Joint Assessment (JANS) of Ghana's Health Sector Medium Term Health Development Plan (HSMTDP) 2010 - 2013

JANS mission report

Final version

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The JANS team wishes MOH and its partners all the best in finalising the Health Sector Medium Term Development Plan.

René Dubbeldam, team leader JANS team

Accra, Reet, November 2010

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This independent JANS team was supported by the JANS support group:

JANS support group

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Introduction

During 2009 and 2010, MOH and its partners have developed[1] the draft 4-year Health Sector Medium Term Health Plan 2010-2013 (HSMTDP) [29], based on guidelines [52] issued by the National Development Planning Commission (NDPC). Under the guidance of this Commission, all sectors in Ghana are currently developing sector medium-term development plans covering the same period. This is a legal requirement by the Constitution. The HSMTDP replaces the current Programme of Work III (2007-2011). [27]

The Ghanaian government requested assistance of a JANS team (Joint Assessment of National Plans and Strategies) to assess the current draft HSMTDP. The latest version of the draft HSMTDP was released on 29th October 2010 and included the results of a costing exercise. All comments on the HSMTDP and references made are based on this draft version.

The main perceived added value of a joint assessment of the HSMTDP is to create an opportunity for strategic discussion in order to strengthen the plan. Related expectations are that the assessment will increase stakeholder confidence in the plan; help to get more partners on-plan and on-budget, and reduce at least some of the burden of separate appraisals / proposal preparations. The independent element is desired in order to provide a fresh, systematic perspective on the plan.

The timing of the joint assessment mission allowed for an in depth review using the JANS tool[2] on an advanced but not final draft of HSMTHP 2010-2013.

The objectives of the joint review, as per TOR (see annex 1) are:

- To make a joint assessment of HSMTDP 2010-2013 using the JANS Tool and accompanying Guidelines as the guiding framework [3]
- To present and discuss the analysis of strengths and weaknesses of HSMTDP 2010-20123 with senior policy makers and other stakeholders, and possible courses of action on specific issues.

More specifically, the review is supposed to produce an assessment profile of the strengths and weaknesses of five sets of attributes (see also the shortened JANS tools in annex 4.5):

1. The situation analysis, coherence of strategic plan with that analysis
2. The process through which the national plans and strategies have been developed; alignment with national development frameworks, multi-sectoral strategies
3. Adequacy of financing projections and strategies; financing and auditing arrangements
4. Implementation and management arrangements, including for procurement
5. Results, monitoring, review mechanisms

[1] Annex 4.7 presents the timeline of events.

[2] See annex 4.5 for the shortened version of the JANS tools.

[3] http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_guidelines_EN.pdf

The review took place from November 4-15 2010. On November 15th, the JANS team presented its findings to the MOH and partners. Annex 4.10 includes the slides used for this purpose. A week later, the JANS team leader presented the findings again during the Health Summit on 22 November 2010.

During the review, the JANS team liaised closely with the local 'support group', consisting of experts from Ministry of Health, Ghana Health Service, WHO, CHAG, and the Ghana Coalition of NGOs in Health. This group provided logistical support and critical feedback to the JANS team on preliminary observations and conclusions. The JANS team had access to most key stakeholders and institutions relevant to the assignment, including top-level officials of different ministries. Annex 4.2 presents the list of persons met, and annex 4.3 outlines the mission schedule. For most of the interviews, questionnaires were developed (annex 4.4) and adapted for other meetings; minutes of the meetings were kept.

This report is organized along the 5 main set of attributes of the JANS tool. Main observations (summary of all findings and recommendations, with a view to inform high level policy makers) are summarized in section 1. Section 2 presents a brief 'road map' for finalizing the plan. Section 3 reports on the strengths, weaknesses and proposed actions for each of the five main attributes. In this report, attributes with similar or related information have been cross-referenced in the footnotes.

A full report on lessons learnt will become available separately.

1. Main observations on the draft HSMTDP 2010-2013

This chapter summarizes the main observations made by the JANS team, for each component of the JANS tool (see annex 4.5). Strong features of the draft HSMTDP are summarized followed by challenges and recommendations. These have also been presented during the debriefing and during the Health Summit on 22 November 2010 (see annex 4.10 for the PowerPoint presentation). In subsequent chapters, more detail is provided for each JANS attribute.

Situation analysis and programming in the HSMTDP

The draft HSMTDP 2010-2013 [29] is consistent with the guidelines [52] provided by the National Development Planning Commission (NDPC) to all sector ministries. It includes an adequate overview of the epidemiology of communicable and (a partial analysis of) non-communicable diseases, and also adequately describes current trends in health services outputs over the last five years using the sector wide indicators

Further, the HSMTDP clearly indicates that the Government aims to achieve health gains, related to MDGs 1, 4, 5, 6 and 7. The plan has a clear focus on Primary Health Care, by strengthening decentralized district health systems. The plan is consistent with existing disease control policies and strategies adopted so far, and its conclusions are evidence-based.

The plan also focuses on promoting an equitable allocation of resources (geographical; socio-economic), and includes an analysis of progress made on 'bridging equity gaps' using relevant sector-wide indicators.

The plan includes measurable 'milestones' to be achieved during the implementation period.

However:

The situation analysis within the draft HSMTDP has not yet captured the key problems, challenges and recommended strategies that have been described in annual reviews and in existing health-sector related strategies. In the draft plan, among the many sector challenges that were mentioned, no clear priorities were set. Given the short time frame available for the plan period, the final draft of the HSMTDP needs to present a well-described analysis of the most important and immediate problems as well as underlying issues that justify objectives, priorities and strategies outlined in the plan.

Strategic options and choices made merit to be made more explicit. The plan could include examples of 'best practices' that supported decision-making on strategic choices. The importance of and efforts to utilize applied health systems research to further build evidence to inform decision-making could be better highlighted in the plan.

Although the plan clearly indicates that health gains are to be achieved through PHC and district health systems, the 'systems approach' is not yet translated into a clear HSS approach, covering all aspects of health systems strengthening, including issues related to fragmentation ('silofication' [5]).

Therefore, the situational analysis needs to be reviewed for coherence to more explicitly link identified problems to objectives and to priority strategies and desired outcomes. In this review, the

five Strategic Objectives may need to be re-evaluated and/or reformulated. This may require discussion and negotiation with the NDPC.

Gaps to be addressed in the final draft of the HSMTDOP 2010-2013:

The following topics and issues have been described in strategy documents and reviews, and need to be addressed in the HSMTDP (some of these are also discussed under JANS components 2-5):

- Pending issues in strengthening district health systems, as described in e.g. the annual review of POW-2009 [5]: limited flexible funding to support local planning and implementation of basic health services; strengthening 'leadership' at the district level; strengthening linkages between top-down and bottom-up health planning.
- Strengthening the stewardship ('oversight') and leadership role of MOH;
- Strategies to address identified sustainability issues regarding NHIS;
- Strategies regarding all aspects (and not only supply management) of the implementation of the national medicines policy (policy development; regulation and inspection; supply management; rational use of medicines);
- Establishing a comprehensive M&E framework, to support the stewardship role of MOH;
- Intersectoral action, to achieve health gains;
- Involvement of the for-profit private health sector, for the public cause; and
- Strategies for health systems strengthening, including Public Financial Management (PFM).

Costing and financing

The HSMTDP includes a clear section on costing. The costing exercise used a combined 'Marginal Budgeting for Bottlenecks' (MBB) and 'activity cost model' approach [8]. Moreover, three costing scenario's have been developed (status quo; conservative; ambitious). The ambitious scenario was included in the HSMTDP.

The costing was made on the assumption that the MDG goals will be met by the end of the plan period. The adopted ambitious scenario would support a 31% reduction in maternal mortality and a 44% reduction in under-five mortality; these reductions would put Ghana on track for MDG 4 and MDG 5 attainment by 2015.

Priorities in capital investment planning, based on the ambitious scenario, reflect a focus on district health care services (i.e. capital budgets have been revised downwards and investments at the regional level have been reduced, while investments in Community Health Planning and Service (CHPS) compounds have been increased). All the district level hospitals included in the investment plan are those who's financing are reported to have been secured. The costing includes plausible recurrent cost implications of the capital investment planning.

A clear fiscal space analysis was made in the plan in which GOG and DP contributions are well described. The assumptions used to project GOG overall and health spending are clearly presented in the plan. Resource flows are clearly shown in an easy to understand chart.

However:

The basis of the unit costs (being an important cost driver) in the capital investment plan (e.g. the cost of a new district hospital) has not been adequately justified in the draft plan as they seem to be set on the higher side. The final draft of the HSMTDP could either justify the higher unit costs or

revise it downwards if evidences support this revision. Further, the level of service coverage targets set in the costing exercise – another important cost driver – may not always be feasible, considering the short implementation period (e.g. the increase in assisted deliveries from 47% to 82%; % complicated deliveries receiving adequate EOC from 30% to 85%, etc.; see annex 1 of [8]).

The HSMTDP indicates that GOG contribution will grow 1% (of the public budget) per year. However, given the downward trend in GOG contribution over recent years, this projected level of increased allocation needs to be justified. .

The fiscal space analysis does not yet include a risk analysis. This needs to be added in the final draft.

The draft HSMTDP has not yet addressed strategies to improve the efficiency of using existing resources. Various analyses, including recent annual reviews, have indicated opportunities to gain efficiencies (e.g. on supply management; gatekeeper function of district health services; maintenance). Therefore, the HSMTDP would need to include strategies that will help gain efficiencies in resource use and provide better health for the money invested (value-for-money).

The draft HSMTDP should also address the – already identified – strategic challenges for health financing, regarding the National Health Insurance Scheme (NHIS) (i.e. financial sustainability of NHIS; efficiency of claims management; equity issues (regressive socio-economic profile of enrolees).

Financing and audit

The HSMTDP refers to key documents and rules and regulations governing the financial management and audit system in Ghana. Therefore, it is implicitly consistent with the national rules and regulations and standards.

The National PFM legal framework, which applies to all MDAs, is in general well crafted and adequate – and comparable to international standards. The HSMTDP refers to it, and refers to the existing Accounting, Treasury and Financial Reporting Rules and Instructions (ATF). This was updated and has been in effect at MOH and all its BMCs as of January 1, 2010.

However:

Despite several positive actions and progress in addressing the FM and fiduciary issues, several challenges remain. The final draft plan needs to highlight the remaining FM issues to be addressed.

Implementation and management

The roles and responsibilities of key actors in the health sector are adequately described. The plan refers to the Common Management Arrangements (CMA III) [31].

In general, the HSMTDP reflects well the existing strategies on HR Development and HR Management [26].

The plan includes a set of 'milestones', regarding the implementation of the five Strategic Objectives (SO).

However:

The plan lacks a description of approaches to strengthen the stewardship role of the MOH, and 'leadership' at all levels.

Further, the paragraph on HRD is incomplete, and does not address the increasing demand for human resources as a result of the capital investment planning (see section for 'costing').

The draft HSMTDP has not developed clear views and strategies to address the known constraints and challenges regarding supply management. Although the plan claims to reform Central Medical Stores (note that an options appraisal was done a decade ago, and issues raised in the appraisal are still pending), it remains unclear what these reforms entail, and what milestones would be envisaged during the implementation period of the HSMTDP [57, 22, 17], nor does it refer to previous recommendations and strategies on how to reform the CMS.

Other elements of the implementation of the essential medicines policy [17] are equally lacking. The final draft of the HSMTDP could provide a short overview of priorities for the next three years with regard to the medicines policy: policy development; regulation and quality assurance; supply management[4]; and, rational use.

Monitoring and Evaluation

The HSMTDP confirms the importance of information for health systems governance. This is most relevant given the stewardship role of the MOH, overseeing a number of autonomous agencies with specific mandates, in an increasingly complex health sector.

A strong element in the current M&E system is the annual review process, including sector performance indicators, and the existence of a nationwide health information system. The HSMTDP builds on these elements.

However:

The situation analysis lists a number of previously developed plans and strategies for health information that have not been implemented due to lack of funding. No analysis is offered as to why this has been the case. Although the importance of good health information is stressed under SO2, the lack of analysis diminishes the expectation that M&E will receive higher priority in the implementation of this HSMTDP 2010-2013.

The selected indicators for the HSMTDP currently focus on implementation by the MOH and its implementing agencies. The final draft of the plan could include indicators on mutual accountability with regard to: degree of alignment of DPs; timeliness of transferring funds (DPs; Ministry of Finance).

[4] Note that current medicines prices in Ghana are in general 3 times higher than the average mean international prices [28, 57].

Process of developing the HSMTDP (component 2 of the JANS[5])

During the development of the draft HSMTDP (annex 7), many relevant stakeholders provided inputs: Development Partners; MOH agencies and partners (GHS; CHAG; regulatory bodies); regional and district health authorities; civil society; members of Parliament; other Ministries. Various committees were created (annex 8) and meetings held to discuss and develop draft sections and versions of the plan.

However, it was noted that the NDPC guidelines, process and timeline for the development of sector plans limited broad and open thinking about objective-setting in particular. In addition, systematic feedback by the MOH to stakeholders on which suggestions were and were not taken on board, was not provided. There are some indications that some agencies within the sector have not been effectively engaged during the development of the plan, and overall involvement by stakeholders during different stages of plan development was not uniform. These challenges in the process have therefore resulted in weak 'buy-in' by some stakeholders. During the final stages of preparing the HSMTDP, it will be important to optimise the policy dialogue so as to ensure a greater buy-in at the end of the process.

[5] Although this component was the 2nd out of 5 JANS components, the summary of it is deliberately put at the end of this chapter, to improve readability.

2. Proposed process / action plan to finalise the HSMTDP 2010-2013

In Ghana, many robust policies and strategies exist, and much information is available on strategic choices from past annual health sector reviews, and relevant research. The JANS team proposes that the MOH and partners fully exploit the available information from these sources, in order to finalise the HSMTDP. It was proposed to do this under the guidance of the Chief Director of the MOH and the Inter-Agency Leadership Council (IALC). This process would be accomplished during the next one to two months.

First, it was discussed during the debriefing with the MOH, the possibility of the MOH organizing a small workshop with high-level MOH and GHS staff, key partners and stakeholders to review the problem analysis, to identify key problems and underlying problems ('problem tree'), and to translate these into clear and 'sharp' strategies. The strategic objectives could be reformulated to reflect the revised strategies. The country office of WHO, as 'lead DP', could play a facilitating role in this process.

After the workshop, a task force would be in charge of finalising the plan with a timeline of approx. 1 month.

3. Assessment of the draft HSMTDP 2010-2013[6]

3.1 Situation analysis and programming

Situation analysis and programming – Soundness of analysis/assessment underlying identification of the programming contained in the national strategy
Attribute 1 – 1.1-1.3; Attribute 2 – 1.4-1.5; Attribute 3 – 1.6-1.9; Attribute 4 – 1.10

Strengths

Attribute 1-4 (cross-cutting)

- The draft HSMTDP 2010-2013 [29] clearly indicates that the Government aims to achieve health gains, related to MDGs 1, 4, 5, 6 and 7. The plan has a clear focus on Primary Health Care, and on strengthening health services at the district and sub-district levels. The plan is consistent with existing disease control policies and strategies adopted so far [35, 36, 37, 38, 39, 40, 41, 47, and 49]. Disease control- and other health strategies are generally evidence-based.

- The health sector plan (Health Sector Medium Term Development Plan 2010-2013 is aligned to overall Country strategic framework (Medium Term National development Policy Framework: Ghana shared Growth and Development Agenda (GSGDA, 2010-2013) [10, 11, 52].

- The situation analysis[7] provides relevant information (with some gaps: see 'weaknesses') about health outcomes. Further, it highlights some key problems with child- and maternity care[8].

- The plan also focuses on an equitable allocation of resources (geographical; socio-economic), and includes an analysis of progress made on 'bridging equity gaps' using relevant sector-wide indicators.

- The plan includes 5 Strategic Objectives (SO) with some measurable 'milestones' for each SO to be achieved during the implementation period.

[6] The assessment refers to the draft HSMTDP of October 2010, and uses the JANS tool and guidelines, as indicated above. The attributes refer to the numbered attributes and characteristics used in the JANS tool.

[7] Draft HSMTDP: in the two first chapters, as well as in Annex 1.

[8] The presentation of some data needs a critical review. For example, on page 9, the plan seems to infer from routine and survey data that the % of supervised deliveries is increasing. However, this increase is rather limited. A more cautious interpretation is warranted.

Attribute 1: Strategy based on sound situational and response analysis

- The draft HSMTDP provides relevant insight in health outcomes, including trends over the last five years (trends in IMR, U5MR, MMR; patterns of and some prevalence figures on communicable diseases;

  prevalence of non-communicable disease: obesitas; stagnation in nutritional status among children; continuing threats by HIV/AIDS, TBV and by neglected diseases such as Buruli Ulcer and Filariasis). Attention is given to the 'double burden of disease', and some figures are provided on non-communicable diseases and health risks, in particular obesitas.

- Further, the draft plan highlights some deficiencies in terms of health services outputs (coverage, utilisation, quality), e.g. poor coverage of comprehensive neonatal services; low access to Essential Obstetric Care; stagnating % of supervised deliveries; stagnation with Family Planning Usage.

- Proven cost effective interventions based on global evidence constitute the majority of interventions comprising the HSMTDP. Maternal, newborn and child health were accorded priority during previous 5-years POWs, and this emphasis is retained in the HSMTDP. Further, HSMTDP aims at strengthening prevention and control of some non-communicable risks and conditions, i.e. lifestyle related conditions and mental health. The government has adopted internationally recommended standards and clinical guidelines to address the major causes of illness and preventable deaths in Ghana.

Attribute 2: Clearly defined priority areas

- The HSMTDP includes 5 Strategic Objectives (SOs):

  1. Bridge the equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
  2. Improve governance and strengthen efficiency and effectiveness in health service delivery, including medical emergencies
  3. Improve access to quality maternal, neonatal, child and adolescent health services
  4. Intensify prevention and control of non-communicable and communicable diseases and promote healthy lifestyle
  5. Strengthen institutional care, including mental health service delivery

  Although their linkages with the problem analysis and their formulation can be questioned (see 'weaknesses' below), these SOs address a broad range of issues related to health outcomes, health services outputs, and institutional development in the health sector. Also, equity is prominently addressed by SO1 (although a more thorough analysis and comprehensive approach to equity are lacking).

- The Strategic Objectives are generally underpinned by time bound and measurable targets. For each SO, a (limited) number of measurable and time-bound milestones have been defined. (However, critical remarks are made in the section below on 'weaknesses'). Further, monitoring of the HSMTDP includes the follow-up of a set of sector-wide and SMART indicators. This set includes some specific indicators on equity (geographically; socio-economic; gender).

Attribute 3: Feasible, appropriate, equitable interventions based on evidence

- The HSMTDP refers to effective existing strategies and programmes on prevention and control of communicable diseases.
- Further, the HSMTDP focuses on strengthening health services at the district level and below. It claims that health gains can be made, by effective outreach services through the CHPS approach, and by strengthening the referral system and Essential Obstetric Care. The capital investment plan reflects these intentions (see also below, under 'costing').
- The HSMTDP acknowledges the importance of improving the quality of (primary) care.
- Interventions on disease prevention and control, and on mother- and child health, are based on evidence.

Attribute 4: Risk assessment

- The plan does not provide a proper risk analysis (see below), but does include a POCC table ('Potential, Opportunities, Constraints, Challenges'), covering 13 broad 'issues' (related to outcome, output, process and input: see below for a critical assessment).

Weaknesses

Attribute 1-4 (cross-cutting)

- The situation analysis within the draft HSMTDP has not fully captured the key problems, challenges and recommended strategies that have been described in annual reviews and in existing health-sector related strategies. In the draft plan, among the many sector challenges that were mentioned, no clear priorities (health problems; health services; various pillars of HSS) have been set yet.
- There is a lack of clear prioritization. The plan does not set out a clear and relatively short list of priorities (e.g. 2 to 3 per SO?) that must be implemented in the next three years. Given the focus on maternal mortality reduction, the milestones of the HSMTDP are not sufficiently capturing MDG5.
- Although the plan clearly indicates that health gains are to be achieved through PHC and district health systems, the 'systems approach' is not yet translated into a clear HSS approach, covering all aspects of health systems strengthening, including issues related to fragmentation, regulation, stewardship and leadership of MOH and GHS at the various levels.
- The HSMTDP describes briefly in one table contributions by other Ministries to the health sector, but aside from additional references to the MoESW and MOE in the Sector Programme of Work, the document lacks clarity or references to specific activities that will be undertaken by other Ministries in relation to HSMTDP Strategic Objectives and timeline, and how these activities align with their individual sector plans.
- The draft HSMTDP does not include a national agenda for strategic health systems research.

Attribute 1: Strategy based on sound situational and response analysis

- Although the draft HSMTDP provides some relevant data on health outcomes and services outputs, it still lacks important information (to justify and/or adapt priority strategies) on:
    - Mental health. Mental health is mentioned as a priority (SO5). However, the situation analysis does not provide any substantial evidence for the importance of it in terms of an important public health problem.
    - Burden of (non-communicable) disease. The draft plan does not include an overview of the top-ten health conditions (in terms of OPD workload; inpatients).
    - Although the situation analysis shows regional differences in health status and health care (e.g. to show imbalances in terms of spread of disease such as nutritional status, and allocation of resources such as HR), it does not highlight inter-district differences. Yet, it is well known that in some regions, such as Greater Accra Region, large differences exist between districts, and that in urban areas some health indicators are much worse than the average (e.g. well documented large pockets of malnutrition in Accra-city). Therefore, resource allocation should also take these facts into consideration, and should not be solely based on regional averages.
    - In some cases, the situation analysis does not provide sufficient explanation about indicators showing poor results. For example, the plan mentions that the 'detection rate' for TB is only 36%. Compared to global standards (Stop TB Partnership), this rate is clearly disappointing. The final plan would need to explain such a situation, by e.g. pointing to the weak collaboration between formal health services (GHS; CHAG) and civil society organizations leading to a low detection rate. Appropriate strategies on public-private collaboration may then follow in the chapter on objectives and strategies.
    - Service provision, especially by the for-profit private sector. The draft HSMTDP is silent on the role the for-profit health can and should play to contribute to public goals (especially when the target is to reach the MDGs by 2015). Yet, recently, relevant baseline data have become available that is worth to be referred to [54]. Although the existing national policy on the private sector [42] is not explicit on involving and strengthening the for-profit private sector, the HSMTDP could consider to give this issue due attention, so as to enhance universal coverage to (primary) care.
    - Geographic gaps in basic health services including essential obstetric care at the district level. Although the official policy promotes 'one district, one district hospital', some (newly created) districts would need a district hospital (including basic obstetric services to provide emergency obstetric care: vacuum extractions, blood transfusions, caesareans) more than others (if one considers geographical access; population sizes; organisation of the referral system; location of tertiary care; health seeking behaviour; etc.). Recently, mapping studies have been undertaken to show priorities in expanding supply of district health services and EOC [EOC mapping survey; 14 – SAM]. The HSMTDP needs to refer to this data, so as to further justify the investment strategies[9].

[9] From the text in the draft HSMTDP '*The district profile exercise revealed that 54 districts, across all regions, have no hospital*.', the strategy on (selectively?) investing in district hospitals does not become entirely clear.

- Information on service coverage – and gaps in coverage – is sometimes difficult to grasp. For example, information on 'regional progress with the CHPS strategy' (see figure 4 in the draft HSMTDP, page 17) does not provide a clear overview of the needs in terms of numbers of CHPS compounds to be made operational, by region and by district. Without this insight, interpretation of absolute numbers of works in the capital investment plan remains complex for outsiders.

- Health seeking behaviour, in relation to the 'gatekeepers function' of PHC and district health. For several reasons (quality of care; costs of health services; efficiency gains), the draft HSMTDP rightly mentions the great importance of strengthening the gatekeepers function of decentralized health systems. The focus should be to treat as many patients at the appropriate level, i.e. in most cases at community- sub-district and/or district levels. Yet, the draft HSMTDP does not clearly refer to data on health seeking behaviour that shows current imbalances in the provision of health care. It is well known that regional and teaching hospitals are overburdened due to a large influx of OPD patients who have not been referred. The HSMTDP needs to address this important systemic issue. Proper analysis may lead to the conclusion that strengthening PHC and district health, rather than investing in tertiary care, is the logical strategic response to this problem. Such an analysis puts some decisions – such as the construction of a new regional hospital in Kumasi - in a more clear perspective.

- Implementation of the national medicines policy [17]. The Ghana National Medicines Policy includes 4 key elements: policy development (National Essential Medicines Lists; Therapeutic Guidelines), regulation (quality assurance; medicines registration; inspection; local production; TRIPS); supply management (procurement of commodities; distribution); and, rational use (prescribers, consumers). In the situation analysis, the draft HSMTDP has not adequately addressed these 4 core components of the medicines policy. It basically limits the situation analysis to supply issues[10] . Yet, relevant baseline data exist [57, 58] and needs to be referred to. Key problems, that need strategies for the short- and medium term, need to be identified subsequently.

- The description of the seven regulatory bodies (see Table 5 in the HSMTDP) is not detailed enough. Aside from recognition that regulatory capacity is weak under Strategic Objective 2, the HSMTDP lacks a description of what specific capacity needs to be strengthened and how this increased capacity will improve the health sector. The HSMTDP also lacks reference to pending legislation that aim to address regulatory issues and their implication for the health sector.

- The GOG has very recently (June 2010) completed the development of a new Decentralization Policy Framework and Action Plan. The implication of this strategy on the health sector is not reflected in the plan.

- Although the role of other Ministries and sectors in promoting better health is mentioned[11], the plan has not yet provided information on the type and scope of various activities undertaken by other sectors. The POCC table included one 'issue' on climate change and environmental factors,

[10] Draft HSMTDP: p. 19-20

[11] Draft HSMTDP: p. 22-23

but did not highlight the existing weak intersectoral dimension of health promotion. The final draft of the HSMTDP needs to make explicit if – and if so, how – intersectoral dimensions of health promotion will get priority.

- Although the draft plan explains the importance of PHC and district health care, it has not presented key problems and constraints, e.g. related to a lack of flexible funding for budget items 2 and 3 (due to a large proportion of funds being earmarked for programmes and services, rather than systems – see the analysis during the latest annual review [28]; and, to a lack of leadership at the district level. Considering the focus of the plan on PHC and district health services, the final draft HSMTDP needs to refer to these analyses, and needs to include strategies to address these crucial constraints. Further, the situation analysis has not addressed the linkages between – and constraints with - central health planning and decentralized, bottom-up planning. These gaps need to be addressed in the final draft HSMTDP.

- The importance of strengthening the 'stewardship' role by the central MOH is recognized by the HSMTDP. However, the situation analysis does not provide a clear view on current weaknesses, not on adequate responses. Indeed, with an increasingly complex health sector, stewardship by MOH is very important. The final draft HSMTDP therefore needs to include a specific strategy to strengthen this key role, based on a clear situation analysis.

- NHIA has become a powerful actor in the Ghanaian health system. The social insurance system has increased access to basic health services. At the same time, threats to the sustainability of this system have been documented [28, 53a]. Also, other challenges with regard to NHIS have been identified: efficiency issues with claims management; equity issues in further roll-out of the system (regressive SES profile of new membership); coordination between NHIA and MOH. However, the draft HSMTDP has not captured these constraints and challenges. Considering the vital importance of sustained social insurance, the HSMTDP needs to address challenges and threats, and propose a convincing strategy to address these.

- In general, for health services including SRH, the emphasis is much more on the supply than on the demand side (e.g. maternal health).

Attribute 2: Clearly defined priority areas

- The relation between the 5 SOs mentioned above and the problem analysis is not entirely clear. One reason is that the problem analysis itself lacks focus. Moreover, the formulation of the SOs shows that the SOs themselves are a 'mix' of interdependent and higher- en lower level issues: they cover health status improvement (i.e. SO3: MDG5; SO4: prevention and disease control); health service outputs (SO5 on institutional care; SO3 on maternal health services); process factors (SO2: governance; management); and input factors (SO1: bridging equity gaps, and strengthening health financing arrangements). These issues are of a different order, and are often interrelated. That is why the SOs are not mutually exclusive; this complicates their interpretation and also complicates the calculation of costs by objective (see later, under 'costing').

- Ideally, the SOs would reflect a limited number of key problems, which together are the underlying problems of the – higher-level – problem of stagnation in health status ('health outcome'). The basis of the formulation of objectives and related strategies would thus be a clear hierarchy of problems (e.g. health status / outcome at the higher level, and a number of key problems related to service outputs and process factors at a lower level): a logical 'problem tree'. The draft HSMTDP does not include such a logical problem analysis and the translation of it in a logical framework (Log Frame) of clear objectives and strategies.

- The number of priority activities proposed in the draft HSMTDP is very high:
  SO1: 6 strategies; 28 priority activities
  SO2: 8 strategies; 32 priority activities
  SO3: 4 strategies; 13 priority activities
  SO4: 5 strategies; 22 priority activities
  SO5: 6 strategies; 16 priority activities

Many of these priority activities are indeed relevant. However, their large number makes that the draft plan is not yet focused enough on a much more limited sub-set of key priorities. Partly, the (too) large number of priority activities can be explained by the formulation of (overlapping) SOs (and, thus, overlapping strategies and priority activities).

The POCC table also includes a rather high number (n=12) of 'issues'. There is no clear relation with the SOs, strategies and priority activities presented in the core text. The mix of 'issues' in the POCC table refers to problems related to: outcome (high IMR/MMR; high morbidity from communicable and non-communicable diseases; neglect of mental disease), supply/output of services (access, distribution of infra, referral system[12]), process (legal framework; governance & accountability; gender; environmental health), and input (low expenditure; weak social protection) aspects. Again, the POCC does not provide a clear picture on the 'real' priorities to be tackled in the short term. The POCC table is less explicit than the core text of the draft HSMTDP on strengthening PHC and district health.

In conclusion, by presenting large numbers of problems and priorities, often without a logical order or hierarchy, the draft plan is still not 'focused' enough on a limited number of key priorities. Lack of focus carries the risk of doing business as usual; allocating too limited resources to too many activities, with the risk that none of them are carried out well and do not contribute to real impact.

- For each SO, some milestones have been identified. The JANS team makes the following remarks:

    - SO-1 (bridging the equity gap) includes clear milestones (on the increased % of LEAP families benefiting from the NHIS).

[12] In the POCC table, problems with the referral system are mainly explained by a lack of ambulance services and a lack of investments in tertiary care. Surprisingly, the poor referral system is not explained by focusing on a poorly functioning gatekeepers role played by health centres and district hospitals (to ensure that the great majority of patients are treated at the district level or below, and that regional and teaching hospitals are only receiving patients that are properly referred by district health services).

- As to SO-2, it is confusing that 'governance' and 'services' are united in one SO. The milestones for SO2 focus on achieving MDG5 (through strengthened Essential Obstetric Care - EOC), and on patient rights. However, governance as such has not been translated into measurable targets/milestones.

- SO-3 (access to maternal- child- neonatal and adolescent health care). Milestones proposed focus on a variety of issues: midwifery certificate, delinkage of minors from parents, expansion of the EPI scope with new vaccines, and introduction of adolescent health services. However, MDG5 has not been specifically targeted over the period with milestones. Adequate emphasis on e.g. assisted deliveries by skilled personnel is not addressed in the milestones. This (i.e. the MDG5) should perhaps be the key focus, and clear targets/milestones for basic maternal care need to be set during this short implementation period of three years.

- SO-4 is related to MDG-6. In general, it appears that the milestones are measurable and relevant. However, milestones should also cover HIV/AIDS, malaria and TB, given that the HSMTDP is also an instrument for resources mobilization vis-à-vis the global initiatives (e.g. GFATM).

- SO-5 is related to institutional care. Apparently, mental health gets much focus and includes 2 milestones (out of 4). Further, strengthening the referral system (by developing a policy, and by strengthening ambulance services) is translated into 2 measurable milestones. However, it would also be needed to measure trends of OPD attendance (and inpatients) by level of care, so as to verify that imbalances due to a poorly performing gatekeepers function are redressed. Annual milestones could be set.

If the SOs are reformulated, based on key priorities, the milestones also need to be reviewed.

Attribute 3: Feasible, appropriate, equitable interventions based on evidence

- The plan does not comprehensively address TA requirements. This might be relevant, given the complexity of strengthening the stewardship role by MOH and developing consistent and complementary HSS strategies.

- The interventions proposed for disease prevention and control are all evidence-based, and based on Ghana's robust past experience with public health programmes.

- However, the draft HSMTDP is not very explicit on the type of interventions on Health Systems Strengthening. Apart from the need to identify clear priorities, the final draft plan needs to be specific on the implementation arrangements of these HSS activities and their expected results.

Attribute 4: Risk assessment

- Apart from the POCC table, the draft HSMTDP does not include a risk analysis. The final version of the plan needs to include one (see also below, under 'costing' and 'health financing'). The risk analysis should also include a short description of fall-back scenario's (i.e. 'priorities among priorities') in case the identified gaps in the resources envelope remain, and available resources are less than the projected resources envelope. Scenario development implies making sharp choices with regard to e.g. : type of health problems (e.g. MDG 4 and 5 versus other health problems), health services (e.g. primary care and district health services versus tertiary care), short-term vs. medium/long term priorities,

(e.g. fast improvement of EOC in deprived areas, versus general promotion of long-term methods in Family Planning[13], etc. The risk assessment would also include risk mitigation strategies.

Suggested actions / recommendations

- The situation analysis of the HSMTDP needs to include a clear and logical 'problem tree' consisting of one central problem (i.e. related to health status: IMR/MMR), and a limited number of underlying key problems (related to service outputs and HSS issues).
- Based on the problem analysis, the SOs need to be reviewed. The most logical approach would be to 'translate' the key problems and central problem into Strategic Objectives. A logical framework of SOs (including indicators and milestones, assumptions) could be prepared, to enhance the visibility of the logical relation between objectives and key activities.
- To ensure that the plan is focusing on key priorities, and that the implementation of the plan is feasible during the limited implementation period of three years, it is essential that the number of priorities be drastically reduced.
- To facilitate the logical formulation of SOs and key activities, it might be helpful to use the existing definitions for HSS by WHO.
- Strategies to address sustainability issues regarding NHIF need to be described in the HSMTDP, in close collaboration with NHIA.

[13] Draft HSMTDP, page 9, on the reduction of unwanted pregnancies to tackle the high MMR. Obviously, FP – as a long term goal - is an important component of reproductive and sexual health and should always be on the agenda. However, in terms of short-term priorities, other approaches to address the (too) high MMR should specifically be highlighted in the HSMTDP: e.g. ensuring EOC in areas where basic health services are not sufficiently available and where MMR remains high due to lack of professional assistance during delivery.

3.2 Process soundness

2. PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy

Attribute 5 – 2.1, Attribute 6 – 2.2-2.5, Attribute 7 – 2.6-2.7

Strengths

Attributes 5-7 (cross-cutting)

- The overall planning and development process of the HSMTDP was impacted by the timeline and guidelines established by the National Development Planning Committee (NDPC) [52]. The guidelines helped to improve alignment between the HSMTDP and the national development strategy or PRS – Ghana Shared Growth & Development Agenda Volume I Policy Framework [10]. The guidelines were also helpful in outlining a desired process & roles of key actors in the development of sector plans. They also facilitated consistency in organization of the document.

Attribute 5: Participation

- There is recognition by different stakeholders that consultation has improved over the last several years. Space has been created at all levels to bring stakeholders to the table in policy and planning discussions.
- In the development of the HSMTDP, the MOH made a good effort to get inputs from a broad range of stakeholders – e.g. MOH agencies, GHS, CHAG, regulatory bodies, private sector, FBOs, CSOs, other ministries, regional/district health authorities, communities, Development Partners.
- Committees and groups related to policy, planning, technical issues, coordination, writing, costing and budget were created (annex 4.8) that include different stakeholders. Two regional consultations were held in the northern and southern parts of the country to get input from stakeholders at the decentralized level.
- A monthly Partners' Forum meets to discuss health-related issues led by the MOH (annex 4.8). This forum includes development partners, FBO and CSO representatives and senior staff of the MOH and partner agencies.
- The Inter-Agency Leadership Committee (IALC) brings together the heads of the MOH and its partner agencies to improve communication and coordination for better and more effective implementation of health sector activities[14].

[14] Draft HSMTDP: Governance pg 21

Attribute 6: Political Commitment

- The MOH has collaborated with Development Partners to develop important plans and policies related to the health sector. These include the MDGs Acceleration Framework (MAF) Country Action Plan (CAP) of August 2010 and the Ghana AID Policy & Strategy (draft as of November 2010).

- The HSMTDP and the PRS includes a focus on reducing equity gaps – in the HSMTDP as one of five Strategic Objectives and in the PRS as a health policy objective.

- Regarding linkages with other relevant ministries, the MOH has entered into a MOU with the Ministry of Employment & Social Welfare in October 2009 which enables collaboration between the two ministries to deliver services for vulnerable and excluded populations under the National Social Protection Strategy (NSPS) Programme. The HSMTDP recognizes contributions of other Ministries, including Ministries of Education, Water Resources, Works & Housing, Transport, Women & Children Affairs, Local Government & Rural Development, Food & Agriculture, Youth & Sports, Tourism, Interior, Finance & Economic Planning, Defense, and Environment.

- Regulatory systems and challenges are described. The need to increase capacity to regulate and enforce legislation is included as a specific activity under one of the Strategic Objectives. Several bills are pending in Parliament that aim to address these challenges.

- Government commitment on health is backed up by efforts to increase financing. Government finances the health sector through GOG allocation; it also introduced a VAT levy of 2.5 % for health that is transferred to the NHIA. Discussion is ongoing to increase the VAT to 3.5 %. With these two together, GOG's contribution is not far from the 15% Abuja target. With the NHIS becoming one of the main sources of financing, the role of cash and carry (catastrophic out-of pocket spending by households) significantly declined (83% IGF is coming from NHIS). In addition to its discretionary and VAT allocations, GOG is also investing in health infrastructure through concessional loans outside the sector allocation. Furthermore, in the 2010 budget, additional employment of staff has been granted for only education and health sectors. Allocation to health closely follows the trend of real growth rate. All these show that there is government commitment for increasing funding to the sector.

Attribute 7: Alignment with central strategies and plans

- The HSMTDP and the Ghana Shared Growth and Development Agenda 2010-2013 [10] mirror the same objectives for the health sector.

- The various programme managers of GHS verified the situational analysis on disease control in the HSMTDP.

Weaknesses

Attribute 5-7 (cross-cutting)

- The planning process was negatively impacted by the NDPC in the sense that the MOH was perhaps pressured by the NDPC timeline to determine Strategic Objectives (SOs) early on. This resulted in a somewhat rigid framework under which activities had to fit. Ideally the MOH would coordinate consultations to gather inputs and identify needs first to inform the development of SOs. As a result, there was widespread perception that the SOs could not be changed. However, the JANS team believes that it is worthwhile to review the SOs, to better reflect the problem analysis.

Attribute 5 : Participation

- The involvement of different stakeholders at different stages of development was inconsistent. Participation varied from one-off to more regular meetings. Copies of the draft document were not always disseminated well in advance of meetings to allow for consultations with constituencies and preparation of positions and views.
- Attendance lists and meeting notes from committee discussions and consultations were not available.
- Systematic feedback mechanism on comments was largely lacking: Stakeholders, including Development Partners, provided feedback in various fora, but many felt that their feedback was not adequately used.
- As a result of difficulties in the consultation process as well as constraints imposed by the NDPC, buy-in to and ownership by different stakeholders to the HSMTDP is sub-optimal. Stakeholders do not yet feel that the HSMTDP necessarily speaks to them, that they have a stake in its success, and that the document as it stands now is sufficient as an initial basis for conversations about funding.

Attribute 6: Political Commitment

- Discretionary budgetary allocation started to decline from 16.2% in 2006 to 12.8 % in 2009. If this trend continues, it will take longer for the government to meet the 15% Abuja target again.
- A Parliamentary Select Committee on Health exists and is reviewing 9 health sector-related bills. This Committee has oversight over the health sector, approves the budget and has the power to allocate and re-allocate resources across the overall budget. Despite its high-level function, the Committee was not involved regularly in the development of the HSMTDP. Individual Committee members were able to secure a draft, but consultation with the Committee as a whole was lacking.

Attribute 7: Alignment with central policies and plans

- The HSMTDP lacks reference to the range of (very good) disease- and issue-specific strategies.

Suggested actions / recommendations

- Include in the final draft of the HSMTDP a short description on the adopted approach to strengthen consultation mechanisms within the sector, to ensure 'buy-in'.
- Include in the HSMTDP a timeline (annex?) for adopting pending health bills, based on discussion with the Parliamentary Select Committee and describe how the bills will impact on the achievement of the HSMTDP.

3.3 Finance and auditing[15]

3. FINANCE AND AUDITING: Soundness of financial and auditing framework and systems
Attribute 8 -3.1, Attribute 9 - 3.2- 3.4, Attribute 10 - 3.5-3.9, Attribute 11 - 3.10-3.13, Attribute 12 - 3.14-3.15.
Strengths *Attributes 8-12 (cross-cutting)* • The draft HSMTDP refers to the documents and rules and regulations governing the financial management and audit in Ghana. Therefore, it is implicitly consistent with the national rules and regulations and standards. • The National PFM legal framework, which applies to all MDAs, is in general well crafted and adequate. In general, it is comparable to international standards. Assessments of the PFM have been regularly carried out and a recent assessment exists (ERPFM – 2009). The HSMTDP refers to it, and refers to the existing "Accounting, Treasury and Financial Reporting Rules and Instructions" (ATF). This was updated and has been in effect at MOH and all its BMCs as of January 1, 2010. • Resources are relatively well identified and flows are clearly shown in an easy to understand chart. Projections were made based on a clear analysis of the fiscal space. • The HSMTDP includes the development of a comprehensive health financing strategy[16]. *Attributes 8 & 9: Expenditure framework and financial gap analysis* • The costing of HSMTDP combined the MBB and activity-based costing approaches. This combination allowed for the costing of both MDG and non-MDG services. Activity-based costing was used to cost mental health and infrastructure investment plans. The advantage of the MBB, which is based on internationally accepted methods, is that it analyzes the results of investments in terms of health impact and outcome targets. • Three costing scenario's were developed based on the different levels of ambitions (status quo, medium and progressive). In the HSMTDP the progressive scenario is reflected, including its impact on various health outcome indicators.

[15] The analysis of this costing, financing and financial management section is made based on the draft sector medium terms plan (the HSMTDP), its background documents: Costing [8]; Investing in Ghana's Future [25]; existing Accounting, Treasury and financial Reporting Rules and Instructions, as well as recent audits and PEFA assessment (annex 4.6), and ERPFM findings, and the NHIA 2009 annual report [53a]. It is also informed by the different information collected from MOFEP and NDPC as well as key informant interviews from MOH, Ghana Health Service, NHIA, Audit Service, and development partners.

[16] Draft HSMTDP, page 44

- The costing exercise was developed in consultation with the program managers of GHS and other MOH staff. The HSMTDP clearly presents the analysis of the overall macro-economic situation and rate of growth, and its association with the government spending. The projected government allocation to health (allocation through GOG and NHIA) was estimated to increase with 1 % every year. An attempt was made to also project the DPs contributions.

- Overall, the projection of the total government spending for the four years of this medium term plan by the MOH is in line with IMF projections.

- Ghana is in the process of finalizing its AID policy. The policy outlines the aid modalities and the implementation of these. It states that ''concessional loan assistance shall be sought selectively, after a careful review of purpose, content and benefit. The Government has identified budget support as its preferred options and sector budget support is also encouraged. Project aid will be considered based on its sustainability and potential to achieve national development priorities. Moreover, the Government plans to request for flexibility on the part of vertical funds in order to align them with sector plans and budget. The government also seeks to secure an increasing amount of aid as untied, including commodity aid'' (GOG Aid Policy 2010). Furthermore, in the health sector, as part of the HSMTDP development process, the common management arrangements (CMA III) were revised and are adequately described in the plan document. The fund flow in the health sector is well described in the plan.

Attributes 10-12: Financial management; audit; funding sources

- The financial planning has been participatory ensuring an adequate expression of the needs by key stakeholders in the health system. Budgeting also follows the same participatory approach. The MTEF guides the annual budgeting process.
- Capital planning focuses on achieving MDGs through strengthening proven interventions at the district level. The capital investment in the plan has been revised downwards over the last two months: while the planned investment on tertiary hospitals and on district hospitals was reduced, the number of CHPS compounds to be established went up. Most of the investments concern the construction and equipment of district hospitals. The selection of sites for district hospitals is also based on geographic coverage considerations (i.e. to avoid that the total population to be covered remains too small), and on recurrent costs implications. These investments are expected to strengthen the provision of comprehensive EMOC and other maternal health services to reach MDGs. The funding is secured.

- The National Public Sector Financial Management (PFM) Legal framework, regulations, and instructions are adequate and clear and, as designed meet substantially the international standards (except for some aspects of budgeting and commitment control - see PEFA 2008 scores (annex 4.6) and this report's section on weaknesses).

- The officials interviewed at the oversight agencies perceive the MOH as one of the better sector ministries in Ghana in following the national PFM and in trying to improve its FM performance. In some areas, it even exceeds the requirements:
  - It has issued a well articulated financial management manual, the "Accounting, Treasury and Financial Reporting Rules and Instructions for staff and has implemented a training program to ensure better accountability and reporting;

- It has reformed its Internal Audit (IA) and has established IA units at all levels. The scope and methodology of the IA is comparable to international guidelines and good practices. However, this is fairly new and the effectiveness is unknown. Also, there is a need for capacity to enable the team to perform at the expected level;

- A committee has been set up to review and follow-up on findings of the auditors. This committee has been meeting on a quarterly basis and has started to show positive results.

- Financial statements of the sector have been regularly produced and submitted to the external auditors. Similarly, the audit committee reviews and follow-up on the findings of the external auditors.

- The External audit is also one of the strengths of the fiduciary and oversight system. The Audit services and a qualified private audit firm jointly carry out the annual audit of the sector. The standards are reported to be INTOSAI and ISA compliant.

- All audit reports are reviewed by independent committees -- the internal audit by IAA and the external audit by the audit committee of the parliament. The MOH also has an Audit Implementation Committee which meets quarterly to discuss the resolution of audit findings and monitor the progress and sanction.

- Resources are relatively well identified and flows are clearly shown in an easy to understand chart. Projections were based on clear analysis of the fiscal space. However, some issues are raised under 'weaknesses' below.

Weaknesses

Attributes 8-12 (cross-cutting)

- Although the plan followed the NDPC guidelines [52], it is yet to include two important sections of these: monitoring and communication plans.
- The five strategic objectives (SO) are not mutually exclusive. This has made the assignment of cost items to SOs challenging.
- Despite several positive actions and progress in addressing the FM and fiduciary issues, several challenges remain. The plan does not provide a situation analysis from the Financial Management and audit perspective in order to highlight the remaining FM issues and allow adequate planning and costing.
- Risk analysis and bottleneck analysis have not been included which results in the fiscal space assumptions and outcomes becoming less reliable.

Attributes 8-9: Expenditure framework and financial gap analysis

- The use of MBB approach has undermined the shared understanding of the costing exercise. Some of its weaknesses are:

  - The MOH was not able to come out with a consistent costing structure as requested by NDPC.
  - The model is a "black box" that has little room for revision in-country without assistance from outside. The quality and timeliness of external support influence the quality of the costing exercise. In this case, support provided seemed inadequate in terms of timing and duration.

- The bottleneck analysis, the basis of MBB, has not been carried out, due to a late decision to adopt the MBB approach. This has negatively affected the consistency of interventions included in the strategic plan and in the costing model. Had the MBB exercise been used as part of the planning rather than as a separate exercise, it would have assisted in the correct identification of health systems bottlenecks to achieve MDGs. In turn, that would have helped to better formulate future health strategies.

- The draft HSMTDP at the moment does not include a risk analysis. Sector plans in general do encounter significant risks during implementation and measures need to be envisaged to counteract them. Some of the risks include: a) lower than expected government resources for health; b) creditability and accountability gaps; c) higher transaction cost for managing aid; d) fragmentation and segmentation within the health sector; e) sustainability of NHIF; and f) availability and retention of human resources and capacity for implementation. These are real risks that need to be analyzed and mitigating measures must be presented in the plan.

- Long-term sustainability of NHIF is a challenge for several reasons: rapid expansion of enrolment rates (now 62%); various services are exempted; extensive benefit package; insufficient cost containment measures; increase of service utilisation (OPD per capita increased from 0.4 in 2005 to about 1 in 2009; inpatient utilization has increased from 22 to 58 per thousand during the same period[17]). The NHIA's annual expenditure has started to exceed its annual revenue. There are several efficiency and management challenges identified by the 2009 annual independent review team, including governance, management, and financing of the NHIS. These challenges are well known [21a]. NHIA is the process of developing its own strategic plan, to contain costs and to raise income. The draft HSMTDP is not yet reflecting the key elements of these strategies to ensure sustainability of NHIS.

- The MBB included the cost of routine maintenance of buildings, equipment, and transport (estimated at about 5-30 % of total cost of capital investment). However, the public budget for maintenance is currently very limited. The HSMTDP has not spelt out how these costs will be translated into an adequate budgetary allocation for maintenance.

- The HSMTDP has omitted to address the complex area of supply management regarding medicines and commodities (see also above; situation analysis). It should be noted that currently medicines prices – in both public and private markets - are on average 2 – 3 times higher than the median of the international price (Int. Reference Prices - IRP).

Attributes 10-12: Financial management; audit; funding sources

- The HSMTDP does not yet describe resource allocation criteria used and does not refer to the governing criteria that exist. These exist, however, and are seemingly being used by the planners. This is particularly clear in the capital expenditure planning.

- The HSMTDP does not address problems around shortages of funding, due to periodic cash rationing, delays in releases.

- Various independent reviews [28, 28a] have pointed to the problem that demand driven, comprehensive district health services are under-sourced, due to: a) an increasing trend of ring-fencing and earmarking by DPs, GHI resources, as well as some portions of NHIF resources; b) an increasing proportion of

[17] NHIA. Annual Report 2009 [53a].

government resources are financing statutory commitments (item 1 and part of item 3 and 4) and ring-fenced activities; c) too high costs of medicines; and d) an increasing proportion of resources going to curative services. These have been expressed as one of the major challenges in the independent review report of 2009 [28]. However, the HSMTDP has not presented adequate strategies to reverse this situation.

- Several positive steps have been taken to improve the Financial Management and fiduciary at the health sector. However, little reference is made to these positive actions. The plan is also silent on the remaining challenges in financial management systems and practices.

- The plan does not have a situation analysis based on which strategies for better PFM systems, more efficient use of resources, more effective controls, and more reliable and timely financial reporting could be devised. Although there is a relatively lengthy PFM improvement plan (57 items), the HSMTDP has not used the content to analyze the problems, to prioritize the activities, plan for them, or cost the activities.

- The MOH computerized system (PRO-AC), installed many years back, is not in use at lower levels. Furthermore, the transactions and controls, and information generation are manual and reports are compiled in part manually and then rolled-up. The PRO-AC is obsolete and will not be able to provide timely and reliable information.

- Instead, the Plan indicates that the GIFMIS that is envisaged to be put in place by MoF would satisfy the needs of the sector. However, there are two problems with this assumption: a) the implementation of the GIFMIS will take a long time and would probably be completed by the end of this HSMTDP (2013); and b) as the GIFMIS plans are at present, the system will only be deployed at the 23 ministries and the LGs. The system will not be deployed at the districts and sector MDAs beyond the headquarters.

- There are other persisting financial and fiduciary issues that are not addressed by the HSMTDP:
    - The regular revisions to the payroll remain inadequate. The changes for new additions or deletions aren't done on a timely and retirees and exiting staff continue to be paid under the payroll, while new staff do not receive salary for months;
    - Advances are not settled regularly and large number of advances aren't retired at all;
    - Bank reconciliation is done by the same staff that keeps the cash book and issues checks. In general, the sector is short of financial management staff, particularly at lower levels, disallowing a proper segregation of duties;
    - Documentation and archiving is a serious issue as revealed by the auditors, year after year;
    - The list of 57 actions in the PFM improvement plan includes several serious issues that deserve to be prioritized and implemented quickly.
- Although flow of funds has been clearly charted out and is well internalized in the sector, there are problems with the release of funds from the consolidated account at the Bank of Ghana (BoG). Sometimes delays are very long. However, the delays seem to be more the result of over commitment and episodic shortage of funds.

- Delayed releases by the MOF/BOG and overdue payments by the HNIA continue to hamper operations. There is no formal or systematic mechanism to ensure timely disbursements. The issues seem to emanate from several problems within as well as outside the control of the MOH and its BMCs and need to be addressed together with the central ministries and the BoG. Furthermore, it is unclear how the BoG prioritizes the outstanding payment orders (in what order do they get paid).

- Due to these issues, the reliability of reports is questionable. DPs have assessed the fiduciary risk, including reporting as substantial and the PEFA and ERPFM has raised substantial issued regarding the PFM (see PEFA score table in annex 4.6). The HSMTDP doesn't refer to these issues and there seem to be no strategy or no costing for the improvement to overcome these difficulties. Furthermore, the issue of systematic delays in releases of funds has not been discussed in order to devise a strategy. This issue needs internal discussion as well as discussion with the MOF and BOG, as it is partly outside the control of the sector.

- Being a national plan, the HSMTDP should include all sources of revenue and all expenditures. One item clearly missing from the resource side is the contribution of the many national private donors (e.g. The Jubilee Association, to name just one) which, normally raise private funds and finance construction of new hospitals or clinics or additions to existing structures. Without a mechanism for data collection and analysis of historical data, it is difficult to estimate such resources. However, the plan does not have a strategy to identify, estimate, and influence the donors, in order to better target the national priorities.

- An important assumption on the fiscal space analysis is the projection of the percentage of government spending allocated to the health sector-- 1 percentage point increase of the share of health from the total government spending per year. This assumption should be justified given two trends that show to the contrary. First, the GOG budget has increasingly being financed through deficit financing. According to the expenditure review of 2008, the 2008 deficit was estimated at 14.8%. There are indications that, since the review, the deficit might have further widened and that such high level of deficit financing might not be sustainable. Second, the past trend shows a declining share of health sector allocation from the total budget and this is well reflected in the plan. Given these trends, the likelihood of obtaining an increased share of health spending is in doubt.

- Another concern regarding the fiscal space analysis is the extent to which enhancing efficiency gains are assessed in the plan. While SO 2 clearly aims at reducing inefficiencies, the effect of the strategies to be implemented on fiscal space has not been reflected. All the evidences suggest that by reducing inefficiencies and resolving these constraints, the fiscal space could be significantly expanded. The plan does not include implication of strategies employed to enhance for efficiency gains and for breaking down rigidities on the fiscal space analysis.
- Risk analysis is missing in the draft plan. The combined lack of risk and bottleneck analyses creates an uncertainty, not only about fiscal space, but also about what would be the criteria for cuts and reprioritization (what-if scenario) in case the planned resources do not materialize at the envisaged levels. The lack of risk analysis does not allow a clear contingency planning.

Suggested actions / recommendations

- Revisit the assumption on the increasing share of spending which is going to be allocated to health. It may be prudent to use a status quo approach, i.e. allocation of health sector will grow in nominal terms as much as the growth rate of overall government spending, and then carry-out a 'what if' (sensitivity) analysis and produce scalable options.
- Try to estimate some of the missing sources of funding (the out of pocket part of IGF, the expected funds that are secured to finance capital investment, national private donors). Revisit the contribution of DPs if new information is available. Review whether the necessary legal requirements will be met to institute sin tax and carry out financial analysis (cost/benefit) to see if the benefits outweigh the cost. If the analysis resulted in possibility, then estimate the likely resources to be collected.
- In addition to mobilization of resources, include efficiency enhancement measures as a strategy to expand fiscal space within this fragmented financing mechanism.
- Ensure the challenges of NHIA (sustainability, revenue enhancing and cost controlling measures as well as the issues related to regulations and the necessary strategic options to be considered are addressed in the plan.
- If the SOs are revised, it is essential the cost is also revised. It is therefore necessary to ensure that the costing team is facilitated to support the process of revision, and to facilitate the bottleneck analysis that was not carried out during the costing exercise. If SOs are not revised, then do not revise the costing exercise.
- Revisit the criteria for allocation of resources, explain them in the plan and, as much as possible describe and demonstrate (evidence) how closely the resource allocation and expenditure plans meet the criteria.
- Better demonstrate linkages between the MTEF and the plan.
- Provide a robust but short situation analysis for financial management and audit. The existing FM improvement plan, the PEFA, audit reports, and comments provided above are useful to produce the situation analysis. The MOH needs to discuss the GIFMIS with MOF and plan for alternative options for its own system in order to enhance the reliability of financial reporting. Drawing from the situation analysis, establish the strategy for resolving those issues, verify the validity and feasibility of assumptions within the timeframe of this plan; then plan and cost them.
- Verify the flow of funds and financial management aspects for mobilization and distribution. In particular the issue of delays in releases and in payments should be analyzed and solution be found. The bank reconciliation work should remain under scrutiny by the Internal auditors and the Financial Controller office; the issue of payroll corrections and the archiving needs urgent attention and costing.
- The Assumptions for fiscal space need to be verified and validated and then a risk analysis needs to be added.

3.4 Implementation and management

4. IMPLEMENTATION AND MANAGEMENT Governance and leadership, institutional arrangements, management support systems for the national strategy

Attribute 13 - 4.1, 4.2; Attribute 14- 4.3,4.4,4.5; Attribute 15- 4.6; Attribute 16- 4.7,4.8,4.9

Strengths

Attributes 13-16 (cross-cutting)

- The HSMTDP broadly defines the roles and responsibilities of each implementing partner. Measurable milestones are assigned to each strategic objective. Human resource management support strategies have been developed in 2007 [26]; and arrangements for improved governance and leadership by MoH have been identified [31; CMA III]. The HSMTDP refers to Annual Programmes of Work (POW) for detailed implementation plans[18].

Attribute 13: Operational Plans

- The process for developing the POW for 2011 under the HSMTDP 2010-2013 is completed (and was presented during the November 2010 Health Summit). MoH, Agency heads and CHAG developed the first draft (18th Oct.2010) based on HSMTDP strategic objectives. The annual plan is underpinned by expectations of the implementation of a number of policies currently under review[19]. Development Partners have reviewed the draft POW 2011 and discussed their inputs at a consultative meeting chaired by the Chief Director, MoH (15 Nov 2009). The annual PoW will be reviewed by all stakeholders (including district level representatives) before the final version is developed.

- The current (final) draft of the POW 2011 does not include a description of the institutional framework for implementation and accountability though this is described in HSMTDP under chapter 2: "Health Systems Organization and Development". The roles and responsibilities of partner agencies have not been described in the POW.

- Previous implementation challenges – and expected results - have been mentioned in the Introduction (NHIS- claims management client ID management, and overall financial management; Human resource management –workload standards and performance based measures to improve institutional and health worker performance; and strengthening district health services). However, strategies to address these have not been described in detail.

- The HSMTDP identifies one measurable milestone to be achieved in each strategic objective every year.

- The plan describes the various stakeholders involved in regulation and implementation of service delivery. This is supported by the revised CMA III.

[18] p32 of draft October HSMTDP

[19] HSMTDP October draft doc. Pg 14; POW 2011 Pg 8 footnotes.

Attribute 14: Deployment of Resources

- The HSMTDP gives an overall view of the organization of health services (community based CHPS, health centres, district, regional and teaching hospitals, private health providers, and non-governmental health-related organizations); the challenges at each level (health workforce ratios, health infrastructure deficits, equipment and transport deficits, health information data capture, analysis and use, drugs procurement and the disappointing performance of the Central Medical Stores, financing, quality assurance and logistics management). Plans for improving the referral system through improved ambulance and local transport, as well as review of the NHIS protocols have been discussed[20]. Specific mention is made of studies relating to each of the challenges mentioned and strategies identified for implementation[21].

- With regard to human resources, the document highlights the specific activities to be implemented in relation to meeting equity challenges posed by the unequal urban-rural distribution of staff as well as total numbers required (reviewing staffing norms as a prelude to redeployment of staff, particularly in the areas of maternal child health); implementation of an incentives package for public sector workers in under-served areas; evaluation of the impact of existing incentive schemes; engagement of other to address housing and infrastructural needs; expansion of midwifery training; and decentralization of some aspects of HR management.

- The document gives an overview of the regulatory system and the responsible agencies. The need to increase capacity to regulate and enforce legislation is included as a specific activity under one of the Strategic Objectives.

- Regarding linkages with other relevant ministries, the MOH has entered into a MOU with the Ministry of Employment & Social Welfare in October 2009 which enables collaboration between the two ministries to deliver services for vulnerable and excluded populations under the National Social Protection Strategy (NSPS) Programme. The HSMTDP recognizes[22] contributions of other Ministries, including Ministries of Education, Water Resources, Works & Housing, Transport, Women & Children Affairs, Local Government & Rural Development, Food & Agriculture, Youth & Sports, Tourism, Interior, Finance & Economic Planning, Defense, and Environment.

Attribute 15: Procurement policies and procurement management systems

- Procurement policy is governed by the Ghana Procurement Act of 2003. It specifies procurement entities, thresholds, processes, systems and documentation required for procurement. Procurement with donor funds follows the appropriate procurement law as specified by these organizations (such as World Bank or the Global Fund). For Government of Ghana (GOG) funded commodities, it is the Procurement Act of 2003 that is enforced [58].

[20] Draft HSMTDP: Pg 13-21.

[21] Capital Investment Plan, Human Resource Strategy, Emergency obstetric care strategy, Health Information Management Strategic Plan, Essential Drugs Policy, Commodity Security Study.

[22] pg 22-23

- Based on the findings of the Commodity Security Study [58], the HSMTDP identifies weak monitoring systems and plans for these to be strengthened to "assure effective enforcement of policies, regulations and practices at facility level". Such enforcement would favorably impact " medicine pricing structure, quality control, rational drug use, approved stock levels and reporting systems to be used for replenishment decisions etc.

- The Commodity Security Study (April 2010) concluded that" *there is no well-articulated quality assurance system in place for the management of procurement and supplies to ensure health commodity security at all levels and facilities. Faith-based health organizations do not receive any external monitoring and supervision at all*." This document is referenced in the HSMTDP as the basis for the prioritization of CMS operations, its relationship with Regional Medical Stores and the issue of price build- up due to purchases from the private sector as interventions. The multiplicity of procurement and supply chains (CMS, NHIA,GHS-BMCs, FBOs) is noted and the recommendation of a single central procurement agency recommended.

Attribute 16: Governance, management and coordination mechanisms

- The roles and responsibilities of the health related agencies (public, private and CSO) are described in the HSMTDP[23] and its regulatory functions recognized in the description of roles of the seven (7) regulatory bodies that control the health sector.

- The document refers to the many platforms for policy dialogue that have been created for planning and delivery of health services. The use of MoUs between MoH and stakeholders (originating with the inception of the sector-wide approach in Ghana to oversee relationships with donor partners) is highlighted. The inception of the Inter Agency Leadership Committee (IALC) comprising all MoH Agency heads including Teaching Hospitals is noted as a means of facilitating dialogue within the framework of performance improvements, adherence to policies and accountability.

- The HSMTDP identifies an improved legal framework as a necessity to ensure better coordination and regulation of services at all levels and the HMSTP includes activities to strengthen the regulatory framework, public financial management and inter and intra-sectoral coordination, and the introduction of performance based appraisal systems.

- Government has already developed a revised edition of Common Management Arrangements for the health Sector (CMAIII, [31] and the HSMTDP refers to it.

Weaknesses

Attribute 13: Operational Plans

- The current version of the HSMTDP is incomplete. The activity mapping table has not yet been completed and as a result the implementation time – Gantt chart - of the 'key activities' (with the exception of very few) has not be indicated in the plan. The sequencing of key activities may have a bearing on the speed up on which some of the MDG results are going to be achieved hence need to be clearly marked.

[23] HSMTDP: p. 22

- Some of the milestones selected for SOs do not seem to reflect the intent of the SO, e.g. SO 2 on strengthening governance. In some SOs, it may be necessary to track some of the critical areas like increase skilled delivery attendance to reflect on whether the country is on track to reach MDG5.

Attribute 14 – 15: Deployment of resources; procurement

- Although the HSMTDP plans to "reform CMS and strengthen regular monitoring and supervision of commodity availability at all levels", the current constraints in logistics management information and management systems are not highlighted in the document. These are, however, well articulated in the Commodity Security Study (April 2010).

- For the same reason, intentions with CMS need to be clearly defined and clear milestones need to be set. The HSMTDP does not explicitly state what reforms are to be implemented at CMS. These should be reflected in the HSMTDP.

- Given the key position of human resources to achievement of the strategic objectives, constraints encountered in the implementation of the 2007 HR strategy [26] are not analyzed and addressed in the draft HSMTP 2010-2013. For example, the HSMTDP's capital investments will create a large demand for new human resources, yet human resources are already a key bottleneck in the public health system. The HSMTDP does not outline a clear response to these current and forecasted constraints.

Attribute 16: Governance, management and coordination mechanisms

- The HSMTDP describes briefly in one table contributions by other Ministries to the health sector. However, the HSMTDP lacks clarity or references to specific activities that will be undertaken by other Ministries in relation to HSMTDP Strategic Objectives and timeline, and how these activities align with their individual sector plans.

- Table 5 describes the functions of the seven regulatory bodies. However, aside from recognition that regulatory capacity is weak under Strategic Objective 2, the HSMTDP lacks a description of what specific capacity needs to be strengthened and how this increased capacity will improve the health sector. The HSMTDP also lacks specificity regarding pending legislation that aim to address regulatory issues and their implication for the health sector[24].

- A Parliamentary Select Committee on Health exists and is reviewing nine health sector-related bills. This Committee has oversight over the health sector, approves the budget and has the power to allocate and re-allocate resources across the overall budget. The HSMTDP does not make clear reference to the roles and responsibilities of the Parliamentary Select Committee.

- The Independent Review (2009; [28]) identifies the challenges and strategies regarding MOH and regulatory authorities to oversee and regulate the sector. Highlighting these findings (perhaps by referencing the Review) would have made a stronger link between the situation analysis, prioritized objectives and the work plan. As it is, leadership and capacity gaps are not yet adequately addressed in the HSMTDP.

[24] p. 21; p. 35.

- The HSMTDP cites rigorous review mechanisms that monitor performance of agencies within the sector (annual independent reviews; senior managers meetings, periodic area specific in-depth reviews); however there are no clear guidelines in the HSMTDP plan for what is being supervised, reported or who is responsible for supervision.
- Leadership and capacity building are not yet adequately addressed. In relation to development partners, reference to the challenges and strategies outlined in the Ghana Aid Policy and Strategy 2011-2015 produced by the Ministry of Finance and Economic Planning could be helpful. The importance of developing accurate, timely data from all partners and implementing agencies should be highlighted as a major leadership challenge.
- The document includes a Potentials, Obstacles, Constraints and Challenges (POCC) table[25] rather than a Risk Assessment. It is not clear from the POCC what mitigating actions would be taken and by whom to address obstacles, constraints and challenges, or to maximize potentials.

Suggested actions / recommendations

- Add a Gantt chart of timed key activities, as an annex to the HSMTDP.
  Revise the milestones to better capture MDG5, governance, regulation and CMS.
- Make explicit strategies on strengthening oversight and regulatory roles of MOH and regulatory authorities.
- Refer to the roles and responsibilities of the Parliamentary Select Committee.
- Describe strategies on leadership strengthening at all levels.
- Describe constraints in logistics, information and management systems, and translate in time-bound strategies.
- Make CMS reform explicit (e.g. by revisiting options appraisal and strategic decision making on institutional change).
- Describe how the increase in demand for human resources, as a result of the capital investment planning (ref. description in the report on costing).
- Add an implementation plan to validate that the HSMTDP can be implemented within the given timeframe.

[25] P. 73-78

3.5 Results, monitoring and review

5. RESULTS, MONITORING AND REVIEW: Soundness of review and evaluation mechanisms and how their results are used

Attribute 17 – 5.1, Attribute 18, 5.2-5.3, Attribute 19 – 5.4-5.5, Attribute 20 – 5.6-5.8, Attribute 21- 5.9

Strengths

Attribute 17-21 (cross-cutting)

- The HSMTDP confirms the importance of information for health systems governance. The JANS team would underline this importance as being even more important in the current institutional arrangement of the health sector with a small Ministry of Health overseeing a number of autonomous agencies with specific mandates. The role of MoH to provide oversight and coordination to these different agencies can only be properly carried out with solid data and analysis.
- A strong element in the current M&E system is the annual review process, including sector performance indicators, and the existence of a nationwide health information system. [26]

Attribute 17: M&E plan, indicators and targets

- The sector wide indicators have been agreed some years back and have been maintained in this planning process, as they cover the strategic objectives in this HSMTDP. In addition, this continuity allows for establishing trends over a longer time period. The difficult process of re-establishing consensus on a new, slightly revised list of sector indicators has been postponed to when there are more strategy changes that warrant that investment.
- The indicators cover the important areas, are clearly defined and have baseline data. Medium term targets covering the plan period are included for most all listed indicators.[27]

Attribute 18: Information sources and flows

- The monitoring of the plan implementation uses the outputs of the District Health Information Management Software (DHIMS), the Demographic and Health Surveys (DHS; [43]) and the Multiple Indicator Cluster Surveys (MICS). The last 2 surveys are done 5-yearly, and provide outcome and impact data in alternate cycles. In addition, programme data and analysis, partially collected in parallel, are also used for sector performance monitoring - data availability has improved.[28]

26 pg 22, MoH/Independent Review Team, Independent Review, Health Sector Programme of Work 2009, Ghana, May 2010

27 pg 57/58, MoH, The health sector medium-term development plan 2010 - 2013, draft of 29th Oct 2010

28 Annex 2, pg 25-28, MoH/Independent Review Team, Independent Review, Health Sector Programme of Work 2009, May 2010

Attribute 19: Methods, tools and analytical processes, incl. Quality Assurance in data management

- The DHIMS is being implemented nationwide, and roles and responsibilities seem clear, although quality issues exist. Standard Operating Procedures have been written but not yet distributed for the management of the DHIMS. However indicator definitions and guidelines for data use are said to be widely available [3a].
- The plans to move from a unit based programme in DHIMS1 to a web based programme in DHIMS2 are very valid and will facilitate flexibility in access, use, and in adapting to data needs. This will reduce the need for parallel data collection systems and allow collective focus on improving the DHIMS management.

Attribute 20: Joint Reviews and follow-up

- The Ghana health sector has long-term experience with an extensive annual review process. It starts with bottom-up information flows [51a] and consultations at all levels. This culminates in the review of these internally generated data by an independent review team, whose report [28] is translated into agreement between all actors in the health sector of the way forward in a Memorandum of Understanding (MOU, May 2010) during the health summit. The annual review assesses the performance of the sector against annual and long term goals, as well as agreements on the way forward in previous health summits.
- Feedback to providers on their performance is partially done through participation in the annual review process and discussion of the independent review report.

Attribute 21 (Processes for M&E informed decision making)

- The MOU-May 2010, based on past performance, is formally designed to inform development of the next year Programme of Work, and thereby influences agenda setting.

Weaknesses

Attribute 17-21 (cross-cutting)

- The situation analysis lists a number of previously developed plans and strategies for health information that have not been implemented due to lack of funding [29]. No analysis is offered as to why this has been the case [28; annex 6]. Although the importance of good health information is stressed under SO2, this lack of analysis diminishes the expectation that M&E will receive higher priority in the implementation of this SMTDP 2010-2013.
- Partial analysis is available in other documents [46a; 51c] that could be built upon to strengthen the plan. Energetic, urgent action has to be taken to develop clear argumentation of the importance in the current environment.
- The M&E system and current sector indicator set currently do not support a sector dialogue on mutual responsibility of all actors that influence implementation in the sector, as agreed upon in the new CMA III [31]. The indicators currently focus on implementation by the MoH and its implementing agencies. Adding some indicators concerning mutual accountability with data collection methods, including items on alignment of DPs and time funds transfer by both DPs and Ministry of Finance, should be considered.

29 pg 19, MoH, The health sector medium-term development plan 2010 - 2013, draft of 29th Oct 2010

Attribute 17: M&E plan, indicators and targets

- While M&E elements are in place and to different degrees implemented nationwide, an overall M&E framework has not been developed - neither for this SMTDP, nor for the current PoW 2007-2011. This framework is urgently needed to develop a common vision in the health sector on how M&E will be carried out; what are its goals? Who is responsible for which elements? Development of this framework is a requirement in the NDPC guidelines, but should be a priority action within the health sector. The M&E framework would need to be specific on the indication of key persons responsible for M&E in the different agencies under the MoH.
- A review of sector indicators should be envisaged during the planning of the next HSMTDP, ensuring continuity and adaptation to new context and health developments.
- The 'expected impact' as calculated in the costing process and presented on page 55 does not have a clear link to the Strategic Objectives of the plan and therefore seems less relevant. Further, the 'black box' methodology is difficult to grasp.

Attribute 18: Information sources and flows

- While various data sources are used, there are some gaps specifically regarding more detailed data on financial resources. In its 'oversight' role, MOH needs this type of data.
- The – still to be developed - M&E framework needs to include a clear description of data sources and information flows.

Attribute 19: Methods, tools and analytical processes, incl. QA

- Quality issues and data gaps have been described in multiple reviews of M&E performance [28: annex 6; 45; 51d; 19b]. The current analysis of main issues to be addressed needs to be included as part of the analysis within the HSMTDP, with a clear flow to prioritization of actions under the strategic objectives.
- Documentation that describes data collection, responsibilities etc, is not publicly available. This needs to be developed and/or distributed for common understanding throughout the sector. Use of available documentation on indicator definition and data use [3a] at all levels can be strengthened in the same process.

Attribute 20: Joint Reviews and follow-up

- The multiple assessments of Ghana's M&E system have been done in a rather ad hoc and donor-driven fashion. The development of a health sector M&E framework allows for setting up mechanisms for regular review of the performance of the M&E system that will allow for timely adjustments and re-prioritization.
- A deliberate decision has been taken to continue the annual joint review process, despite the recommendation in the 2009 annual review report [28, recommendation 7.1, p.38]. This is based on the fact that this process, while rather heavy, is functional and allows for dialogue at multiple levels. Improvement of this dialogue is possible to avoid formulaic presentation, and to become more targeted towards performance review and decision-making.

- Feedback mechanisms need to be reinvigorated and made routine, especially towards the decentralized levels and towards autonomous agencies under the MoH. The use of league tables [28, recommendation 4.5, p. 37] is recommended, as developed within certain regions, using peer review.

Attribute 21: Processes for M&E informed decision making

- Processes for decision making on resource allocation and prioritization for fund disbursements to various levels need strengthening, including more explicit reference to performance monitoring and review processes.

Suggested actions/recommendations

- The development of the M&E framework for this HSMTDP needs to start as soon as possible and involve all those responsible for health information in the sector; i.e. autonomous agencies (regulators; professional bodies; etc.) as well as health services provider organizations. Elements for consideration in the development of the M&E framework:
    - Agree on an overarching goal of 'data collection for decision making'; including more robust capacity of MoH to play its oversight role in the sector;
    - Involve all implementing agencies, public and private providers; specifically those within those agencies and organizations responsible for M&E;
    - Build on existing systems, develop and/or distribute documentation to those responsible at all level, describing data collection, quality assurance, indicator description, data use and methods for analysis at all levels, as well as suggestions for ways of ensuring data are influencing decision making at all levels;
    - Address data quality issues by reaching broad consensus on: weaknesses and priorities; strategies for improvement; responsibilities.
- Develop indicators to enrich the sector wide indicators and medium targets table[30], to allow for dialogue on mutual accountability of all actors influencing implementation of the SMTDP beyond MoH and its agencies and agreed providers.

30 pg 57/58, MoH, The health sector medium-term development plan 2010 - 2013, draft of 29th Oct 2010

4. Annexes

4.1 Terms of Reference

Joint assessment of Ghana's Health Sector Medium Term Development Plan 2010-2013

Terms of Reference for the joint mission

Background

Ghana has, to date, implemented the Ghana Poverty Reduction Strategy (GPRS I, 2003-2005) and the Growth and Poverty Reduction Strategy (GPRS II, 2006-2009) with key policy areas including macroeconomic stability and accelerated growth. The GPRS I was initiated as a condition for development assistance under the IMF/World Bank-supported Highly Indebted Poor Countries (HIPC) debt relief initiative in 2002. It sought to restore macro-economic stability, and focused on areas including human resource development and basic services; and special programmes for the poor and vulnerable. The GPRS-II shifted focus from social services to accelerated growth to facilitate the achievement of middle-income status within a measurable planning period. Its thematic areas also included human resource development. Both GPRS I and GPRS II have contributed significantly to guiding the allocation of resources, especially under the national budget, and have also provided a platform for dialogue between the Government of Ghana and development partners, including the incorporation of the Millennium Development Goals (MDGs) into the country's development.

As a follow up to the GPRS II, the country is developing a medium-term framework to continue the broad path of GPRSI and II. This framework outlines the macroeconomic framework that will guide the management of the economy between 2010 and 2013 within the context of the long-term vision of attaining a just, free, and productive society.

Policy context

Ghana has an advanced Sector-Wide Approach in place, as evidenced by the three successive Five Year Programmes of Work (5YPOW) – 1997-2001, 2002-06, and 2007-11 - around which the various partners have mobilized resources and supported implementation of the annual programmes of work. Initially adopting an innovative pooled funding approach under the Ministry of Health (MOH), several development partners have in recent years moved further towards aligning with government systems through a shift to sector and/or multi-donor (general) budget support.

The 5YPOW generally sets the broad framework for health service delivery to complement the efforts of other sectors for the derivation of the national growth and development agenda. In response to the new medium term development framework, the MOH is in the process of developing its Sector Medium Term Development Plan (SMTDP) covering the period 2010 – 2013, thereby replacing the last years of the third 5YPOW. In order to make the SMTDP more robust and to encourage more buy-in from a wide range of stakeholders, the Ministry has decided to subject it to the "Joint Assessment of National Strategies (JANS)" process.

In Ghana, the perceived added value of such a joint assessment of SMTDP is to create an opportunity for strategic discussion and thus strengthen the plan. Related expectations are that the assessment and any subsequent revision will increase confidence in the plan, help bring more partners on-plan and on-budget,

and reduce at least some of the burden of separate appraisals or proposal preparations. The independent element is desired in order to provide a fresh, systematic perspective on the plan.

Status of SMTDP development in Ghana

The new health SMTDP has gone through several drafts, and awaits the costing component and other minor reviews to make it complete An initial draft was presented at the November 2009 Summit, and further work was then undertaken to strengthen the situation analysis. A revised draft was shared at the April 2010 Summit, following which consultative meetings were held in early June with Programme Heads and also sector stakeholders in both the north and southern sectors of the country. Changes from those meetings were then incorporated at the same time as further streamlining of the document, using the JANS tool as a guide. Field surveys of district profiles were also carried out and incorporated. Most recently, the sector Budget Committee has proposed minor changes, and the Ministry is in the process of finalizing milestones. As earlier indicated, the costing of the plan is outstanding, but expected to take place in the coming few weeks.

The timing of this joint assessment mission allows for an in-depth review of an advanced draft of SMTDP, in order for recommendations to be incorporated in the final document.

Joint assessment mission objectives

The overall objective of the mission is:

- To assess, the draft Ghana health SMTDP, using the JANS tool and guidelines, in order to identify its strengths and weaknesses, and to recommend improvements where necessary.

Specifically, the mission will develop a profile of the strengths and weaknesses of five sets of attributes:

1. The situation analysis, and coherence of the SMTDP and its strategies with that analysis;
2. The process through which the national plan and its strategies have been developed, including its alignment with national development frameworks and multi-sectoral strategies, and the role of key stakeholders;
3. The adequacy of financing projections and strategies, and financing and auditing arrangements;
4. Implementation and management arrangements, including those for procurement; and
5. The results, monitoring, and review mechanisms.

It is understood that while it is not the task of the joint assessment team to make any recommendation for funding, it is envisaged that individual agencies will be able to use the findings of the assessment to inform their decisions and, ideally, in some cases to use these instead of carrying out separate missions.

Team composition

It is envisaged that the team will comprise a mix of international and local members, roughly half of whom may be seen as “external” or “independent” to the process of developing the SMTDP.

A Team Leader will be identified, ideally with experience in undertaking such a JANS assessment, and will be supported by three independent consultants drawn both from within and outside Ghana in order to ensure a strong mix of local knowledge and international experience. As the aim is to subject the SMTDP to a general assessment, the key skills required are those of : a) public health, and b) health systems/economics/financing/planning. It is envisaged that the team will therefore include both a local and international independent member in each of these two areas.

The independent team will be supported during their time in-country by a local team drawn from MOH, Ghana Health Service, and other agencies and stakeholders. Some of these local members will have been involved in the process of developing the SMTDP.

Methodology

The assessment will involve both a preparation and an in-country phase. It will be undertaken through the following:

- Teleconferences between MOH and members to agree details of the mission;
- Desk review of the draft SMTDP, National Development Planning Commission guidelines for preparation of the plan, the current annual and 5YPOW, and other relevant documents;
- Interviews with key persons from MOH and agencies, civil society organisations, development partners, and other government ministries, departments and agencies (e.g. NDPC, Ministry of Finance and Economic Planning);
- Discussion meetings with key stakeholders, including a debriefing at the end of the mission.

Deliverables

The Team Leader will ensure the following outputs:

- Presentation at the debriefing meeting
- A concise report of the findings and recommendations within one week after the mission end (not more than 15 pages plus annexes)
- Presentation at the November Health Summit (tentatively 22-26 November)

Timeframe

In order to permit the MOH to incorporate the preliminary costing of the SMTDP into the document, the proposed timeframe for the JANS mission is the first half of October, subject to the availability of key team members. It is envisaged that the team will spend at least one full week in Ghana. Desk review work may start earlier.

Key documents

- Draft Health Sector Medium Term Development Plan, MOH
- Growth and Poverty Reduction Strategy II (2006-09)
- Ghana Joint Assistance Strategy 2007
- NDPC Guidelines for development of SMTDP
- Latest Five year Programme of Work (2007-11)
- 2009 Independent Review Report
- Final (draft) of Common Management Arrangements 2010
- 2010 Annual Programme of Work
- Reports of stakeholder meetings on the SMTDP
- Summary of information gathered for the district profile exercise
- GHS Annual Report 2009
- 2007 Ghana Maternal Health Survey
- 2008 Ghana Demographic and Health Survey
- 2007-11 Human resource policies and strategies for health
- National Health Policy 2009
- MOH Gender policy 2009
- Regional and Global Initiatives to Strengthen Health Services e.g. Frameworks for Implementation of the Ouagadougou, Algiers and Bamako Declarations.
- 2009 Background note on Multi-Donor Budget Support

4.2 List of persons met

Name	Designation
A-Tackie, Marian	MOH
Abunyewa, Adu-Gyamfi	World Bank
Adams, Isaac	MOH, PPME
Adjei-Fosu, Kwaku	NDPC, Principal Development Plan Analyst
Adjorlolo, Emmanuel	Min. Finance; Budget Directorate
Adu-Gyamfi, A	World Bank; procurement
Adusei, Kofi	MOH, PPME
Agbeibor, Windfred	NHIA Director of Strategy
Agbozo, Eric	Ghana Coalition of NGOs in Health; CSO representative
Agongo, Erasmus	GHS; Regional Director Health Services
Agyabeng, John	Parliamentary Select Committee; Member of Parliament
Aheto-Tsegah, Charles	Ministry of Education
Akuamoah, Danso Collins	NHIA
Akunye, Simon	Member of Parliament
Alluah-Vaal, Elizabeth	World Bank, Financial mgmt; fiduciary issues
Ametor-Quarmyne, Eric	NHIA, Deputy Director Strategy and Corporate Affairs
Amofah, George	GHS, Dep. Director General
Amoo, Philip	Korle Bu Hospital
Ampomah Nkansah, Ben	MOH, Capital Investment Unit
Amponsah, James Ntim	Min. Finance Dep. C&Ag
Anane, Richard	Parliamentary Select Committee, ranking member
Andoh-Adjei	NHIA, Deputy Director of Strategy
Anemana, Sylvester	MOH, Chief Director
Ansah, Justina K	National Blood Service
Anyidoho, Esther A.M	St John Ambulance
Appiah-Denkyira, Ebenezer	MOH, Director HRDD
Asante, Yaa	GHS; FHO
Asare, Anthony A	Ghana Mental Health Association

Ashie, George	National Ambulance Service
Ataaya, Regina Nelly	Private Hospitals / Maternity Homes Regulatory Body
Attipoe, Robert S	MOH
Awuyah, George	MOH, PPME
Ayugari, Theophilus	SKN
Baba-Seidu, Alhadj Fuseini	Min. Finance; Budget Directorate
Baku, Noah A	Ghana Mental Health Association
Banda, Ben Abdallah	Parliamentary Select Committee; Member of Parliament
Bannerman, Cynthia	GHS. Inst Care Division
Bartels, Maame	MOH; Head, Supplies and Stores
Ben Abdallah Banda	Member of Parliament
Bennen, C	MOH
Boakye, Samuel	National Coordinator Coalition of NGOs in Health
Boateng, Paul Coonley	Free Africa from Mosquitoes
Borg, Jan	DANIDA
Brown, Thelma	MOH, PPME
Buckle, Gilbert	CHAG Executive Director
Chatterjee, Anirban	UNICEF
Clark, Edith	GHS, Occ. And Envir. Health
Coleman, Nii Ayite	Coleman & Partners
Conduah, Christopher	NDPC
d'Almeida, Anita	Danish Embassy
d'Almeida, Selassie	WHO
Dakpallah, F.G	MOH, Director PPME
Danquah-Boateng, R.A	MOH
Dartey, Marion	MOH
Degbotse, Daniel	MOH
Dessus, Sebastian	World Bank
Draegert, Mia Kjems	Danish Embassy
Dusu, Herman	MOH Financial Controller
Elebly, Christopher Kofi	MOH Internal Auditor
Evans, Oheneba M	Basic Needs

Ewusi-Wilson, Matilda	MOH
Fain, Laurel	USAID
Gaisy, Richard	Min. Women & Children Affairs
Gerhardt, Charles	CHAG Advisor
Gidisu, Kirsdom	Parliamentary Select Committee; Member of Parliament
Gingong, Anthony	NHIA, Deputy Director Operations
Gyansa-Lutterodt, Martha	GNDP Director
Hesse, Afua	Korle Bu Hospital
Ibrahim, Ali	MOH
Imoro, Ahmed	NHIA
Kan-Senaya, Kafui	MOH, Chief Economic Officer
Kato, Megumi	JICA
Kertesz, Daniel	WHO Representative
Kojo Appiah-Kubi	Member of Parliament
Kontor, Kwakye	MOH PPME
Korto, Peter	MOH
Kotey, Nii Abossey	Free Africa from Mosquitoes
Kudi, Kojo	Parliamentary Select Committee; Member of Parliament
Kyeremeh, George K	GHS
Lake, Sally	MOH Health Economist PPME
Longe, Emmanuel M	MOH, Deputy Director
Machira, Yuki	JICA
Martey, Maureen	MOH, Private Sector Unit
Mensah-Ayettey, Eric	Nurses & Midwives Council
Mensah, Freda Maame Bartels	MOH Director Procurement & Supply
Mensah, Sylvester A	NHIA, Chief Executive Officer
Nartey, Prof	Korle Bu Hospital
Nii Adai, Henry	Min of Employ & Soc Welfare; Director, Social & Demographic Statistics
Ntim A.C	Member of Parliament
Ntim Amponsah, James	Min. Finance, Deputy Controller & Accountant Gen
Ntim, A.C.	Parliamentary Select Committee; Member of Parliament
Ntumi, Victor	Chair GHANET

Nyonator, Frank	GHS; Director PPME
Obeng Afriyie, Docia	Registrar, Private Hosp. & Maternity Homes Board
Ofori-Addo, Lawrence	Min of Employ & Soc Welfare, Deputy Director, Social Welfare with responsibility for LEAP
Ofosu, Anthony	GHS, PPME
Ofosu, Jones	Food & Drugs Board
Okrah, Jane	UNAIDS
Okyere, Kobina	NDPC, Deputy Director
Ommen, Lander van	Netherlands Embassy
Oppong, Charles K	NAP+ Ghana
Osei-Mensah, Simon	Parliamentary Select Committee; Member of Parliament
Osei, Dan	GHS
Owusu-Ansah, Emmanuel	MOH, PPME
Owusu-Bonsu, Patrick	CHAG
Puozaa, Mathias	Parliamentary Select Committee; Member of Parliament
Quarmyne, Eric Ametor	NHIA, Deputy Director Strategy & Corporate Affairs
Sagoe, Ken	Tamale Teaching Hospital, Chief Executive
Sakaa, Docia Obeng A	Private Hospitals / Maternity Homes Regulatory Body, Registrar
Saleh, Karima	World Bank
Senoo, Cecilia	Exec Director Hope for Future Generations
Simon, Akyune	Parliamentary Select Committee; Member of Parliament
Summers, Carolyn	DfID
Tandoh, Rita	MOH
Tekawa, Aska	Japan Embassy
Turchi, Michele	Free Africa from Mosquitoes
Ulzeu-Christian, Becklin,	Vice Chair Malaria Coalition
Umanta, Ramatu Ude	GHS, Ag. Dir. Finance
Woode George	JICA
Wright, Susan	USAID
Yakusu, Stephen	Parliamentary Select Committee; Member of Parliament
Zekeng, Leo	UNAIDS, Country Director
Zibila, Mahama Al Hassan	Auditor General; Director Audit Service

4.3 Programme of the JANS process

Date	Activity
3 November	Arrival JANS team
4 November	MOH Partners meeting; Briefing by MOH; Meeting with Chief Director MOH; Programming the mission
5 November	Meeting with support group, on mission programme; Interviews with: M&E (MOH; GHS); MOH Procurement Unit; MOH Private Sector Unit; NDPC
6 November	JANS team meeting
7 November	Documents review
8 November	Interviews with: CHAG; Internal auditor MOH; Financial Controller MOH; Korle Bu Hospital; Development Partners meeting;
9 November	Meeting with World Bank (procurement; macro-economics; financial management/fiduciary) Meeting with MOH PPME on costing; Interviews: Private Hospitals and Maternity Homes Board; Min. Local Government; Ministry of Finance; GHS team of Directors.
10 November	Interview with MOH Financial Controller; Accountant General; Interview with Min. Of Finance (budget directorate); Interviews with NHIA CEO and team; Interview with MOH/HRD; Ghana Coalition of NGOs in Health; Diseases specific CSO networks; Ministry of Employment and Social Welfare.
11 November	Interviews with: Ministry of Education; Parliamentary Select Committee on Health; Ministry of Women & Children Affairs; Interview with Auditor General (audit service; directorate of health sector audits)
12 November	Working session with the support group on the draft presentation for debriefing;

	Meeting with Director of Ghana National Drugs Programme
13 – 14 November	Preparation debriefing
15 November	Meeting with NHIA Directorate of Strategy Development; Debriefing at MOH Conference Room; Departure.

4.4 Questionnaires for the structured interviews.

JANS team

Interview with GHS Directorate and programme managers

Tuesday 9 November 2010

1. About the JANS process:

- What are your general expectations from this JANS mission?
- How has GHS been involved in the preparation of the JANS? (Decision making; TORs development; ..)

2. About the HSMTDP:

- What has been, and will be, the role of the GHS in its development?
- Were Districts and Regions also actively involved in the development of the plan?
- To what extent the plan (including its targets) is a result of bottom-up planning? Explain.
- How could a robust HSMTDP help GHS in its routine activities, so as to achieve tangible results?

3. Does the situational analysis in the HSMTDP (mostly in Annex A) accurately describe the current situation in terms of health status and health services development? Are the key problems clearly identified (to form a sound basis for strategic choices)? Any suggestions?

4. In general, does the (draft) HSMTDP adequately address the needs of GHS? Are listed strategies & activities (under Chapter 4) reflective of your priority activities?

5. In the HSMTDP, do you consider the balance between (focus on) primary (health) care services and tertiary care to be adequate?

6. How well does the plan deal with the issue of fragmentation of health services by programmes and by levels of care?

7. Please indicate the most important strengths and weaknesses/challenges in the relation between MOH and GHS as an autonomous service provider (institutional; organizational; financial). To what extent is the current draft of the HSMTDP addressing important challenges, and is proposing concrete strategies to deal with these?

8. Which role GHS has in developing a robust and comprehensive*, sector-wide*, M&E framework? Is there a clear division of tasks and responsibilities between the M&E of GHS and the M&E function of MOH? Has this been addressed by the HSMTDP, and does it include clear strategies to strengthen the M&E framework?

9. With regard to the costing of the HSMTDP:

- Has GHS been actively involved in the costing and financing exercise?
- Do you feel that the unit costs used in the plan are realistic? Are the 2013 targets set for each of your programme areas congruent with your strategic plans? Are they entirely feasible? *[Please note that unit costs and targets are key cost drivers in the costing methodology applied].*
- Have you been involved in the development of the capital investment plan? How do you assess the relevance and rationale of this capital investment planning, in the context of national health policy intentions and of current and future health service demand and utilisation?

JANS team
Interview with MOH / Capital Planning Unit within PPME

10 November 2010

Questionnaire on Capital Investment Planning

1. With regard to the development of the Capital Investment Plan 2007-2011:

- Which stakeholders were involved in the process?
- How was priority setting done?
- How does the Capital Investment Plan 'link' with broader health strategies?
- The POW-2007 to 2011 will be replaced by the HSMTDP (health sector medium term development plan). Does this mean that the Capital Investment Plan must be renewed?
- Is there a system for planning and execution of routine and periodic maintenance of assets? How/where is the cost of such actions included?

2. To what extent does the HSMTDP 'capture' the capital investment plan? Could you comment on that?

3. Is capital planning also based on a review of efficient use of existing assets? What about cost of refurbishment rather than new structures/assets?

4. Are new, innovative approaches (e.g. result-based financing initiatives by WB) included in the HSMTDP 2010-2013?

5. How did you consider the recurrent costs implications of the capital investments for:

- manpower;
- maintenance;
- transport;
- consumables;
- others.

Were these considerations clearly and sufficiently presented in the health development plan? Suggestions for improvement of the plan?

6. With regard to the resources envelope for the Capital Investment Plan:

- Does the budget for the Capital Investment Plan include the costs of all investments, including investments through (commercial) loans?
- Does the budget for the HSMTDP include all investments?
- Can we have a copy of the committed expenditures for the period 2010 – 2013 as to capital investments, financed through all sources?

7. Does the HSMTDP provide for readjusting the (capital investment) ambitions, in case the actual resources envelope is not congruent with the projected resources envelope? If so, what are the priorities?

Questions for National Health Insurance Authority

1. What do you expect from this (JANS) process?

2. How have you been involved in developing the Health Sector Medium Term Development Plan (HSMTDP) 2010-2013?

3. Do you think the Plan adequately deals with the issues of health insurance, particularly?

- Increasing coverage for poor and vulnerable
- Protecting the poor against catastrophic health expenditure
- Sustaining the sources of funding for NHIS (what is the expected role of sin tax?)
- Claims management
- Governance and regulatory issues:
    - working relationship between NHIA and MOH
    - NHIA and beneficiary agencies
    - Regulation, accreditation and control functions
- Controlling the escalating costs specifically on medicines
- Discouraging patients to directly seek care from tertiary hospital (gate keeping strategy?
- Actuarial analysis?

3b. How is NHIA dealing with (or intends to deal with) the issues listed above?

3c. What other issues would you want specifically included in the strategic plan?

4. What evidence is there to show whether out of pocket expenditure has decreased or increased since NHIS was put in place? (It was expected to fall from 63% in 2002 to 46% in 2007)

JANS team
Interview with Korle-Bu tertiary hospital, Accra

Monday November 7, 2010

Key questions to be discussed:

1. What are your expectations from this JANS process? Have you been involved in the JANS process so far?

2. Was the management of Korle-Bu hospital involved in the development of the (draft) HSMTDP? If so, how?

3. What are your overall views on strengths and weaknesses of the (draft) HSMTDP?

Please consider each of the 5 objectives, and provide opinions on:

- the situation analysis;
- the translation of identified challenges in clear goals and strategies; and,
- the translation of goals in key activities.

4. Do you acknowledge the importance of the focus of HSMTDP on Primary Health Care (to make substantial health gains, with regard to MDG targets)? Why? Do you consider the focus on PHC a threat for Korle-Bu? Do you feel that the HSMTDP sufficiently and adequately addresses your needs?

5. The teaching hospitals, such as Korle-Bu, are to a certain extent 'autonomous'. What are strengths and weaknesses of the institutional and organisational relation with MOH? What are pending bottlenecks and/or contentious issues? Are these adequately addressed by the HSMTDP? Is the HSMTDP congruent with existing legislation?

6. Is the HSMTDP adequately addressing the role and mandate of the teaching hospitals within the health system, with regard to:

- the referral system;

- HRD; and,

- M&E?

Do you have suggestions for the final version of the HSMTDP?

7. What are strengths and weaknesses of the relation between the hospital and NHIA? Has the introduction of social insurance though NHIA led to an increase in funding for the hospital? Have any constraints been adequately addressed by the HSMTDP? Has this led to an improvement in procuring commodities and medicines? Is the HSMTDP sufficiently addressing prevailing procurement issues?

8. Do you have any other suggestions for improving the final version of the HSMTDP?

JANS team
Interview with CHAG Secretariat

Monday November 7, 2010

Key questions to be discussed:

1. What are your expectations from this JANS process?

2. How was the CHAG Secretariat involved in the JANS process so far?

3. How was CHAG involved in the development of the (draft) HSMTDP? To what extent have the CHAG members also been involved?

4. What are your overall views on strengths and weaknesses of the (draft) HSMTDP?

Please consider each of the 5 objectives, and provide opinions on:

- the situation analysis;
- the translation of identified challenges in clear goals and strategies; and,
- the translation of goals in key activities.

Would you have suggestions for the final version of the HSMTDP?

5. Considering your organisational and institutional relations with:

- MOH;
- GHS; and,
- NHIA,

Could you indicate key constraints and/or contentious issues (e.g. M&E issues; institutional; financial; issues on decentralization; other), for each of these relations?

Has the formulation of the HSMTDP addressed these adequately? Is the HSMTDP clearly indicating ways and means to strengthen these relationships, to ensure that CHAG remains an essential provider of essential PHC services, complementary to other PHC services providers, in a sustainable manner?

6. Considering the private sector as a whole (including the for-profit sector; traditional medicine; others), does the HSMTDP adequately capture strategic issues (e.g. exploiting the potential of the growing private sector to serve public health goals); opportunities for win-wins between the public and private sectors?

7. Do you have specific recommendations for the final version of the HSMTDP, as to:

- process and

- content?

JANS team
Interview with Parliamentary Select Committee on Health

TBD; Wednesday - Friday 10 - 12 November 2010

1. What is the view of the Parliament (or the Committee) with regards to a number of larger picture health issues, like

- the balance between primary, secondary and tertiary care;
- the regional inequities that persist;
- (the development of the health system in support to disease results)
- the mandate and roles of the different agencies under the MoH - are they clear and implemented in the best way?
- the role of the health sector in Ghana's vision towards (higher) middle income country status.

2. About the Health Sector MTDP:

- What has been the involvement of the Parliamentary Select Committee on Health in the process of developing the Health Sector MTDP?
- How is the plan seen in the framework of trying to reach results?
- What is the role of the Parliament of putting the plan in action, and to what extent is the quality of the document including e.g. its internal coherence important for the Parliament to be able to do its job.

3. About the analysis and priorities in the HSMTDP:

- Does the situational analysis in the HSMTDP accurately describe the current situation in terms of health status and health services development?
- Does the (draft) HSMTDP and the listed strategies & activities (Chapter 4) adequately address the current health status and health service issues?
- What are the most important strengths and weaknesses of the current draft HSMTDP and the process that was used to develop it?

4. Please indicate the most important strengths and weaknesses/challenges in the relation between MOH and the different autonomous agencies under it.

   To what extent is the current draft of the HSMTDP addressing important challenges, and is it proposing concrete strategies to deal with these?

Joint Assessment of National Strategies (JANS)

Brainstorm Meeting between the independent JANS team and Development Partner in the health sector

Monday 8 November 2010, 1400 – 1600 hrs, WHO/Accra

The JANS team wishes to discuss the following topics and questions with the representatives of the DPs:

1. What are your general expectations from this JANS mission?

2. With regard to the JANS process:

- How have the DPs been involved?

- What has been the DP's role in the JANS process?

- Has the JANS process the potential to replace and/or reduce parallel and DP specific assessments?

- How can the JANS process help to further align independent or 'joint' assessments within the health sector? What would be critical factors in such an alignment process?

- How could the JANS process further contribute to strengthening the confidence by DPs in national strategic (health) planning?

3. With regard to the content of the health sector medium term health development plan 2010 – 2013:

3.1. Involvement of DPs and other stakeholders in the development of the HSMTDP:

- What was the role of the DPs in its development? Were there any constraints in their participation? How can the participatory process be eventually improved?

- Have other stakeholders in the health sector been involved? How? Were there any constraints? Suggestions?

3.2. Underlying documentation, to support the content of the HSMTDP:

- What are the most important (health) policy and health strategy documents that should be considered as the foundation of the HSMTDP? Is the draft HSMTDP adequately referring to these? Is the draft HSMTDP adequately 'capturing' the content of these underlying essential policy and strategy documents?

3.3. DPs perceptions on the quality of the draft HSMTDP (version October 2010):

- What is the collective DPs view on strengths and weaknesses of the HSMTDP, by each of the 5 broad objectives, regarding:

- the situation analysis;
- the translation of identified challenges in clear goals and strategies; and,
- the translation of goals in key activities.

- Does the plan provide sufficient fall back scenario's to readjust its ambitions, in case available resources might not be in conformity to the projected resource envelope?

3.4. Costing of HSMTDP:

- Overall:

- Is the level of MDG-related target-setting (being an important cost-driver for the Marginal Budgeting for Performance approach) adequate?
- Have efficiency gains been sufficiently identified and worked out?

- Capital investment planning:

- Is the capital component adequately addressing the overall goal and broad strategic objectives of the HSMTDP? Have 'sharp choices' been made?
- Have implications for recurrent costs been adequately considered?
- Were the DPs involved in the formulation of the medium-term capital planning? If so, how? How has the capital investment component of the HSMTDP been discussed among key stakeholders?

3.5. Projected financing of the HSMTDP:

- Are the assumptions plausible (e.g. on the increase of the share of the public budget to health services and health care; on IGFs; on external funding)?

4. Robustness of the HSMTDP to boost confidence, and to secure external resource mobilisation.

- Considering the formulation of the (draft) HSMTDP, will the local DPs be willing to recommend to their 'HQs' to maintain and increase external funding?

- Are there any major constraints or conditionalities? (E.g. is the PFM framework adequate, and are strategies to strengthen it appropriate and feasible?)

4.5 Shortened JANS tools

JANS TOOL Version: 22 July 2009

JOINT ASSESSMENT ATTRIBUTES AND CRITERIA		
Attributes	**No.**	**Essential Characteristics of the Attributes**
1. SITUATION ANALYSIS AND PROGRAMMING Soundness of analysis/assessment underlying identification of the programming contained in the national strategy		
Attribute 1: National strategy is based on a sound situational and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, and institutional determinants).	1.1	The situation analysis is based on a comprehensive and participatory analysis of health determinants and health outcome trends within the epidemiological, political, socio-economic and organizational context prevailing in the country.
	1.2	The analysis uses disaggregated data to describe progress towards achieving overall health sector policy objectives in line with the policy dimensions of resolution WHA 2009 62.12 on primary health care: • Universal coverage, to improve health equity • Service delivery, to make health systems people-centred • Public policies, to promote and protect the health of communities • Leadership, to make health authorities more reliable.
	1.3	An analysis of past and current health sector responses identifies priority problem areas and programmatic gaps.
Attribute 2: Clearly-defined priority areas, goals, objectives, interventions, and expected outcomes/products that contribute to improving health outcomes and meeting national and global commitments (such as the Millennium Development Goals and WHA resolution on PHC)	1.4	Objectives are measurable, realistic and time-bound.
	1.5	Goals, objectives and interventions address health priorities, equitable access, quality and health outcomes across all population sub-groups, especially vulnerable groups.
Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness and sustainability (both financial and programmatic).	1.6	Planned strategies and interventions are based upon analysis of effectiveness and impact and clearly identify how they contribute to expected results.
	1.7	The plan identifies and addresses key systems issues that impact on sustainability including equity, financial, human resource, and technical sustainability gaps and constraints.
	1.8	Plan describes short- and long-term strategies to meet technical assistance requirements for its implementation.
	1.9	Contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases), in line with the International Health Regulations, is included in national planning process at all levels.
Attribute 4: Both assessment of risks (analysing feasibility of and potential obstacles to implementation) and proposed mitigation strategies (including specifying technical assistance needs) are present and credible.	1.10	The plan includes a risk assessment of potential barriers to successful implementation.
2. PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy		
Attribute 5: Multi-stakeholder (including government) involvement in development of national strategy and operational plans (led by government, with a transparent participative process) and multi-stakeholder final endorsement of national strategy.	2.1	A multi-partner mechanism exists, which ensures the lead of the government and the participation of all stakeholders providing input systematically and regularly into all phases of multi-year strategic plan development and all phases of the annual operational planning.
Attribute 6: High level of political commitment (at the highest level) to national strategy.	2.2	All needed sectoral and multi-sectoral policies and legislation, under the spirit of "health in all policies", are in place to allow successful implementation.
	2.3	The plan specifically notes any problems with implementing the needed regulatory and legislative framework and has a strategy to overcome enforcement problems.
	2.4	Political commitment is evidenced by meeting agreed targets in government health related expenditures and by a move towards increasing the proportion of government's financing of the national strategy.
	2.5	High-level (e.g. parliament, national assembly) political discussion, agreement and formal endorsement of the national strategy and budget.

JANS TOOL Version: 22 July 2009

Attributes	No.	Essential Characteristics of the Attributes
Attribute 7: National strategy consistent with relevant higher- and/or lower-level strategies, financing frameworks and underlying operational plans.	2.6	The national health strategy, including disease specific programmes and other sub-strategies are consistent with each other and with overarching national development objectives.
	2.7	In decentralized health systems, there is an effective mechanism to ensure sub-national strategies and processes address all main national-level goals and targets.
3. FINANCE AND AUDITING Soundness of financial and auditing framework and systems		
Attribute 8: Expenditure framework with comprehensive budget/costing of the program areas covered by the national strategy.	3.1	The strategy is accompanied by a sound expenditure framework with a costed plan. It should ensure pertinent recurrent and investment financing of e.g. human resources, access to medicines, decentralized management, infrastructures and logistics.
Attribute 9: Expenditure framework includes financial gap analysis – including a specification of known financial pledges against the budget from key domestic and international funding sources (specification of sources of domestic funds desirable).	3.2	Revenue projections are based upon explicit assumptions, include all sources of finance (local and external) and account for any foreseen uncertainties or risks.
	3.3	Ensure health-financing systems that avoid catastrophic health-care expenditure and impoverishment from result of seeking care; (WHA 2005 58.33)
	3.4	Costing and budget estimates for scaling up equitable services are based on sound economic analysis.
Attribute 10: Description of financial management system (including financial reporting against budgeted costs, and accounting policies and processes) and evidence that it is adequate, accountable, and transparent.	3.5	Financial plans have transparent criteria governing allocation of funds across programmes, including sub-national levels and non-state actors (where appropriate).
	3.6	Financial management system meets national and international standards, as well as produces reports appropriate for decision-making, oversight and analysis.
	3.7	Sufficient staff capacity and skills to provide oversight, detect and prevent unauthorized use of funds at all levels.
	3.8	Sufficient staff capacity and core competencies to ensure efficient disbursement to all levels; and, where appropriate, to different implementing partners.
	3.9	There are formal and systematic mechanisms to ensure timely disbursements and identify fund flow bottlenecks and resolve them.
Attribute 11: Description of audit procedures and evidence of appropriate scope of audit work, as well as independence and capacity of auditors.	3.10	There is an effective fiduciary process, as evidenced by routine internal and external audits of financing, procurement and resources management at all administrative levels.
	3.11	Independence, authority, skills and competencies of auditors meets national and international standards.
	3.12	Audit system assures performance is routinely assessed against "value for money".
	3.13	A parliamentary or other public accounts auditing committee credibly investigates alleged irregularities. Appropriate sanctions are applied.
Attribute 12: In the context of national development policies (where applicable): - Explanation of how external resources will be channelled, managed and reported on; - Description of relevant domestic financing policies (in relation to different approaches to resource pooling); - If relevant, description of how fiscal space constraints to scaling-up spending will be managed.	3.14	Plan clearly describes all internal financial arrangements and funding modalities, and how internal and external funds will be channelled, managed and reported on.
	3.15	Plan has explicit guidance on how programmes will manage fiscal space constraints to scaling up.
4. IMPLEMENTATION AND MANAGEMENT Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy		
Attribute 13: Operational plans are regularly developed through a participatory process and detail how strategic plan objectives will be achieved.	4.1	Roles and responsibilities of implementing partners are described for each strategy and intervention.
	4.2	Each strategic objective has measurable annual milestones to assess progress towards implementation.

JANS TOOL Version: 22 July 2009

Attributes	No.	Essential Characteristics of the Attributes
Attribute 14: Description of how resources will be deployed to achieve clearly defined outcomes (with attention to staffing, procurement, logistics and distribution. Plan describes transfer of resources [human, commodities] to sub-national level and non-state actors).	4.3	The organization of service delivery is defined and identifies equitable allocation of resources (recurrent, investments) by level of care and roles and responsibilities of service providers; including plans for referrals and supervision.
	4.4	Human resource (management and capacity) needs are identified, including staffing levels, skills mix, training, supervision and incentives. Gaps needed to implement the national strategy are identified and a plan provided to solve identified gaps.
	4.5	Current logistics, information and management system constraints are described, and credible actions are put in place to resolve constraints.
Attribute 15: Procurement policy that complies with international guidelines and evidence of adequate, accountable, and transparent procurement and supply management systems with capacity to reach target populations.	4.6	Procurement and supply management (PSM) policies, strategies and systems in place to assure universal access to safe, effective and good quality pharmaceuticals and commodities.
Attribute 16: Specification of governance, management and coordination mechanisms/ framework for implementation (describing roles, responsibilities and decision-making of all stakeholders).	4.7	Internal and multi-stakeholder external governance arrangements exist that specify management, oversight, coordination, and reporting mechanisms for plan implementation.
	4.8	Plan describes in detail supervisory and oversight systems to oversee resource use and HR management at all levels.
	4.9	National government governance policies include a description of accountability, oversight, enforcement and reporting mechanisms within the Ministry and relevant departments.
5. RESULTS, MONITORING AND REVIEW Soundness of review and evaluation mechanisms and how their results are used		
Attribute 17: Plan for monitoring and evaluation that includes clearly-described output and outcome/impact indicators, with related multi-year targets that can be used to measure progress and make performance based decisions.	5.1	There is a detailed performance based framework for monitoring and evaluation that includes valid and collectable output, outcome and impact indicators.
Attribute 18: Plan for monitoring and evaluation includes sources of information for indicators and description of information flows.	5.2	M&E of implementation uses HMIS, survey and other epidemiological data disaggregated by major determinants of health as well as data on resource allocation.
	5.3	Monitoring and evaluation plan components includes a description of information flows and gaps, sources, methodologies and processes.
Attribute 19: Plan for monitoring and evaluation that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance).	5.4	Critical gaps and weaknesses in M&E plan implementation are identified and an explicit strategy to overcome these is described and costed.
	5.5	The plan details the roles and responsibilities at all levels for each required data management components.
Attribute 20: There is a plan for joint periodic performance reviews (reporting of results against specified objectives and respective targets explaining any deviations) and processes for the development of related corrective measures.	5.6	M&E system is regularly assessed for how well it monitors progress and generates needed information.
	5.7	A multi-partner (independent, when required) review mechanism inputs systematically and regularly into assessing sector or programme performance against annual and long-term goals.
	5.8	The plan details credible, multi-stakeholder mechanisms to provide routine feedback on performance to sub-national and non-state providers.
Attribute 21: Monitoring and evaluation plan describes processes by which monitoring results can influence decision making (including financial disbursement).	5.9	M&E components of plan detail how results from performance analyses will formally be incorporated into future decision making; including resource allocations and financial disbursements to programmes and sub-national levels.

4.6 PEFA scores

PFM Performance Indicator		Scoring Method	Dimension Ratings i.	ii.	iii.	iv.	Overall Rating
A. PFM-OUT-TURNS: Credibility of the budget							
PI-1	Aggregate expenditure out-turn compared to original approved budget	M1	C				**C**
PI-2	Composition of expenditure out-turn compared to original approved budget	M1	C				**C**
PI-3	Aggregate revenue out-turn compared to original approved budget	M1	B				**B**
PI-4	Stock and monitoring of expenditure payment arrears	M1	NS	D			**NS**
B. KEY CROSS-CUTTING ISSUES: Comprehensiveness and Transparency							
PI-5	Classification of the budget	M1	C				**C**
PI-6	Comprehensiveness of information included in budget documentation	M1	B				**B**
PI-7	Extent of unreported government operations	M1	A	A			**A**
PI-8	Transparency of inter-governmental fiscal relations	M2	C	D	D		**D+**
PI-9	Oversight of aggregate fiscal risk from other public sector entities	M1	C	D			**D+**
PI-10	Public access to key fiscal information	M1	A				**A**
C. BUDGET CYCLE							
C(i) Policy-Based Budgeting							
PI-11	Orderliness and participation in the annual budget process	M2	A	A	B		**A**
PI-12	Multi-year perspective in fiscal planning, expenditure policy and budgeting	M2	D	A	B	C	**C+**
C(ii) Predictability and Control in Budget Execution							
PI-13	Transparency of taxpayer obligations and liabilities	M2	D	A	C		**C+**
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	M2	C	C	C		**C**
PI-15	Effectiveness in collection of tax payments	M1	B	A	C		**C+**
PI-16	Predictability in the availability of funds for commitment of expenditures	M1	C	D	D		**D+**
PI-17	Recording and management of cash balances, debt and guarantees	M2	B	C	C		**C+**
PI-18	Effectiveness of payroll controls	M1	A	C	B	B	**C+**
PI-19	Competition, value for money and controls in procurement	M2	A	B	B		**B+**
PI-20	Effectiveness of internal controls for non-salary expenditure	M1	D	B	C		**D+**
PI-21	Effectiveness of internal audit	M1	C	B	D		**D+**
C(iii) Accounting, Recording and Reporting							
PI-22	Timeliness and regularity of accounts reconciliation	M2	C	C			**C**
PI-23	Availability of information on resources received by service delivery units	M1	B				**B**
PI-24	Quality and timeliness of in-year budget reports	M1	C	B	C		**C+**
PI-25	Quality and timeliness of annual financial statements	M1	C	A	C		**C+**
C(iv) External Scrutiny and Audit							
PI-26	Scope, nature and follow-up of external audit	M1	B	B	C		**C+**
PI-27	Legislative scrutiny of the annual budget law	M1	C	B	B	D	**D+**
PI-28	Legislative scrutiny of external audit reports	M1	D	C	B		**D+**
D. DONOR PRACTICES							
D-1	Predictability of Direct Budget Support	M1	A	A			**A**
D-2	Financial info provided by donors for budgeting/reporting on project/program aid	M1	B	C			**C+**
D-3	Proportion of aid that is managed by use of national procedures	M1	D				**D**

4.7 Timeline of HSMTDP preparation

HSMTDP 2010-2013 PLANNING TIMELINE (as of November 2010)

January 2009
- President John Evans Atta Mills inaugurated [Law stipulates that within 2 years of being in office, the President must produce a national development strategy.]

April 2009
- Deadline to submit internal draft health sector plan to NDPC to inform sector priorities outlined in the next PRS 2010-2013

June 2009
- NDPC issues initial guidelines for preparation of SMTDP 2010-2013

July 2009
- NDPC guidelines for preparation of SMTDP 2010-2013 finalized
- MOH guidelines for preparation of the HSMTDP 2010-2013 disseminated to MOH agencies

November 2009
- First draft of HSMTDP shared at Health Summit [Strategic Objectives discussed; copies of draft HSMTDP emailed to registered participants and made available on CD]

March 2010
- Workshop with MOH/GHS programme managers to expand situational analysis and to work on Strategic Objectives

April 2010
- Second draft of HSMTDP shared at Health Summit

June 2010
- Regional consultations in Swedru (south) and Ejisu (north)

August 2010
- Draft HSMTDP circulated to health sector group (i.e. MOH-Partners Group)
- Costing exercise begins

September 2010
- PRS 2010-2013 finalized – Ghana Shared Growth & Development Agenda Vol I Policy & Content
- Costing of the HSMTDP completed by consultants and circulated to health sector group

October 2010
- Third draft of HSMTDP completed (29 October version)

November 2010
- 4-15 November: JANS conducted
- 15 November: Debriefing by the JANS team at health sector group meeting
- 22-26 November: Health Summit
    - JANS report to be presented

4.8 MOH planning committee and groups for the HSMTDP 2010-2013

NAME OF COMMITTEE/WG	FREQUENCY OF MEETING	HOSTED BY	PARTICIPANTS	MAIN FOCUS
Inter-Agency Leadership Committee	Quarterly	MOH	Minister of Health as Chair, Heads of Agencies, Directors of MOH, (PPME as Secretariat)	
Budget Committee	Quarterly	MOH	Budget directors of MOH, agencies	Review and agree on budget levels and allocation; review disbursement levels and revise as necessary
Procurement Committee	Monthly	MOH	Procurement offices, MOH directors	Procurement issues & approval of tenders
MOH-Partners Group Meeting	Monthly	MOH	MOH, agencies, DPs	Update on sector activities
Business Meeting	3x per year	MOH	MOH, agencies, DPs	Review of performance; agreement on priority actions (monitored through the Aide Memoire matrix); receive annual audit
Half Year Review Committee	Annually	MOH	Heads of agencies	Review of performance
Senior Managers Meeting	3 x per year	GHS	GHS Senior Managers, MOH	Review of performance
Health Summits	Bi-annually (usually April & November)	MOH	MOH, Agencies, DPs, other MDAs, NGOs, CSOs, MMDAs	Review of performance in year -1 (April) and planning/budget for year + 1 (Nov)
District Directors Annual Meeting	Annually	GHS	District Directors, GHS HQ and Regions, MOH, CSOs, MMDAs	Review of performance
Medical Superintendent Annual Meeting	Annually	GHS	Districts Directors, Med Supers, GHS HQ and Regions, MOH, CSOs, MMDAs	Review of performance
MOH Directors Meeting	Monthly (approximately)	MOH	Chief Director, all MOH Directors	Update on business
GHS Directors Meeting	Weekly	GHS		Update on business
Meeting with Parliamentary Select Committee on Health	Quarterly	MOH	MOH and agencies	Review of performance (and one to review budget and plan)

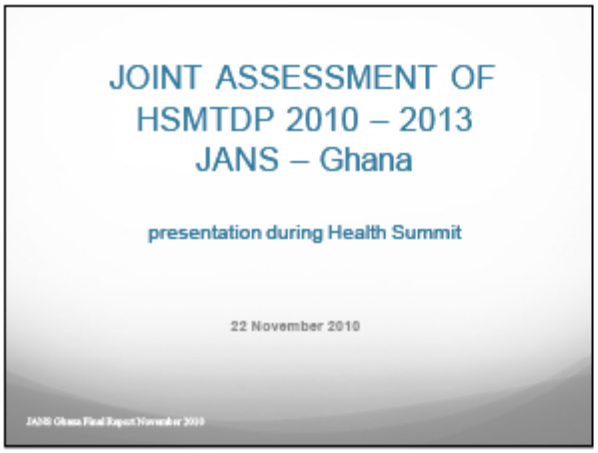
4.9 Abbreviations

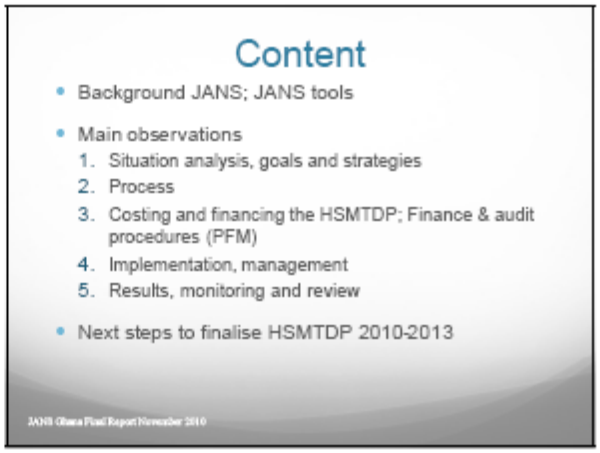
BOG	Bank of Ghana
CABAs	Children Affected by AIDS
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHPS	Community Health Planning and Service
CMA	Common Management Arrangements (CMA III is 3rd version)
DfID	Department for International Development
DHA	District Health Administration
DHIMS	District Health Information Management Software
DHS	Demographic and Health Survey
DP	Development Partner
DSW	Department of Social Welfare
EKN	Embassy of the Kingdom of the Netherlands
EmOC	Emergency obstetric care
ERPFM	External Review of Public Financial Management
GAVI	Global Alliance for Vaccines and Immunisation
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GIFMIS	Government Integrated financial management Information system
GOG	Government of Ghana
GSGDA	Ghana Shared Growth and Development Agenda
HRH	Human Resources for Health
HSMTDP	Health Sector Medium Term Development Plan
HSS	Health Systems Strengthening
IAA	Internal Audit Agency
IALC	Inter Agency Leadership Committee
IGF	Internally Generated Fund
IHP+	International Health Partnership and related initiatives

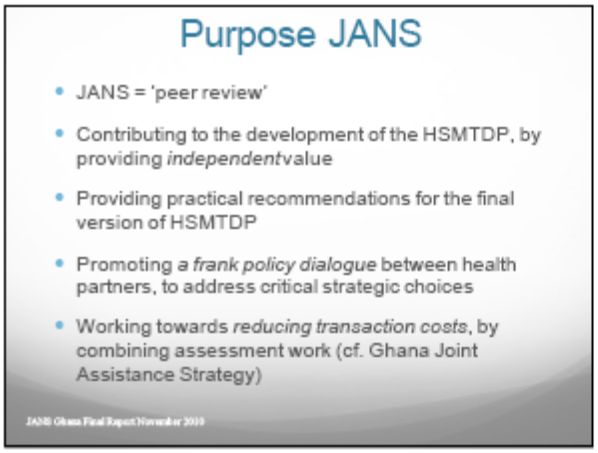
INTOSAI	International Organization of Supreme Audit Institutions
IRP	International Reference Price (Medicines)
ISA	International Standard on Auditing
JANS	Joint Assessment of National Plans and Strategies
JICA	Japanese International Cooperation Agency
LEAP	Livelihood Empowerment Against Poverty
M&E	Monitoring & Evaluation
MBB	Marginal Budgeting for Bottlenecks
MDAs	Ministries, Departments and Agencies
MoESW	Ministry of Employment and Social Welfare
MICS	Multiple Indicator Cluster Survey
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NDPC	National Development Planning Commission
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
MMDAs	Metropolitan, Municipal, and District Assemblies
NSPS	National Social Protection Strategy
OPD	Out-Patient Department
OVCs	Orphans and Vulnerable Children
PE	Personal Emoluments
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PLWHA	People Living with HIV/AIDs
PNC	Post Natal Care
POW	Programme of Work
PPM	Planned Preventive Maintenance

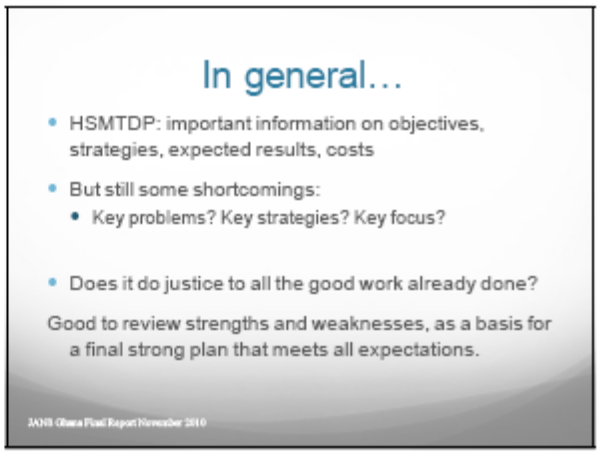
PPME	Policy, Planning, Monitoring and Evaluation
PPP	Public-Private Partnership
QA	Quality Assurance
RCH	Reproductive and Child Health
RDHS	Regional Director of Health Services
RH	Reproductive Health
RHA	Regional Health Administration
RHMT	Regional Health Management Team
RHNP	Regenerative Health and Nutrition Programme
SBS	Sector Budget Support
SD	Supervised Delivery
SMTDP	Sector Medium Term Development Plan
SO	Strategic Objective
SPLIT	Social Protection Livelihood Technical Committee
SPU	Social Protection Unit
SWAP	Sector-Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
TH	Teaching Hospital
TTH	Tamale Teaching Hospital
U5MR	Under-Five Mortality Rate
UNAIDS	Joint UN Programme on HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

4.10 PowerPoint presentation









Situation analysis (a)

Strengths:

- Epidemiology and trends in health services outputs well captured
- Overall design consistent with guidelines from NDPC
- In various paragraphs (e.g. on HR), good synopsis, reflecting detailed sit.analyses in underlying policies and strategies

Situation analysis (b)

Weaknesses

- No clear 'problem tree' analysis
- HSMTDP situation analysis not yet complete. Could better capture existing analyses and strategies (e.g sector reviews; existing programme plans and strategies)

Situation analysis (c)

Recommendations:

- Refine the situation analysis, and refer to more detailed analyses carried out in other documents
- Show hierarchy of key- and underlying problems. Use this hierarchy for the definition of key strategies.

Strategies, goals, interventions, expected outcomes (a)

Strengths:

- Clear focus on strengthening decentralised district health, to achieve health gains and to reach MDGs; CHPS
- Clear focus on equity (geography; SES) and on vulnerable groups
- Comprehensive set of sector-wide indicators; SMART
- Public health interventions evidence-based (disease control; EOC; HIRD)

Strategies, goals, interventions, expected outcomes (b)

Weaknesses:

- Priority setting? Link between problem analysis and SOs / strategic choices?
- Scenario's and options not always made explicit; Bold decisions not sufficiently made explicit to correct gross imbalances in the health system (e.g. supply management issues)
- Existing best practices not visible in the HSMTDP

Gaps: existing issues and strategies not in HSMTDP

- 'District health': constraints and solutions; decentralization
- Stewardship role of MOH; oversight, regulation, inspection
- M&E framework (for MOH oversight role)
- Inter-sectoral dimensions of health
- Strategies to strengthen support systems, including PFM

Strategies, goals, interventions, expected outcomes (c)

Recommendations

- Review the formulation of SOs, based on a clear problem analysis
- Set sharp priorities and feasible targets, considering short implementation period
- Include strategies on the 'gaps'

Process of HSMTDP development

Strengths

- Involvement of broad range of stakeholders via committees, working groups, consultations with MOH agencies, regional/district health authorities, communities, DPs, CSOs
- Participatory costing process

Weaknesses:

- Feedback to stakeholders not systematic
- Buy-in?

Costing the sector (a)

Strengths

- Combined MBB and activity cost models; three scenarios
- Recurrent cost implications and HR consequences for capital investments
- Strong focus on districts in capital planning: increase # CHPS, decrease in # tertiary care investments

Weaknesses

- Unit costs for capital investment appear high; justification? (specs.standards; costs composition)
- Targets as cost-driver: realistic?

Costing the sector (b)

Recommendations

- Review unit costs (cost driver)
- Review targets (cost driver), based on a 3-year timeline
- Ensure that costing team is involved in the revision process; WB and UNICEF to facilitate

Financing the sector (a)

Strengths

- Fiscal space analysis on GOG and DP contributions well presented
- Aid policy and CMA III appropriately articulated

Weaknesses

- Projected increase of GOG contribution for health contradicts recent trends
- Efficiency gains not considered
- Risk assessment not yet carried out

NHIS

- HSMTDP to capture the following – already identified - challenges:
  - **Sustainability**: income vs costs; scope benefit package; exemptions; present actuarial analyses done; address strategies for costs containment (e.g. medicines; gate keeper function)
  - **Efficiency** and accuracy of claims management: delays; false claims
  - **Equity**: regressive SES profile of membership
  - **Institutional arrangements** / mandates among NHIA, MOH, agencies

Financing the sector (b)

Recommendations

- Present a convincing GOG contribution to health
- Work out effective strategies on efficiency gains
- Address NHIA strategic issues
- Undertake risk analysis

Financing and Audit (a)

Strengths

- MOH is one of the better MDAs (comprehensive FM manual; internal Audit system)
- Plan refers to ATF, to its extensive dissemination, and to staff training

Weaknesses

- Issues in MOH PFM plan and in auditors findings not addressed
- Training PFM staff: costed? training non-PFM staff: included?

Financing and Audit (b)

Recommendations:

- Make short descriptions of the (already known) issues, suggest strategies to address them, and cost them

Implementation and management (a)

Strengths

- Roles of actors, and the organization of services, are well described
- Milestones available; measurable
- Human Resources Management and Development: issues on distribution and on HR-management well described, including strategies
- CMA III describes governance, management and coordination mechanisms, and the framework for implementation. HSMTDP refers to it. Presence of IALC (more functionality needed)

Implementation and management (b)

Weaknesses:

- Milestones and focus on e.g. MDG5 (e.g. skilled delivery attendance)
- Challenges and strategies regarding MOH and regulatory authorities to oversee and regulate the sector
- Leadership and capacity building
- Current constraints in logistics, information and management systems not sufficiently described;
- Intentions with CMS / supply management: milestones??

Implementation and management (c)

Recommendations:

- Review milestones; capture MDG5, governance, regulation, CMS
- Include strategies on strengthening oversight and regulatory roles of MOH and regulatory authorities.
- Describe strategies on leadership strengthening at all levels
- Describe constraints in logistics, information and management systems, and translate in time-bound strategies
- Make CMS reform explicit (e.g. by revisiting options appraisal and strategic decision making on institutional change)
- Add an implementation plan to validate that the HSMTDP can be implemented within the given timeframe

M & E (a)

Strengths

- Plan endorses the importance of M&E
- Sector review process well established
- SMART sector performance indicators

Weaknesses

- M&E strategies not yet clear
- Quality issues in HIS/M&E only partly addressed

M & E (b)

Recommendations:

- Develop comprehensive, inclusive M&E framework
- Include data collection/evidence base as first item in 'new' programmes (Mental Health, NCDs)

Next steps, to finalise HSMTDP

- Decide on deadline. First quarter 2011?
- IALC: lead role?
- Organise small workshop, to revisit problem tree, objectives and key strategies; revisit service targets (3 years horizon; focus on MDG5)
- Establish a (small) taskforce to finalise the plan; expertise and skills mix on health policy development and editing.

JANS report

- Closely follows JANS tools
- Per 'attribute': strengths, weaknesses, recommendations
- Recommendations for next steps
- And… lessons learnt about JANS, to improve the JANS approach

4.11 References

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9	GOG	Terms of Reference	2010
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11	GOG	Ghana PRSP 2006-2009	2006
12	GOG	National Health Policy. Creating Wealth through Health.	2007
13	GOG/Min.Fin.	Guidelines for the 2011-2013 Budget Preparation	2010
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34	MOH	HIV Sentinel Survey Report	2009
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36	MOH	National Reproductive Health Service Policy and Standards	?
37	MOH	Under 5 Child Health Policy 2007-2015	2007
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39	MOH	National Malaria Control M&E Plan 2008-2015	2008
40	MOH	Reproductive Health Strategic Plan 2007-2011	2007
41	MOH	Road Map for Accelerating the Attainment of the MDGs related to maternal and new born health in Ghana	?
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50	MOH/GHS	High Impact Rapid Delivery (HIRD) Supplementary Survey 2008; District MICS, Accra and Kumasi Metropolitan Areas	?

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