of factors including child health and reproductive health interventions, quality of service delivery, and planning and ownership by communities and DA.
Sustainability	Lack of sustainability was and is an identified risk. Most of the promising systems put in place, especially in UWR, could not be sustained.
Cross-cutting Issues	Cross-cutting issues such as gender, environment, HIV/AIDs and environment were mentioned and mainstreamed into the support. Governance has also be mainstreamed.
Coherence, Co-ordination, Complementarity	Donor co-ordination in the health sector, which did not exist during HSSP I, has consistently improved over the period. Harmonisation of procedures and use of national systems as well as alignment of programmes have improved over the period. The shift from project support to SWAp in 1997 ensured harmonisation and improved dialogue but the shift to MDBS may hamper this achievement. Danida plans to shift from SWAp to SBS from 2008. Danida's programme support to the sector is fully coherent with higher level policies such as Ghana Vision 2020 and GPRS I and II. Finally, Danida support is fully coherent with health sector polices such as the MHTS and POWs.
Issues of Procedures, Administration and	Danida support has been flexible, predictable, holistic and consistent in terms of procedures, administration, and management of the health sector programmes

Criterion	*Assessment*
Management	
Global Assessment	The main aim of Danida's health sector policy for the developing countries is to improve the health status of the population, especially the most vulnerable and poorest sections. Denmark endorsed the Primary Health Care (PHC) approach adopted at the Alma-Ata conference in 1978 and subscribed to the main principles of equity, community involvement, focus on prevention, appropriate technology and a multi-sectoral approach. Danida was instrumental in operationalising the principles and elements of PHC in the 1990, and focused on primary and public health essential services and developing the health systems to provide them. Danida pioneered the new concept of an Essential Drug programme (EDP) and placed emphasis on the principles of equity and utilisation of health services by poor and vulnerable groups. It advocated community participation and stimulated community-based health care by supporting the training of community health workers and the construction of community health centres.

7 Overall conclusions and recommendations

7.1 Overall conclusions of the assessment

The evaluation has assessed the performance of the health sector of Ghana and the Danida contribution to the sector over the past 16 years. Danish development assistance to the sector aimed to contribute to poverty reduction by improving financial and geographical access to quality health services for the poor and vulnerable, especially women and children. During the period, Danida supported three programmes, namely HSSP I, and HSPS II & III. The support provided by Danida was informed by national and the sector policies, programmes and strategies and the support address priority health needs of the country. The aid modality for supporting the sector shifted from project support under HSSP I to the SWAp and earmarked funds, under HSPS I & II.. Under the SWAp, and through the use of earmarked funds, Danida was able to provide budgetary support to the health sector priority programmes and at the same time channel resources to specific programmes, issues and areas with the objectives to increase access to health services for the poor. The combination of aid modalities has increased efficiency and increased allocation of resources to the health sector, in particular to the lower levels of care. This strategy enabled Danida to promote ownership by the MoH in the health sector whilst simultaneously pursuing its poverty objective and interventions.

Overall, the health sector of Ghana has seen major changes and improvements in many spheres over the period under review. Danida through its support to the Health Fund and earmarked funding has contributed to these major changes that include institutional reforms and development of a vision for health service delivery policies and procedures that aimed to shift service delivery to the district level, the introduction of far-reaching fiscal and management decentralization (BMC) concept and the introduction of the National Health Insurance Scheme (NHIS). Other major changes of significance that have been introduced include the creation of Quality Assurance Teams, maternal audits and clients satisfaction surveys at facility levels. Also, systems have been developed and capacity of the sector has been built to facilitate the provision of quality health care to the people.

The MoH has also been at the forefront of the design and implementation of the High Impact Rapid Delivery (HIRD) to address three of the MDG indicators, which has received support from DPs including Danida. The MoH, during the same period pioneered the SWAp approach, harmonised programmes in the sector and enjoyed flexibility in funding from its partners. During the period, the Ministry has been in the driving seat; the Ministry initiated and led its own sector programmes. Dialogue among donor partners and MoH improved considerably during the implementation of the POWI, deteriorated in the early 2000 but there are signs of improvement again. A common funding mechanism was adopted for all donor partners. Danida had a strong voice and influence. Per capita funding for the sector has increased from USD 6.3 in 2001 to USD 25.4 in 2006. Similarly, GoG increased the proportion of government recurrent expenditure on health to 18% in 2006, exceeding the Abuja declaration.

During the same period the MoH took the lead role in the sector and implemented the innovative exemption policy which aims at increasing access of health services to the poor. Unfortunately, this laudable policy has failed to achieve its intended results due to implementation difficulties, including delays and, in some cases, non-reimbursements of outstanding bills.

Other important impact indicators like IMR and U5MR have not changed significantly, especially since 1998. Though health status is not only dependent on health sector achievements, the sector has thoroughly been examined in an attempt to explain the unsatisfactory performance. An independent review carried out in 2006 concluded that the chal-

lenges in the sector primarily relate to the budget, to the way it is managed, to the workforce and to its motivation.

Major problems of the sector continue to exist and theses include:

- Widening inequalities in health, though efforts are being made to address the issue;
- Inability of many people to access health services due to financial barrier. The NHIS is expected to address this issue since the exemption did not work as expected;
- High brain drain of key health service staff, especially doctors and nurses and the poorly utilisation of the human resources in the system;
- Limited integration of the private sector for service delivery and the untapped multi-sectoral collaboration.

Overall, the view of the evaluation of the Danida support to the sector is very positive; the support is highly relevant and addresses the priority health needs of the country; it also supports primary health care services. The support to the development of systems, innovative approaches and the establishment of important units within the MOH such as the EMU and the NTCP are relevant. Furthermore the role of Danida to policy dialogue and contribution to financial access to health services by the poor and vulnerable is commendable. Areas Danida invested in were strategically selected with key stakeholders and were informed by the health needs of the sector as identified in the national and sector policies. Capacity-building and health systems received major attention by the support and these impacted positively on the sector. The evaluation is also of the view that support through earmarked funds was relevant, adequate and effective. The SWAp modality has also contributed to increased efficiency, and resource allocation to the health sector, especially to the lower levels of care. Trainings and support to cross-cutting issues were relevant and effective. In all, Danida support to the sector has been relevant, effective, efficient, well-managed and has made a telling impact on capacity-building and the performance of the sector. In spite of some challenges in sustaining some of the systems developed, the fact that some of the gains made in improved health outcomes have either stabilized or retrogressed and, to some extent, the ineffectiveness of the support to the private sector (except CHAG), the support by Danida has left an indelible mark on the health sector. Conclusions and recommendations

Conclusions	***Recommendations***
Support to private sectors strengthening has been identified as one component that did not yielded the desired results, except support to CHAG. The minimal effectiveness of this component may be attributed to many factors, which may include but not limited to inadequate capacity of the sector, lack of identification of common needs, goals and objectives, weak institutional arrangements, especially at the district level and inadequate financial resources within the MOH to facilitate the participation of other stakeholders in the management and delivery of health services. The nature of support offered by Danida e.g. training may not be of interest to the private sector practitioner.	GHS should engage more the private-sector to determine their specific needs. It is further recommended that GoG should mainstream private public partnership into all the policies, strategies, guidelines and agencies of the sector.
Under Act 525, there are mechanisms for some involvement of civil society and communities as advocates for the needs of the poor and vulnerable in health policy formulation and implementation. However, in practice, linkages between the health sector and other health related sectors and communities in policy formulation and implementation are weak and bureaucrats and professionals dominate the policy development process within the health sector. Danish assistance to the health sector has promoted more multi-sectoral collaboration and community participation	Government should engage more the CSOs to participate actively in the policy dialogue and issues affecting the sector. Danida can use its respect and influence in the sector at the policy dialogue to get civil society to take lead role in the sector

Conclusions	*Recommendations*
from within the health sector.	
Central government funding to the sector has increased but allocation to for services has been inadequate. Available information show that government allocation to the health sector since 2001 has increased steadily. However, a greater proportion t of the allocations go into payment of health worker salaries.	Government should ensure a balance in allocation of resources in the sector such that service delivery receives a fair share of the allocation. Danida should use its donor sector lead to discuss with government and other donors at the dialogue on certain proportion of the health sector budget that should go into service provisions, especially at the district level.
The stabilisation and or worsening selected health outcomes, particularly relating to infant, under-five and maternal mortality is worrying. If immediate measures are not taken, the country may not be able to meet the targets of the UN MDGS. The decreasing funding for service delivery (in spite of increasing funding to the sector) and the brain drain of health professional to seek greener pastures outside the country or moving from the more deprived areas to a more endowed area may be contributing factors. What is even more concern is Danida heavy investment in UWR and the worsening perinatal and neonatal mortality recorded in the region in 2003 and 2003.	Government and the sector partners should undertake an in-depth study to identify the possible causes and to possibly identify mitigation measures that would reverse the trend the stagnation in the performance of some impact indicators over the past few years.
Retention and distribution of health professionals, especially medical officers and nurses is a major constraint of the health sector and major contributory factor to the worsening of some health outcomes. Brain drain of health professionals to foreign countries and within the country from deprived to more endowed areas for better condition of services are the push and pull factors for the observed trend.	Government should continue with the implementation of measures that aims at stemming the brain drain. It should also look at a more efficient and balance distribution of current available health professionals in the public sector.
There exists a lack of career development for certain categories of health professional, i.e. CHNs and the frustrations they go through compels them to upgrade themselves by enrolling in the SRN programmes. The shift is affecting government PHC programme.	The HR of the MOH has developed a new approach to HRH planning, development and management. One of the three new strategies includes initiating the process of HRH decentralisation and implementing key strategies. In view of Danida technical expertise in decentralisation, support in the form technical assistance could be extended to the MOH
The implementation of the NHIS faces initial implementation difficulties and will need some technical assistance and resources at the district level to ensure it sustainability	Government should as a matter of urgency identify implementation difficulties of the NHIS and take immediate steps to address them. To also address delays in reimbursement, government should facilitate the establishment of Regional Councils to reduce the burden on the National Council. Danida has been supportive of risk-sharing arrangement, especially at the community level and has been a pioneer in supporting and promoting health insurance in the country. The continued technical assistance to the Council and district schemes still remains relevant now as it was before the implementation of the scheme nation wide. Danida support in terms of technical and other resources is critical at this point of the implementation of the scheme. Danida can continue with its strong technical assistance in insurance administration and management to the scheme to ensure that all implementation bottlenecks are identified and addressed.

8 Annexes

8.1 Persons met

Name, first name	***Organisation / institution***	***Function***
Ghana Health Service		
Elias Sory	Ghana Health Service	Director-General
Sam Adjei	Ghana Health Service	Chief Consultant to the Director General of Ghana Health Service
Frank Nyonator	Ghana Health Service	Director, PPME
Dan Osei	GHS	Deputy Director, Budget and Planning
Alex Odoi Nartey	GHS	Director, Finance/Financial Controller
Yaw Brobbey Mpiani	GHS	Deputy Director, Administration
Alex Odoi Nartey	GHS	Financial Controller
Emmanuel Tidakbi	GHS	Director, HASS
Felix Yellu	GHS	Chief Pharmacist
Yayha Kahsim	GHS	Deputy Director, GHS
Ministry of Health		
Emmanuel Owusu-Ansah	MOH	Deputy Director, Capital Investment,
Saaka Dumba	MOH	Transport Manager
Herman Dusu	MOH	Financial Controller
Royal Danish Embassy		
Camilla Christensen	Royal Embassy of Denmark	First Secretary
Health Sector Support Office (HSSO)		
Helen K. Dzikunu	Danida HSSO	Senior Programme Advisor
Partners/Donors		
Mark Young	UNICEF	Chief of Health and Nutrition
Marius W. de Jong	Royal Netherlands Embassy and representative of DFID	First Secretary, Health and Gender
Robert Mensah	UNFPA	Programme Officer, Reproductive Health
Morhring Ute	European Delegation	Programme Officer, Governance, Society and Culture
Laura Rose	World Bank	Senior Health Economist. Population, Health and Nutrition
Eastern Region		
Regional Health Administration		
Appiah Denkyira	GHS	Eastern Regional Health Director
Kwahu West District		
Collins Danso Akuamoah	Kwahu West District Insurance Scheme	Scheme Manager
Rev. Daniel O. Berkoh	Kwahu West District Insurance Scheme	Vice-Chairperson of the Board
Mr. Andrew O. Mensah	Kwahu West District Insurance Scheme	Member of the Board
Oda Community Health Nursing Training School		
Susan Adjei	CHNT School	Principal
Linda Rockson	CHNT School	Vice-Principal

Name, first name	*Organisation / institution*	*Function*
Brong Ahafo Region		
Nkoransa District		
Stephen Opoku Brobbey S	Nkoransa District Insrurance Scheme	Scheme Manager
Evans Osei Kwame	Nkoransa District Insrurance Scheme	Chairperson of the Board
Henne	DHMT, Nkoranza district	District Director of Health services
Kintampo North District		
Amoako Jacob	District Health insurance Scheme	Scheme Manager
Bennert Bayoh	Assembly member	DA representative
Salamatu P. Ibrahim	DHMT	Ag. Director of Health Services
Kintampo North: Rural Integrated Health School		
Isaac Azindow	RTHS	Dean of Students
N. A. Ashitey	RTHS	Deputy Director in-charge of Academic
Tachiman Municipal Assembly		
Benjamin Gyarko	Municipal Insurance Scheme	Scheme Manager
Kofi Amoako	Municipal Insurance Scheme	Claims Manager
Cynthia Amponsah	Municipal Insurance Scheme	Data Entry Clerk
Laurentia Afari-Boachie	Municipal Insurance Scheme	Scheme Accountant
Jaman South District		
Nicholas Nsrawudi	District Health Insurance Scheme	Scheme Manager
S.K Dapaah	Retired Medical Assistant	Chairperson, Board
Michael Nsiah Bo-amah	DHMT	District Accountant
Grace Vire	DHMT	Ag. District Director of Health
Upper West Region		
Regional Health Administration (RHA)		
Francis Banka	Consultant	Former UW Regional Health Director
Erasmus Adongo	GHS	Regional Director of Health, UWR
Manfred Y. Owusu-Ansah	RHA, WA	Regional Information Officer
Gordon k. Pongo	RHA, WA	Regional Health Administrators
Rebecca Lamisi Al-abila	RHA, WA	Ag. Regional training Officer
Peter Issah	RHA, WA	Accounting Officer
Georgina Osmanu	RHA, WA	DDNS, Public Health
Adams Asumah	RHA, WA	Regional Estate Manager/Officer
Gerald Asakeya	Regional Hospital, Wa	Hospital Estate Manager
Jacob Mumuni	Former Regional transport Officer	Currently Regional Guinea Worm officer
Richard Basadi	RHA, WA	Regional Health Insurance Co-ordinator
Kwami Boye	Regional Medical Stores	Regional Supply Officer
John Bosco Zury	Wa Municipal Insurance	Municipal Scheme Manager
Martin Twabazuing	RHA, Equipment Unit	Equipment Manager
IMCC		
Sara Skovbolling	IMCC	Medical and Public Health Student
Rikke Vognbjerg	IMCC	Medical and Public Health Student
Thomas Sydenham	IMCC	Medical and Public Health Student
Rasmus Byorn	IMCC	Medical and Public Health Student

Name, first name	***Organisation / institution***	***Function***
District Director of Health Services		
Rosina T. Yenli		District Director of Health
Virginia Kuuder	Lawra District DHMT	District Director
Joseph Bolibie	Wa East District	District Health Director
Thompson Dumba	Sisala East District	District Director of health
Bennette Annyaa-kuu	Sisala District	District Public Health Nurse
Alex Bufunla	Sisala District	Health Information Officer
Poebe Balagumye-time	Wa West, DHMT	District Director of Health
Jirapa CHNT, NTC and MTS		
Elizabeth R. Dab-now	CHNTS	Ag. Principal
Walter D. Mwinbo	NTC	Ag. Principal
Elizabeth Angsot-inge	MTS	Ag. Principal
Christiana Nyewala	CHNTS	Tutor
Noela Anglaere Neebo	MTS	Tutor
Vincent K. Tanye	NTC	Tutor
Angela Aminzia	NTC	Retired Tutor
Matilda Z. Dery	MTS	Retired Tutor
Christian Health Association of Ghana (CHAG)		
Philibert Kankye	CHAG	Executive Secretary
James Boateng	CHAG	Project Co-ordinator
Bro. Henry M. Surnye	CHAG	Administrator

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8.3 Summary of Danida support to the UWR

Danida support to the UWR was one of the three main projects of the Ghana-Denmark HSSP (1994-1997). Danida reached an agreement with the MOH in 1993 to implement a 10-15 year programme of strengthening the health care delivery system in the region. The UWR was chosen by Danida for support because at that time it was the poorest region in the country and received the least resources for the sector. The region lacked health service facilities and equipment and had very high rates of infant, child and maternal mortality (refer to phase II document). In order to improve the health status of the population in the region, Phase I support was designed to address specific problems of health service delivery in the region. These health problems were identified as poor physical access to health care, low utilisation of heath services, weak management practices, low quality of care, poor infrastructure and transportation system and inadequate community participation in decisions affecting the health of the people. Support also included the general running costs of the health system in the region. During Phase II, the earmarked funds were meant for the provision of Technical Assistance (TA) and consultancy services, supplies, training as well as renovation of Jirapa Nursing Training Center. A holistic approach was therefore adopted by Danida, which aimed at providing integrated support to health care delivery in UWR.

The components of the support to strengthen PHC in UWR were:

- Organisation and management supported to improve the effectiveness and efficiency of service delivery; additional financial resources and improved financial management system provided;
- Primary Health Care delivery at sub-district level strengthened, and vertical programmes integrated
- Quality of Care (QC) increased in all health facilities;
- Infrastructural improvement in health facilities, including transport and medical equipment; and
- Women empowerment and community participation

The intermediate objective of the support was to establish a functional health system able to deliver accessible and quality care effectively and continuously to the population of the UWR even after the withdrawal of support from Danida.

8.3.1 Organisation and management (O&M)

The O&M component of the support was aimed at strengthening the organisational and management capacity of the regional health administration to manage an effective and efficient health system. All Directors were trained in support services such as personnel management, finance and accounting, transport, health and management information system, supplies and estate and equipment. In all, the support contributed to the strengthening the management systems within the health sector in UWR:

- Annual review and planning meetings have been institutionalised by the region.
- All districts have functioning District Health Management Teams (DHMTs) and hold regular meetings and also undertake supervisory support visits to sub-districts.
- Every year, each district prepares plans and budgets for their activities and these are presented and reviewed at the annual review meetings.

These plans are however not always followed and monitored. The Mid-term assessment found that the training had been valuable to the beneficiaries in undertaking their duties efficiently and helped built group capacity. Team members at the district level indicated that there were fewer conflicts in the teams than in the earlier times.

The assessment of the financial system of the UWR hospitals in June 2001 by an external accountant, validated by the evaluation, showed that managers and accounting staff of the region have a good understanding of the accounting system. This evaluation further revealed a strengthened capacity of the DHMTs to plan and prepare budgets

The support to O&M was relevant and capacity-building aspect has been effective. However, the region has lost most of the initial key personnel at the regional level to transfers, mostly to the national level. This kind of regional "brain drain" concerns for instance the Regional Medical Stores Officer who is currently in-charge of the Central Medical Stores; the Regional Pharmacist who is the current Chief Pharmacist of MOH and the Regional Transport Officer who is the Transport Manager of MOH.

Equipment management

In 2000, Danida provided support for the establishment of the equipment unit of the health administration to enable the unit be responsible for the maintenance of all equipment of the sector in the region. As part of the support, solar panels, solar fridges and pumps as well as TD radios were provided to the region. The equipment unit has the responsibility of ensuring the maintenance and repairs of these and other hospital equipment in the region. There is an Equipment Manager who is assisted by four support staff at the regional level who supervises the districts. Danida also supported the region to construct and equip a maintenance workshop and provided a stock of spare parts to support its operation.

The setting up of the equipment management unit brought visible changes in the performance of equipment. It contributed to the cost reduction of maintenance and brought efficiency of service delivery. Services were brought closer to the facilities and there was a very high response rate to the maintenance of equipment, compared with the situation prior to the establishment of the unit.

However, currently the major constraints of the unit are:

- Revolving fund for maintenance has not yet been set up hence leading to difficulty in acquiring adequate amounts of spare parts
- Replacement of solar batteries
- Official payment for work done

Transport management

The numbers and management of transport in UWR has improved considerably since 1994. Transport management encompasses daily planning of vehicle movements, regular servicing of vehicles and motorbikes, monthly vehicle inspection called "vehicle parades", monitoring, supervision and support to districts, and training of users of 4-wheel vehicles and motor bikes.To ensure that an effective transport system is put in place, Danida provided Technical Advisor who was attached to the unit.

Evidence from programme reviews, monitoring reports and the participatory stocktaking of the Danida UWR (August/Sept, 1997) indicate that by the end of the forth project year, the UWR project had achieved impressive gains. As one interviewee retorted during the field work "*before Danida's intervention in the region, there was transport in the UWR but not a transport system*". Unfortunately, most of the vehicles in the pool are old as presented in the table below. It shows that the vehicles are ageing; close to 60% of the vehicles are over 6 years. However, they are still functioning but maintenance cost is very high.

Table 31: Age classification of transport vehicles in health in UWR

Age Classification	***Quantity***	***%***
1-5	35	41%
6-9	19	22%
10 and above	32	37%
All ages	**86**	**100%**

Source: GHS, First quarter Report, UWR, 2007

It must be stated that Improvement in the transport system in the region helped facilitated outreach activities and for that matter the frontiers of access of health delivery to the people were expanded. In view of the ageing of the vehicles and the slow rate of replacement, outreach activities, including sub-district activities have been greatly affected.

Danida earmarked support ended with the second phase in 2002. In the meantime, some major problems occur with transport management which threatens the sustainability of the system. These include:

- Over ageing vehicles and high maintenance cost,
- health sector vehicles seem to wait too long at the MTC because vehicles from non-health departments are given priority attention because the latter pay ready cash while health services only pay on credit; and
- Inadequate funds to restock the parts.

Estate management:

The Estate Management Unit was established at the regional level in 1998. The unit has two full time Estate Managers at the regional level with an office, equipment and a vehicle. The Regional Estate Officer recently completed a post-graduate programme in UK with fellowship from Danida. His assistant who is the Estate Manager for the Wa Regional Hospital has also up-graded himself from an HND to a degree. Each of the 5 districts has an Estates Co-ordinator and some selected health facilities have full time or part time Estate Officers and artisans. All the officers have had extensive orientation in estate management.

Besides the impressive number of renovations supervised by the estate management unit, described under infrastructure development, other achievements in estate management include:

- The reduction of the over reliance on the Public Works Department;
- Increased survival of trees and landscaping plants in health facilities and around public health offices;
- Training occasions have been used to renovate five health institutions;
- Community committees who are involved in the maintenance of health centres have been set up;
- Reduction in the cost of rehabilitation by getting more work done for the same amount of money and thereby improving own efficiency
- The estate units have started proper acquisition of land for the ministry;
- The sector now has a complete inventory of buildings and furniture for the whole region.

Some of the constraints identified include the following:

- Too few artisans employed by the ministry
- Inadequate budgetary allocation for estate management. Moreover, the budget only includes corrective and not planned preventive maintenance.

- The role of the estate officers is not fully appreciated especially at the district and facility level.

Drug management

The Upper West Regional Drug Programme (UWRDP) was set up in 1995 to improve the availability, accessibility, affordability, quality and the rational use of drugs in the region. The piloted drug management system in the UWR provided lessons for the improvement of the national drug management system.

Danida support to the UWR drug programme include:

- Storage facilities at the Regional Medical Store (RMS) and Service Delivery Points (SDP) were greatly improved by renovation and provision of needed equipment,
- The regional medical stores and health facilities were provided with “top up “ money for the Regional Drug Fund (RDF),
- Technical assistance in drug management,
- A stock management system with a computerised inventory control,
- Provision of haulage trucks,
- Training of all staff who manage drugs; this included on the job training and post-graduate training of the regional medical Stores officer who is currently in-charge of the Central Medical Stores at the national level. ,
- Training of chemical sellers,
- Scheduled drug delivery.

The drug management programme of the UWR was relevant as it ensured accessible, affordable, reliable and quality of drugs. It was also effective, especially the scheduled drug delivery because it ensured that drugs were delivered to facilities upon request. The haulage truck provided by Danida facilitated transportation of drugs from the central medical stores and this made it possible for drugs to be available at the regional stores at all times. The revolving fund established for the regional stores was helpful because it enabled the stores remained liquid and offered credit facility to the BMCs without affecting its operation. Unfortunately, the system could not be sustained after Danida had existed. It was expected that with the system put in place, including the revolving fund, the haulage truck and the delivery van as well as trained human resources, the system could stand on its feet even with the exit of Danida support.

8.3.2 Quality of care

Improving the quality of health services has been one of the main objectives of the Danida support to the UWR. Since 1995, and with support from Danida, UWR has been in the forefront of developing systems to improve and monitor the quality of services. Local consultants were contracted and worked with service personnel to create awareness of quality issues at all levels. Quality of Care Teams was formed, trained and guidelines developed for the practice of quality assurance and monitoring systems. Peer review mechanisms were also instituted in the region as part of the quality of care practices.

The UWR quality initiatives have subsequently been integrated into the national quality assurance programme, ensuring user satisfaction with heath services, improvement of professional competence and improving the working environment of health care services in the region.

Patient satisfaction surveys are carried out to gauge the quality of care of clients. Findings of the surveys conducted twice yearly are used to improve quality of care. The major quality concerns of users of the public health care system have been:

- unfriendly attitude of health staff,

- long waiting time,
- inadequate provision of information to clients and
- high cost of services.

Unfortunately, patient satisfaction surveys have not been implemented regularly because of the heavy load on the service providers and also for lack of capacity. However, discussions with community members and health staff revealed that people are more satisfied with the quality of care now than before the intervention of Danida and the health sector reforms. A review of the Stocktaking Report of 1997 also confirms that changes in attitudes of service providers towards clients have actually taken place.

Patient care management

Since February 2000, significant improvements have taken place in the management of patient care at all Upper West Hospitals. All facilities have operational protocols and most are displayed on notice boards. In practice there is not yet full and comprehensive 24-hour emergency service in all facilities, but all have some coverage with on-call staff for the various units such as laboratory, theatre, pharmacy and X-ray who are readily mobilised when their services are needed.

Currently, clinical audits have been instituted in the health administration of the region and all facilities are expected to conduct regular audits. Furthermore a number of hospitals are following up on these audits to improve their practices. The system for the retrieval of records has improved since the reforms took off, though in some of the facilities, retrieval of past patient folders are still problematic.

8.3.3 Infrastructure development

Of the 46 new staff housing units built and 49 old units either rehabilitated or completed in UWR, Danida constructed 72% (33) and rehabilitated or completed 51% (25). With Danida support two housing units for staff were built at the Jirapa Nursing and Midwifery Training Schools and 29 solar systems installed to provide lighting and refrigeration for the storage of vaccines.

In addition to health facilities, staff houses and the training schools, Danida also supported a number of other major construction and rehabilitation works in the region. These include:

- Construction of Mechanical Technology Centre to enhance transport maintenance and management (1995),
- Estate Maintenance Unit workshop to carry out/manage planned preventive maintenance, rehabilitation/renovation and capital works (1999),
- Rehabilitation of Wa Regional Hospital OPD to enhance organisational access for patients (1995),
- Rehabilitation of Wa DHMT (1995),
- Renovation of Tumu DHMT office block,
- Rehabilitation of Disease Control Office of MFU of RHD (1999).

Solar systems comprising a solar panel, fridges, standing fans and florescent light tubes were procured and installed in 17 deprived health centres before some of them were connected to the national grid. Solar systems were also installed in 45 health facilities and 29 staff quarters. The provision of solar systems contributed to improved cold chain management, enhancement of patient care at night and improved data management by way of computers. It has also improved the quality of life for staff.

Further, 37 boreholes have been provided with pumps, including all the health facilities constructed or rehabilitated with Danida support. The old borehole and pump at Jirapa Hospital was repaired in 2000. 39 health facilities have been connected via TP radiotele-

phone to the district health offices, hospitals and the regional directorate by radio. The TP radiotelephones has improved communication and enhanced promptness of attention by the BMCs to emergencies.

Also, medical equipment and office equipment such as computers were provided to support service delivery. In addition, desktop computers, laptops and printers were purchased for the Regional Health Administration. These increased in 2000 to 20 desktop computers, 9 laptops and 15 printers distributed at the Regional Health Directorate, district directorates and in the hospitals. The provision of laptops, desktop computers and printers has improved efficiency in the handling of Health Management Information data and enhanced the quality of plans and reports.

Altogether, interventions on infrastructure development has significantly contributed to enhancing health performance of health delivery in the region, to the extent that the UWR became a star "region", from existence of virtually no health delivery system.

8.3.4 Community participation and women empowerment

Community participation was identified as an important area of intervention by Danida in both Phases I & II for several reasons, among them were the following:

- Inadequate community participation in decisions affecting their own health;
- Communities did not see the health services as relevant to them;
- Cultural gap between village life and health care service providers;
- Major cultural misconceptions contributed to weak interaction between communities and service provider;
- Several interventions instituted to involved communities in health delivery included the formation of Sub-district health Management Team (SDHMT), a joint community and health unit groups to plan and implement health activities. Other interventions included service providers' recognition of traditional values systems, where decision-making in the community tradition involves a number of meetings between the chief, the residents and their representatives. Once a commitment is made by the community to undertake a particular task, the traditional system actively participates in ensuring the realisation of the activity. Through the community participation activities, health workers and managers recognised this traditional system of community decision-making and initiating action. Through this initiation, women were increasingly involved in decision-making, though gender specific roles still hinder the full realisation of getting the desired women active participation.
- The implementation of community participation has made positive results including improved information flow to and flow communities, leading to increased health awareness and utilisation of preventive and curative services as well as greater trust in the health system; and improved community spirit and decreased morbidity.

8.3.5 Utilisation of health services

The regional OPD attendance has shown steady increases from 2000 to 2005, except 2003 where there was a decline (. Similarly pattern is observed in the analysis of the district statistics over the same period. The establishment of mutual health insurance, support for exemption, especially for pregnant women and the vulnerable and an increase outreach activities might have created enough awareness in the communities about the need healthy life styles. Significantly too, geographic access to health services has increased as a result of improved and expanded health infrastructure since 1994.The increase utilisation of health services in the region could be attributed to the investment of Danida to the health sector in UWR.

Table 32: OPD Attendance in UWR by districts, 2000-2006

Hospitals	2000	2001	2002	2003	2004	2005
Wa	33,878	37,198	42,926	37,250	52,024	54,434
Nadowli	9,362	7,525	8,367	7,554	8,121	45,934
Lawra	11,135	13,127	11,690	12,581	13,980	23,826[7]
Nandom	19,292	25,938	28,200	22,754	26,670	-
Jirapa	26,976	32,034	28,077	24,160	31,340	44,878
Tumu	9,111	11,621	12,673	16,270	13,162	22,127
Ahmaddiya[8]	-	6,138	4,054	-	-	-
Total	**109,754**	**133,714**	**135,987**	**120,569**	**145,297**	**191,199**

Table 33 shows ANC coverage in UWR from 2001 to 2006. Only mid-year statistics for 2006 is available for the analysis. On average, the regional coverage of ANC decline from about 92% in 2000 to 86% in 2005, an indication of a decline performance. A number of factors may explain this observed tend and this may include decrease in outreach activities due to lack of logistics and inadequate health staff. District performance follows the same trend and regional, except Wa municipality where coverage in 2005 increased over the 2005 coverage performance. Informants during the field work revealed that since the exit of Danida, "things" in the health delivery system in the region "have not been the same". Most of the vehicles provided by Danida which facilitated outreach activities at the sub-districts have broken down and this has affected outreach activities. Vehicles sent for repairs stayed at the Mechanical Workshop for months for lack of spare parts.

Table 33: Ante natal coverage in UWR by district, 2000-2006

District	2000		2001		2002		2003		2004		2005		2006	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Jirapa/Lambussie	3479	92.1	3395	87.6	3319	83.3	3469	84.8	3819	92.1	3298	78.9	-	-
Lawra	2706	87.0	2899	83.3	2605	72.9	2799	76.3	2917	80.1	2651	69.6	1202	31.0
Nadowli	3448	101	3059	87.5	3307	92.1	3003	81.5	3301	93.2	3138	87.2	1692	46.4
Sissala West	2553	75.0	2812	80.4	3026	84.2	3921	106.4	1571	105.9	1412	72.2	674	-
Sissala East	-	-	-	-	-	-	-	-	2531	116.5	2196	77.7	957	42.6
Wa West	-	-	-	-	-	-	-	-	2708	80.9	2683	78.5	1536	44.2
Wa East	-	-	-	-	-	-	-	-	2549	117.4	2552	115.6	1391	61.9
Wa Municipal	9418	93.0	8360	90.7	8617	90.0	9420	96.9	4296	106.2	4573	110.9	2213	52.8
Regional Total	**21604**	**91.9**	**20525**	**87.1**	**20874**	**86.2**	**22725**	**90.0**	**23756**	**93.8**	**22507**	**86.1**	**11273**	**44.2**

Source: UWR Health Administration Annual Reports, 2001, 2002, 2003, 2004, 2005; and half year report of 2006.

8.3.6 Supervised delivery

Statistics is for supervised delivery for the region is available for the period 2003 to 2005 (Table 34). The regional average reveals that the region's performance regarding supervised delivery did not improve during the period. Delays in government releases of funds for service activities during the period might have contributed to the observed non-performance in supervised delivery.

[7] This figure cover both Lawra and Nandom hospitals

[8] This facility started reporting in 2001

Table 34: Number of supervised deliveries by district, UWR from 2003 to 2005

Districts	Supervised Delivery		
	2003	2004	2005
Jirapa/Lamb	2,751	3,068	3,566
Lawra	2,479	2,736	2,475
Nadowli	2,148	2,740	2,247
Sissala East	1,636	1,743	1,772
Sissala West	1,136	1,299	1,215
Wa East	1,654	2,453	2,111
Wa Municipal	2,454	3,310	3,686
Wa West	1,280	1,415	1,095
Regional Total	17,843	17,343	18,154
Regional Coverage	**73.6**	**70.3**	**72.4**

Family planning coverage

Family planning acceptors in the year has increased on average from about 40% a year in 2001 to about 58% in 2005 for the region. This is quite encouraging because of the deep seated socio-cultural beliefs and misconception about family planning. Increased community activities through community participation might have contributed to changing attitudes towards accessing health services, including family planning. It is noted that Danida contribution to the UWR was holistic and included interventions such as community participation in health, women empowerment and provision of logistics for outreach activities, which might have collectively contributed to increasing awareness among the population.

Table 35: Coverage of FP acceptors in UWR by district, 2001-2006

District	2001		2002		2003		2004		2005		2006[9]	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Jirapa/Lambussie	6,687	34.4	7,121	36.1	7,317	35.9	7,801	37.7	7,801	37.0	4,317	20.1
Lawra	6,083	34.8	6,949	38.6	7,347	38.0	8,288	44.3	8,288	43.5	4,077	20.8
Nadowli	10,766	61.4	7,451	41.2	8,817	47.4	11,438	64.6	11,438	63.6	6,281	28.5
Sissala (West & East)	6,052	34.5	6,700	38.8	7,000	29.6	-	-	-	-	-	-
Sissala East	-	-	-	-	-	-	2,188	12.0	5,793	52.5	2,764	23.0
Sissala West	-	-	-	-	-	-	-	-	2,716	36.0	1,543	14
Wa (Municipal, West & East)	17,524	38.0	20,680	43.2	20,165	40.8	-	-	-	-	-	-
Wa West	-	-	-	-	-	-	-	-	4,088	23.9	2,990	13.4
Wa East	-	-	-	-	-	-	-	-	5,054	39.6	15,570	12.4
Wa Municipal	-	-	-	-	-	-	25,029	52.2	27,267	132.3	11,948	36.1
Regional Total	**47,162**	**39.9**	**48,901**	**40.0**	**50,709**	**48.1**	**54,744**	**44.4**	**72,445**	**57.7**	**36,325**	**28.7**

8.3.7 Effective maintenance systems e.g. construction of new and rehabilitation of old facilities and transport have been put in place

In 1995, the MOH made a request to Danida to provide support to build the capacity in capital assets management. This decision of MOH was informed by the need for the ministry to take over the responsibility of managing all health estates from the then Ministry of Works and Housing. This support was in addition to the support to the Ghana-Denmark

[9] Mid-Year Statistics

Health Sector Support Programme provided by Danida between 1994 and 1997. A separate government agreement for the EMU support was therefore signed in March 1997 for a period of three and half years. However, due to delays in the implementation of project activities, the project was extended for two more years to September 2001.

The initial support for the EMU covered the establishment of two sections: the Capital Project Management and Planned Preventive Maintenance (PPM). In 2000, however, a new Capital Planning section was added as a third section in an effort to strengthen the capacity in the health sector to plan capital investments according to set national policies, strategies and guidelines.

The table below provides a summary of budget, disbursement and% of budget disbursed for the EMU between 1999 and 2006. In general, the budget implementation has been very remarkable. A total grant of DKK 26,815,515 was budgeted for the EMU with an amount of DKK 28,052,435 being spent, representing 108.3% of the budget.

Table 36: Danida support to EMU: Programme budget against disbursement, 1999-2006

Year	***Budget for programme (DKK)***	***Disbursement (DKK)***	***Disbursement (%)***
1999	3.000.000	4.186.599	139,6%
2000	3.000.000	4.715.962	157,2%
2001	999.803	1.339.662	134,0%
2002	254.959	258.945	101,6%
2003	5.854.000	4.853.494	82,9%
2004	5.449.434	5.445.019	99,9%
2005	6.075.678	6.075.678	100,0%
2006	2.181.641	2.177.046	99,8%
Total	**26.815.515**	**29.052.405**	108,3%

The immediate objective of the EMU support was to design and build-up a hospital based maintenance system over a three-year period covering all Government Health Estates, making use of existing structures and procedures, resulting in lower overall running building expenditures and an improved working environment. The establishment of the EMU unit through Danida support was to reduce the dependence on the PWD of the then Ministry of Works and Housing.

The various sections of the EMU have made tremendous strides since their establishment. For instance, the PPM has trained staff, distributed tools, and raised awareness among users of the importance of maintenance. On the other hand, with the establishment of the Capital Management Section, an architect and a quantity surveyor has been appointed. Regional Estate Officers have been trained and deployed to all the regions, including the appointment of Regional Estate Officers for the Regional Hospitals. Capacity has also been established to manage and monitor capital projects more effectively. Below is a summary of the achievements of the three sections under the EMU:

- Planned Preventive Management (PPM) System for health centres and clinics available, personnel trained, manuals and guidelines and appropriate tools distributed
- Awareness created among users on the importance of maintenance, community participation and improved methods of waste disposal.
- The Capital Project Management (CPM) Section has appropriate complement of staff (an architect, a quantity surveyor, estate managers, etc)
- 24 Estate Managers trained in Preventive Management of buildings.

- A total of 1650 maintenance persons from 820 institutions trained
- Policies and Principles for Management of Capital Investment developed
- Procedures manual for Implementation of Civil Works developed and distributed to all regions
- Standard Modular Design System developed for clinics, health centres, Polyclinics, and district hospitals.
- Room schedules, plans and specifications for the health facilities have been developed
- Survey and database of health facilities almost completed
- Database of pre-qualified building contractors developed
- Standard Contract Document for Civil Works developed
- An assessment, survey and analysis of the state of physical facilities and maintenance procedures have been undertaken.
- Capital Project of the MOH has been enabled to be competent client by overseeing contract management and ensuring that the Ministry's requirements are followed by employed consultants
- Maintenance Programme has been implemented in decentralised manner from the regions to the districts and sub-districts-Estate Managers etc.
- Training in construction and waste care management
- Designed and built incinerators for the disposal of hospital waste through out the country. Five pilot incinerators have been built by the unit whilst the EPI has funded the construction of 150

Two TAs have been provided to the unit since its establishment but only one has remained since 2005. The support of the TAs have been extremely helpful to the unit as they have provided the needed technical guidance to the unit, trained and shared their experiences with local staff as well as building their skills and confidence. However, it was noted that he has assisted to develop a Geographic Information Systems (GIS) for the health sector. The head of the unit noted that the GIS has helped them expand their activities and that with the GIS they are able to offer a better advice to the DHMTs on the citing of health facilities.

In a nutshell, Danish support to the EMU has ensured improved access, quality and cost-effectiveness of health care through the provision of more efficient and effective management of physical facilities. The vision is to be manifested through improved functional and technical standards of health facilities in both rural and urban areas. The main outputs for the preventive maintenance programme are to build technical, managerial and logistical capacity, create awareness about preventive maintenance, promote community participation and develop policies and guidelines.

Under Danida support, the capacity of the management of civil works within the ministry has considerably improved. Qualified professionals (architects, quantity surveyors etc.) have been employed at the Capital Project Management section. Regional Estate Officers have been appointed for the Regional Health Administrations and Hospital Estate Officers for the regional hospitals. The appointment of these professionals has strengthened the planning, implementation and monitoring of preventive maintenance programmes in the regions (artisans have been trained for the health facilities). A database, standard modular designs for health facilities and procedures and guidelines for capital project management and training of all staff in contract management have been developed. Also, policies, principles and guidelines for capital planning and investments have been developed in line with national and international standards for sound implementation of civil works.

The Planned Preventive Maintenance Section has put in place a maintenance system in all the regions. Estate managers and maintenance persons have been adequately trained,

and provided with tools (tool kit box) to carry out their assignment effectively. Manuals and guidelines have been developed and tool kits distributed.

The findings of the completion report of the Phase I of EMU show a fair representation of women in the employment of EMU, against a background that this is a perceived male dominated field. Of the estate managers, about 25% were reported to be women at the end of the first phase of the project. Among the maintenance staff in the districts, there are about equal female and male representations. The situation has not changed much in the second phase of implementation of EMU.

Some of the constraints of the EMU include the following:

- Resignation to of about 13% (6 out of 47) of trained personnel to seek greener pastures outside the country
- Lack of funding for maintenance works
- Lack of clear co-ordinated institutional responsibility for capital planning on behalf of MOH/GHS for the overall implementation of capital projects; and
- Lack of clear procedures and institutional responsibility for capital planning

The major issue, however, is how to sustain the operations of the unit with the exit of Danida funding. During the 10-year of EMU, Danida solely funded the operations of the Unit with government paying for salaries. The evaluation team is rather optimistic that the mechanisms being put in place by the unit if fully implemented will ensure the optimal functioning of EMU. Some of the expected measures include the following:

- Budgetary allocation from central government. Since its establishment, government has not provided funding to the unit for its operations, except salaries
- Setting up Technical Consultancy Services unit to provide consultancy services to GHS and others for a token fee. The consultant will offer services will provide technical information and design to the GHS, CHAG and private health practitioners
- Sale of tender documents will also generate some revenue