Ministry of Foreign Affairs
Denmark

Ministry of Health
Ghana

Danida

GHANA HEALTH SECTOR PROGRAMME SUPPORT

HSPS Phase V (2012 – 2016)

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Cover page

Country	:	Ghana
Sector	:	Health
Title	:	Health Sector Programme Support, Phase V
National Agency	:	Ministry of Health
Duration	:	5 years
Starting Date	:	January 2012 – December 2016
Overall Budget	:	400 million DKK
Budget by component	:	

	Mill DKK
Component 1: Financial support to SMTDP	**364**
Sector budget support	345
Long term TA	19
Component 2: Support to private health sector	**26**
CHAG Core funding	20
Long term TA	6
Reviews and studies	**10**
Grand total	**400**

Signatures:

Ministry of Foreign Affairs
Government of Denmark

Ministry of Health
Government of Ghana

Christian Health Association of Ghana

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Acronyms and abbreviations

CHAG	Christian Health Association of Ghana
CHPS	Community health planning and service
CMA	Common Management Arrangements
Danida	Danish International Development Assistance
DP	Development partners
DK	Denmark
GAC	Ghana Aids Commission
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global fund for the fight against Aids, Tuberculosis and Malaria
GHS	Ghana Health Service
GOG	Government of Ghana
GTZ	German Technical Cooperation
HSPS	Health Sector Programme Support
HSS	Health System Strengthening
IALC	Inter Agency Leadership Committee
IGF	Internally-Generated Funds
ITR	Independent Technical Review
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MDBS	Multi Donor Budget Support
MDG	Millennium development goal
MARPS	Most At Risk Populations
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NASA	National Aids Spending Assessment
NGO	Non-Government Organisation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NHIL	National Health Insurance Levy
NL	The Netherlands
NSP	National Strategic Plan for HIV/AIDS
PFM	Public Financial Management
PLHA	People Living with HIV/AIDS
POW	Programme of Work
RDE	Royal Danish Embassy
SBS	Sector Budget Support
SMTDP	Sector Medium Term Development Plan
SPPW	Strategic Plan and Programme of Work
TA	Technical Assistance
TOR	Terms of reference
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

Denmark has supported the health sector in Ghana since 1994. Throughout the years, Danida has focused on primary health care interventions aimed at the poorest Ghanaians with the highest mortality rates, recognising from the beginning also the importance of the non-governmental sector in service delivery. From a project approach, the assistance has gradually moved to budgetary support with engagement in the policy dialogue on issues of key strategic importance to the sector development and to Danida.

Danida was one of the key drivers of the development of the Sector Wide Approach (SWAp) and in the second phase of Danida's support to the health sector (HSPS II, 1999-2002) boldly provided 65% of the Danish support through the Health Fund. To become more aligned Danida shifted to sector budget support (SBS) in phase IV (2008), providing approx. 90% of the budget through a modality jointly developed with Ministry of Health (MOH), Ministry of Finance and Economic Planning (MOFEP), the Netherlands and the United Kingdom. The experience with SBS has generally been positive and key health indicators have continued to improve. However, the use of SBS has been less efficient than anticipated and efforts to address this have been initiated. The experience with embedded technical assistance to the MOH has generally been very well received and much appreciated and has been an important instrument in capacity building. The importance of building broad ownership to technical assistance and a more planned approach to capacity building of teams has become clear.

Danida has focused on strengthening the organisation of the private non-profit sector for several years, initially on a small scale. Under phase IV support to the Christian Health Association of Ghana (CHAG) increased, including more funding and long term technical assistance. The experience has been very positive and support from Danida has enabled CHAG to become a strategically positioned and respected partner in the health sector.

Support to the multi-sectoral response to HIV/AIDS was included in phase IV. Despite being a small player Danida's support has been very well received and highly appreciated for its flexibility. Some of the small scale projects piloted with Danida funding has been scale up by other larger development partners. Compared to the size of the support, it has however taken up disproportionate administrative time. Phase V of the Danish Health Sector Programme Support (HSPS V) builds on these previous experiences.

This Programme Support Document describes the programme objectives, strategies and implementation arrangements of HSPS V with reference to key national medium-term plans and memoranda of understanding, see Annex 1 for an overview.

2. Objectives and programme strategy

The overall aim for Danish development assistance to Ghana is to contribute to poverty reduction and to the achievements of the MDGs.

The development objective of HSPS V is fully congruent with the mission stated in the National Health Policy (2007) and the Health Sector Medium Term Development Plan (2010-2013): *"to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry."*

The objectives of the Danish support of financial and technical assistance through HSPS V corresponds to three inter-related and mutually reinforcing health sector objectives - as formulated in the National Health Policy (2007):

- To ensure that people live long, healthy, and productive lives and reproduce without risk of injuries or death,
- To reduce the excess risk and burden of morbidity, mortality, and disability, especially in the poor and marginalized groups, and
- To reduce inequalities in access to health, population and nutrition services and health outcomes.

The strategic approach to achieve poverty reduction is to improve social development by helping Ghana implement its Health Sector Medium Term Development Plan (SMTDP), primarily by the provision of budgetary support, but also through targeted technical assistance (TA). Recognising that the non-public service providers deliver a considerable share of services, often in remote areas, and therefore are essential for the attainment of the milestones and targets of the SMTDP, support is provided for strengthening the not-for-profit health service provision, through support to Christian Health Association of Ghana (CHAG). As in the previous phases the strategic approach is to ensure the highest possible degree of alignment and harmonisation with Government of Ghana (GOG) policies, systems and procedures.

3. National Sector context

3.1 Significance of sector in the national context

The Ghana Shared Growth and Development Agenda (2010-2013) is intended to continue the broad path of the Ghana Poverty Reduction Strategy I and II. The overall objective is to improve the living conditions of Ghanaians by addressing economic imbalances, stabilising the economy, and placing the country on a path of accelerated growth for poverty reduction and achieving the MDGs. All ministries will have a corresponding SMTDP. The Health SMTDP is an integral part of this agenda and of chief importance for obtaining the MDGs 4, 5 and 6.

The health sector has made significant progress in several areas, for example, in some equity indicators related to supervised deliveries and distribution of nurses between regions, in reducing guinea worm cases, under five mortality rate and tuberculosis treatment success rates [Independent

Technical Review (ITR) for 2010 and previous years]. Maternal mortality, however, remains a challenge, being unacceptably high and coupled with neonatal deaths, thereby contributing to high infant mortality rate. MDG 4 & 5 have been main priorities in recent years and maternal health has received increased focus, being declared a national emergency in 2008. But there is scope for further speeding up existing initiatives, finding new solutions, and increasing access to and use of family planning and safe management of unwanted pregnancies.

Median HIV prevalence at sentinel sites (pregnant women 15-24 years) was 2% in 2010 and has hovered at the low end of the 'generalised epidemic' range for a number of year (ITR 2011). In some Most At Risk Populations (MARPs), however, prevalence can reach up to around 40%. The small rates of change in recent years suggests that the epidemic has stabilised; with some geographical variation. Nevertheless, to achieve MDG 6, continued emphasis must be put on the multi-sectoral response.

Other persistent communicable diseases, particularly those that intensify poverty such as malaria also need to be addressed with effective preventive and curative measures. In addition, the country faces a growing burden related to non-communicable diseases, including mental health and high-cost chronic and degenerative conditions, which will need to be addressed in the coming years.

Utilisation of health services has continued to increase. Despite general progress for all, some income and age groups have benefited more than others (UNICEF 2011). The poverty related equity gap in child mortality does not seem to be closing, and NHIS coverage also appears to be strongly related to wealth (ITR 2009). The very clear divide between the North and South in health and equity indicators persists. In this regard the slow implementation of Community Health Planning and Service (CHPS) and the low priority given to capital investments at the lower health unit levels raises concern. The long planned long term health facility plan using rational criteria is much needed to guide infrastructure development. Key stakeholders involved (e.g. community representatives, health planners, financiers) sometimes have divergent views on key priorities for investments in health infrastructure.

The number of health workers trained, especially middle level health cadres, has improved significantly; steps have been taken to improve deployment and enhanced salaries and incentives resulted in decline in the imbalance between staff development and staff attrition. Nevertheless, a number of challenges remain, including disparities in the health workforce distribution, high attrition of health workers (due to retirement), high costs, low performance, poor management practices and continued centralisation of key human resource management functions (e.g. salary management, posting and deployment, approval of training).

Drug stock-outs in health facilities occur partly due to long delays in reimbursement from the National Health Insurance Scheme (NHIS) which contributes about 80% of Internally Generated Funds (IGF) in the health facilities. Inefficiency of the Central Medical Stores and lack of accountability contributes to the problem. Regional Medical Stores and hospitals are increasingly procuring directly from the private sector. Ghana medical drug prices are way above international market prices, negatively affecting sustainability as well as affordability for uninsured patients. Prescription practices and more rational use of drugs at consumer level, are also issues needing more attention in order to reduce expenditures and improve quality of care.

3.2 Institutional structure of sector

The Ministry of Health (MOH) is the overall national body responsible for policy, planning, regulation, coordination, budgeting, monitoring and evaluation (M&E) in the health sector. Ghana Health Service (GHS) is the key implementing agency. As the largest agency under MOH, GHS is a de-concentrated agency, with regional and district offices reporting upwards, and with responsibility for managing and delivering public sector health services. A decentralisation process is ongoing in order to strengthen the primary health care at the district and sub-district level. Other large agencies include the Teaching Hospitals and the CHAG. CHAG is an umbrella organisation comprising more than 180 health service facilities (including 10 Training Institutions) essentially located in remote rural and semi-rural areas with substantial poor and marginalized populations. Faith-based health services operate nearly 20% of hospitals, and primary health clinics (Research for Development 2010). CHAG estimates that they provide 35-40% of health services

Other key actors include the National Health Insurance Authority (NHIA), Ghana Aids Commission (GAC), the Coalition of NGOs in Health, private-for-profit service providers, research institutions, traditional healers and professional or patient-based interest groups. In addition, institutional reforms have resulted in the creation of a number of semi-autonomous agencies responsible for essential service functions, e.g. National Ambulance Services.

The increasing compartmentalisation of the sector has made vertical and horizontal coordination increasingly complex. District health services have to navigate between the demands of national programmes and different agencies, each with earmarked resources. Further, the needed coordination of the many agencies and departments under the MOH has proven a challenge however, it is essential for effective service delivery. The MOH needs strong leadership as well as relevant senior management and technical skills to ensure that all agencies implement sector priorities in a complementary and reinforcing way. MOH has responded to the challenge by re-invigorating the Inter-Agency-Leadership Committee (IALC), a forum of heads of agencies of the MOH aimed at dialogue between agencies within the framework of performance improvements, adherence to policies and accountability. The IALC has the potential for becoming the most important forum for internal dialogue and coordination, but there is a need to realign meetings to the planning, budgeting and review cycle to obtain maximum impact. IALC at present does not have the mandate to enforce collaboration or decision-making.

3.3 Key sector policies, legislation, programmes

The National Health Policy (2007) guides health sector development. The legal framework of the health sector has been under review; linked with this effort, several draft bills have been submitted to Parliament for consideration, including the Mental Health Bill, the National Health Insurance Bill and the Public Health Bill.

Effective decentralisation still faces considerable challenges, particularly in the absence of true fiscal decentralisation and spending control at district level. While legal documents define the Ghanaian decentralisation process as one of devolution to districts, the MOH itself has delegated the responsibility of managing its facility network to GHS, in accordance with the Ghana Health Services and Teaching Hospitals Act (Act 525, 1996). The result is unclear lines of accountability horizontally (to local government) and vertically (to higher government authority). Some functions

and responsibilities have been devolved to District Assemblies and the District Health Management Teams while others remain centralised or simply deconcentrated. For this reason District Assemblies' involvement in health activities and financial contribution through the District Assemblies Common Fund varies greatly across districts. Act 525 (establishing the GHS) has recently been reviewed and amendments proposed.

A clear implementation strategy identifying the sector's decentralisation priorities, intended achievements and the expected building blocks is very much needed. The recent passing of the Legal Instrument for the Decentralisation Policy and the finalisation of the Decentralisation Action Plan may present an opportunity to get the district health plans integrated into the composite district plans, to strengthen the inter-sectoral collaboration in health and to restore the focus on district level service delivery in response to local priorities.

3.4 Sector financing

The Medium-Term Expenditure Framework allocation for health out of the national budgetary discretionary allocation has been stable around 15% (ITR 2010) with the exact share varying by calculation method[1]. Regrettably, the budget does not capture all funds for the sector as an unknown number of contributions – from development partners (DPs) as well as other emerging 'non-traditional' sources, including an increasing (concessional) loan portfolio – are not reported to Ministry of Finance and Economic Planning (MOFEP). Over the period 2007-2010, the total annual per capita allocation to the health sector has been increasing from USD 22 to 29 (ITR for 2010). Funds raised by the MOFEP, NHIS and DPs contributed 51%, 32% and 17%, to the health sector budget in 2009. Changes in Ghana's macroeconomic environment in relation to the oil find has the potential to impact positively on the GOG support to social services in the future.

The establishment of the NHIS has changed the domestic financing of the sector. The share of direct GOG funding is levelling off; the significant increase in share of IGF at facility level is powered by the growth of the NHIS. Some critical aspects of primary health care continue to be funded through MOH, i.e. health promotion, specific preventive campaigns and general system strengthening including quality assurance, supervision, and M&E. Despite a strong political commitment to prevention, the increasing significance of IGF, which basically can be seen as reimbursement for curative services, risks unintentionally to skew health expenditure towards curative care.

The NHIS is mainly financed through a National Health Insurance Levy (NHIL), and formal sector payroll deductions. Although several groups, including the elderly, indigents[2], children under 18 and pregnant women are currently exempt from premium payment, premium payment has proven to be a major obstacle for the poor. Inter-sectoral collaboration has been initiated to develop strategies to cover this group.

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[1] As pointed out in a number of ITRs, the calculation method used in the annual assessments includes double counting of (some) NHIS funding. The ITR 2010 notes that the target allocation for 2010 had been brought down to 11.5% which may be due to a change in calculation methodology.

[2] The indigent are defined as people who are unemployed and have no visible source of income; does not have a fixed place of residence; does not live with a person who is employed and who has a fixed place of residence; and does not have any identifiable consistent support from another person. (LI 1809 National Health Insurance Regulations, 2004).

The NHIS card-holders have access to a package of free health care services. Gross enrolment (i.e. not accounting for drop-outs through lack of renewal, death and emigration) was approximately 62% of the population (48% active members) ultimo 2010 (ITR 2010). The consequent sharp rise in utilisation has put the health system, and the health facilities in particular, under pressure. At the same time, districts and health facilities face the challenges of delayed and often ring-fenced disbursements from GOG on the one side and problems in claims processing and reimbursement from NHIS on the other. It is essential that NHIA address these issues, while also taking up the challenge of ensuring sustainability in an environment with increased use of services, for example by rethinking the renumeration mechanisms as well as administrative processes.

The rationalisation of capital investments is still outstanding and the risk of ad hoc political interference at individual level for projects that are not of the highest priority still prevails. Efficiency gains have been slow to materialise, but will be necessary to ensure sustainability of the health services in the long run. Although progress has been made on targets, the question is whether more could have been expected given the amounts of funding available.

Funding for multi-sectoral HIV/AIDS activities, including health, increased consistently from 2005 to 2007, but decreased in 2008, however, still above 2006 levels (NASA 2009). Nearly 85% of the funding in 2008 came from international sources, indicating over-reliance on external funding.

3.5 Partner coordination

Key DPs in health and HIV/AIDS include: DK, NL, UK, USA, Japan, UNFPA, UNAIDS, UNICEF, World Bank, WHO, GAVI and GFATM. Support modalities include sector budget support (SBS), Health Fund (basket), earmarked projects, mixed financial credits and other direct support. DK, UK and NL use SBS as the main modality. Japan has recently joined the SBS. From constituting less than 25% of the external funding to the health sector in 2004, project funding now constitutes more than 50%. This change is mainly due to global vertical initiatives, scaled up earmarked funding (e.g. new US initiatives) and non-OECD donors, but also due to the fact that some partners shifted from the Health Fund (earmarked for MOH) to the Multi-Donor Budget Support (MDBS) (unearmarked to MOFEP and may be used as GOG's health contribution). Increasing projectisation and projects being negotiated through diplomatic channels with little MOH involvement have magnified the challenges of coordination in the sector. Strong leadership by MOH is required to ensure that the projects are supporting the national strategies and are as harmonised as possible.

The partner cooperation structure is well-developed in Ghana. A sector working group for Health, HIV/AIDS with participation of DPs, MOH and its agencies has been in place for many years with clear terms of reference (TORs June 2008). The sector working group is a forum for bringing together (with varying intensity) MOH, and its agencies, civil society, DPs and academia. Over the years, the collaboration between MOH and CHAG has been strengthened and it is today viewed as an example of effective public-private partnership. CHAG is represented in all major key decision making bodies in the health sector and is emerging in the sector dialogue as a strong representative of its members. The sector group for Health is led by MOH and the sub-sector group for HIV/AIDS is led by GAC. The role of the DP sector and sub-sector lead rotates according to well-defined principles.

The collaboration arrangements that will support the implementation of the SMTDP are further elaborated in the Common Management Arrangements III (CMA III). All stakeholders that support the sector with significant activities and resources are expected to comply with the arrangements set out in the CMA III. All sector partners undergo an annual peer review to assess their level of compliance with the key principles of the CMA III. A particular challenge will be to integrate emerging actors in the sector coordination. Lack of transparency on a number of new investments limits the ability of partners to engage in a meaningful policy dialogue on rational and balanced use of resources, for example in relation to capital investments. A meaningful dialogue based on a comprehensive medium term plan and annual operational plans is at the core of SBS.

The Technical Advisory Committee to address intersectoral collaboration that was envisaged in the National Health Policy (2007) has not yet been operationalised. Recognising that the collaboration with partners in other sectors has been limited and the need for more leadership, the MOH has agreed to pursue a more pro-active approach by requesting the National Development Planning Commission for re-activation of the high level intersectoral meetings.

3.6 Capacity issues

Throughout the years MOH has shown ownership of the SWAp. Overall comprehensive planning, financial management systems and review processes are in place, but need further strengthening to ensure efficient use of financial and human resources and value for money.

The MOH recognises that the compartmentalisation of the health sector without effective communication between agencies presents an increasing challenge. Institutional and organisational development, leadership and management skills as well as effective management tools are key to ensuring that the sector optimises its potential towards implementing the sector priorities. It is generally recognised that there is a need to strengthen leadership and capacity for sector management at central level. For more efficient management it is necessary to revisit the organisation of the work in the ministry itself. While the IALC can foster coordination, effective management tools to follow up on agency performance are yet to be (re)introduced.

The Health SMTDP also identifies other weaknesses to be addressed, including weak M&E systems, inequitable systems of resource allocation and deployment, absence of performance-based allocations, and need for continued strengthening of the Public Financial Management (PFM) system to ensure effective and efficient use of resources in the sector. The implementation of the PFM strengthening plan with agreed timeline and budget has been slow to materialise and the process needs more focus, support, and GOG ownership.

The NHIA is a young organisation that has expanded its operations rapidly over a relatively short period of time. Low capacity in the District Mutual Health Insurance Schemes and at the health facility management level causes some problems in adherence to uniform procedures, effective claims submission and management as well as effective revenue collection and membership management. Although the NHIA has strengthened key functions in the central organisation, challenges remain. The M&E function needs to be strengthened to support effective management, increase transparency and document contributions to the national development agenda. Concern about sustainability has forced the NHIA to focus on cost containment and administratively simpler provider payment mechanisms, e.g. capitation payment. A pilot on capitation will be

starting in 2011, but there is only limited capacity within the organisation to analyse the results and develop the system for roll-out.

4. Programme components

4.1 Component 1: Support to the implementation of the Health SMTDP

Danida will provide DKK 345 million in sector budget support to the implementation of the Health SMTDP and DKK 19 million for targeted long term TA.

Objectives: The objective is to enable the health sector to achieve the five strategic objectives of the SMTDP: 1) Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements to protect the poor; 2) Strengthen governance and improve the effectiveness of the health system; 3) Improve access to quality maternal, neonatal, child and adolescent health services including nutrition; 4) Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles; and 5) Improve institutional care, including mental health service delivery.

Summary of the partner programme: The Health SMTDP (2010-13) identifies 2-4 key strategies for each of the health policy objectives. These strategies will be operationalised in annual plans (i.e. Programme of Works (POW)). The SMTDP reflects GOG's health policy agenda: strengthening district health services with emphasis on primary health care, developing sustainable financing strategies that protect the poor and vulnerable, improving financial access through the NHIS; controlling endemic diseases; improving health infrastructure and emergency response systems; and creating an enabling environment for an efficient health care delivery in Ghana. It also reflects the need for strengthening human resources required for effective service delivery with emphasis on equity and improvements in the regulation and management of the service to address efficiency and quality of care at all levels.

It is assumed that a new SMTDP (2014-17), or equivalent, will be developed in line with the National Health Policy, and go through a joint DP-MOH assessment during HSPS V.

Component strategy: The main strategy is to support the implementation of the Health SMTDP (2010-2013 and following years) by providing sector budget support (SBS). The SBS consists of two elements: a) the transfer of financial resources and b) a joint policy dialogue on critical and strategic policy issues and planned achievements. This is supplemented by TA to strengthen areas of crucial importance for improving the implementation of the SMTDP.

The provision of ***financial resources for SBS*** rests on the assumption that the priorities and commitment of GOG, to the health sector and to increasing access to basic services for the poor, are reflected in terms of progress towards agreed targets and milestones. Further, the provision of SBS rests on the basic assumptions that an acceptable and realistic annual Programme of Work (POW) including budget, is available; that implementation is according to the plan and budget; and that there is timely disbursement of funds to the Budget Management Centres, as the effective implementation of the plans depends heavily on timely release of the approved budget.

RDE will participate actively in the ***policy dialogue***, particularly on the contents, comprehensiveness and quality of sector policies and implementation plans. Denmark will

maintain a focus on improving access to health services for the poor and vulnerable, including vulnerable women and children. Issues addressed in the dialogue may include:

- Access to care and inclusion of the poor in NHIS – The focus of the dialogue will be on the sector expenditure plan, including the shares of overall sector spending going to pro-poor and gender focused expenditure categories; on the inclusion of the poor in NHIS and the definition of the poor.
- Adequacy and distribution of resources (financial and human resources) to health services in general and in particular to primary health care services. Issues would include GOG financial commitment to the sector, CHPS implementation, balance between curative and preventive care, balance between strategic objectives and capital investment, geographical distribution of resources, flexibility in resources to the districts.
- Sexual and reproductive health and rights. Issues would include access to family planning services (by men, women and adolescents), safe abortions and post-abortion care to reduce maternal mortality; information on sexual and reproductive health and rights and empowerment of women to reduce unwanted pregnancies, gender-based violence and sexual and reproductive ill-health; and the importance of linking HIV/AIDS and sexual and reproductive health and rights.
- Management of the increasing compartmentalisation of the health sector. Issues would include performance contracts, M&E systems, accountability structures, and accountability to end-users, harmonisation and coordination/joint approaches.
- Health sector decentralisation. Issues would include the development of a strategy for fiscal decentralisation; steps taken to prepare agencies for decentralisation, clarifying the role of regions.
- Gender equity – The implementation of the health dimensions of the National Gender Policy and the MoH Gender Policy at national, decentralized and facility levels would be a major consideration. Issues would include need for sex-disaggregation and gender analysis in sector planning and programming towards equality promotion. Critical issues would include addressing health consequences of domestic violence on victims, negative socio-cultural practices on the health seeking behaviours of women and men, girls and boys.
- Use of information for evidence-based decision-making. Issues would include the need for a comprehensive agenda for research, resource allocation for research and measures to translate knowledge to policy.
- Cost containment measures and efficiency improvements in service delivery as well as in the NHIS.

In response to requests from MOH, ***long term TA*** to support capacity strengthening in MOH in PFM and M&E is envisaged, see draft Job descriptions in Annex 2 and 3. A situation analysis with focus on organisational and institutional issues will be undertaken jointly with MOH, its agencies and other DPs before the start of HSPS V. It is envisaged that the situation analysis will lead to the development of an institutional capacity development plan for the MOH and central agencies. As MOH had requested long term TA in leadership and organisational development, an amount is set aside for such TA if found necessary in relation to the institutional capacity development plan.

Finally, in response to a request from NHIA an amount is set aside for 5 person years of long term TA primarily in the first years. An M&E adviser (2-3 years) is envisaged to assist in strengthening of the M&E system and use of data, see Draft Job Description in Annex 4. TA of shorter (but possibly recurrent) duration is envisaged in other areas, e.g. development of provider payment mechanisms and development of systematic capacity building of District Mutual Health Insurance Schemes and other staff.

National outcome indicators: The SMTDP 2010-2013 with indicators, milestones, baseline and targets has gone through the Joint Assessment of National Strategies process in the fall 2010, was discussed at the Health Summit in November 2010, and was adopted by the National Development Planning Commission in 2011.

4.2 Component 2: Support to the private not-for-profit health sector

Danida will provide DKK 20 million in core funding to support CHAG's Strategic Plan 2012-2015 and DKK 6 million for TA.

Objectives: The overall objective is to assist the institutional development of the private health sector, particularly non-profit organisations, and the establishment of an enduring capacity to serve and promote the health needs of the poor, to support and strengthen health service delivery and to develop accessible and affordable health services across the country.

The immediate objectives will be to support CHAG to 1) improve the organisational capacity of the CHAG secretariat to carry out its roles and responsibilities; 2) provide leadership and coordination for internal and external network activities; and 3) support members to efficiently and effectively manage pro-poor service provision towards improving access to and quality of services.[3]

Summary of Partner programme: The CHAG's Strategic Framework 2010-2011 is aligned to the Health SMTDP 2010-2013 and will remain the reference for the 2012-2015 CHAG Strategic Plan and Programme of Work (SPPW). The Strategic Framework addresses the capacity of CHAG's Secretariat to carry out its roles, responsibilities and functions both for internal and external network activities and to support members to efficiently and effectively manage pro-poor service provision towards improving access to and quality of services.

CHAG's Secretariat is re-defining its scope of work to become less operational while building up the capacity of member institutions to be more effective in service delivery. CHAG will continue to pursue a Health Systems Strengthening (HSS) approach[4] in which the secretariat will support members towards the achievement of improved health outcomes. To stimulate this shift, the secretariat will focus on performance measurement, M&E and the use of evidence in intervention planning and implementation. Skills and competencies required for critical and analytical thinking that lead to improvement will be developed at all levels of service delivery. In 2009 CHAG set up an "Innovation Fund" dedicated to support member institutions to strengthen capacity along the

[3] These are the expected objectives for the Strategic Plan 2012-15, see CHAG paper called "CHAG input into Danida formulation mission".

[4] In line with the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium". This declaration recognises 9 building blocks of health systems: Leadership and Governance, Health, Services Delivery, Human Resources for Health, Health Financing, Health Information, Health Technologies, Community Ownership and Participation, Partnerships for Health Development and Research for Health).

HSS approach. CHAG also intends to engage in operational research that will support performance improvement and measurement as well as contributing to effective policy dialogue and advocacy activities of CHAG. To improve teaching capacity at the CHAG nursing schools, institutional twinning will be considered

Component strategy: The support received through the HSPS IV has enabled CHAG to re-organise and to evolve into a strategically positioned, respected, and credible (private) partner within the Ghanaian health sector. CHAG's Secretariat is evolving towards an effective lobbying, advocacy, coordination and membership support body. While there is still a need to strengthen CHAG in its process of redefinition of scope, the support will, however, be gradually phased out over the five years.

The main strategy is to support the implementation of the CHAG SPPW (2012-2015) by providing core funding to CHAG. The provision of core funding consists of two elements: a) the transfer of financial resources and b) a joint dialogue on crucial and strategic policy issues and planned achievements. The core funding is supplemented by funding for TA to help build the capacity for implementation of the HSS approach.

The transfer of ***financial resources*** is based on the assumptions that an acceptable and realistic annual plan and budget is available, that actual implementation reflects the priorities indicated in the budget and plan and that the results are reflected in progress towards agreed indicators and milestones. Since the administrative costs of the CHAG's Secretariat are now being covered from a combination of government contribution, increased membership fees and returns on previous investments, Danida funding will de facto mainly be used to strengthen the capacity of members through the HSS approach.

In the ***joint dialogue*** with CHAG, RDE may include the following areas in relation to CHAG activities:

- Sexual and reproductive health and rights
- HIV/AIDS activities and engagement with GAC and National Aids Control Programme
- Links between the HSS approach, equity, gender issues, and governmental decentralisation
- The collaboration between CHAG training institutions and Government (i.e.; HSS courses)
- Operational research to improve institutional performance and policy dialogue
- Follow up of the exit strategy for ending Danida support to CHAG
- Further alignment within the network

Besides the MOH-CHAG Partnership Steering Committee, CHAG's secretariat is an active participant in the major MOH and DP fora[5]. Therefore much of the policy dialogue will take place in these fora.

Technical assistance for CHAG will be needed primarily in the first years of Phase V. A long term Senior Health Systems Adviser (2-4 years) is envisaged to assist in the development of the capacity of the Secretariat's HSS group and indirectly of member institutions, see Draft Job Description in Annex 5. TA of shorter duration (2-3 years total) is foreseen in various areas, e.g.

[5] IALC, Business & Partners meetings, Ministerial Committee on Posting, Budget Committee.

advocacy, communication and public relations; design and implementation of a comprehensive performance management system; and operational research.

Outcome indicators: In adopting performance management the CHAG secretariat intend to focus on results and not activities as during HSPS IV. CHAG's performance indicators and milestones will be an integrated part of the SPPW 2012-2015 and will be aligned to the national health indicators.

5. Measures to address cross-cutting issues and priority themes

5.1 Danida objectives

HSPS V is in line with key Danish priorities, such as gender equality, primary health care, sexual and reproductive health and rights, women and children, and the fight against HIV/AIDS. Support to the health sector complements and provides room for synergy with the other components in the Ghana development cooperation programme, e.g., regarding decentralisation issues (Local Service Delivery and Governance Programme), public financial management and strengthening the role of civil society in good governance (Good governance programme). Through the policy dialogue, RDE may, for example, encourage the engagement of the health sector in the operationalisation of decentralisation strategies, pursue necessary change in regulations and practices for decentralisation to work; and roll out of instruments and guidelines in PFM. The other programmes on the other hand can contribute to the success of HSPS V by improving the general PFM capacity and by strengthening the capacity of district administrations in comprehensive planning for the social sectors. Likewise there is room for synergy with recent initiatives in research and tertiary education, i.e. the Building Stronger Universities in Developing Countries initiative by Danish Universities (Health Platform) and the pilot research project for Ghana.

HSPS V will contribute to poverty alleviation through improving access to health services for poor and vulnerable groups, by pursuing enrolment of the poor in NHIS, emphasising the need for equitable allocation of human and financial resources to the lower levels of care and rationalisation of capital investments, and strengthening CHAG facilities of which many are located in remote districts.

5.2 Cross-cutting and priority issues

Gender equality: Gender equality is a priority for GOG. Gender budgeting is currently implemented on a pilot basis in three MDAs in a collaboration between MOFEP and Ministry of Women and Children's Affairs, with the MOH being one of the pilot ministries. Gender indicators have been integrated into the M&E system of the MOH. DPs continue to dialogue with MOH to ensure sufficient attention to the area of sexual and reproductive health and rights, including available and affordable services for family planning and addressing gender based violence.

The implementation of the Health Sector Gender Policy (MOH, 2009) and the Draft Gender Strategy (2009) will continue with the SMTDP. The HSPS V support to the medium-term plans of MOH and CHAG will enable GOG and the non-public sector to promote health in Ghana by

addressing gender based factors affecting health. RDE will continue to use policy dialogue to promote gender equality and gender mainstreaming throughout the health sector. It will strive to better address the causes of inequalities, stigma and discrimination affecting the choices of both women and men about prevention, reproduction and access to treatment and care.

Good governance, human rights and democratisation: GOG has a strong focus on human rights, including the rights of the mentally ill. A new Mental Health Bill is at the floor of Parliament for consideration. HSPS V will continue to support efforts to ensure universal access to prevention, treatment and care for all. Issues on sexual and reproductive health and rights will in general be brought up in the policy dialogue. Interaction with civil society and human rights groups to strengthen accountability mechanisms towards end-users will also be sought in collaboration with the Danish supported good governance programme.

Environmental and climate issues: Ghana has a relatively robust environmental framework and considerable capacity to set environmental management standards. Health is identified as one of the priority areas for the national Climate Change Adaptation Programme and a national framework for climate change adaptation to cover all ministries and agencies is under elaboration. In health, strategies for addressing malaria and water borne diseases, being to a large extent environmentally determined, are likely to be modified in view of the expected climate changes. HSPS V is unlikely to cause any direct environmental impact. The design process of the SMTDP has not raised any specific implications for sustainable natural resource management.

HIV/AIDS: The National Strategic Plan (NSP) for the National Response to HIV/AIDS (2011-2015) was launched in December 2010. The MOH plays a key role in the response and all health sector activities for HIV/AIDS will be implemented in the context of the NSP. MOH priority areas in relation to HIV/AIDS include the implementation of the Adolescent Health Policy and Strategy that was launched in 2010 in recognition of the critical role of the youth in terms of prevention of HIV; expansion of care and support to increase coverage; and piloting of a nutritional programme and food assistance for food insecure PLHA on ART. In the policy dialogue RDE will focus on the linkage with sexual and reproductive health and rights and will also in the dialogue with CHAG discuss HIV/AIDS activities and engagement with GAC and the National Aids Control Programme.

Decentralisation: Primary and maternal health care targeting the poorest and most vulnerable population in rural communities remains a priority. Strengthening the health departments in the district assemblies and the CHPS in the communities will contribute to achieving the MDG4 and the MDG5. Increased decentralisation in Ghana will support the cross sectoral efforts to improve health in rural areas e.g. combined efforts between health and sanitation.

6. Budget

Denmark will provide support for a five-year period (2012-2016) through a grant of DKK 400 million. Table 1 below gives an indicative picture of how those funds will be allocated between the different years for the two components.

Table 1. Budget per component (DKK million)

HSPS V	2012	2013	2014	2015	2016	Total
Component 1 Support to SMTDP	**83**	**79**	**74**	**67**	**61**	**364**
Sector Budget Support	80	75	70	63	57	345
Long Term TA	3	4	4	4	4	19
Component 2 Support to the private not-for-profit health sector	**10**	**7**	**5**	**3**	**1**	**26**
CHAG Core Funding	7	5	4	3	1	20
Long Term TA	3	2	1	0	0	6
Reviews and Studies	**2**	**2**	**2**	**2**	**2**	**10**
Grand Total	**95**	**88**	**81**	**72**	**64**	**400**

Note: Breakdown by year is indicative.

The Long Term TA budget includes 19 person years TA for component 1 and 6 person years TA for component 2. Short term TA and fellowships are included in the SBS and core funding for CHAG. The budget line "Review and Studies" contains funding for annual and mid-term reviews and studies needed by the RDE, including consultancies needed for such activities.

Projected funding gap of the SMTDP[6]: The Health SMTDP has been costed under three implementation scenarios with different levels of ambition with regard to the strategies to be implemented and targets to be achieved (status quo, moderate, ambitious) and these scenarios compared to two alternative projections of the resource envelope available to finance it. Following this exercise adjustments were made, e.g. that number of hospitals should be reduced in favour of slightly expanded CHPS targets, and a preferred scenario was selected mainly due to its expected impact particularly on the health-related MDGs. The results of the costing exercise suggest that the total cost over the four years for the preferred scenario will be GHS 6.94bn (approx. DKK 2 bn).

The least ambitious resource envelope projection does not calculate any increase in oil revenues, but assumes that GOG will raise its percentage allocation to health by 1%-point per year. This has been added to projections from development partners to obtain total expected public health spending. Under this scenario, public health spending is estimated to rise from GHS 1.3 billion (approx. DKK 380 mn) in 2010 to GHS 2.1 billion in 2013 (approx. DKK 615 mn), giving a total for four year of GHS 6.6bn (approx. DKK 1.9 bn)[7]. Comparison of the projected funding with the estimated costs reveals that a funding gap will remain in some years (8.5% and 5.3% in 2012 and 2013 respectively). The outer year projections for DP funding are, however, likely to be on the low side and actually entails a reduction in DP support by 25-50%.

[6] Based on the costing exercise of the SMTDP undertaken in 2010 and finalised in 2011.
[7] Interbank exchange rate as of September 1st, 2011: DKK 1 = GHS 0.29259

DP contribution to funding of the SMTDP (2010-13): According to the resource envelope projections DPs will contribute GHS 681mn over the four years or just above 10% of total funding projected. Comparing the average annual costs and DP-funding of the SMTDP (2010-13) with average annual HSPS V (2012-16) budget, Danida's support to Component 1 and 2 corresponds to 13% of the DP funding and 1.3% of the total funding.

7. Management and Organisation

The key partner institutions are MOFEP, MOH and CHAG. The agreement between Ghana and Denmark covering the Danish support to HSPS V will provide the legal framework for the programme. The MOFEP will sign the Government Agreement and will be the overall responsible counterpart for the programme. MOH and CHAG, as implementing partners are signatories to this Programme Support Document in as far as their areas of responsibility are concerned. GOG is not responsible for the implementation of component 2, but is merely signing on a "no-objection" basis. Budget reallocations between the components will be subject to consultations between RDE and partners and will be assessed at an annual review. Depending on the size of the proposed reallocation Danida Copenhagen may have to approve the reallocation.

7.1 Oversight and decision-making structures

The oversight and decision-making structures are well-developed for the health sector and HSPS V will continue to use the existing joint structures.

Component 1: The dialogue and decision-making structures for the sector are described in the CMA III. In addition, MOH, MOFEP, the Netherlands, the United Kingdom, and Denmark have signed a Framework Memorandum of Understanding for the SBS, which outlines the mechanisms for dialogue and decision-making structures for DPs providing SBS. The biannual health summits, the tri-annual business meetings, and monthly partners meetings will function as a steering committee arrangement. Issues relating exclusively to the Danish support may be dealt with in ad hoc-meetings between the RDE and MOH leadership.

Component 2: Based on the existing strategic framework 2010-2011, CHAG's secretariat will prepare a new SPPW for 2012-2015 (with indication of priorities if the budget shows financial gaps) including outputs, activities, indicators, targets and milestones. The draft will go through a consultative process which will involve Danida. The approved version will be made available to the different MOH-DP forums.

The responsibility for CHAG's adherence to the agreement with Danida lies with CHAG's Executive Board. Issues related to the agreement between CHAG and Danida will be dealt with in ad-hoc meetings between RDE and CHAG's leadership. To the extent that the MOH has a stake in what is up for discussion, the MOH leadership can be invited to participate. Before the start of each year, CHAG is responsible for developing an annual work plan and budget based on the 4-Year SPPW and aligned with the annual POW of the health sector. The annual work plan and budget will be submitted to RDE (for no-objection).

For MOFEP and MOH to be aware of CHAG activities and use of Danida funds the CHAG secretariat will regularly submit work plans and budget, activity implementation reports, financial

statements, and external audit reports on implementation of the Strategic Plan 2012-2015 to MoH, MOFEP, as well as RDE and other DPs that support the network. In all instances comments will be requested from the ministries and RDE.

Routine oversight of the components will be the responsibility of the Health Coordinator at the RDE.

7.2 Day-to-day management

Partner programme activities will be detailed in the annual health sector programme of work, and the CHAG annual work plan. The Chief Director, MOH, and the Executive Director, CHAG, are overall responsible for their programme implementation. Day to day management tasks may be delegated to senior staff. Day-to-day management specifically related to Danida financial support will be at a minimum, being mainly limited to request for transfers and follow-up on these.

7.3 Technical assistance

In response to requests from MOH, NHIA and CHAG, long-term TA will be recruited, see Chapter 4. Funding for up to 6 person years in CHAG, up to 14 person years in MOH and up to 5 person years in NHIA has been reserved. However, the actual duration of the deployment will be defined with MOH, NHIA and CHAG as the programme evolves. Furthermore, the TA can take the form of a single period posting or consist of a series of periodic short-term inputs over a longer period. It is expected that the advisers will be phased out towards the end of the programme period.

Partner organisations and other technical expertise will be involved from the outset in the drafting of TOR, identification and selection of advisers. MOH, NHIA and CHAG will be responsible for development and regular review of TORs, work planning and supervision as well as annual performance assessments. Identified needs for change in TOR, working environment or performance issues will be discussed with RDE. All advisers will work within a unit or department and with a designated counterpart or team and report to their head of unit/department. MOH, NHIA, and CHAG will be responsible for developing a capacity building plan for the unit supported by the TA, including milestones. The TA will relate to the RDE on personnel issues only. Counterpart institutions will bear the responsibility and be accountable for TA assisted interventions.

Needs for short term TA, studies and training have been identified in various areas, including health financing and insurance, capital investment planning, health management information systems organisational development and institutional strengthening of the MOH and improving access for poor people. Funding for such activities will no longer have a separate budget line, but should be budgeted by MOH and CHAG under the SBS and core funding respectively.

8. Financial Management and Procurement

8.1 Disbursement, accounting and auditing

Component 1: Financial management under component 1 will generally follow the procedures agreed between the partners in the signed "Framework Memorandum of Understanding for the

health sector budget support" and as otherwise described in the CMA III. This implies using government procedures for planning and budgeting, disbursement, procurement, accounting, financial reporting and audit.

SBS is not yet (September 2011) fully integrated into the health sector financial management system, as it is treated separately from GOG funds in planning and financial reporting. As agreed in the CMA III, MOH and SBS DPs will prepare a plan for integrating the SBS funds into GOG funds for expenditure management. Together with MOFEP, MOH, SBS-partners, and other key partners a study is planned to identify bottlenecks in the disbursement of SBS as well as the general flow of funds to the different service levels and to propose measures to increase predictability and timeliness of the flow of funds. The study will also identify the way forward to enable integration of SBS funds into GOG funds. This study is expected to be completed before the start of HSPS V.

Unless otherwise agreed, RDE will upon request from MOH disburse its annual financial contribution in one single disbursement at the beginning of the year.

Component 2: A separate account will be used for Danida support. Based on an approved annual work plan, RDE will disburse funds to CHAG. Disbursements will unless otherwise agreed be made in equal portions on half-yearly basis. Disbursements will depend on financial reporting on previous periods.

The accounts will be kept in accordance with international recognised accounting principles. The CHAG Secretariat will have full responsibility for managing these funds, complying with Danida financial requirements and for timely accounting and reporting for these funds (see Danida Guidelines for Accounting and Auditing of Grants through Non-Danish NGOs). The CHAG's Secretariat will prepare a set of uniform administrative & financial management procedures that will be assessed by an external auditing firm in 2011. CHAG's Secretariat will prepare comprehensive half-yearly financial reports (e.g. not limited to Danida but including Danida funded activities) and submit these in a timely manner to the CHAG Executive Board and RDE.

At the end of each financial year there will be an external audit by an audit company of international standard of CHAG's books of account and financial statements. The audited financial reports will be made available to MOH, MOFEP and RDE and other DPs no later than 6 months after the end of the financial year.

8.2 Procurement

Procurement undertaken by MOH in the implementation of the SMDTP will follow the national procurement rules [the Public Procurement Act 663 (2003)].

Procurement undertaken by CHAG will be undertaken in accordance with international principles for procurement and follow the CHAG's Financial and Administrative Procedures, assessed by an internationally recognised auditing firm under the previous phase. All assets purchased will be recorded in a fixed assets register, which will be audited as part of the annual audit.

For long term TA recruitment through Danida, Copenhagen will be used until a sufficiently robust pooled arrangement may have been developed. Danida's procurement procedures and regulation

will apply. Payment will be made directly by Danida in Copenhagen to the TA according to a contract between these two parties. MOH, NHIA and CHAG will be notified on the expenditures.

9. Monitoring, Reporting, Reviews and Evaluation

9.1 Monitoring mechanisms

Joint mechanisms for monitoring, reporting, reviewing and evaluation have been developed in the context of the Health SWAp, and the MDBS, e.g., as regards public financial management. Monitoring of HSPS V will make use of these joint monitoring systems following the agreed joint procedures as outlined in the CMA III. A joint monitoring system may similarly be set up as part of the CHAG SPPW.

The SMTDP as well as the CHAG SPPW will include a set of indicators with baseline and targets as well as a set of milestones. While RDE will monitor progress on all indicators, the RDE will also select a small number for specific focus in tracking performance in HSPS V, see Annex 6.

MOH and CHAG will be responsible for monitoring sector progress and follow up. The development in indicators and milestones will be a subject for discussion in business meetings as well as annual review meetings.

9.2 Reporting

MOH will as part of its regular reporting prepare quarterly financial statements and half-yearly progress reports on physical progress.

In addition to the requirements for financial reports described in section 7 above, CHAG will prepare bi-annual progress reports and comprehensive and consolidated annual reports focusing on outputs, expenditure and problems encountered in the implementation of the CHAG SPPW. Annual reports will assess progress against agreed indicators, targets and milestones.

9.3 Joint Sector Reviews

RDE will participate in the joint health sector review mechanisms, which include the annual regional reviews, joint monitoring visits and the joint annual health sector review by MOH, its agencies, DPs and other sector stakeholders. This will constitute a comprehensive review of progress in outcomes/impact and performance indicators, medium-term plans for the sectors, critical short-term achievements, and the agreed upon milestones.

A technical review will be conducted prior to the Joint Sector Review Meeting. The technical review will assess changes in programme context, sector development, and effectiveness and value for money. As one of the DPs, RDE will, as far as possible, incorporate issues of special interest into this technical review and contribute with expert resources to support the exercise. The findings of the technical review will feed into the Joint Annual Sector Review Meeting. The full review will draw conclusions about the performance of the sector and appropriateness of forward allocation of GOG and donor resources and will confirm financial commitment for the following financial year. New critical areas for achievement, short-term targets or milestones will also be agreed at the end of this joint annual review.

9.4 Danida specific issues

The Health Coordinator at the RDE will monitor the outputs and achievements of HSPS V. The main monitoring tool will be the Joint Annual Sector Reviews. The RDE will monitor the selected indicators for the programme, see Annex 6.

Every second year of HSPS V an external review (with participation of the Technical Advisory Services, Ministry of Foreign Affairs, Denmark) will assess the progress of component 2 including the planning and implementation of the exit strategy as well as the progress on capacity building and plans for phasing out of TA in component 1, the need for continued involvement in the health sector beyond Phase V and if relevant, initiate the design of an exit strategy. Otherwise such reviews will be kept to a minimum.

Table 2 Danida Review Plan

Type of review *Focus*	**Joint Health Sector Review** *Comprehensive review of sector progress. Component 1 and parts of Component 2.*	**Bilateral Review** *Component 2, capacity building all components (TA), phasing out of TA and exit strategies.*
2012	x	
2013	x	X
2014	x	
2015	x	X
2016	x	

Danida will, if the need arises, carry out separate evaluations. Such decisions will be taken in consultation with MOH and CHAG in order to minimise the administrative burden on the institutions and maximise the benefits. However, such independent evaluations will as far as possible be carried out jointly with other partners and will not occur frequently. In accordance with Denmark's Aid Management Guidelines, the programme will be subject to an End of Term Evaluation at the end of the phase.

10. Key Assumptions and Risks

Lack of commitment to access for poor people: Probability: Unlikely Impact: Major

Currently, health insurance excludes a significant proportion of the population who cannot afford the annual premium cost; i.e., they are 'poor' but don't meet the very stringent legal criterion of being 'indigent' which qualifies for exemption. At the same time user fees have increased considerably and so have out-of-pocket expenditures for the uninsured. Work to develop strategies to cover this group has been initiated, e.g. in collaboration with Ministry of Social Welfare and Employment. The issue is further pursued actively in the policy dialogue.

Lack of commitment to financing health: NHIS Probability: Unlikely Impact: Major
Other Probability: Possible Impact: Moderate

While the budget allocation to health has been stable around 15% of planned Government expenditures, the funding flows have however sometimes been lacking or significantly delayed (from MOFEP to MOH and NHIS and from these to districts and health facilities). The oil find may increase available GOG funding, but there seem to be many plans and commitments for such funds and not all may materialise. The recent indications that part of the NHIL will be used for other purposes puts NHIS sustainability at risk given the cost escalations in the NHIS. Risk mitigation measures include TA to strengthening of MOH leadership and capacity to document and justify needs to MOFEP as well as policy dialogue at sector and MDBS level. TA for NHIA to strengthen M&E, develop cost containing provider payment mechanisms and improving scheme management capacity at district level will reduce the threat to sustainability.

Proliferation of fragmentation in funding: Probability: Possible Impact: Major

Off-budget funding and large vertical funding flows (e.g. GFATM) as well as the influence of new actors in the sector may skew sector priorities. Although individual projects may be of high quality, the fragmentation of support risks compromising the overall development effectiveness by undermining the national planning and budgeting process when bypassing the national system. Development of a new health sector financing strategy, active policy dialogue and TA to strengthening of leadership and effective organisation, PFM and M&E are intended to mitigate these challenges.

Capital investment not based on rational plan: Probability: Possible Impact: Moderate

Increasing commitment in terms of matching funds for loans threaten to tie up the budget, with little proportionate health impact. Some agreements on major infrastructure development are made through diplomatic/political channels with late and limited involvement of MOH. The recurrent cost implications are rarely taken into account. This is a genuine risk which requires improved policy dialogue and prioritisation on the part of GOG. A health facility development plan based on rational criteria will help the MOH with this. Capacity building within the MOH regarding their function to inform politicians, based on evidence, as part of the leadership and systems strengthening is intended to mitigate this risk somewhat. It is further hoped that the CMA III will strengthen the harmonisation and alignment of non-traditional partners in the sector.

Inequitable distribution of human resources: Probability: Possible Impact: Moderate

Inequitable geographical distribution of human resources affects the accessibility of health services, especially for rural primary care services (i.e., CHPS level). A divide between the under-developed North and the rapidly developing South has persisted for many years and threatens major progress in health outcomes in the under-serviced northern part of the country. GOG and partners are in a continued dialogue on devising strategies to address this issue. TA to strengthen M&E in both MOH and NHIA may help in providing evidence on progress.

Corruption Probability: Possible Impact: Moderate

Corruption is damaging to the trust needed for budget support. GOG's commitment to pursue the anti-corruption campaign and its desire to take forward new PFM reforms are important mitigating factors. A new National Anti-Corruption Action Plan is under development. Further a Code of Conduct for public Officers has been developed. Improved tracking of funds and capacity strengthening of accounting and audit staff is expected to reduce the risk in the health sector.

Delays in decentralisation Probability: Possible Impact: Moderate

Decentralisation, including fiscal decentralisation, can turn out to be slow in materialising or to be poorly managed. Devolution and strengthening of local accountability structures, if managed well, holds the potential for increasing effectiveness in service delivery at district level, tailoring services to local needs and priorities and directing resources to cost effective use. Decentralisation has been on the agenda for many years and risks further delays. Poorly managed decentralisation and a weak coordinating MOH may result in potential gains not materialising. Risk mitigation includes support to strengthening the leadership capacity and effective management in MOH through TA and active policy dialogue on this issue. RDE will also follow the process through the local service delivery and good governance programmes.

CHAG HSS approach focus on capital investment: Probability: Possible Impact: Moderate

The major risk of providing core funding to CHAG Strategic Plan and POW 2012-2015 is that the actual expenditure would be biased towards capital investment (both for CHAG's Secretariat and for member institutions through the HSS approach) and/or towards administrative and operating costs of CHAG's Secretariat and Churches Health Coordination Units. Mitigation: Dialogue on annual work plan and budget; follow up on financial reports; requirement that internal revenues (MI fees and interests on capital) at all times exceed running costs of CHAG's Secretariat.

Annex 1: List of documents that supplements the Programme Document as basis for the agreement

Component 1:

Health Sector Medium Term Development Plan
Common Management Arrangements III
Framework Memorandum of Understanding for Sector Budget Support

Component 2:

CHAG Strategic Framework
CHAG Strategic Plan and Programme of Work
Memorandum of Understanding between CHAG and RDE *(to be developed before the start of the programme)*

Annex 2: Draft Job Description - Monitoring and Evaluation Adviser, Ministry of Health

Background

Danida has supported the health sector in Ghana for almost two decades, and a fifth phase is planned from 2012-2016. Support to the Ministry of Health will be through sector budget support and technical assistance using the Government's policy and planning framework, monitoring system and the public financial management system.

Overall comprehensive planning, financial management systems and review processes are in place, but need further strengthening to ensure more efficient use of financial and human resources. Weak monitoring systems hamper the availability of data for tracking progress and outcomes, for planning and decision-making and for developing evidence-based policies.

Well-functioning monitoring and evaluation systems are central for the Ministry of Health to effectively perform its stewardship role in the sector. The Ministry of Health intends to develop an active programme of research, monitoring and evaluation at all levels. A comprehensive framework for monitoring and evaluation and research is currently under development and will include strengthening of information management, documentation and reporting systems within the Ministry of Health and its agencies.

The Policy, Planning, Monitoring and Evaluation Directorate (PPME) in Ministry of Health consists of the Monitoring and Evaluation (M&E) Unit; Policy Analysis Unit, Planning and Budget (PBU), Private Sector Unit, External Aid Coordination Unit; and Project Management Unit

The four major areas of responsibility of the M&E Unit are:

a) Production of information for decision-making (e.g. evaluations, productivity analysis, service availability mapping, policy briefs, maintenance of information and database)
b) Production of regular sector reports (e.g. annual performance reviews, annual and quarterly reports, MDBS report)
c) Monitoring (e.g. of joint decisions in aide memoire, implementation of programmes of work, budget execution, health partners joint monitoring, health matrix network etc.);
d) Evaluation (Evaluation of health sector performance, policies, programmes, health investment/infrastructure, and special initiatives)

Acknowledging the importance of M&E in the sector, the Policy Planning Monitoring and Evaluation (PPME) Directorate of the Ministry of Health was restructured this year (2011) and an M&E expert was assigned to head the unit. The staff strength of the unit however, remains low and efforts are being made to strengthen the unit.

Objective

The long term objective for posting a Monitoring and Evaluation advisor at the M&E unit is to have an M&E Unit that works as a team player within PPME and effectively delivers high quality monitoring and evaluation reports as well as carry out its technical support function to the agencies.

Scope of Work
The M&E advisor will be placed in the M&E unit of the Policy Planning, Monitoring and Evaluation Directorate (PPMED) of the Ministry of Health and report to the Director of PPMED with the Head of M&E as the direct counterpart. The adviser will help institutionalise the health sectors holistic assessment in the M&E unit, build capacity and also work closely with other units and agencies to strengthen the overall M&E system and to allow the M&E unit to focus on use and analysis of data rather than chasing reports. Presently, comprehensive data for routine monitoring and evaluation are not readily available while evaluations are rarely carried out. Capacity for M&E activities including the holistic assessment of the sector remains low at all levels.

The advisor will be tasked to carry out the following tasks among others:

- Assist the M&E Unit to institutionalise the application of the holistic assessment tool to assess sector performance
- Assist the M&E Unit to evaluate programs, projects and special initiatives to enable PPME as a whole meet its M&E obligations
- Assist in developing and implementing a capacity building plan for the M&E Unit, defining desired end-of-period competencies and including targets and milestones to be achieved during the support period
- Build capacities of staff to more systematically and effectively monitor and evaluate the health policies and initiatives as set forth by the Ministry of Health.
- Assist in developing and operationalising the M&E Strengthening Plan for the sector
- Facilitate increased collaboration between Ministry of Health M&E Unit and the monitoring staff in the health agencies to increase the quality of data
- Enhance the capacity for use and maintenance of District Health Information Management System by the M&E and other PPME staff
- Assist in any other activities that will enhance M&E efforts and capacity in the sector

Qualification
The advisor will be a health systems or similar professional with at least a Masters level degree and with qualifications/experience in at least Public Health and Health Planning. Professional experience with programme/project/policy implementation and monitoring in the public sector (especially with local authorities focus) will be an advantage.

- Theoretical background at M.Sc. level in health systems, health planning or similar
- Experience/qualifications in public health
- Experience/qualifications with health information systems and databases
- Experience with institutional development, training of trainers, teaching, operational research will be an advantage
- Demonstrated ability to mentor and coach staff
- At least 5 years of experience from working in developing countries
- Skills in interdisciplinary co-ordination and communication
- Fluency in spoken and written English.
- Computer literate
- Fluency in spoken and written English

Annex 3: Draft Job Description - Public Financial Management Adviser, Ministry of Health

Background

Danida has supported the health sector in Ghana for almost two decades, and a fifth phase is planned from 2012-2016, mainly with sector budget support, relying on one policy and planning framework for the sector, the MOH monitoring system and the public financial management system, and complemented by technical assistance to improve performance.

The SWAp is well-developed in Ghana and MOH has throughout the years taken strong ownership to the process. Overall comprehensive planning, financial management systems and review processes are in place, but need further strengthening to ensure efficient use of financial and human resources and value for money. Despite the existence and operationalisation of relevant regulation, there remains non-adherence to some financial rules and other due processes. A major contributory factor is the insufficient knowledge of these regulations at practical level and insufficient capacity at the various levels of financial management. The matter is further worsened by structural rigidities which tend to weaken coordination amongst PFM operators. This results in some side-stepping of processes, procedures and the non-optimisation of scarce funded resources.

A Public Financial Management Strengthening Plan has been developed, but the implementation has been slow. The MOH is increasingly coming under pressure from the Parliamentary Select Committees on Health and Public Accounts, Civil Society groups, Ministry of Finance and Office of the President to deliver improved outputs/outcomes to justify resources allocated to the sector, and strengthening public finance management throughout the sector has moved on to the centre stage of governance and improved accountability.

The MOH in its Health Sector Medium Term Development Plan (2010-13) intends to implement the PFM Strengthening plan fully as part of the strategy to "Develop capacity to enhance the performance of the national health system". Furthermore, the MOH has been enrolled under the first phase of the introduction of the Ghana Integrated Financial Management Information System (GIFMIS).

The Policy, Planning, Monitoring and Evaluation Directorate (PPME) in Ministry of Health now consists of five units: Monitoring and Evaluation (M&E); Policy Analysis Unit (PAU), Planning and Budgeting (PBU); Private Sector Unit (PSU) and Project Management Unit (PMU), formally the Capital Investment Management Unit. (CIMU)

Objective

The main objective for posting a Public Financial Management Advisor to Policy, Planning, Monitoring and Evaluation Directorate (PPMED) to work within the Planning & Budgeting Unit is to support: (i) improved budgetary, financial accounting, and procurement processes at all levels of the health sector; and (ii) strengthen internal controls. This will include assistance in the continued implementation of the PFM strengthening plan.

Scope of Assignment

The Advisor will be placed in the PPMED of the Ministry of Health and report to the Director of PPMED. The Head of the Planning and Budgeting Unit (PBU), will be the direct counterpart, but the adviser will work with capacity building of all staff in the unit. The adviser will also work closely with other units and agencies to strengthen the overall PFM system.

The technical assistance will, in the main, include, but not be limited to:

a. Assisting in the continued implementation of the PFM Strengthening Plan.

b. Assisting in developing a capacity building plan for the PBU, including targets and milestones to be achieved during the programme support period

c. Developing, in close collaboration with the PPME, systems and models to capture and analyse budget information in respect of budget execution and tracking of flow of funds and expenditures across the sector;

d. In relation to the above, work closely with PMU to review the budgeting & planning, disbursement and flow of funds for investment (item 4), including links to planning for future recurrent expenditures.

e. Assisting in the follow up on the first phase of GIFMIS and in the roll out, including strengthening the working relationships between the GIFMIS implementation teams in MOH and its agencies, especially GHS.

f. Assisting in the development and implementation of a plan that systematically addresses the issues that will be identified in the study planned for 2011 on bottlenecks in flow of funds to health facilities.

g. Assessing, with the relevant directorates of the Ministry, the current financial, accounting, procurement, stores and internal control systems and interface, identifying weaknesses, and suggesting plausible measures to improve financial management throughout the sector;

h. Review, in close collaboration with the sector, the current health financing mechanisms, and especially the areas of resource deficits, equity, and sustainability, and advise the Ministry on plausible ways to improve health financing and increase coverage;

i. Assisting the team working on the National Health Accounts module; and

j. Working closely with the Directorates of Finance, Internal Audit, and Procurement & Supplies, as well as the PPMED and General Administration of MOH to prepare a capacity building plan and oversee its implementation.

Qualifications

- At least a Master's level degree in Financing and Accounting, Economics with specialisation in public finance, or Health economics with substantial working experience in health financing and management; and conversant with the operations of the health sector.
- Demonstrated experience in budget modelling and analysis as well as those of public financial management systems
- Public sector experience, preferably in the health sector
- Demonstrated ability to mentor and coaching of staff
- Experience in training of trainers, teaching, operational research, will be an advantage;
- Excellent communication skills and fluency in English

Annex 4: Draft Job Description – Strategic Planning, Monitoring and Evaluation Adviser, NHIA

Background

The financing and provision of health care for the citizenry has been a major challenge facing governments of many countries in the world. Since independence, several types of health financing mechanisms have been introduced, ranging from a universal tax funded system of health care delivery, through partial cost recovery to a complete cost recovery. These financing mechanisms had numerous challenges and as response, the National Health Insurance Scheme (NHIS) was established in 2003.

The National Health Insurance 2003, Act 650 which seeks to secure the provision of basic healthcare services to persons resident in Ghana through district mutual, private mutual and private commercial health insurance schemes. Government has elected to support the district mutual schemes as part of its social intervention programs intended to provide financial risk protection in health care access for residents in Ghana. Currently 145 districts, municipal and sub-metro health insurance schemes are operational throughout Ghana. The National Health Insurance Authority (NHIA) is responsible for the registration and licensing of health insurance schemes in the country. It also has the role of monitoring and supervising the operations of schemes, granting of accreditation to healthcare providers and monitoring their performance for efficient and quality service delivery. The Authority is responsible for managing the National Health Insurance Fund and devising mechanisms to ensure that indigents are adequately catered for under the NHIS.

Planning, Monitoring and Evaluation Gaps

The Strategy and Corporate Affairs Division was established to provide strategic direction to the NHIA. It is responsible for planning, monitoring and evaluation at the corporate level. There are, however, capacity gaps in terms of numbers and expertise in this area. Besides, since its nationwide rollout in 2005, the NHIS has evolved to become the preferred healthcare financing plan for residents in Ghana dealing with about five thousand (5,000) Health Care Providers throughout the country. There is also growing pressure on the NHIS to improve services, and performance towards clients, stakeholders, and the general public. In order to fulfil this, an efficient and effective monitoring and evaluation system is needed.

To ensure quality of service at both the scheme and provider sites, there is the need for regular monitoring of schemes and their accredited providers. The NHIA therefore established Regional Offices to monitor the operations of the District Schemes (DMHIS) and Health Care Providers (HCPs) to ensure that they conform to policies and procedures of NHIS in order to achieve efficiency and effectiveness and provide quality services to its clients.

However, inadequate technical capacity in planning, monitoring and evaluation resulting in weak monitoring and evaluation activities, poor reporting and dissemination of findings and poor feedback system hinder management from achieving its intended purpose effectively. There is therefore the need to build and develop capacity and institutionalise M&E within the NHIS. Improving the M&E

system will contribute to providing evidence-based information for management to streamline and improve interventions to address current challenges including sustainability and improve the scheme's operations. Acknowledging monitoring and evaluation as key management tool as well as critical success factor to the NHIS, management finds the need for a technical advisor whose duty will among other things; provide coaching and mentoring to staff of relevant division(s) in addition to any off-site competency-based training programme that may be deemed necessary.

Objective

The long term objective for requesting technical assistance in strategic planning, monitoring and evaluation is to strengthen the Strategy and Corporate Affairs Division, institutionalise M&E within the NHIS and build internal capacity in planning, monitoring and evaluation for the NHIS.

Scope of work

The technical advisor will be placed in the Strategy and Corporate Affairs Division and report to the Director of Strategy and Corporate Affairs. The Deputy Director Strategy will be his/her counterpart.

The advisor will primarily provide technical support to the Strategy and Corporate Affairs and Operations Divisions in the development and designing of a results-based Medium Term Development Plans, Annual Programme of Work and Monitoring and Evaluation System to track performance of the NHIS as well as build internal capacity in Strategic Planning, and Monitoring and Evaluation.

The technical assistance will include, but not limited to the following:

Partner and collaborate with the NHIA to:

- Design and institutionalise an effective M&E system for tracking performance within the NHIS.
- Develop internal capacity in M&E for a sustained monitoring and evaluation of the entire operations of the NHIS.
- Develop internal capacity in strategic planning and output/outcome-based budgeting within the NHIS.
- Identify internal talents in strategic planning, monitoring and evaluation for further development to assure sustainable succession plan in Planning, Monitoring and Evaluation within the NHIS.
- Assist in coordinating planning, monitoring, and evaluation activities among the various divisions.
- Participate in the development and review of NHIA corporate strategic plan and annual programme of work.
- Assist in ensuring that NHIA programme planning, monitoring and evaluation tie in with the National Health Policy and national development agenda.
- Advice management on all issues related to results-based planning and management, monitoring and evaluation.
- Assist in the preparation of annual monitoring and evaluation plans for the NHIA/S.

- Provide technical support to all the divisions within NHIA and M&E offices in the regions with regard to results-based planning, monitoring and evaluation.
- Assist in the preparation of quarterly and annual standard progress report for submission to NHI Council.
- Assist and participate in regular field monitoring visits to the regions.
- Assist in ensuring compliance with the mandatory monitoring and evaluation activities within the NHIS.

Qualification of candidate

The advisor should possess:

- At least, a Masters degree in Health Policy, Planning and management or Health Economics or Sociology.
- At least 5 years working experience in programme/project/policy implementation in the public health sector in low and middle income countries.
- Experience in health systems strengthening, including health policy and financing/economics (including health insurance) in developing countries will be an advantage.
- Strong analytical and strategic thinking and committed to achieving results.
- Ability to organise work effectively and to meet planned deadlines.
- Demonstrated ability to work harmoniously with persons of different backgrounds.

Annex 5: Draft Job Description - Health Systems Adviser, CHAG

Background
Danida has supported the health sector in Ghana for almost two decades, and a fifth phase is planned from 2012-2016. One of the components in the present as well as the new phase has been funding and technical support for institutional development of CHAG.

Since 2010, there has been an increasing recognition, within CHAG, that activities of its member facilities must more clearly focus on impacting national health outcomes. CHAG has adopted performance management as a strategic approach to improving the output and impact of the health systems of member institutions and CHAG as a whole. Health Systems Strengthening has been adopted as the model for supporting member institutions.

A 'Health System Strengthening' (HSS) group has been established at the Executive Secretariat [2010] with a view to:

- support member institutions in efficiently and effectively manage pro-poor service provision towards improving access to and quality of services;
- participate in the national policy dialogue by articulating CHAGs position on relevant issues;
- promote strategic partnerships that will enhance CHAG's contribution to the national health development.

The HSS group is made up of an inter-disciplinary team of professionals in the areas of health planning & management, health financing, HRH, public health and performance management. There is an identified need to further strengthen this team in HSS.

Objective
At the end of the programme support CHAG will have a well-functioning HSS team that provide high quality technical support to member institutions on demand and provide high quality inputs to the policy dialogue.

Scope of Work
The Senior Health Systems Adviser will be based at the Executive Secretariat of CHAG in Accra and shall report to the Executive Secretary. He/she will provide direct technical support to the members of the HSS group and indirectly to the health facilities, Church Health Coordinating Units and training schools.

Tasks and responsibilities will include but not necessarily be limited to the following:

- To assist the HSS unit in overall data analysis for performance-based planning and decision making;
- To assist the HSS unit in preparing user-friendly tools for diagnosing reasons for underperformance at health facility level and options for addressing identified weaknesses;
- To provide technical support in preparing and implementing HSS capacity development programmes at facility level upon request;

- To provide technical and methodological input in the preparation of the Executive Secretariat's Annual Work programme and CHAG's comprehensive annual progress reports;
- To assist members of the HSS unit in preparing evidence-based summary documents for policy, planning and advocacy purposes;
- To initiate HSS training at the training schools, affiliated to CHAG;
- To assist senior management of the Executive Secretariat in monitoring and review of technical progress on the Workplan and the Strategic Plan, including achievement of indicators and milestones.

Required qualifications

- The adviser will have a relevant academic degree and post graduate qualification in public health;
- Minimum of 10 years working experience in developing countries in the field of operational health planning and health system strengthening;
- Experience in training of trainers, teaching, operational research, curriculum development and quality assurance will be an advantage;
- Excellent, communication, writing and presentation skills;
- Demonstrate ability to mentor and coach senior management staff
- Demonstrated ability to work in a multi-disciplinary team of professionals;
- Willingness to travel widely in Ghana.

Time allocation

An initial period of two years commencing from 2012 is envisaged with a possibility of extension.

Annex 6: Selected indicators

For internal reporting purposes RDE will report on selected indicators. These indicators are chosen from the indicators and milestones agreed as part of the SMTDP and the CHAG SPPW.

Table 3 Indicators for Danida Internal Reporting

Indicator	Baseline (year)	Targets for 2016*	Sources of data	Institution responsible	Frequency
Overall programme indicators					
Maternal Mortality Rate (MMR)	451 per 100,000 live births (2008)	226 per 100,000 live births	DHS	MOH	Five yearly
Under-five Mortality Rate	80 per 1,000 live births (2008)	< 50 per 1,000 live births	DHS	MOH	Five yearly
Contraceptive Prevalence Rate	16.7% (2008)	To be established	DHIMS	MOH	Yearly
Holistic assessment of the health sector **	Green	Green	DHIMS Sector Review	MOH	Yearly
Component 1 Indicators					
Equity index: NHIS Poverty (Ratio lowest quintile to whole population, who holds NHIS cards)	To be established	To be established	DHS or GLSS	MOH	Five yearly
% of population with valid NHI membership card	45% (2009)	75%	NHIA registers	NHIA/MOH	Yearly
% deliveries attended by trained health worker	48.2% (2010)	65%	DHIMS	MOH/GHS	Yearly
HIV+ prevalence rate among pregnant women 15-24 years	2.0% (2010)	<1.6%	Surveillance reports	MOH/NACP	Yearly
Component 2 Indicators					
Annual median patient satisfaction score	Yet to be determined	80%	Survey	CHAG Secretariat	Yearly
Institutional maternal mortality rate	181 per 100,000 live births (2010)	91 per 100,000 live births	Service output data from member institutions	CHAG Secretatiat	Yearly
Annual overall organisational capacity assessment score of CHAG Secretariat***	2.5	5.0	Independent assessor	CHAG Secretariat	Yearly

* Targets for the programme and component 1 indicators are from the SMTDP (2010-13). The targets will be aligned to government targets for 2016, when they are available.

** The Holistic Assessment assesses progress towards achieving the objectives of the Annual Plan and the SMTDP (2010-2013) based on clusters of sector wide indicators and milestones. Ranking from highly performing (green) – attention needed (yellow) - not performing (red).

*** Stage of System Development, scores from 1-6 with the stages of Nascent (1.0-1.4), Emerging (1.5-2.9), Expanding (3.0-4.4) and Mature (4.5-6.0).