Document of
The World Bank

Report No.: 39118

PROJECT PERFORMANCE ASSESSMENT REPORT

GHANA

SECOND HEALTH AND POPULATION PROJECT (CREDIT NO. 2193)
HEALTH SECTOR SUPPORT PROJECT (CREDIT NO. 2994)

July 31, 2007

Sector, Thematic and Global Evaluation Division
Independent Evaluation Group (World Bank)

Currency Equivalents (annual averages)

Currency Unit = *Second Health and Population Project*

(as of January 16, 1990)	*(as of June 30, 1997)*
US$1.00 = C$340	US$1 = C$2 050
C$1.00 = US$0.003	C$1.00 = US$0.0005

Health Sector Program Support Project

(as of August 30, 1997)	*(as of June 4, 2003)*
US$1 = C$2 165	US$1 = C$7 150
C$1 million = US$462	C$ 1million = US*$140*

Abbreviations and Acronyms

BMC	Budget and Management Center
CAGD	Controller and Accountant General
CHAG	Christian Health Association of Ghana
CHPS	Community Health Planning and Services
CI	Confidence Interval
CMA	Common management arrangements
DANIDA	Danish International Development Assistance
DFID	UK Department of International Development
DHMT	District health management teams
EU	European Union
ESW	Economic and Sector Work
GARFUND	Ghana Aids Response Fund
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GoG	Government of Ghana
HMIS	Health Management and Information System
HNP	Health, Nutrition, Population
HPP II	Second Health and Population Project
HSSP	Health Sector Support Program
ICR	Implementation Completion Report
IEG	Independent Evaluation Group
IGF	Internally-generated funds
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MCH	Maternal and child health
MDBS	Multi-donor budget support
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NCS	National Catholic Secretariat
OED	Operations Evaluation Department (now known as IEG)
PPAG	Planned Parenthood Association of Ghana
PPAR	Project Performance Assessment Report
PoW I	First Five-Year Programme of Work (1997 – 2001)
PoW II	Second Five-Year Programme of Work (2002 – 2007)
PRSP	Poverty Reduction Strategy Paper
SDR	Special Drawing Rights
SWAp	Sector-Wide Approach
TTL	Task Team Leader
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Fiscal Year

Government: January – December

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IEGWB Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGWB annually assesses about 25 percent of the Bank's lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGWB staff examine project files and other documents, interview operational staff, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGWB peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. IEGWB incorporates the comments as relevant. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

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Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High Significant, Moderate, Negligible to Low, Not Evaluable.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

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PRINCIPAL RATINGS

	ICR*	ICR Review*	PPAR
Second Health and Population Project (Credit 2193)			
Outcome	Highly Satisfactory	Moderately Satisfactory	Satisfactory
Sustainability	Likely	Likely	**
Institutional Development Impact	Partial	Modest	
Risk to Development Outcome			Modest
Bank Performance	Highly Satisfactory	Satisfactory	Moderately Satisfactory
Borrower Performance	Highly Satisfactory	Satisfactory	Moderately Satisfactory
Ghana Health Sector Support Project (Credit 2994)			
Outcome	Satisfactory	Moderately satisfactory	Moderately Unsatisfactory
Sustainability	Likely	Likely	
Institutional Development Impact	Substantial	Substantial	
Risk to Development Outcome			Modest
Bank Performance	Satisfactory	Satisfactory	Moderately Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Moderately Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.
**As of July 1, 2006, Institutional Development Impact is assessed as part of the Outcome rating.
***As of July 1, 2006, Sustainability has been replaced by Risk to Development Outcome. As the scales are different, the ratings are not directly comparable.
** Rating discontinued

KEY STAFF RESPONSIBLE

Project	Task Manager/Leader	Division Chief/ Sector Manager	Country Director
Second Health and Population Project (Credit 2193)			
Appraisal	David Berk	Janet de Merode	Edwin Lim
Supervision	David Berk/David Peters	Ian Porter/Helena Ribe	Edwin Lim/Peter Harrold
Completion	David Peters	Helena Ribe	Peter Harrold
Ghana Health Sector Support Project (Credit 2994)			
Appraisal	David Peters	Helena Ribe	Kazi Matin (Acting)
Supervision	François Decaillet	Helena Ribe/Rosemary Bellew	Peter Harrold/Mats Karlsson
Completion	Ousmane Bangoura	Alexandre V. Abrantes	Mats Karlsson

PREFACE

This is the Project Performance Assessment Report (PPAR) for the Ghana Second Health and Population Project (HPP II) and the Ghana Health Sector Support Project (HSSP). The first operation was financed through IDA Credit No. 2193 in the amount of US$27.0 million (19.5 million SDR), with planned government and community contributions of US$7.0 million and US$0.4 million, respectively. The credit was approved on December 13, 1990, became effective on June 18, 1991, and was 97 percent disbursed when it closed on December 31, 1997, two years after the originally planned closing date. The second operation was financed through IDA Credit No. 2994 in the amount of US$37.8 million (25.1 million SDR), with planned contributions of government (US$573.4 million), internally-generated funds (US$36 million) and bilateral and multilateral co-financing (US$165.0 million). The credit was approved on October 21, 1997, became effective on June 18, 1998, and was 99 percent disbursed when it closed as planned on June 30, 2002. A third operation, the Second Health Sector Program Support Project, was financed by an IDA credit of US$57.6 million and an IDA grant of US$32.4 million. Approved on February 6, 2003 and declared effective on May 22, 2003, the IDA funds are 99 percent disbursed and scheduled to close on June 30, 2007. This PPAR includes some analysis of the performance of this project to date.

The findings of this assessment are based on an Independent Evaluation Group (IEG) mission to Ghana carried out in June 2006. The mission met in Accra with authorities and staff of: the Ministry of Health, the Ghana Health Service and the Ghana AIDS Commission; other public sector agencies implementing health activities; selected NGOs and civil society groups; and development partners. The mission also visited the Regions (Districts/Municipalities) of: Greater Accra (Tema), Upper West (Wa, Nadowli), Upper East (Bolgatanga, Kassena Nankana and Navrongo), Northern (Tamale, Tolon) and Ashanti (Kumasi), where it met with health authorities, services providers and stakeholders and assessed health inputs and activities supported by the Bank. Key sources of evidence consulted include: (a) World Bank project files; (b) project-related reporting and evaluation; and (c) epidemiological data, studies, surveys and research on health, much of it generated in Ghana.

This PPAR is one of several to be conducted on the development effectiveness of the World Bank's support to health, nutrition and population in different countries. Evidence from these assessments will contribute to a forthcoming evaluation by IEG of the World Bank's support to health, nutrition and population outcomes. As such, more material has been presented in this "enhanced" PPAR than is the IEG standard.

This report draws on the technical inputs of the following team members: Dr. Moses Aikins, Health Economist, JSA Consultants of Ghana, and Mr. Michael Azefor, Public Health Specialist. The IEG team gratefully acknowledges the contributions of Ms. Flora Nankhuni, who analyzed household survey data, and Ms. Mollie Fair, who contributed to the analysis of other data on project performance and outcome. The IEG team also gratefully acknowledges all those who made time for interviews and provided documents and information.

Following standard IEG procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and feedback. However no formal response was received.

SUMMARY

Following dramatic improvements in health status in the three decades after independence, the health of Ghanaians continued improving during the late 1980s and through most of the 1990s. In recent years, however, health indicators have leveled off. This report assesses the development effectiveness of two completed Bank-financed health operations and the performance to date of a third operation, scheduled to close in 2007. These projects were implemented during a period of growing momentum, both within and outside of the Bank, to evolve development assistance into a Sector-Wide Approach (SWAp). The SWAp represents a paradigm shift in the focus, relationship and behavior of donors and government. It involves high levels of donor and country coordination, with the government in the lead, and the fuller use of country capacity for the achievement of nationally articulated program goals. This evaluation explores: the extent to which health services and health status improved especially among the poor and disadvantaged; the contribution of the Bank's support to this end; and the effectiveness of the SWAp for achieving sector development objectives.

The objective of the Second Health and Population Project (HPP II), approved in 1990, was to improve the quality and coverage of health services and increase the availability and accessibility of family planning services with the goal of improving health and fertility indicators. It also aimed to improve equity in the availability of services by rehabilitating facilities in the three underserved regions in the north. Its outcome is *satisfactory,* based on its *substantial* relevance, *substantial* efficacy, and *substantial* efficiency.

HPP II contributed to improvements in service availability and quality by improving essential drugs supply, strengthening district health teams, and, in the northern regions, rehabilitating and expanding health infrastructure. Utilization of outpatient services increased both nationally and in the North, although cost recovery was found to depress utilization by the poorest. Investment in the immunization program supported increases in vaccination rates, which rose among the poor and rural residents and in the northern regions. However, overall rates fell short of project targets. Project support also facilitated a rapid response to a meningitis epidemic. Utilization of pre-natal services was very high and quite equitable, but there was no change in the very low rate of births attended by skilled staff and the use of these services remained highly inequitable. Strategic sector management was strengthened, laying important groundwork for a SWAp, but progress in involving NGOs in health sector operations was modest. Between 1993 and 1998 infant and under-five mortality decreased. Project support contributed to the improvement and expansion of family planning services in Ghana and is likely to have contributed to the modest increase in the use of modern contraception. Between 1993 and 1998 the total fertility rate dropped from 5.5 to 4.6 children.

The objective of the Health Sector Support Program (HSSP), approved in 1997, was to assist Ghana in implementing its five-year Program of Work (PoW) (1997-2001) to: (a) provide universal access to basic health services and improve the quality and efficiency of health services; and (b) foster linkages with other sectors to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation and reduce poverty. The IDA credit contributed annually to a common fund, made up of pooled donor financing that was managed by GoG, along with its own budget, to achieve PoW targets including reductions in child and maternal mortality, fertility and child malnutrition. Project outcome is rated *moderately unsatisfactory,* based on *substantial* relevance, *modest* efficacy and *modest efficiency.*

HSSP was successful in achieving a number of *process* objectives, inherent in its SWAp design. The Government assumed leadership in sector management and established working partnerships with the consortium of donors. Regular health summits provided a forum for the annual monitoring of sector performance and for the planning and budgeting of future activities and commitments. National capacity was strengthened and utilized, particularly for planning and budgeting, procurement, financial flows and financial management. The SWAp was less successful in mobilizing financial resources and in ensuring efficiencies in its allocation and use, and it was not sufficiently results-based. Important aspects of institution building were neglected, which undermined sector performance: (i) chronic competition and overlap in responsibilities between the Ministry of Health and the Ghana Health Service; (ii) failure to expand service delivery through contracts with NGOs and the private sector; and (iii) failure to implement fully the PoW's highest priority, highest-impact programs and services.

Despite substantial investment in the five-year PoW (US$690 million) most health service and health outcome targets were not achieved. The quality and access of basic services have not substantially improved. In 2003 national immunization rates achieved the target of 80 percent, with gains for the poor, rural residents and northern regions and improved equity in coverage, but improvement was marginal as the actual (1998) baseline was 72 percent and not 49 percent as originally estimated. Little progress was made on malaria prevention, with less than 4 percent of children sleeping under an insecticide treated bednet by 2003. The use of oral rehydration therapy for the treatment of children suffering from diarrhea has not improved. National rates for births supervised by skilled workers remained at unacceptably low levels, and inequities in the use of these services were extremely high. Gains were made on the use of family planning services and on the already high rates of antenatal care visits. While general targets for outpatient utilization rates were achieved, exemptions for poor people have not been adequate to lift financial barriers to access. Program investments increased the production of human resources for health, but staffing of health facilities was undermined by brain drain and inequitable distribution of health workers. Services efficiency has not improved notably. Inter-sectoral action was undertaken to influence key determinants of health, but a clear framework and strategy for selective action is lacking. Between 1998 and 2003 there were no statistically significant changes in infant and under-five mortality and in total fertility.

The Second Health Sector Program Support Project (HSPSP II), the follow-on SWAp operation, aimed to support Ghana's second PoW for 2002-2007 to improve the health status, while reducing geographic, socio-economic and gender inequalities in health and health outcomes. Pending an Implementation Completion Report (expected by end-2007) and a new Demographic and Health Survey (planned for 2008), this project has not yet been rated by IEG.

HSPSP II has continued good progress in the building and utilization of sector capacity, but some of the SWAp processes for sector management are in need of revitalization, including the health summits and the dialogue between the Government and its partners. Health financing continued to increase, but concerns about efficiency in the use of sector resources persist. Plans to develop a performance-based management system and to monitor accountabilities have not been realized.

Exemption funding for the poor has increased, but is still inadequate; and current exemption provisions are not financially sustainable. The national health insurance scheme is intended to assume the role of protecting the poor, but this is unlikely to happen until coverage of this scheme increases beyond 50 percent. The expansion of community health services and the support of health interventions have improved service availability. However, under-financing of district health services and the failure to reimburse district facilities for exemptions have put them in financial difficulty and compromise the regularity of these services, as well as their accessibility to the poor. Annual reports provide little indication of improved services quality or

efficiency. The ratios of medical staff to the population have improved slightly during the program period. Considerable challenges remain to: promote and exploit participation of the non-governmental sector in health service delivery; streamline and render functional the MoH and GHS; and ensure that priority programs and services are sufficiently financed and implemented.

The main finding of this evaluation is that the first health SWAp in Ghana has strengthened sector stewardship and sector capacity, but has not culminated in the achievement of most health service delivery and health outcome targets set by Government. Between 1998 (when the first SWAp became effective) and 2003, the PoW goal of improving key health indicators was not achieved. The SWAp process took precedence over a focus on results, and sector dialogue became more deferential, even on issues of critical importance to sector performance. The following **lessons** point to opportunities for improving development effectiveness in the context of a SWAp.

- Success in establishing a process for sector-wide management and dialogue will not by itself ensure the achievement of health services performance and outcome targets. The absence of a strong results focus, the absence of a viable system and incentives for M&E and the failure to move towards a performance-based health system to ensure accountabilities can seriously undermine the achievement of sector objectives.
- A dialogue between Government and its health partners, which is not sufficiently rigorous or frank, can result in the neglect of critical constraints to sector performance. The institutional competition and overlap between MoH and GHS and the failure to harness the potential of the non-governmental sector for delivering health services are issues with both technical and political dimensions, which might have benefited from the technical input and leverage of outsiders.
- High priority, high-impact health programs and services risk not being implemented as planned if (a) they are financed almost exclusively by earmarked, outside funds; and (b) if district/local-level autonomy and responsibility for health planning and spending are not checked or balanced with the technical and strategic knowledge of specialized staff and managers of these priority programs (located in the central and regional levels).
- Sector efficiency needs to be measured in order to be achieved. The failure to carry out annual public expenditure reviews and incidence analyses, and to define fully a program results chain and monitor progress on each link has undermined Ghana's ability to measure and fine-tune the development effectiveness of the substantial investments in the health sector.

Vinod Thomas
Director General
Evaluation

1. BACKGROUND AND CONTEXT

HEALTH, POPULATION AND NUTRITION (HNP) IN THE LATE 1980S AND 1990S[1]

1.1 **Trends in HNP Status.** Following dramatic improvements in health status in the three decades after independence,[2] the health of Ghanaians continued improving during the late 1980s and through most of the 1990s. However, since 1998 key health, nutrition and population indicators have plateaued (Figure 1-1). Likewise, trends in fertility reveal improvements between 1988 and 1998, and a stagnation in indicators thereafter. Fertility dropped from 6.4 to 4.4 children per woman between 1988 and 1998, and has remained at the same level over the past decade. The percentage of children 3-35 months who were stunted[3] declined from 29 percent to 21 percent between 1988 and 1998 but this gain was reversed in recent years when rates climbed to 28 percent in 2003. Analysis of household survey data corroborate that stunting did not decline between 1998 and 2003, with an estimated one out of four children being stunted throughout this period. These general trends in HNP status mask wide variations within Ghana. Rural populations, residents of the poorer (especially northern) regions and those in lower wealth quintiles all have higher infant and child mortality, fertility and malnutrition rates than their counterparts living in urban areas and in the better-off regions and belonging to the higher wealth quintiles.

1.2 **Disease Burden.** Malaria, tuberculosis, respiratory and gastro-intestinal infections and nutritional deficiencies constitute the main burden of disease, with non-communicable diseases (diabetes and cardio-vascular diseases) assuming more significance. Since the mid-1980s HIV/AIDS has also added to this growing burden. Ghana continues to face serious reproductive health problems with many women dying from complications of pregnancy, childbirth or unsafe abortion.

1.3 **Determinants of Health, Nutrition and Fertility.** Two categories of determinants affect health, nutrition and fertility: (a) *the performance of the health sector* in meeting the HNP needs of the population; and (b) *non-health sector determinants.*

1.4 **Health Sector Performance.** A number of health systems issues and constraints have undermined the delivery of essential health services to improve the health of Ghanaians during the late 1980s and in the 1990s. These have been candidly and consistently noted in the Government of Ghana's (GoG's) policy and strategy documents *(MoH, 1996, 1999 and 2003)* as well as in analyses conducted by the World Bank *(World Bank, 1989, 1991, 1997b and 2002).* In summary, geographical access to a primary health care facility has been limited and exacerbated by a severe shortage of health personnel, especially in remote areas. Financial access, especially of the poorest, has

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[1] *Source: Demographic and Health Surveys (GDHS), 1988, 1993, 1998, 2003.*

[2] Infant mortality was reduced by almost half from a level of 133 in 1957 (the year of Ghana's independence) to 77 in 1988.

[3] Height for age more than two standard deviations below the median of an international reference population.

been impeded by cost recovery for services (introduced in the mid-1980s), with the poor less inclined to report illness and seek treatment than the rich. Service quality has been compromised by shortages of drugs and medical supplies, poorly maintained equipment, long lines, and the poor demeanor and low skills level of health staff. Weak quality assurance and underdeveloped monitoring and evaluation systems have also been factors of poor service quality. Inadequate funding of health services, especially non-salary recurrent costs, has also compromised the provision of services. Furthermore, the allocation of sector resources has not necessarily reflected stated priorities, a case in point being the chronic under-financing of primary health care in favor of secondary and tertiary referral hospitals through the late 1980s and first half of the 1990s. Inequitable distribution of financial and human resources have caused the poorest and most underserved regions in the north to be most neglected. Issues of sector organization and management have undermined sector efficiency and the accountabilities for delivering results have not been well defined or tracked. Until the mid-1990s, donor support[4] had been only loosely coordinated, and contributed to a proliferation of management and monitoring systems and approaches.

1.5 GoG and strategy documents have also noted that communities have had limited involvement in the planning, management and monitoring of local health services. Ghana's large non-governmental sector (providing both for-profit and not-for-profit services) has had weak links with the Ministry of Health (MoH) and the potential for contracting with this existing capacity for health service delivery has not been exploited. Multi-sectoral coordination and collaboration for better health outcomes has remained elusive.

1.6 **Non-Health Sector Determinants of HNP.** Poor health in Ghana during the late 1980s and 1990s has also been attributed to poverty, poor nutrition of vulnerable groups, low literacy, especially among women, a high population growth rate, and limited access to safe water and sanitation *(MoH, 1996)*. Ghana has been very successful in its efforts to fight poverty, reducing almost by half the share of its population living in poverty, from 52 percent in 1991/92 to 29 percent in 2005/06. However, inequities persist: poverty remains very widespread in the northern regions, even though it has decreased in these regions in recent years. Poverty fell by about 16 points in urban areas and by 23 points in rural areas (*Coulombe and Wodon, 2007*). Ghana DHS data reveal increases in female education and in access to clean water and sanitation facilities between 1998 and 2003, but gains were very modest and extremely inequitable.[5]

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[4] In the late 1980s and early 1990s about 15 donors provided about US$40 million from bilateral sources and US$45 million from multilateral sources, or a little over US$1.00 per capita per annum. An additional US$120 million was committed for the period 1991-1995 *(World Bank, 1991)*.

[5] During this period (a) the female population with no education decreased from 40 percent in 1988 to 28 percent and the proportion of women with secondary school or higher increased from 8 to 12 percent; (b) there was an increase of 9 percentage points (from 33 percent to 42 percent) in households with piped drinking water, with urban access six times the level of rural access; (c) the proportion of women living in households with a flush toilet increased from 7 to 14 percent, with the urban rate for 2003 (26 percent) 13 times the rural rate (2 percent). Other indicators of low and inequitable access to water and sanitation facilities documented in IEG's analysis of GLSS data (Annex H) corroborate these trends.

WORLD BANK SUPPORT TO HNP: 1986 - PRESENT

1.7 **Health Portfolio in Ghana.** From 1986 to the present the World Bank has committed approximately US$222 million in IDA credits and grants to support four health sector operations (totaling US$162 million) and three HIV/AIDS operations (US$60 million) in Ghana (Table 1.1). Over and above these projects, managed by the Bank's HNP network, additional IDA financing to HNP in Ghana has been made available through multisectoral operations, managed by other sector networks. Four Poverty Reduction Strategy Credits (PRSCs)[6] aimed to support the achievement of Ghana's poverty reduction objectives, including the reduction of inequities in health status. Two Community-Based Poverty Reduction Projects were designed to finance community-level, demand-driven projects, including those aimed at improving community health and well-being.[7] Annex C presents in detail the full portfolio of the Bank's lending and non-lending support to health sector development in Ghana, categorized by those managed within and outside of the Bank's HNP network.

Table 1-1. Total IDA Commitments for Stand alone Health and HIV/AIDS Operations

Projects	**IDA Commitments** (US$ million)		
	Health	**HIV/AIDS**	**Total**
Health and Education Rehabilitation Project	10*		10
Second Health and Population Project (HPP II)	27		27
Health Sector Support Project (HSSP)	35		35
AIDS Response Project (GARFUND)		25	25
Second Health Sector Program Support Project (HSPSP II)	90		90
HIV/AIDS Treatment Acceleration Project (TAP)		15**	15
Multi-sectoral HIV/AIDS Program (MSHAP)		20	20
Totals	162	60	222

Source: World Bank
Shaded areas highlight projects evaluated in this PPAR.
* Total commitment under this project amounted to US$15 million, of which US$10 million was committed to the health sector.
** Total commitment under this multi-country project was US$60 million, of which US$15 million was committed to Ghana.

1.8 **Move towards a Sector-Wide Approach**. In 1995 the Bank defined and promoted a growing trend in its approach to lending, which was assumed to be more

[6] The Poverty Reduction Support Credit (PRSC) is defined as a programmatic approach, designed for IDA countries, that seeks to bolster a Government's poverty reduction strategy. The series of loans principally draw policy actions from and elaborate on reform measures set out in the Poverty Reduction Strategy Paper (PRSP). PRSC programs are envisioned to have a lifespan of 3 to 4 years, allowing significant room for change if needed. *(World Bank Operations Policy and Country Services Department).*

[7] The four PRSCs together provided IDA financing in the amount of US$515 million to support implementation of GoG's poverty reduction strategy; although the PRSCs included health-specific objectives, allocation of PRSC funding for health was not specified. Of the US$65 million in IDA funds made available for community-based initiatives under the Community-Based Poverty Reduction Project and the Community-Based Rural Development Project, an estimated US$24 million was allocated to health.

effective in addressing chronic implementation problems. [8] A package of six principles of sound project development was identified as a "Sector Investment Program" (SIP) that supported a "broad sector approach to lending" (Box 1.1). Strongly advocated "…as the only sure way of increasing the impact and sustainability of the Bank's assistance and of the country's own resources" (*Harrold et al, 1995*), this approach was relabeled as a "Sector-Wide Approach" (SWAp) two years later, but its definition remains essentially the same (Box 1.2). During the 1990s the call for a broad sector approach was also increasingly articulated by other development partners and client countries working on health sector development in Africa (Box 1.3). Growing momentum to move towards the SWAp inside and outside of the Bank strongly influenced the nature of the Bank's health portfolio in Ghana, as will be discussed in this report.

Box 1-1 Basic Features of a Sector Investment Program

- A SIP must be sector-wide in scope, where a "sector" is defined as a coherent set of activities, which need to be looked at together to make a meaningful assessment, and it must cover all sector expenditures, both current and capital;
- A SIP must be based on a clear sector strategy and policy framework;
- Local stakeholders, meaning government, direct beneficiaries, and private sector representatives have to be fully in charge;
- All main donors must sign on to the approach and participate in its financing;
- Implementation arrangements should to the extent possible be common to all financiers;
- Local capacity, rather than long-term technical assistance, should be relied upon as much as possible for the project.

Source: Harrold et al., 1995

Box 1-2 World Bank's Definition of a SWAp

A Sector-Wide Approach (SWAp) is an *approach* to support a locally owned program for a coherent sector in a comprehensive and coordinated manner, moving toward use of country systems. SWAps represent a paradigm shift in the focus, relationship and behavior of donors and governments. SWAps involve high levels of donor and country coordination for the achievement of program goals. A SWAp is not a lending instrument, nor a particular financing modality. Programs to support SWAps can be financed through parallel financing, pooled financing, general budget support, or a combination.

Source: World Bank Operations Policy and Country Services

Box 1-3 Genesis of the Health SWAp: An International Consensus

During the 1990s, a forum on health sector reform, chaired by the World Health Organization with the active participation of Ghana, Zambia, DFID and other partners, explored the concepts of a program-wide approach. Their deliberations led to the first meeting of donor agencies to discuss this topic, held in 1997. Co-hosted by the Danish Ministry of Foreign Affairs and the World Bank, this meeting took three decisions: (a) to coin the term "Sector-Wide Approach" (SWAp), as SIP was considered too closely associated with the World Bank; (2) to commission a SWAp guide for the health sector (financed by DFID, EU and WHO); and (3) to create an Inter-Agency Group to foster learning and promotion of SWAps with WHO as the chair and the active participation of partners and developing countries (including strong representation of Ghana's Ministry of Health and development partners working on Ghana). Both Ghana and some of its development partners were thus convinced of the rationale for adopting a sector-wide approach.

Sources: Cassels, 1997 and Interview with Katja Janovsky, (former) Chair of the Inter-Agency Group on SWAps

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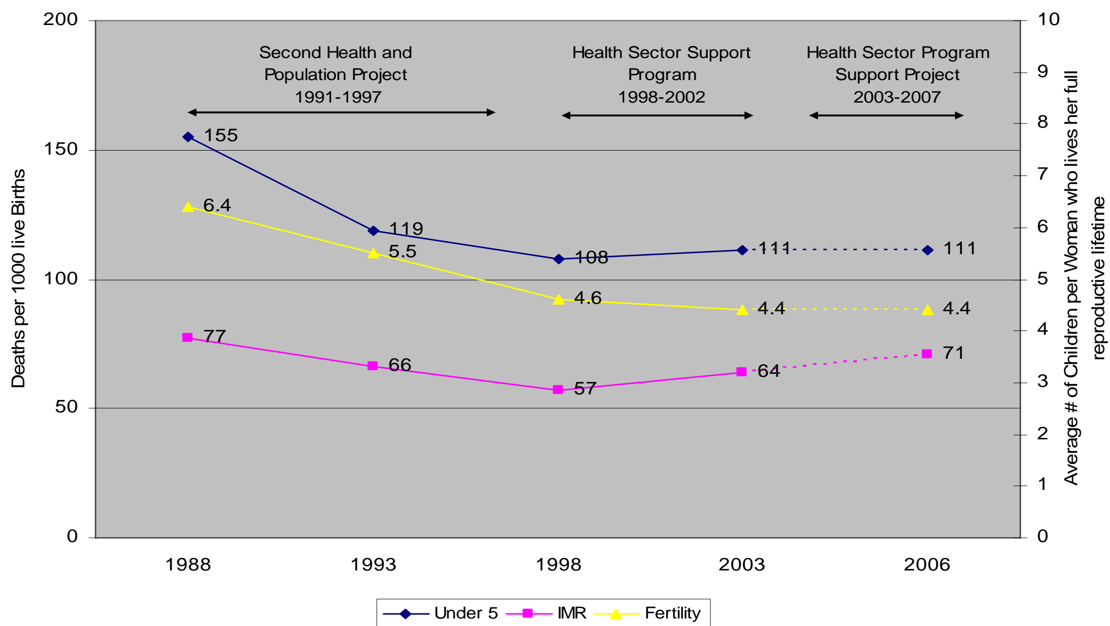
[8] The problems that the SIP was designed to address included: insufficient local ownership and commitment; the lack of any noticeable "trickle-down" effect from some individual projects; projects not sustained or maintained after initial implementation; confusion and dissipation of effort caused by different approaches pushed by different donors; excessive numbers of expatriate technical assistance personnel and weakening of government capacity by the creation of donor-financed project units; and a lack of satisfactory results from some adjustment operations, especially with regard to the allocation of public expenditure *(Harrold et al., 1995).*

ORGANIZATION AND UNDERLYING THEMES OF THE REPORT

1.9 This PPAR assesses the development effectiveness of the World Bank's direct lending for Ghana's health sector during the period 1990-2005. Figure 1-1 shows that improvements in key HNP indicators have stagnated during a period when the Bank was providing substantial financing for Ghana's health sector and had evolved its assistance into a SWAp approach. This assessment attempts to answer the following key questions in order to establish the links between Bank investments and health sector performance and outcomes. Did health services and health status improve, especially for the poor? To what extent did the Bank's support contribute to any improvements? What has been the effectiveness of the sector-wide approach employed by the Bank (and other partners)? What lessons can be drawn from this experience that will contribute to improvements in the performance and outcomes of the World Bank's support to health sector development – in Ghana and elsewhere?

Figure 1-1 – Trends in Mortality and Fertility in Ghana



Sources for solid lines: GDHS: 1988, 1993, 1998, 2003
Sources for broken lines: MICS 2007 (for 2006 Under 5 and Infant Mortality) Population Reference Bureau (for 2006 fertility)

Notes: (a) The mortality rates are averaged over the five years preceding the GDHS surveys. The fertility rates for GDHS 1988, 1993 and 1998 are averaged over the five years preceding the surveys while the fertility rates for GDHS 2003 and MICS 2006 are averaged over the three years preceding the surveys. (b) Confidence intervals calculated by GDHS on these mortality and fertility estimates are provided in Annex F. Unfortunately, there are gaps: some are only available on the 10-year mortality averages and not on the five-year averages.

1.10 To this end, this report assesses two completed operations: the Second Health and Population Project – HPP II (1991-1997), and the Health Sector Support Program -- HSSP (1997-2002). It also assesses the performance *to date* of the almost-fully-disbursed Second Health Sector Program Support Project -- HSPSP (2002-2007), which

will close on June 30, 2007. [9] [10] Chapters 2, 3 and 4 analyze each respective project's: policy and contextual underpinnings; objectives and design; implementation and costs; monitoring and evaluation; and achievement of objectives. In addition, Chapters 2 and 3 rate the performance of the two closed projects in terms of their outcomes. Chapters 2-4 also assess, for each respective project, the extent to which equity issues were raised and effectively addressed by the Bank and by GoG.

1.11 Chapter 5 examines the evolution of the Bank's (and other partners') support to Ghana's health sector over the past two decades, from traditional projects to a SWAp, and analyzes whether and to what extent the expected benefits of this approach were met. Finally, Chapter 6 distills lessons and insights of the series of projects, which point to ways and means of enhancing the impact of the Bank's support to health sector development.

2. SECOND HEALTH AND POPULATION PROJECT (1991-1997)

BACKGROUND AND CONTEXT

2.1 Following a period of good economic performance during the 1960s, Ghana's economy deteriorated significantly during the following decade and into the early 1980s. Real GDP fell by 30 percent between 1975 and 1982, and exports as well as imports fell by annual averages of 6.4 percent and 8.0 percent, respectively. Inflation rose to an average of 56 percent during the 70s and early 80s, peaking at 123 percent in 1983. This downward turn in Ghana's economy had a profoundly negative impact on the provision of health services and on the health status of Ghanaians. Starting in 1983 Ghana embarked on an Economic Recovery Program, which was eventually successful in turning the economy around *(MoH, 1999)*.

2.2 As part of its package of support to Ghana's economic recovery the Bank approved in 1985 a Health and Education Rehabilitation project designed to provide critical inputs to the health and education sectors to keep them from collapsing during the period of economic adjustment. In 1988 the Bank carried out an extensive review of Ghana's HNP sectors in order to provide the basis for a better informed dialogue with MoH and for more sustainable investment in the development of these sectors. Issues and recommendations emanating from this report (Box 2.1) received the broad agreement of MoH and influenced their policy choices.

[9] IEG will assess this project fully and rate its performance once (a) an Implementation Completion Report has been jointly prepared by the World Bank's team and GoG; and (b) the results of the 2008 GDHS are available.

[10] A PPAR on the Ghana AIDS Response Project (GARFUND) has recently been published (*World Bank, IEG, 2007).*

Box 2-1 Ghana Population, Health and Nutrition Sector Review: Issues and Recommendations

Issues	Recommendations
Population:	
Population policy adopted in 1969, and family planning program long-established. However: • High fertility • Rapid population growth • Low demand for contraceptives • Low priority of population program accorded by national leaders	• Renew commitment to fertility reduction among high-level government leaders • Create a population council • Strengthen and expand family planning services (public and non-governmental sectors), including social marketing • Institute a MIS, performance monitoring and incentives • Ensure donor assistance supports national strategy and plans
Health:	
• High infant mortality • Inequities in health status • Very high child and maternal malnutrition • Low quality and coverage of primary health care services • Financial impediments to service access	• Reorganize MoH and decentralize operational responsibilities, control of budgets and personnel to regions • Formalize coordination with NGOs • Prioritize primary health care, highest impact services, non-salary recurrent expenditures, including maintenance • Reform drugs financing, procurement, distribution • Improve equity in service provision • Subsidize service charges to the poor • Set up an institution for the proposed health insurance scheme outside of MoH • Mobilize and channel donor support on the basis of the long-term investment plan
Nutrition:	
• Very high child and maternal malnutrition	• Give serious policy-level recognition to malnutrition and articulate national goals for its reduction • Design and implement a community-based strategy • Improve and expand nutrition education, weaning-food program, micronutrients provision • Ensure regular evaluation of nutrition programs
Sector Management/Donor Coordination	
• Inadequate financing • Mismatch between donor support and priorities • Slow project implementation and disbursements • Inadequate coordination of assistance	• Prepare annual and medium-term rolling plans and develop systems/capacity to monitor sector performance • Ensure that donors fund sector priorities, including recurrent expenditures and local costs • Improve aid coordination to address overlaps and multiple-source financing of activities
Source: World Bank, 1989	

2.3 Immediately following the Bank's sector mission, Ghana's MoH organized in June 1988 a national health symposium and carried out additional analytic work which underpinned a number of reforms to improve health sector performance, commensurate with those recommended by the Bank. It launched a national drugs policy and competitive tendering to improve drug availability and affordability and introduced a cost-recovery scheme to replenish drug stocks in health facilities. Budgets were revised to accommodate more recurrent financing for health services, and greater priority was accorded to the rehabilitation and extension of primary health facilities, including district hospitals. In 1990 MoH and the Ministry of Finance and Economic Planning (MoFEP) identified key priorities in health and population for the period 1991-93: (a) expansion and strengthening of primary health care, including family planning; (b) strengthening of procurement and distribution of supplies, especially essential drugs; (c) the reorganization and decentralization of MoH, including: strengthening central and district-level capacities, performance monitoring, and better cooperation with the non-

governmental sector; (d) human resource development, especially the establishment and application of staffing norms and performance incentives; and (e) improved public expenditures in favor of primary health care.

SUPPORT OF OTHER PARTNERS

2.4 In the late 1980s about 15 donors provided about US$40 million from bilateral sources and US$45 million from multilateral sources, or a little over US$1.00 per capita per annum. An additional US$120 million was expected for the period 1991-95 with additional funding under discussion *(World Bank, 1989)*.

OBJECTIVES AND DESIGN

2.5 The Second Health and Population Project (HPP II), designed to support MoH in the implementation of its stated priorities, was financed through an IDA credit of US$27.0 million equivalent,[11] approved on December 13, 1990 and declared effective on June 18, 1991. With the overall goal of improving health indicators in Ghana, its ***objectives*** were "…to improve the quality and coverage of health services and increase the availability and accessibility of family planning services."[12] The project's focus on the rehabilitation of facilities in the underserved three northernmost regions of Ghana aimed to improve equity in the availability of basic health services. The project supported six ***components*** (Box 2.2).

Box 2-2 Second Health and Population Project: Components

(a) ***Drug and Vaccine Supplies and Drug Infrastructure Rehabilitation***, including: the acquisition of drugs, vaccines and cold chain equipment, drug infrastructure rehabilitation, and capacity building in the management, quality control and prescription of drugs;
(b) ***MoH Institution Building -- the reorganization and decentralization of MoH***, including: strengthening of six new divisions at the central level; district-level capacity building, the establishment of a management information system and regular performance monitoring; the formalization of cooperation with NGOs, and the reform of public expenditure in health (transparent and systematic planning of investment and recurrent expenditures);
(c)***District and Regional Hospital Equipment in Northern, Upper West and Upper East Regions***, including the re-equipment of ten district hospitals (seven public sector and three run by the National Catholic Secretariat and possibly other NGO-run hospitals) and the establishment of repair and maintenance capacity for hospital equipment and vehicles;
(d) ***Support to Primary Health Care and District Health Management Teams (DHMTs)***, including: training for DHMT (including NGO actors) in planning, management and problem-solving, construction/furnishing of 40 houses for district physicians, equipment of 44 DHMT offices, vehicles and other logistical support, financing of primary health care studies and innovative activities;
(e) ***Population/Family Planning in partnership with NGOs***, including the purchase of contraceptives, rehabilitation of 100 public sector service delivery points, refurbishment/equipment of 26 clinics of the Planned Parenthood Association of Ghana (PPAG) and support to community-based distribution through PPAG; and
(f) ***a Prizes Fund*** to provide incentives for improved performance of human resources.

Notes: All components are national in scope, except for component (c) which aimed to re-equip neglected health infrastructure in the Northern, Upper West and Upper East Regions. Estimated costs of components are shown in Table 2-1

2.6 ***Project Management***. Overall responsibility for project coordination was vested in the MoH. The Director of MoH's Division for External Aid Coordination and Project

[11] The US$ amounts shown in this report are the equivalents of Special Drawing Rights (SDRs) or other currencies.

[12] Development Credit Agreement between the Republic of Ghana and IDA signed on December 21, 1990.

Management, which had only recently been established under MoH's new organization at the time of project design, was designated as Project Director. A project management unit for IDA financed projects was to be established within this Division, staffed by a project manager, a procurement specialist, a logistics specialist and a monitoring and evaluation specialist. A working level project implementation committee was to be set up and chaired by the MoH project manager, with membership to include NGO project coordinators. Bi-monthly meetings of this committee were envisaged to address constraints to smooth implementation.

2.7 ***Contracts with NGOs for Component Management and Implementation***. Two well-established NGOs were given responsibility for implementing key components. The National Catholic Secretariat (NCS) was to receive a grant of 590,000 SDR to manage and implement the re-equipment of three of its mission hospitals operating in the Northern, Upper West and Upper East Regions of Ghana; and the Planned Parenthood Association of Ghana (PPAG) was allocated a 2.0 million SDR grant to manage and implement the refurbishing of 26 of its clinics and the expansion of its community-based distribution activities. An additional amount of 220,000 SDR was designated for grant financing for the re-equipment of other missionary hospitals in the Northern, Upper West and Upper East Regions. NCS and PPAG were expected to sign an agreement with MoH, which would lay out the terms and conditions for the use and management of grant funds, and to designate a project coordinator from its staff.

2.8 ***Legal Covenants*** underpinned key elements of MoH policy and priorities and aimed to ensure successful implementation**.** Ten covenants involved decisions and actions for formal collaborative arrangements with NGOs. Four supported the production of plans for improving service quality and coverage. Covenants also supported the full staffing of district health teams, the establishment of a management and health information system and the annual review of public expenditure. Remaining covenants aimed at ensuring fiduciary exigencies and sound project management. Conditions of disbursement also underpinned recommendations of the Bank's sector review, agreed with Government (Box 2.1): the establishment of a national population council, improvements to drugs procurement and resupply; and the appointment of a hospital equipment maintenance expert for the northern regions.

2.9 ***Risks.*** The main risks identified during project design were the limited implementation capacity of MoH and weak commitment of the Government to implement population and health reforms, allocate sufficient resources to primary health care and support a major expansion of family planning services. The project sought to mitigate these risks by: focusing on a number of priorities scaled to match capacity, the sharing of implementation responsibility with NGOs, agreement with high-level authorities and key conditionality on public expenditure and other policy commitments.

IMPLEMENTATION AND COSTS

2.10 This project was implemented over a period of six and one half years, including a two-year extension of the credit closing date from December 31, 1995 to December 31, 1997.

2.11 ***Planned versus Actual Costs and Financing***. The total project cost was US$28.9 million or 84 percent of the cost estimated at appraisal. Final component cost estimates reflect greater expenditures on civil works than originally planned and considerably less than planned expenditures on contraceptives and the prizes fund. Actual Government counterpart funding fell far short of projections at US$1.5 million, or 21 percent of its commitment. Of the total IDA credit amount of 19.5 million SDRs, 18.9 million SDRs (97 percent of the credit) were disbursed.

Table 2-1 Planned Versus Actual Costs by Component (US$ million equivalent)

Component	Planned	Actual	Estimated Actual as Proportion of Planned
Drug and Vaccine Supplies and Drug Infrastructure Rehabilitation	9.6	9.1	95%
Ministry of Health Institution Building	0.6	0.7	120%
District and Regional Hospital Equipment/Maintenance in northern Regions	5.5	6.6	120%
Primary Health Care	5.1	7.5	150%
Population/Family Planning	7.7	4.2	55%
Prizes Fund	0.9	0.3	30%
Project Implementation	0.4	0.5	120%
Physical and price contingencies	4.6	-	-
Total	**34.4**	**28.9**	**84%**

Sources: World Bank, 1993 (for planned); World Bank, 1998 and World Bank disbursement data for actuals.

2.12 ***Planned versus Actual Inputs/Activities by Component[13].*** Project activities were largely implemented as planned. US$4 million worth of essential drugs and vaccines were purchased and distributed, estimated to cover seven percent of national needs and 80 percent of vaccine requirements. Five-hundred health staff were trained to manage drug revolving funds and 850 professionals were trained in rational drug prescription. A quality testing laboratory was set up and 8 regional medical stores were constructed or rehabilitated. With technical and financial support: MoH was reorganized, a strategic framework and five-year plan were developed, district action plans were produced and new procedures were set up for improved aid coordination. Northern regions benefited from the re-equipment of 7 public sector district hospitals and three NGO-run district hospitals and the upgrading of two health centers into district hospitals. An equipment repair and maintenance system was also established for the northern regions. The construction of 40 houses for medical staff attracted human resources to the districts; and the equipment of DHMT offices and provision of 500 motorcycles strengthened district capacity for managing primary health care. Some 100 health centers were re-equipped to improve public sector provision of family planning. PPAG received US$2.3 million in contraceptives, logistical support for supervision, and 26 of their clinics were rehabilitated. In support of PPAG community-based distribution activities, 800 community-based distribution agents were trained and supplied and 82 bicycles were provided.

2.13 There were only a few departures from originally planned activities: (a) the project supported a number of additional civil works and equipment activities in the

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[13] This section is based on a detailed inventory of planned versus actual project support by component carried out by IEG, and available in IEG files.

underserved northern regions (construction/equipment of 11 district health offices; upgrading/transformation of 2 health centers into district hospitals; construction/equipment of 10 health centers); (b) contraceptives needs for MoH having been largely financed by USAID and UNFPA, project funding of contraceptives was devoted primarily to the supply of the NGO sector; and (c) the Prizes Fund component was dropped at the MTR because it was unfavorably perceived by the public and by other public sector agencies.[14]

2.14 ***Legal covenants*** were respected, for the most part. Their implementation is discussed in substance in the following section on achievement of objectives. Twenty-six of the 30 covenants were fully complied with, and three were partially complied with.[15] Most dated covenants (guiding sector development and management) were delayed by two years through amendment of the credit agreement but were complied with. Four conditions of disbursement were ultimately met, but were cause for significant delays in project implementation.[16]

2.15 ***Procurement*** under the project contributed to significant delays in implementation, attributable to: inadequate capacity and experience in procurement planning, a one-year vacancy in the procurement specialist position following the departure of two trained procurement specialists, the unavailability of counterpart funds for procured items, long processing delays, and inadequate specificity in tender documents. Procurement capacity was noted, however, to have improved significantly as a result of project support and experience (*World Bank, 1998).* At the request of GoG and on an emergency basis, the Bank approved the purchase of meningitis vaccines to mitigate an epidemic.

2.16 ***Disbursement*** lags were significant due to slow project start-up, with only 20 percent of the project funds utilized by the time of the MTR (a full three years into the project). Disbursements picked up considerably after a successful MTR that effectively addressed implementation bottlenecks and issues of ownership. ***Financial management*** was carried out as planned.

2.17 The ***Mid-Term Review (MTR)*** took place in June 1994, 18 months after the originally scheduled date of December 1992**.** Jointly carried out by IDA (under a new task manager) and the MoH, this review culminated in recommendations to accelerate implementation and to build long-term MoH capacity for program coordination and

[14] This scheme of awarding prizes for good performing units failed as staff objected to perceived non-transparency of the awards, and the decisions over the choice of prizes (e.g., televisions sets for waiting rooms rather than staff bonuses). This is reported to have had a long-lasting effect on the unwillingness to test performance-based payments that was difficult to overcome.

[15] (a) making available project funds for grants to additional NGOs to expand service delivery; (b) preparing a framework agreement governing the relationship between MoH and NGOs in areas of health and population activities; and (c) designing a health information system.

[16] For drugs disbursement: (a) formalization of competitive bidding for drugs and set-up of an advisory tender committee; (b) functioning of the cash and carry system for resupply of drugs. For hospital equipment disbursement: assignment of a MoH engineer for the maintenance of equipment in project regions. For contraceptives disbursements: establishment of a National Population Commission.

management. Implementation was to be facilitated through more rigorous civil works supervision, more technical assistance and capacity building for commodities planning, procurement and management. Agreements were reached on MoH capacity building, including: measures to refine sector strategy, strengthen sector institutions, improve and consolidate partnerships with donors, and strengthen implementation skills and systems.

2.18 ***Risks and Risk Mitigation.*** Project risks came to pass but were mitigated by (a) the integration of the PIU into the MoH; and (b) decisions taken at the MTR to support and nurture Government commitment and leadership through measures to utilize more fully and to further strengthen MoH capacity.

MONITORING AND EVALUATION

2.19 **Design.** The design of monitoring and evaluation (M&E) under this project was extremely weak. Targets were not quantified.[17] Objectives were articulated more around the provision of services rather than around the performance and outcomes of these services. No baselines were established at the project's outset. Some baselines could be found in the 1989 ESW, but these were not reflected in the project design document. Two years after the start of implementation the 1993 GDHS did provide some relevant baseline data. A M&E plan and system were not designed during project preparation, but rather left to Government to undertake during implementation with apparently little guidance.[18] The design document did specify the appointment of a M&E specialist to monitor implementation and to evaluate the impact of the project on expanding primary health care, but provided no details or guidance on how this would be carried out.

2.20 **Implementation.** The MIS developed for project monitoring remained quite rudimentary and proposed detailed project indicators were never adopted. As a consequence, monitoring activities were limited to the tracking of inputs and implementation progress. The MTR attempted to improve project monitoring, but other items took precedence[19] during this review and this was never followed through.

2.21 **Utilization.** Failure to monitor and evaluate limited opportunities to utilize information to improve project/sector performance.

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[17] The only two targets cited were: (a) a contraceptive prevalence rate (CPR) of 20 percent (but it was not specified whether this was for modern methods only or all methods); and (b) 80 percent immunization rate.

[18] Schedule 4 of the Development Credit Agreement specified that MoH would design "…not later than December 31, 1991, a management and health information system; and after having reviewed this system with the Association, implement such a system not later than December 31, 1992…"

[19] Most notably: the acceleration of implementation; and discussions on how to improve partnerships among donors and between donors and the MoH.

ACHIEVEMENT OF OBJECTIVES[20] [21] [22]

Objective #1: To improve the quality and coverage of health services, with a focus on the underserved three northernmost regions of Ghana to improve equity in the availability of basic health services

2.22 ***HPP II contributed to improvements in the quality and coverage of basic health services through its investments in critical inputs and in capacity building.*** The procurement of *essential drugs* improved the availability of this commodity at the point of service delivery. Investments in procurement capacity, medical stores and the strengthening of cost recovery all contributed to improving prospects for replenishing initial drug stocks on a sustainable basis; and training of service providers contributed to more rational use of drugs. Interviews, field visits and district-level data confirmed that drug availability improved significantly from pre-project levels and has remained reliable, and that these improvements are associated with HPP II support. Substantial investment in the *setting up and functioning of DHMTs* improved the management and oversight of basic services. Equipment, logistical support and training have enabled more regular and disciplined supervision, an increase in outreach activities and more locally appropriate plans and activities. Targeted investments in the *upgrading of dilapidated health infrastructure and in the strengthening of maintenance capacity and practices in the north* have rendered health facilities capable of delivering basic services. Interviews with a number of managers and service providers who have worked in the north since the time of this project attested to the major improvements such investments brought to service quality, although they did raise concerns about shortfalls in the maintenance budget, especially in the recent past. *Construction of new facilities in the north and support for outreach* have extended coverage to areas that had no reasonable access to health services.

2.23 ***Per capita utilization of outpatient services (a proxy for quality) increased nationally (from 0.20 in 1991 to 0.37 in 1997) and even more rapidly in the north, but overall levels remain low.***[23] While these trends are positive, they are limited to public sector facilities and thus difficult to interpret. Trends in utilization of non-governmental facilities, including NCS facilities benefiting from project support, are not available. Another important caveat in interpreting these trends is survey evidence (*Core Welfare Indicator Questionnaire, 1997*), which indicates that the policy of cost recovery for

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[20] This section is based on the ICR, IEG field visits/interviews and Bank files. Government files on this project could not be made available, despite many attempts by IEG to access them. Nevertheless, DHS data showing trends between 1993 and 1998 roughly correspond to project implementation period 1992 through 1997.

[21] This section provides a summary of project outcomes. More detail is provided in a matrix on project objectives and targets, prepared by IEG and available in IEG files.

[22] Assessment of service performance and outcome is based on analysis of GDHS and household survey data detailed in Annexes F, G and H. Issues concerning comparability of data are detailed in these Annexes to ensure that data are interpreted knowledgeably and cautiously. Annexes F and G also document confidence intervals drawn from the GDHS reports.

[23] Trends in utilization for the Northern, Upper East and Upper West regions between 1995 and 1998 indicated increases, respectively, from 0.14 to 0.23; 0.29 to 0.42; and 0.20 to 0.28 *(MoH Statistics).*

health services negatively affected service access by the poorest segments of Ghana's population.

2.24 ***Project investments in Ghana's national immunization program achieved immunization coverage just below the project target, but immunization improved for all vulnerable groups: the poor, rural residents, and the northern regions. And the project did facilitate a rapid response to a meningitis epidemic, thus mitigating its potential impact.*** The project financed about 80 percent of Ghana's vaccine requirements and cold chain equipment and maintenance. The percent of children aged 12-23 months who were fully vaccinated was 55 *[CI: 51-59]* in 1993 and 62 *[CI: 57-67]* in 1998, but this change was not statically significant. Immunization rates in the northern regions remained almost on par with national averages, increasing from 47 to 59 percent. The increase in DPT3 coverage was statistically significant, increasing from 62 percent *[CI: 58-66]* in 1993 to 72 percent *[CI: 68-76]* in 1998, falling slightly short of the project goal of 80 percent. IEG's analysis of household surveys (Annex H) corroborates this trend of improved vaccination coverage over the project period and also indicates improved equity in coverage between the poor and rich, and rural and urban areas.

2.25 ***The coverage of reproductive health services did not substantially improve at the national level.*** Throughout the project period, the percent of deliveries supervised by a doctor, nurse or midwife remained stable at a low 44 percent (Annex F, Table F.4). Inequities between the poor and rich and between rural and urban areas were extremely high at the project's outset and did not change over the life of the project. Use of these services by the rich was five times the level of use by the poor, urban use was twice the level of rural use by rural residents, and national averages were one and one half times the levels in the northern regions (Annex G, Tables G.1, G.2 and G.3). The percent of women receiving ante-natal care remained virtually the same, but, unlike supervised deliveries, coverage was already substantially high (at 87 percent) (Annex F, Table F.6) and these services were delivered more equitably to poor and rich populations as well as to rural and urban populations and to the northern regions (Annex G, Tables G.1, G.2 and G.3).

2.26 ***The use of oral rehydration therapy (ORT) for the treatment of diarrhea in children improved substantially.*** Between 1993 and 1998 the proportion of child diarrhea cases treated with the use of oral rehydration salts, recommended home fluids and/or increased liquids[24] increased by more than 20 percentage points from 46 percent to 67 percent (Annex F, Table F.6). Improvements are documented for both the poorest quintile (from 41 to 60 percent) and the richest quintile (from 62 to 78 percent) (*GDHS 1993 and 1998)* (Annex G, Table G.1).

2.27 ***Capacity for improved strategic sector management at central and district levels was significantly strengthened with project support, but progress in involving NGOs in health sector operations was modest at best.*** Project support culminated in the production of a coherent policy and strategic framework, notably: a medium-term health strategy; a five-year Programme of Work for the period 1997-2001; and a three-year rolling investment program and annual recurrent budgets (*World Bank, 1998*). This

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[24] GDHS 2003 definition of ORT

support complemented other financing for these activities.[25] The project also provided technical assistance and other support for the reorganization of the MoH and the creation of the Ghana Health Service (GHS)[26] with a view to separating policy and regulatory functions from service provision. Project-financed training and logistical and technical inputs facilitated the production of annual plans and budgets by all districts. While a contractual arrangement with NCS in the north was functioning reasonably well, the extension of cooperative arrangements to other regions, private partners and activities was not fully developed or exploited.

2.28 ***Child health outcomes improved nationally between 1993 and 1998.*** During this period national infant mortality rates fell from 66 to 57 deaths per 1000 live births and mortality among children under five fell from 119 to 108 (Annex F, Table F.1).[27] Given substantial project investment, it is plausible to assume that HPP II might have contributed to these trends. Other non-health sector determinants of infant and child mortality and the health sector support of other partners (para. 2.4) are also likely to have contributed.

Objective #2: To increase the availability and accessibility of family planning services

2.29 ***Project support was instrumental to the successful improvement and expansion of family planning services in Ghana and is likely to have contributed to the modest increase in contraceptive use achieved during the life of the project.*** Project investments in the public sector complemented substantial financial and technical assistance provided by USAID to the public sector and to contraceptive social marketing activities. The project's support to PPAG expanded national coverage considerably, in particular the refurbishment of 26 fixed facilities and the training, supply and oversight of 800 community-based workers. Between 1993 and 1998 the use of modern contraception by married women increased from 10 percent to 13 percent; the difference between actual and wanted fertility declined from 1.3 children to 0.9; and the median length of the preceding birth interval increased from 36 to 38 months (*GDHS, 1993 and 1998*).

2.30 ***A National Population Commission was established in 1994 to strengthen the coordination of efforts to implement Ghana's population policy and to raise commitment to this effect.*** This outcome can be partly attributed to HPP II, which included this action as a condition of disbursement. However, the project did not include any financial or technical assistance to establish and support the functioning of this

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[25] In the context of the preparation of the follow-on operation, designed as a SWAp, the Bank's preparation budget and a Japanese Grant Facility also provided financing for these building blocks of a coherent framework for sector development and financing. SWAp preparation financing also supported the definition of new management arrangements for the establishment of stronger partnerships between MoH and its partners.

[26] The creation of the GHS was mandated in Ghana's Constitution and applied to other sectors, as well as health.

[27] Averages for the five years preceding the surveys. Confidence intervals on infant and under-five mortality for 1993 and 1998 were only provided in the GDHS for 10-year averages, and not for five-year averages, which are more appropriate for measuring project performance.

agency, which was provided by USAID. The IEG team did not assess the performance of the Commission.

2.31 ***Between 1993 and 1998 the total fertility rate dropped from 5.5 to 4.6 children.***[28] In addition to family planning investments financed under the project and by USAID and others, changes in fertility are also attributable to other proximate determinants of fertility (girls' education, poverty reduction, women's empowerment, urbanization, among others).

RATINGS

2.32 The **outcome** of the Second Health and Population Project is rated *satisfactory.* This rating is derived from ratings of relevance, efficacy and efficiency of the two project objectives, summarized in Table 2.2 and discussed below.

Table 2-2 Second Health and Population Project: Summary of IEG Ratings* by Objective

Development Objective	Relevance of Objectives and Design	Efficacy	Efficiency	Outcome
Improvement in the quality and coverage of health services	Substantial	Modest	Substantial	Moderately Satisfactory
Increase the availability and accessibility of family planning services	Substantial	Substantial	Substantial	Satisfactory
Overall Project Rating				Satisfactory

2.33 The overall **relevance** of the project is *substantial.* The relevance of the project goals and objectives is *substantial.* They were fully supportive of MoH stated priorities at the time of project design. They are still highly relevant to Ghana's most recent Poverty Reduction Strategy, which includes a human development pillar, aimed at the achievement of the MDGs. The Bank's most recent Country Assistance Strategy *(World Bank 2004)* also emphasizes improved basic services delivery in support of the MDGs.[29] The relevance of the design is also *substantial*. It favored underserved areas of the country, prioritized primary health care and sought to build capacity at the central and district levels. Government ownership of the project was initially compromised by one design feature. While the PIU was appropriately established within the MoH's Division for External Aid Coordination and Project Management, its staff (mostly consultants) and somewhat autonomous functioning were found in practice to be inadequately integrated into the MoH's normal functions. This was corrected during project implementation and MoH's engagement in the project improved as a consequence.

2.34 The overall **efficacy** of this project is *substantial*. The quality and coverage of basic health services improved, especially in the underserved north. Utilization rates increased for Ghana as a whole, and more rapidly in the north, although utilization by the

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[28] Rates are for the five-year period preceding the GDHS surveys. The confidence internal for the 1998 rate is 4.3-4.8. It is not provided for the 1993 rate.

[29] This CAS specifies in particular the goals of: improved nutritional status of children under five; improved health status of communities; reduced child mortality associated with malaria and other preventable diseases; improved access to essential quality obstetric care and implementation of behavior change communications activities.

poorest may have been negatively affected by the cost recovery policy. Immunization coverage improved, although it did fall short of the project target. In addition, the project did provide emergency support to mitigate a meningitis epidemic. Capacity building, especially at the district level, also contributed to improved basic services. Infant and child mortality rates fell in Ghana during the project period, especially in the northern regions. Family planning services were expanded, contraceptive prevalence increased, albeit modestly, and fertility dropped substantially.

2.35 Project **efficiency** is *substantial.* The decision to channel funds to PPAG to improve and expand family planning service delivery made efficient use of a well-established, capable agency that complemented the efforts of the public sector. A focus on the three northernmost regions was an efficient way of targeting populations that were both poorest and most underserved. Capacity building of district health management teams helped to make better use of this resource and to facilitate the decentralization of decision-making and oversight to the local level, which has a better grasp of sector issues and challenges at the local level.

2.36 The project's **risk to development outcome** is *modest*. Since this project closed in 1997, MoH has transformed its way of managing the sector and coordinating its partners. With increasing resources and a sector-wide approach to sector management and aid coordination, the achievements under HPP II have been consolidated and further improved. Contraceptive prevalence continues to rise, district health care services continue to receive financial and technical support, immunization rates continue to rise, and efforts are ongoing to further decrease inequities across regions.

2.37 **Bank Performance.** The Bank's overall performance is *moderately satisfactory.* Its performance during *preparation* was *moderately unsatisfactory.* The project was based on good quality analytic work carried out by the Bank, which assessed the status and dynamics of population/fertility, health and nutrition in Ghana as well as national programs and efforts to deliver services. Recommendations were in keeping with good public health knowledge and practice. The design emanating from this analytic work also reflected Ghana's policies and priorities for improving population, health and nutrition indicators. A concern for addressing poverty was what incited a special focus on the northern regions. The Bank did exchange with other donors supporting health during project design, but did not work in full partnership with them. A significant shortfall of the Bank's preparation work was the weak design of M&E.

2.38 The Bank's performance during *implementation* was *satisfactory*. In retrospect, and compared with the current SWAp approach, some informants have noted that the Bank had been somewhat rigid during the early years of implementation, monitoring very closely adherence to clauses in the legal agreement and implementation progress. However, close supervision of the project seems reasonable, given that (a) the project was focused on stated MoH priorities; and (b) conditionality was linked with actions and decisions essential to good sector performance that were fully discussed and agreed with Government in the context of technically sound sector work. Around the time of the MTR, which coincided with a change in the Bank's Task Team Leader (TTL), the Bank intensified and expanded its dialogue with MoH and especially with development partners. The dialogue was said to improve both in terms of the technical quality and in terms of the Bank's capacity for listening. Supervision missions were regular.

2.39 **Borrower's performance** was *moderately satisfactory* overall. Government performance was *moderately satisfactory.* Legal covenants were ultimately complied with. Implementation was slow due to delays in the appointment of a procurement specialist. Government fell far short of its counterpart financing obligations. Government became more engaged after the mid-term review when the content and dynamics of the Bank's dialogue began to change and a SWAp process was launched. M&E were not adequately carried out.

2.40 The performance of the PIU was *moderately satisfactory.* Day-to-day management and oversight were adequate, especially when the functions of the PIU were more fully integrated into the normal MoH functions. Supervision of civil works was inadequate, and civil works implementation was considerably delayed. Poor procurement performance also delayed considerably project implementation. Over and above the long time it took to recruit a procurement specialist for the PIU, procurement planning, management and execution were deficient.

2.41 **Monitoring and evaluation** *was negligible* (paras. 2.19-2.21)**.**

3. HEALTH SECTOR SUPPORT PROGRAM (1997-2002)

BACKGROUND AND CONTEXT

3.1 **Policy and Strategic Framework.** With the support of the Bank (under HPP II) and other partners, Ghana produced a coherent strategic framework and plan for achieving health sector goals laid out in *Ghana Vision 2020.*[30] A Medium-Term Health Strategy (MTHS), prepared in 1996 (and later updated in 1999), specifies five objectives: increasing *access* to health care; improving the *quality* of health care; improving the *efficiency* of delivery of care and avoiding waste; fostering *partnership* with other (non-governmental) providers; and more and better management of *financing* for health care delivery *(MoH, 1999).* A five-year Programme of Work (PoW) was also prepared to provide a framework for the financing and implementation of the MTHS for the period 1997-2001 (Box 3-1). Those involved in the preparation of this framework (nationals and international partners alike) report that during this process MoH leadership of the sector emerged and donors transformed into a more coherent consortium of support.

3.2 The preparation of this strategic framework and five-year PoW in the mid-1990s coincided with the very strong momentum, both within and outside of the Bank, to move towards a SWAp (Chapter 1). Ghana's MoH, an active participant in international deliberations about the SWAp, decided to embark on a sector-wide approach. Both the process and outcome of the strategic planning convinced Ghana that the PoW goals would

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[30] This national development strategy document issued in the early 1990s called for: significant reduction in the rates of infant, child and maternal mortality; effective control of risk factors that expose individuals to the major communicable diseases; increased access to health services especially in rural areas; establishment of a health system effectively reoriented toward delivery of public health services; and effective and efficient management of the health system.

best be served by moving towards a more coherent and coordinated collaboration with its partners that would address the issues and constraints it was facing at the time.[31]

Box 3-1 First Health Sector Five-Year Programme of Work – PoW I: 1997-2001

Policy Goal: To improve the health status of all Ghanaians

Objectives

- Increased geographical and financial *access* to basic services
- Better *quality* of care in all health facilities and during outreaches
- Improved *efficiency* in the health sector
- Closer collaboration and *partnership* between the health sector and communities, other sectors and private providers, both allopathic and traditional
- *Increased* overall *resources* in the health sector, equitably and efficiently distributed.

Strategies

- To strengthen primary health services (district health services)
- To re-orient secondary and tertiary services delivery to support primary health services
- To develop and implement a programme to train adequate numbers of new health teams to provide and manage these services
- To improve capacity for policy analysis, performance monitoring and evaluation, and regulation of service delivery by health professionals
- To strengthen central support systems for human resources, logistics and supplies, financial and health information management
- To promote private sector involvement in the delivery of health services
- To strengthen intersectoral collaboration.

Source: Ministry of Health, 1996

OBJECTIVES AND DESIGN

3.3 The Health Sector Support Program (HSSP) was financed by an IDA credit of US$35 million, approved on October 21, 1997 and declared effective on June 18, 1998. Its ***objective*** was "…to assist the Borrower in implementing subprograms under the PoW to: (a) provide universal access to basic health services and improve the quality and efficiency of health services; and (b) foster linkages with other sectors in the Borrower's economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation and reduce poverty."[32] Program targets for 2001 were to: (a) increase life expectancy from 58 to 60 years; (b) reduce the infant mortality rate from 66 to 50 deaths per 1000 live births; (c) reduce under five mortality from 132 to 100 per 1000 live births; (c) reduce maternal mortality from 214 to 100 per 100,000 live births; (e) reduce the annual population growth rate to 2.75 percent; (f) reduce the total fertility rate from 5.5 to 5.0 births; and (g) reduce the proportion of children with severe malnutrition from 12 to 8 percent *(World Bank, 1997b)*.

3.4 The HSSP did not specify project ***components***. Rather it was designed to contribute annual tranches of financing to a common fund, made up of pooled donor financing,[33] that would be used and managed by GoG, along with its own budget, internally generated funds and other (non-pooled) financing to support the implementation of the seven strategies (or

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[31] Similar to issues raised in *Harrold et al* (Chapter 1).

[32] Development Credit Agreement between the Republic of Ghana and IDA signed on April 3, 1998.

[33] DANIDA, DFID, the Netherlands and the Nordic Fund also contributed to this Health Fund.

components) of the PoW (Box 3-2). The primary focus of the PoW was on the delivery of a package of priority health interventions.[34]

3.5 Distinct from the objectives and targets of the PoW that aimed at improved health indicators and improved health services, the SWAp was also expected to culminate in a number of achievements or outcomes that are more process-oriented, related to *how* the GoG and its partners would coordinate and collaborate to achieve PoW goals and objectives. Box 3-3 itemizes the expectations of the SWAp, as laid out in the HSSP design document, which represented a consensus of GoG, and its partners, including the Bank.

Box 3-2 PoW Components to Be Supported by the Health Sector Support Project

(a) improve access quality and efficiency of primary health services, including, the establishment of standards, human resource development rehabilitation of infrastructure, essential drugs and other inputs, community participation and greater responsibility and resources for service delivery for districts;
(b) strengthen and reorient secondary and tertiary service delivery, including rationalization of referral system, more support for regional public health disease control activities and for research, and rehabilitation and improved management of psychiatric and teaching hospitals and quality assurance programs;
(c) train adequate numbers of new health teams, including in-service training, expanding and restructuring pre-service training, improved management of post-basic specialist training, rehabilitation and technical assistance for 23 training schools, improved personnel management and planning, including effective deployment and motivation;
(d) improve capacity for policy, regulation, resource allocation and performance monitoring, including training, studies, continued policy monitoring and refinement, strengthening of statutory regulatory bodies;
(e) strengthen national support systems for human resources, logistics and supplies, financial management and health information to support implementation;
(f) promote private sector involvement in the delivery of health services, including development/expansion of contractual arrangements, development of regulatory and licensing mechanisms, and promotion of partnerships with traditional medical providers (clinical trials, professional association, and regulatory body);
(g) Strengthen intersectoral collaboration, including advocacy and participation in the planning and monitoring of activities important to health, especially nutrition, population growth, water and sanitation, female education and poverty alleviation. This will involve collaboration with specific structures at the decentralized level (district assemblies and regional coordinating councils) and at the national level (National Population Council, and relevant sector Ministries).
Source: World Bank, 1997b

3.6 ***SWAp Program Management and Implementation.*** The SWAp (inclusive of the Bank's and others' financial contribution to PoW implementation) was to be implemented through the regular channels of the Government, with MoH retaining responsibility for policy, monitoring, coordination of donors and inter-sectoral agencies and public financing for health services. The GHS[35] and two Teaching Hospital Boards were being established at the project's outset to manage the efficient delivery of a decentralized public service. District health management teams (DHMTs) in each of the 110 districts were responsible for organizing the local provision of health services, preparing annual plans and budgets for their districts and using effectively finances for non-salary recurrent expenditures. The ten

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[34] Immunization, reproductive health services, prevention and control of infections with epidemic potential, health protection and promotion, prevention and control of micronutrient deficiencies, management of selected endemic diseases, and emergency care for injuries and trauma.

[35] The Ghana Health Service was established in 1996 in accordance with the Constitution, which mandated certain development sectors (health included) to separate policy and regulatory functions (responsibilities to be retained by sector ministries) from service delivery functions (which would be assumed by newly created service agencies).

Regional Health Teams were to provide supervision and logistic support to districts and organize referral hospital care.

Box 3-3 Expectations of the SWAp

Improved sector stewardship and management on the following fronts:

- Country ***leadership and ownership*** of policy framework, strategy and resource allocation and expenditures
- ***Coherence*** of sector goals, policy, strategy, priorities and spending
  - Internal: policy, strategy, plan, budget, financing, cost-effectiveness
  - External: coherence with macro/country context
- ***Comprehensiveness*** of scope, covering the entire sector and all sources of financing
- Strong and effective ***partnerships*** between Government and its partners (donors, technical agencies, NGOs, stakeholders) for:
  - Improved coordination and rationalization of technical and financial inputs of all national and development partners and other actors/stakeholders
  - Improved forum for open and frank dialogue and debate on policy, strategy, planning, resource allocation and monitoring
- ***Flexible, performance-based financing***
- ***Efficiency gains*** through reduced transaction costs, more efficient spending
- ***Improved local systems and capacity and their effective use***
  - ***common implementation arrangements***
    - *Procurement*
    - *Financial flows and financial management*
    - *Planning and budgeting*
    - *Monitoring and evaluation*
  - ***Institution building***
- ***Sustainability*** of sector investments (financial, institutional, socio-political)

Source: World Bank, 1997b

3.7 ***Common management arrangements*** (CMA) for the management and implementation of PoW further defined and guided the transition to a sector-wide approach, aiming for the further development and fuller use of national systems and capacity (Box 3-4).

3.8 ***Risks.*** The main risks identified during project design were: the decentralization of budgeting and financial management in the face of political sensitivities and limited experience of BMCs; capacity to manage an ambitious program in line with the common implementation procedures; and Government’s ability to honor its financing commitments. Proposed actions to mitigate these risks included the certification of BMCs as and when they would fulfill eligibility criteria, the establishment of a Government-donor forum and framework for resource allocation, a focus on the development and use of national systems, and the fixing of annual IDA funding amounts on the basis of GoG fiscal effort and capacity.

Box 3-4 Common Management Arrangements under the Health SWAp
Flow of Funds and Disbursement. The CMA advocated the financing of the PoW through GoG funds, IGF funds and pooled donor funds, which would be managed by MoH and the Controller and Accountant General (CAGD), and disbursed and accounted for by Budget and Management Centers (BMCs).[36] IDA funds would thus be transferred into a central Health Account, a basket fund to which other donors would also contribute,[37] that would be under the direct control of MoH. These funds would be distributed to all eligible[38] BMCs, which would use and account for funds in line with their approved plans and budgets. *Planning and Budgeting*. The CMA defined a consolidated planning and budgeting process that would be decentralized, strongly linked to national strategy, and organized around an annual planning and budgeting cycle. The preparation of guidelines and the provision of training were envisaged for needed capacity building. Essentially, all BMCs would prepare plans and budgets in line with guidelines, that would be reviewed and consolidated at district, regional, and, ultimately, national levels for adherence with guidelines and approved for financing. The cycle also envisaged reviews of performance against program performance indicators and specified the timing of periodic joint meetings between Government and its partners, both to finalize plans and budgets and to review sector performance. Annex H provides the detailed components of the planning, budgeting and review cycles. *Procurement arrangements* under the CMA were designed to satisfy donor exigencies and at the same time enable the health sector to begin to undertake the purchase of some goods and services, including those funded by donors.[39] Thus, all procurement from the Health Account was to be carried out under MoH procedures, acceptable to IDA and other donors. A posteriori third party review was to become the main method of review, with IDA prior reviews limited to all ICB packages of works and goods if the financing involves funds from IDA either in whole or in part. *Financial Management and Reporting.* The CMA envisaged a consolidated system for financial control, accounting and audit that would be used to manage and track all financial resources, no matter the source. While initially this system was to apply to donor funds that were pooled, it was ultimately to be applied to all donor funds. Considerable capacity building had already been carried out to this end at project effectiveness, and further support (manuals, training) was planned. Accounting and reporting of expenditures for GoG funds were to be carried out in accordance with the well-established Government procedures. The Financial Controller in MoH was responsible for monitoring and ensuring that eligible BMCs remained in compliance of the readiness criteria. The delegation of monitoring tasks to qualified regional- and district-level financial staff was also envisaged. The Health Fund and larger BMCs were to be independently audited annually, with remaining BMCs to be audited at least once over 2-3 years.

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[36] BMCs were expected to include eventually over 1,000 operating units at the district level (health centers and hospitals), ten Regional hospitals, ten Regional and 110 District health administrations, five tertiary institutions and 8 headquarters Divisions.

[37] List of other donors providing basket funding at design stage.

[38] Eligibility was contingent on the fulfillment of the following criteria: preparation and submission of annual budget for internally generated funds (IGF) and health account funds; statement of quantified targets and objectives; satisfactory procedures for collecting and regular banking of IEG; acceptable procedure for authorization of payments out of the IGF/Health Account funds; books maintained and monthly reconciliation of bank balance; and adequate staff and procedures to prepare regular reports on revenues and expenditures.

[39] The ultimate goal was for the health sector to assume full responsibility for all procurement, but it was recognized that this would not be fully achieved under PoW I.

IMPLEMENTATION AND COSTS

3.9 This IDA credit became effective on June 18, 1998, during the second year of the five-year PoW. It closed four years later, on June 30, 2002, as originally scheduled.

3.10 ***Planned versus Actual Costs and Financing.*** The total cost of the five-year PoW was estimated by MoH at US$773.4 million *(MoH, 1996)*. Actual costs of program implementation amounted to US$689.5 million, or 89 percent of GoG's original estimates (Table 3-1). World Bank's initial estimate of program costs was higher at US$823.9 million. The analysis of planned vs. actual costs (Table 3-1) is based on GoG estimates *(MoH 1996)*. Neither the Government nor the Bank estimated PoW costs by component. Actual financing provided by Government and external partners fell short of projections by 65 percent and 81 percent, respectively (Annex E, Table E.1). The SDR 25.1 million IDA credit was 99 percent disbursed, with a cancellation of SDR 0.14 million. (Annex E, Table E.2).

Table 3-1 Planned Versus Actual Costs of PoW I, 1997-2001 (US$ million equivalent)

	Planned (PoW)	*Planned (WB Estimates)*	**Actual**	**Actual as % of PoW Projections**
1997 Annual PoW	126.9	*172.9*	159.0	125%
1998 Annual PoW	139.7	*160.5*	155.0	111%
1999 Annual PoW	155.2	*148.4*	162.0	104%
2000 Annual PoW	167.1	*160.3*	107.5	64%
2001 Annual PoW	184.6	*181.8*	106.0	57%
Total	**773.4**	*823.9*	**689.5**	**89%**

Sources: MoH, 1996 (for planned PoW I); World Bank, 1997b (for Bank estimates); MoH financial data (for Actuals).

3.11 ***Planned versus Actual Inputs/Activities by Program Component.*** Neither MoH nor the Bank systematically tracked PoW I implementation by component, to monitor planned vs. actual inputs and activities. According to IEG's analysis (based on program documentation, field visits and interviews)[40] most components were implemented as planned. The minimum package of services was defined. Health infrastructure investments included the construction of three regional hospitals and 52 health centers, the upgrading of 11 and the renovation and equipment of still more facilities, with priority given to the north. Considerable investment in training of health personnel was made, but net outputs just made up for staff loss through attrition per annum. Districts became more responsible for managing and overseeing services in their respective catchment areas. Exploratory work on the potential of health insurance systems was undertaken. Periodic reviews of sector performance at district, regional and national levels were held. A procurement unit was established within MoH and further strengthening of other management systems was undertaken (drugs and supplies, equipment management, estate management and capital investment, and financial management). A number of program components, however, were implemented only partially, including: quality assurance activities, performance monitoring, human resources management, partnerships with the non-governmental sector,[41] and inter-

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[40] This detailed analysis is based on an inventory of planned versus actual program support, compiled by IEG, which is available in IEG files.

[41] A key informant indicated that NGO contracts were never given out because of disagreement between MoH and GHS on who controls them.

sectoral collaboration for better health. Key inputs and activities implemented are further discussed in this chapter in relation to program outputs and outcomes.

3.12 ***Legal covenants,*** focusing on fiduciary exigencies and the sector reviews and reporting requirements in line with a SWAp approach, were fully complied with.

3.13 Other aspects of implementation (procurement, disbursement, annual sector performance reviews) are discussed later in this chapter (see section on ***Achievement of SWAp Objectives***).

3.14 ***Risks and Risk Mitigation.*** Risks were well managed overall. Implementation capacity was effectively built and used. However, not all risks were fully mitigated. The mobilization of funding fell short of expectations. The allocation and use of funds were not optimal. Partnerships with the private sector were slow to establish, and the creation of the GHS caused turbulence and undermined sector management and implementation capacity.

MONITORING AND EVALUATION

3.15 Monitoring and evaluation focused primarily on SWAp performance indicators with insufficient attention to health services and health outcome indicators and to the strengthening of accountabilities for results (Box 3-5).

Box 3-5 Monitoring and Evaluation

Design. At its very outset the PoW I established baselines and targets for program impact for indicators of health status, health services performance and a few indicators outside of the health sector that were considered important determinants of good health *(MoH, 1996).* However, this document includes no discussion of a M&E plan, strategy, methodology, roles and responsibilities or design. It did include a subcomponent on Performance Monitoring and Evaluation and it also emphasized the importance of linking inputs, outputs and outcomes and measures of client satisfaction. The Bank's design document notes that the Government and donors subsequently agreed on a set of 20 annual sector indicators to that would monitor some health objectives as well as policy, institutional and systems development. Presented in Annex E (Table E.11), it is this set of indicators that was ultimately used for monitoring performance and impact under PoW I through the process of semi-annual reviews.[42] It is interesting to note that these indicators focused more on measuring progress in launching the SWAp and had only modest overlap with health service and outcome indicators proposed in the PoW I document. Both sets of indicators were, in fact, important to sector monitoring and, together, they might have contributed to the development of a more coherent results chain for monitoring performance and outcomes under PoW I. Two other elements were lacking in the PoW logframe and M&E framework: (a) indicators to document systematically, costs, financing and efficiency of expenditures as they relate to objectives and equity issues, in short, a series of annual public expenditure reviews that would include incidence analysis;[43] and (b) indicators to document systematically the extent to which planned activities under each of the seven PoW components (or strategies) were implemented. It was also envisaged under PoW I that operational research would be supported at central, regional and district levels to document and enhance the cost-effectiveness of various schemes and interventions and to improve health sector performance and outcome.

Implementation. MoH/GHS were very systematic in ensuring the regular reviews of sector performance, at central, regional and district levels, in line with the planning/review cycles agreed under the CMA, analyzing and consolidating information around the 20 performance indicators agreed with their partners. Because the results chain was not clearly articulated, the relationship between the indicators and the strategic objectives of the PoW was not fully established, making it difficult to assess performance against PoW targets and objectives. Notwithstanding the inadequacies of these indicators, and the difficulty of interpreting them and collecting/aggregating information on them at various levels of the system, annual reviews did generate useful data and insight on progress achieved against these indicators; and they were refreshingly candid in citing shortfalls in meeting targets and weaknesses in implementation. Surveys envisaged to monitor an extremely important indicator (percent of pregnant women and children sleeping under bednets) were not undertaken. Patient satisfaction surveys were not carried out as planned and so the client perspective was not fully incorporated into sector reviews. Data collected, for the most part, were limited to public facilities. Failure to collect and report on non-governmental services/facilities leaves out some 45 percent of all services in the country.

Likewise, annual reviews of public expenditure on health were not carried out. This leaves an important void in the knowledge about the levels, adequacy and efficiency of expenditure. Indicators on the amount of health financing mobilized and on the allocation of budgets and expenditures are presented in annual reports in terms of shares and percentages and the actual values of numerators and denominators are not systematically presented to enable independent validation and trend analysis with any degree of certainty. A series of public expenditure reviews would have filled this important void.

Utilization. Reports and meetings to review sector performance were used effectively at all levels to point to weaknesses and shortfalls in sector performance and to agree on and implement recommendations to improve performance. Districts and subdistricts visited noted the value of these reviews at all levels, which have provided them with perspective on their own performance *vis-à-vis* other entities and inspired and guided them to further improve their performance. While performance contracts were signed during PoW I, they were not utilized as an effective management tool for monitoring and ensuring accountabilities of BMCs, their managers and health workers. Some health research was undertaken, but there is no evidence to indicate that it was focused on assessing and improving the cost effectiveness of health interventions or that it was utilized to this effect.

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[42] In its retrospective of PoW I, MoH noted the inadequacy of the 20 monitoring indicators, their weak links to program objectives, the failure to establish baselines on a number of them, the difficulty of BMCs to report on some of them, their lack of clear definition, and their failure to provide a reasonable assessment of the sector's performance against PoW I objectives.

[43] The Bank's design document did note that program evaluation should include an analysis of how much the poor and other vulnerable groups are benefiting from public expenditures on health, but provided no specifics on how this would be carried out. The Bank's design document also noted that IDA was likely to lead in areas of public expenditure and procurement issues.

ACHIEVEMENT OF OBJECTIVES[44]

3.16 The World Bank's financial contribution to the implementation of PoW I (1997-2001) amounted to about 5 percent of total program costs. However, given that the Bank's contribution was pooled together with that of other financiers and with the GoG budget for health, it was agreed, in the spirit of a SWAp approach, that all financiers would measure (and be measured against) GoG's health program objectives and indicators, since all were buying into the program. This section assesses project performance against two categories of outcomes: (a) the achievement of the expected benefits of a SWAp; and (b) the achievement of national health program outputs and outcomes.

(A) Achievement of SWAp Objectives

Table 3-2 Achievement of SWAp Expectations -- Summary

Expectations *(as defined in World Bank 1997b)*	**Results**
Country leadership and ownership	*Substantially achieved*
Coherence of sector goals, policy, strategy, priorities	*Substantially achieved*
Coherence of spending vis-à-vis priorities	*Modestly achieved*
Comprehensiveness of scope (entire sector, all financiers)	*Substantially achieved*
Flexible, performance-based financing	*Modestly achieved*
Efficiency gains	
• Reduced transaction costs	*Not measured*
• More efficient spending	*Modestly achieved*
Improved local systems and their effective uses	
• Procurement	*Substantially achieved*
• Financial flows and financial management	*Substantially achieved*
• Planning and budgeting	*Modestly achieved*
• Monitoring and evaluation	*Modestly achieved*
Institution Building	*Modestly achieved*
Sustainability	*Substantially achieved*

3.17 ***With the support of HSSP and the assistance of other partners, the SWAp was firmly established in Ghana's health sector and culminated in improved sector coordination, management and oversight.*** Throughout program implementation MoH convened two health summits per year, attended by development partners and other key stakeholders: one (around April) to review annual progress against the 20 agreed performance indicators and to agree on priorities and guidelines for preparing the following year's program, the other (around September) to agree on the following year's program of work and budget (including contributions of all donors). The process of annual sector reviews and annual planning and budgeting exercises was participatory, encompassing BMC exercises and their discussion and consolidation at the district level, and, in turn, regional level exercises to discuss and consolidate district-level inputs. Final consolidation of reviews and plans at the national level involved representatives from districts and regions, as well as central-level agencies, and partners. By all accounts (interviews, reports), MoH was successful in assuming sector *leadership* and national

[44] This section provides a summary of program outcomes. More detail is provided in a matrix on program objectives and targets, prepared by IEG and available in IEG files.

ownership was broad-based and high. The transaction costs of a SWAp, expected to be reduced from previous transaction costs of dealing with donors bilaterally, were not measured.

3.18 The process of sector review and management was *comprehensive* in scope. Because it was grounded in the strategic framework of the MTHS and PoW, it covered the entire sector. This process improved the transparency of investment planning for the sector.[45] It also encompassed all financiers, both those that pooled their funding and those that continued their support through earmarked financing (or projects). Partnerships between MoH and development partners were strengthened through this process. It is important to note, however, that only donors providing pooled financing were allowed to sign the joint aide-memoires at the conclusion of summits.

3.19 ***Efforts under PoW I to mobilize financial resources for basic health services fell short of targets.*** A total of US$689.5 million was mobilized for PoW I, or 89 percent of the US$773.4 million target. Both Government and donors fell short of their targets providing, respectively, 65 percent and 81 percent of their original commitments, while cost recovery activities succeeded in generating more than double the financial resources initially projected for this source (Annex E, Table E.1).[46] Health expenditure per capita (all financing sources included) slowly declined during the PoW from a high of US$8.10 in 1997 to a low of US$6.30 in 2001, falling short of the target of US$9.00. The Bank's and other pooled financing remained flexible in that it was programmed annually by MoH in light of needs and emerging challenges. However, it was not fully performance-based. The establishment of performance-based management was a goal of the PoW, as well as of the SWAp, but this was not successfully implemented.

3.20 ***Available data on the allocation and utilization of health financing indicate that some efficiency targets were met, while others have not.***

3.21 *Recurrent financing increased as a proportion of total financing, exceeding targets.* During the first three years of the PoW, recurrent financing for health as a share of total financing for health increased from 56 percent (1997) to 82 percent (1999) exceeding the end-of-PoW target of 74 percent (Annex E, Table E-3), with the share of the investment component decreasing as a consequence.

3.22 *Efforts to shift non-salary recurrent financing increasingly to districts in support of basic health services were successful.* The district-level share of non-salary recurrent spending for health reached 43 percent by 2001, fully meeting the PoW I target of 42 percent, and representing an almost doubling of the pre-PoW I (1996) share of 23 percent

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[45] Informants and documents have shown that the definition of the financing program of the health SWAp during its preparation and the monitoring of plans during SWAp implementation served both to reveal and to mitigate a trend of investments in tertiary infrastructure financed with commercial loans, which was not in keeping with the new policy of increased investments in district-level and primary health care facilities.

[46] Data on MoH spending as a share of total GoG spending reveal mixed performance against targets. Total MoH expenditure as a share of total GoG expenditure in 2001 was 8.7 percent (*MoH, 2006)* exceeding the target of 7.3 percent. However, MoH recurrent spending as a share of total GoG recurrent spending fell short of the 12 percent target: *MoH 2002* reports it as 6.9 percent, while *MoH 2006* reports it at 10.2 percent. Annex E provides more detail.

(Annex E, Table E-5). While this is an important step towards improved efficiency of spending, health reviews and key informants have raised the continued challenge of developing tools to ensure more efficient allocations across and within districts.

3.23 *However, achievements fell short of targets for increasing the share of non-salary recurrent financing of the total recurrent budget.* In 1999, 59 percent of recurrent financing was spent on non-salary items, falling short of the target of 67 percent for that year (Annex E, Table E.5). Expenditures on wages and wage incentives for staff in deprived areas were increased to address persistent and pressing issues of shortages and inequitable distribution of human resources for health and were projected to further increase in this regard. Informants have also noted that strikes of health workers usually result in reductions in non-salary recurrent budgets and expenditures to compensate for increased expenditures on salaries.

3.24 ***Capacities in procurement, planning, budgeting, financial management and strategic sector management were significantly strengthened and expanded.***

3.25 *Procurement* capacity was strengthened with the establishment of a procurement unit within the GHS and the development of a Procurement and Procedures Manual and of standard bidding documents. This unit has become increasingly competent in carrying out NCB and ICB (in line with Bank standards and guidelines, no matter the source of financing), as evidenced in the annual procurement audits. Bank monitoring included the conduct of post reviews. Remaining challenges identified at the end of the project included the need to: increase the quantity of procurement skills including at decentralized levels, improve procurement planning and linking it to finance, planning and implementation tracking systems.

3.26 *Disbursements/Financial Flows.* Because the IDA credit became effective after the start of PoW I, the credit agreement made provision for retroactive financing of a part of program implementation costs incurred prior to effectiveness. About three-quarters of the Bank's disbursements went into the Health Fund, with the remaining quarter used, at Government's request, to advance funds to UN agencies for procurement of some commodities and to make direct payments to suppliers. Flow of GoG and Health Fund monies to BMCs in the regions and districts experienced some delays because disbursements were made on the basis of financial reporting, for which many BMCs had difficulty, initially, completing. Financial flows improved as experience was gained and districts visited expressed great appreciation for the additional liquidity at their disposal which greatly facilitated district plan implementation.

3.27 *Budgeting, Planning, Financial Management.* Objectives to strengthen and decentralize planning, budgeting and financial management were substantially achieved. While data are incomplete, they do indicate (and are corroborated with findings from field visits) that by the end of the Bank project, the staffing of BMCs with fiduciary officers was achieved and BMCs were routinely preparing plans and budgets encompassing all funding sources. By the mid-point (1999) of the PoW 92 percent of BMCs had satisfied eligibility criteria permitting them to manage and account for funds received, and these BMCs were providing timely quarterly income and expenditure reports on all sources of financing. In short, the BMC concept became firmly established with strategic improvements in capacity building, planning, budgeting, and financial management.

3.28 ***However, sector institution building under the SWAp fell short of expectations.*** In 1996 the Ghana Health Service (GHS) was established under Act 525 as an autonomous executive agency responsible for health services delivery through the public health system. This reform was articulated in Ghana's MTHS and grounded in the national constitution, which called for a separation of the policy/regulatory functions (the responsibility of sector ministries) from service delivery functions (to be assumed by new sector services agencies). The implementation of this reform was plagued by a number of issues including: the lack of clarity of roles and responsibilities and complementarities between MoH and GHS, the duplication of services between the two agencies, the weak capacity of MoH after most senior staff left this agency to join the GHS and were replaced with less experienced staff, and the failure to review/adopt the legislative instrument to implement Act 525. While these issues were repeatedly raised in summit (and other) meetings and documented in progress reports, they persisted throughout the PoW implementation period, causing confusion and inefficiencies in health sector operations, especially at the national level. The MoH also failed to expand its service capacity through the development of contractual arrangements with the NGO and private-for-profit sector.

(B) Achievement of Health Outputs

3.29 This section draws heavily on the analysis of GDHS data (1998, 2003) that reveal trends in key indicators of health services performance and health status, roughly coinciding with the implementation period of the PoW (1997-2001) and the IDA credit (1998-2002). Annex F presents overall national trends, and Annex G disaggregates this data to show trends for the poorest and richest wealth quintiles, rural and urban populations and the three northern regions and the equity of health services utilization and health status is assessed. It is critical to note that the trends emanating from these two surveys must be interpreted with caution. Definitions, the way in which data were collected and presented, and timeframes for these indicators differ from one survey to the other. Annexes F and G include detailed annotation to highlight and clarify these differences for careful and accurate interpretation of the data. Confidence intervals and standard errors drawn from GDHS reports are provided in these annexes. This section also draws on IEG's analysis of household data (Annex H) and on MoH service indicators.

Objective #1: Provide universal access to basic health services and improve the quality and efficiency of health services

3.30 ***The majority of health service and health outcome targets established by GoG for the end of PoW I (2001) were not achieved.*** Table F.7 in Annex F provides an overview of performance in achieving these targets and the following paragraphs provide highlights. Table F.7 also reveals that PoW baselines and targets for health indicators, established in 1997, were not updated in 1998 on the basis of newly available GDHS data. The differences between the estimated (1997) and real (1998) PoW baselines was significant for some indicators. A number of real baselines (*GDHS 1998)* were much closer in value (in some cases almost equal) to end-of-program targets than to the estimated baselines (e.g., infant and under-five mortality, immunization coverage, use of oral rehydration therapy for diarrhea and tuberculosis cure rate). Actual baseline fertility exceeded the program target. However, program targets were never adjusted accordingly.

3.31 ***Between 1998 and 2003 the percent of children aged 12-23 months, who were fully vaccinated[47] rose modestly from 62 to 69 percent and overall equity in vaccination coverage improved.*** Rates for the poorest and rural residents rose faster than those for their counterparts belonging, to the highest wealth quintile and living in urban areas, respectively; and rates in the northern regions rose at the same rate as the national average. ***The DPT3 target coverage of 80 percent was achieved. However, the improvement was marginal since the real (GDHS 1998) baseline of 72 percent was considerably higher than the PoW's baseline estimate of 49 percent (Annex F, Table F.5).[48] Immunization rates for the poor, rural residents and northern populations are still unacceptably low (Annex G, Table G.1, G.2 and G.3).*** Immunization remains one of the most cost-effective public health interventions.

3.32 ***Despite the high priority accorded to malaria prevention and control in the PoW, very little progress was achieved between 1996 and 2003.*** Annual health sector reviews reported a very low level of use of insecticide treated bednets (ITN) (less than 1 percent each year) from 1996 to 1999, and no data was available from MoH for 2000-2001. DHS data for 2003 indicate that less than 4 percent of children slept under an ITN the previous night. This level is extremely low, given the effectiveness of ITN use for preventing malaria. The affordability of malaria treatment appears to be prohibitive for some. The average user fee for malaria treatment was 105,776 in 2001, with regional variations averaging 73,846 in the northern belt, 141,443 in the middle belt and 124,237 in the southern belt (*MoH statistics)*. A study in Kassena-Nankana District (Upper East region) found that, while the cost of malaria care was just one percent of the income of the richest households, it was 34 percent of the income of the poorest. The number of malaria cases that consulted the public health system increased by 50 percent from 2.0 million in 1997 to 3.0 million in 2001, but trends in the total number of cases in Ghana are not known.

3.33 ***Interviews, field visits and documentation all indicate that priority disease programs may suffer from (a) almost exclusive use of earmarked funds for their financing; and (b) failure of districts to devote adequate attention and resources to their implementation.*** MoH's strategy not to use its own resources to finance priority interests of donors (malaria and HIV/AIDS, for example) is pragmatic because it makes sense both to make effective use of funding earmarked for these programs and because it has proven effective to raise additional resources for these programs. However, this has also undermined the reliability and sustainability of financing. The malaria and HIV/AIDS financing provided to the MoH is virtually all externally financed. Recent analysis of HIV/AIDS accounts has revealed, however, that the financing of health sector activities is inadequate to the needs (*Ghana AIDS Commission, 2004*). Districts are reported to be still counting on parallel financing of priority programs through the central programs and are thus not likely to use their discretionary financing to support program activities.

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[47] Full vaccination includes BCG, 3 doses of DPT and polio (not including Polio 0) and one dose of measles. Beginning in 2002, the three doses of DPT were replaced with DPT/HepB/HiB (Annex F, Table F.5).

[48] Confidence intervals cited in GDHS: 68-76 for 1998 and 76-83 for 2003.

3.34 ***The use of oral rehydration therapy (ORT) for treating diarrhea in children under five did not change significantly between 1998 and 2003.***[49] In 1998, 67 percent of children under three years with diarrhea were treated with ORT, and this proportion was 64 percent in 2003, indicating no substantial change (Annex F, Table F.6). In 1998 8 percent of child diarrhea cases received no treatment and this rate increased to 13 percent in 2003. While the rural and northern populations had rates of ORT use close to the national average in 2003, inequities persisted between the poorest and richest income quintiles (with respective rates of 60 and 78 percent) (Annex G, Tables G.1, G.2 and G.3). There is considerable scope to increase the coverage of treatment of child diarrhea both nationally and especially for the poor, which is both a cheap and effective way of fighting child morbidity and mortality.

3.35 ***Utilization of ante-natal care services was consistently high between 1998 and 2003, and actual coverage of this service is equitable.*** In 1998, 88 percent of women who gave birth five years preceding the survey reported at least one visit with a doctor, nurse or midwife during their pregnancies. This level increased to 92 percent in 2003 with the important caveat that auxiliary nurses were added to the "skilled worker" definition, so exact comparisons are not possible (Annex F, Table F.6). Poorest, rural and northern populations had greater rates of increase between 1998 and 2003 than rates for the richest, urban residents and the national average, thus improving equity (Annex G, Tables G.1, G.2 and G.3).

3.36 ***By contrast, national rates for deliveries attended by skilled workers remained at unacceptably low levels, and inequities in the use of these services were extremely high between the poor and rich, rural and urban residents, and for northern populations compared with Ghana as a whole.*** In 1998 of all births in the previous five years, only 44 percent were attended by a doctor, nurse or midwife. In 2003, 47 percent of all births in the previous five years were reported to be attended by a skilled worker (Annex F, Table F.4). The rate for 2003 was based on an expanded definition of a skilled worker, which also included an auxiliary nurse, and thus is not likely to reflect any real increase. Even with the inclusion of an auxiliary nurse in the definition of skilled workers, in Ghana on average less than one half of all births are attended. Use of these services by the richest quintile is four and one half times the level of the poorest quintile, urban residents are more than twice as likely to use these services as their rural counterparts, and the rate of use in the north is less than half the national average (Annex G, Tables G.1, G.2 and G.3).

3.37 ***Exemptions for vulnerable people may have had partial success in lifting financial barriers to health services utilization. However, they were insufficient in allowing them to take full advantage of available services and are not sustainable.*** Available data indicates significant increases in exemptions for pregnant women using antenatal services (from 2.6 billion cedis in 1997 to 3.5 billion in 2000), persons over 70 years (from 0.7 billion in 1997 to 1.3 billion in 2000), and children under 5 (from 54 million in 1998 to 3.0 billion excluding Greater Accra Region, in 2000). High utilization of antenatal services by all vulnerable groups is a likely outcome of such increases.

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[49] According to the GDHS 2003 definition, ORT includes oral rehydration salts (ORS), recommended home fluids (RHF) or increased liquids.

Exemptions for paupers remained virtually unchanged (at 0.4 billion cedis); and data were not available for psychiatry/leprosy (Annex E, Table E.8). An estimated 3.6 percent of the recurrent budget was spent on exemptions in 2001. However, user fees are reported (*MoH, 2001*) to have risen faster than exemptions, and the poor were not necessarily the primary beneficiaries of exemptions (*World Bank 2003*). It has also been documented that budgets for exemptions amounted to far less than actual exemptions. For example, the Northern Region, which performed very well in making exemptions available to clients, received a total of 1 billion cedis to cover for exemptions in 2000, but total claims for that year amounted to 2.2 billion cedis. While DANIDA financed the difference for that particular year, the following year only 1.6 billion cedis were made available to this region against a total claim of 2.6 billion cedis for 2001. Interviews with regional and district level staff noted the difficulties in honoring exemption policy when they are not reimbursed for these costs. It has also been found that under the "cash and carry" (drugs cost recovery) system, incentive has been stronger for health staff to generate resources for their facilities than to ensure the protection of the poor against financial barriers to access (*MoH, Bulletin of Health Information, Vol 1, Number 2 and 3, March 2002*).

3.38 ***Efforts and outcomes of service quality improvements were not well documented and patient satisfaction was not systematically monitored***. The adoption of the practice of auditing maternal deaths is likely to have contributed to improved service quality. Another investment in quality was the establishment of quality assurance teams in some facilities and an increase in supervision. The program objective of monitoring patient satisfaction through surveys was not achieved. Teaching hospitals did not carry out patient satisfaction surveys. Regional hospitals improved their reporting from 33 percent of hospitals reporting in 1998 to 89 percent in 1999, and subsequently stopped reporting in 2000-2001. District hospitals for the most part did not carry out patient surveys during 1997-2001, with the notable exceptions of routine surveys for all district hospitals in the Eastern Region and 12 surveys for district hospitals in Brong-Ahafo. Unfortunately, annual reports only recorded the number of patient satisfaction surveys carried out, providing no information on the findings of these surveys.

3.39 ***Program investments helped increase the production of human resources for health, essential to quality, but improved staffing of health facilities was undermined by significant brain drain and inequitable distribution of health workers across the country.*** Ghana's success in expanding and restructuring pre-service training culminated in a quadrupling of state registered nurses (SRN) training intake since 1995. Average annual output during PoW I was 395 SRNs; 125 post SRN Midwifery; 110 EN/CHN Midwifery; 162 community health nurses and 52 environmental health assistants. Shortages of inputs, staff, infrastructure, equipment and learning materials have undermined the efficiency of SRN schools. Ghana also produced about 120 doctors and 80 pharmacists, annually, with medical and pharmacy schools noted to be working at full capacity. However, attrition rates following graduation are high, such that graduates going to work in Ghana's health system on an annual basis just make up for staff loss through attrition. Low motivation and remuneration of health workers, combined with a high demand for Ghana's health workers overseas, add to the problem. Inequitable distribution of scarce human resources across Ghana is exacerbated by the refusal of some to be posted in remote areas. A US$4 million package to provide incentives to

those posted in hardship areas was developed at the end of PoW I. In 2001 the doctor to population ratio was 20,036, ranging from a high of 58,493 in the Northern Region to a low of 8,288 in the Greater Accra Region. The nurse to population ratio for that same year was 1,728, ranging from a high of 3,149 in Brong Ahafo (and 2,509 in the Northern Region) to a low of 1,211 in the Eastern Region (and 1,280 in the Greater Accra Region) (data on file in IEG). Considerable investment in Masters programs has contributed to the increased specialization of Ghana's health work force.[50]

3.40 ***Health services efficiency has not improved notably during PoW I***. Over and above the failure to prioritize adequately the implementation of key health interventions, particularly as a result of integration and decentralization, health facilities services are inadequately utilized. Program indicators are not a perfect measure of service efficiency: national average bed occupancy was 59 percent in 2001, excluding (higher-occupancy) psychiatric hospitals; and the hospital admissions rate increased only modestly from 30 to 35 percent. More significantly, at the end of 2001 hospitals were still providing primary health care services, which are more cost-effectively delivered by lower-level facilities; and the referral system is not well defined or developed. Furthermore, at the end of 2001 the potential for contributions from non-governmental health service providers remained largely untapped. At the start of PoW I a Memorandum of Understanding (MoU) was developed and a consensus meeting was held with the Christian Health Association of Ghana (CHAG).[51] No contracts were signed in 1997-1999, but 43 contracts were finally signed with CHAG institutions in 2000. No contracts were signed with the private sector. Given that there were an estimated 1,296 non-governmental health facilities in Ghana in 2004 (*MoH data*)[52], the 43 CHAG institutions, which did have signed contracts, represent a mere 3 percent of these facilities.

Objective #2: Foster linkages with other sectors in the Borrower's economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation, and reduce poverty.

3.41 ***The MoH undertook a number of initiatives to foster inter-sectoral action to influence key determinants of health.*** MoH: disseminated family planning information (through active collaboration with the National Population Council); contributed to poverty alleviation (through the financing of exemptions and its contributions to the preparation of the national poverty reduction program); enhanced cross-sectoral collaboration at the district level (through participation in relevant subcommittees, and collaboration with other sectors on key health activities -- especially on immunizations and guinea worm eradication); addressed malnutrition (through the passage of an act on

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[50] Ninety masters programs were awarded in 2000 to staff working in all regions, in a number of disciplines: health economics, health promotion, information sciences, hospital management, tropical medicine, medical electronics, occupational therapy, radiology. Short specialization courses were awarded in nutrition, reproductive health, and health services management. Ghana's requirement for specialized staff is still not fully met.

[51] CHAG is an umbrella organization that coordinates the activities of the Christian Health Institutions and Christian Churchs' health programs in Ghana. It is the body through which most of the Christian Church programs and facilities liaise with MoH to ensure proper collaboration and complementarity.

[52] Including mission, quasi-government and private facilities.

salt iodization and a Legislative Instrument on breastfeeding, although enforcement of these has been inadequate); addressed school health (through some collaboration with Ministry of Education on the School Health Programme). However, MoH reports that its contributions were suboptimal with regard to water and sanitation, girls' education and food supplementation. Constraints to inter-sectoral collaboration identified by MoH included: failure to identify common needs, goals and objectives across agencies; and weak or non-existent institutional arrangements for such collaboration (no definition of roles, responsibilities and accountabilities for planning, financing, implementation, monitoring and evaluation).

(C) Overall Health Outcomes

3.42 ***Between 1998 and 2003 there were no improvements in child health outcomes.*** GDHS data reveal that there were no statistically significant changes in infant and under-five mortality[53] during this period (Annex F, Table F.1). Infant mortality was 57 per 1000 live births in 1998 and 64 in 2003,[54] and under-five mortality was 108 in 1998 and 111 in 2003,[55] ending the long trend of improvements recorded since independence (Chapter 1). ***Likewise, there was no statistically significant change in total fertility (4.6 in 1998 and 4.4 in 2003) (Annex F, Table F.2).***[56]

3.43 ***GDHS data on malnutrition reveal no major trends of improvement.*** Severe stunting of children under the age of 5 years was 9 percent in 1998 and 11 percent in 2003. The proportion of children under five who were severely underweight did not change, estimated to be 5 percent in 1998 and again in 2003. Likewise 1.4 percent of children under five were severely wasted in 1998; and in 2003 this proportion remained at the same level (1.3 percent) (Annex F, Table F.7). ***IEG's analysis of household survey data on stunted and underweight children show that 2003 rates for each indicator are no different than rates in 1988 (Annex H) corroborating the series of GDHS survey data (Annex F, Table F.1)***. According to these data in 1988 and again in 2003 one in four children is stunted and one in four children is underweight.

RATINGS

3.44 The **outcome** of the Health Sector Development Project is *moderately unsatisfactory,* based on ratings of relevance, efficacy and efficiency summarized in Table 3-3.

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[53] For the five-year period preceding GDHS surveys.

[54] GDHS 1998 provides the confidence interval for the 10-year infant mortality average, but not for the five-year average, which is more appropriate for this assessment. The confidence interval for the 2003 rate is 55-73.

[55] Likewise, GDHS 1998 does not provide the confidence interval for the five-year average of under-five mortality. The confidence interval for the 2003 rate is 99-123.

[56] Confidence intervals cited in GDHS: 4.3-4.8 for 1998 and 4.2-4.7 for 2003. The 1998 fertility rate is the average for the five years preceding the survey, while the 2003 fertility rate is for the three preceding years.

Table 3-3 Health Sector Development Project: Summary of IEG Ratings* by Objective

Development Objective	Relevance of Objectives and Design	Efficacy	Efficiency	Outcome
1. Provide *universal access* to basic health services and	Substantial	Modest	Modest	Moderately Unsatisfactory
improve the *quality* and		Modest		
efficiency of health services		Modest		
2. Foster linkages with other sectors in the Borrower's economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation, and reduce poverty.	Substantial	Modest	Modest	Moderately Unsatisfactory
Overall Project Rating				Moderately Unsatisfactory

3.45 The overall **relevance** of the project is substantial. Its objectives are derived from a five-year health sector program, which is a component of Ghana's PRSP. Its objectives are relevant to three of the five pillars of Ghana's PRSP (human resources development; implementing special programs for the vulnerable and excluded; and ensuring good governance through accountability and transparency), which targets reductions in under-five mortality, maternal mortality and infant mortality. Its objectives are also relevant to the Bank's most recent CAS (*World Bank, 2004*), which includes a human development and services pillar and which aims to improve the health and nutrition status of women and children, improve access to quality obstetric care and increase healthy behaviors. The project's SWAp design supports Ghana's goal to assume leadership in the strategic management of its health sector and in the coordination of technical and financial assistance to the sector. However, the design was deficient in that the sector program results chain and causal links were not clearly laid out, nor were the indicators and M&E plan and system sufficiently developed to ensure the proper tracking and linkage of the various components of the program logframe.

3.46 **Efficacy** in improving service access, quality and efficiency of services was *modest* overall. This rating is based on the facts that the majority of PoW I targets was not met (Annex F, Table F.7) and that changes in key health indicators between 1998 (the year of project effectiveness) and 2003 were not statistically significant (Annex F). The objective to strengthen inter-sectoral coordination was met only *modestly* (para. 3.40).

3.47 Project **efficiency** was *modest,* overall. The increased financial resources for health were not used more efficiently. Trends indicate a growth in investment and salaries budgets to the detriment of recurrent budgets (for administration and services). There is still inefficiency in how the expenditures are allocated across regions. Likewise, little progress was made in motivating and rewarding health managers and workers to be posted to hardship areas, leaving the distribution of human resources for health chronically inequitable. Hospital occupancy rates reveal an under-utilization of this level of service. Furthermore, hospitals still deliver primary health care services, which are an expensive proposition, and a referral system defining the different levels of services offered at the different levels of the health system had not been developed by the program's end. The underutilization of the non-governmental sector in the delivery of health services is also an indicator of inefficiency. During the life of the project the integration and decentralization of health programs and services led to inefficiencies in the delivery of these programs at the district level, with priorities accorded these programs by the districts not always commensurate with the epidemiological justification

for action. While the benefits of two Summit meetings every year and similar meetings at regional and district levels are evident, the costs and opportunity costs of these meetings have not been calculated. Chronic overlap and competition between MoH and GHS also undermine efficiency.

3.48 The project's **risk to development outcome** is *modest.* The achievement of health outcomes, especially among the poor, remains a priority for GoG, as articulated in the PRSP. The SWAp is well established, with a follow-on five-year program (PoW II, 2002-2007) to be completed this year, and is likely to continue receiving the support of Government and its partners. Nevertheless, the SWAp is undergoing changes that will need to be managed to minimize the risks of health outcomes not being maintained or improved. Among these changes are: (a) the move of a number of partners away from pooled program financing and to general budget support, which requires adjustment of systems and processes for mobilizing and accounting for financial resources and for reporting on results; (b) the establishment of a National Health Insurance Scheme, which is replacing "cash and carry" cost recovery and assuming responsibility for protecting the poor's access to health services; and (c) significant staff turnover, both within GoG and among partners, that will require renewal and adjustment of Ghana's relationship with its health partners.

3.49 **Bank Performance.** The Bank's performance during preparation was *satisfactory.* The Bank's team had a strong technical capacity and health officials report that it was highly credible with Government in its technical discussions, providing valuable technical input and guidance to the preparation of PoW I. Perhaps even more importantly, the Bank's team recognized the strong leadership and technical capacity in MoH at the time of preparation and was reported to be an effective listener and respectful and supportive of its potential for leadership. As a strong proponent of the SWAp for Ghana, the Bank's team was proactive in undertaking intensive advocacy work inside of the Bank, successfully convincing, with the support of its managers, decision-makers at the highest levels (legal, financial, procurement) to allow more creativity, flexibility and client orientation in the Bank's procedures in support of a SWAp. The Bank was also instrumental in catalyzing Ghana's health partners to work in a SWAp mode. The Bank was the only one among all partners that put 100 percent of its health support into the Health Fund, the other Health Fund contributors having some projects/parallel financing in addition to pooled financing. An important caveat to the Bank's (otherwise) excellent performance during preparation was its failure to guide and support the development of a sector-wide logframe, with a well articulated results chain and a viable M&E plan and system that would have monitored more effectively health sector performance and outcome.[57]

3.50 The Bank's performance during implementation was *moderately satisfactory.* Supervision missions were regular, timed around the Health Summit meetings, and the quality of the technical team is reported by informants to have remained high, despite a

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[57] While the Bank's team has noted that considerable discussion and debate did in fact take place around the challenge of program M&E, IEG could find no evidence of the production of a viable M&E plan and system in the official PoW document (*MoH, 1996*) or in any other MoH document reviewed covering the PoW implementation period. The list of 20 program performance indicators shown in Annex E, Table E.11, was insufficient, as noted in Box 3-5, and in *MoH 2001*.

change in task manager. By the very nature of the SWAp, dialogue and the quest for learning and improving through annual reviews remained prominent and actively pursued by the Bank and its partners. However, it was noted by a few informants that while the Bank task manager contributed significantly to the Summit Meetings, around which missions were timed, these missions did not include field visits to Ghana's regions. The Bank did have a full-time staff in the Ghana office who undertook frequent site visits, but this did not replace the needed technical supervisions by the HQ-based staff. Even in the context of a SWAp, the Bank neglected two important issues: inadequate program M&E and the tensions, duplications and competition between the MoH and the GHS.

3.51 **Borrower's Performance.** Government's performance was *moderately satisfactory*. It was successful in preparing for and implementing the semi-annual Health Summits and in carrying out procurement and financial management in a manner satisfactory to the Bank. It did, however, fall short of its financial obligations in support of PoW I implementation. Ownership of the PoW was strong. Its relationships with partners and stakeholders were strong. However, it has been noted by many informants that civil society participation in Health Summits was inadequate. The Borrower deserves praise for the candor with which its monitoring reports were written, both annual and the end-of-PoW I reports. They were issues-oriented and focused on the resolution of bottlenecks to smooth and efficient implementation and on efforts to improve performance. While some indicators were changed at the end of PoW I, in preparation for (improved) PoW II monitoring, and while considerable effort was given to strengthening the health MIS, the fundamental deficiencies of program M&E were never addressed. Performance management through performance contracts was never fully or successfully implemented.

3.52 **Monitoring and Evaluation** was *modest* for reasons noted in Box 3-5.

4. HEALTH SECTOR PROGRAM SUPPORT PROJECT II (2002-2007)

BACKGROUND AND CONTEXT

4.1 A second five-year PoW covering the period 2002-2007 was issued in 2002. While it supported the same strategic objectives, it emphasized much more strongly than the first PoW the importance of reducing inequalities in health outcomes (poor/rich, rural/urban, and across regions). A number of observations and lessons from implementation of the first PoW guided the strategic focus of the second one. These included low availability and use of health services; growing financial barriers to access; unresponsiveness of health services to demand; underexploited potential of non-governmental providers; significant brain drain of human resources for health; low sector efficiency and lack of performance incentives and low per capita expenditure. As shown in Box 4.1 these challenges are addressed in the PoW strategies.

Box 4-1 Second Health Sector Five-Year Programme of Work (2002-2006) PoW II
Vision: Improved overall health status and reduced inequalities in health outcomes of people living in Ghana. ***Policy Goal:*** Working together for equity and good health for all people living in Ghana. ***Strategic Objectives:*** • To improve *quality* of health delivery • To increase *access* to health services • To improve the *efficiency* of health services delivery • To foster *partnerships* in improving health • To improve *financing* of the health sector ***Key Program Components:*** • Strengthening and support of priority health interventions • Developing human resources for health • Enhancing infrastructure and support services • Fostering partnerships for health • Promoting private sector participation in health service delivery • Improving regulation • Reforming organizational arrangements • Improving health sector financing, including the introduction of national health insurance • Improving management systems • Strengthening management information systems and performance monitoring • Improving links and synergies with traditional and alternative medicine *Source: Ministry of Health (revised edition), 2003*

OBJECTIVES AND DESIGN

4.2 The Second Health Sector Program Support Project was financed by an IDA credit of US$57.6 million and an IDA grant of US$32.4 million, approved on February 6, 2003 and declared effective on May 22, 2003. Its *objective* is "…to support the Borrower's Program (the second Health Programme of Work for 2002-2007 – PoW II) to improve the health of the Borrower's population, while reducing geographic, socio-economic and gender inequalities in health and health outcomes."[58] Key performance indicators for measuring program performance are grouped under five categories, in line with the five strategic objectives of PoW II: access, quality, efficiency, partnership and financing. The 11 key *components* of PoW II are listed in Box 1.2 and itemized in Annex F.

4.3 **The *program implementation arrangements*** under the Health Sector Support Program/PoW I were continued under this second SWAp operation, notably: implementation through regular channels and systems of Government, common implementation arrangements for the MoH and a core group of donors,[59] and a MoU between Government and these donors. The annual planning cycle defined at the program's outset was slightly revised to improve the approval/availability of financing at the beginning of the year.

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[58] Development Financing Agreement between the Republic of Ghana and IDA signed on April 16, 2003.

[59] World Bank, DfID, DANIDA, European Union and the Netherlands, who had agreed to continue to pool an increasing part (about 75% or more) of their resources into a Health Fund managed by MoH, constituted the core group of donors. Other donors maintained earmarked funds or projects (USAID, JICA and WHO). At the time of design, some donors (EU and DFID) were considering moving from sector budget to general budget support.

4.4 ***Program risks*** were similar to those under the previous operation (insufficient political commitment, GoG failure to meet financing commitments and insufficient implementation capacity). The challenges of forging partnerships with mission and private sectors and of retaining human resources were also raised.

4.5 With an effectiveness date of May 22, 2003, and an imminent closing date of June 30, 2007 the implementation period for this IDA support is 4 years and one month. Total program costs were estimated at US$1.1 billion (Annex E, Table E-9). Actual costs of PoW II are not yet available. As of end-February 2007, IDA's financial support of 68 million SDRs (of which 43.5 million SDRs is credit and 24.5 million SDR is grant funding) was 99 percent disbursed.

4.6 ***Planned versus Actual Inputs/Activities by Component***[60]. Most components have been implemented, with some caveats. First, some health interventions, which were accorded high priority, are still not given sufficient priority in implementation (maternal health, outreach activities, and enhanced targeting of services to the poor), while others lack efficacy and efficiency (malaria). Second, activities to improve human resources for health were partially implemented. Third are shortcomings in efforts to enhance partnerships with the non-governmental sector and with other public sector agencies and to consolidate and render fully functional the institutional and organizational frameworks for the MoH and the GHS. Fourth, while some progress in strengthening the health management information system was made it is not yet fully functional or utilized for strategic management. Implementation of the immunization program, on the other hand, was fully implemented, as was the further strengthening of financing and financial management systems.

4.7 ***Legal covenants*** were few in number and fully complied with, focusing on financial flows, financial management and financial reporting and audits; key steps in the annual SWAp process and their timing (reviews of performance; preparation of plans/budgets; submission of the budget to Ministry of Finance), and the appointment of a procurement auditor responsible for reviewing all procurement financed under the Program.

4.8 ***Procurement*** continued to be strengthened, most notably with regard to (a) the decentralization of procurement to MoH agencies and providers; and (b) the phasing out of the Bank's practice under PoW I of carrying out post-reviews of MoH procurement and the transfer of that responsibility from the Bank to a procurement auditor.

4.9 ***Disbursements*** to BMCs were facilitated as (a) they gained more experience in submitting financial reports necessary for releasing disbursements; and (b) financial reporting was simplified and streamlined. However, field visits revealed that there was a shortage of funds in the latter years of the program. Bank's disbursement pattern indicates that the lion's share (88%) of the IDA financing was disbursed during 2004 and 2005.

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[60] This section is based on a detailed inventory of planned versus actual program support, carried out by IEG, and available in IEG files.

Monitoring and Evaluation

4.10 **Design.** PoW II Sector-Wide Indicators were almost the same as those for PoW I. No indicators were included to track equity even though this was the theme of PoW II. PoW II took note of weaknesses in M&E, specifically that: data are not used systematically for decision-making; performance is not linked with resource allocation; data collected is of poor quality; sector information does not include the non-governmental sector; some performance indicators are difficult to interpret; the use of research findings is limited; and baseline data for PoW I were lacking. PoW II thus resolved: to develop more relevant performance indicators, provide a stronger evidence base for policy and practice; build the capacity to monitor contractual arrangements; strengthen the capacity for operations research; and improve the use of information technology. In its annual report on 2001 (final year of PoW I), MoH called for the development of sector-wide indicators that would be: aligned with strategic objectives of the PoW; consistent with the measures for evaluating Ghana's PRS and other international commitments of Ghana; supported by the routine information system and applicable at the district level; and able to provide scope for monitoring input, output and outcome *(MoH 2000).* The indicators adopted for tracking performance under PoW II included 9 of the original 20 and 20 new ones. The new ones consist essentially of those sector-wide indicators on service delivery performance that were envisaged in the original PoW I document, but not adopted as part of the 20 indicators agreed with the development partners. While these indicators represent an improvement, they do not fill all the gaps for a coherent M&E framework. Still missing are: more precise indicators on costs, financing, and utilization of resources; and the tracking of planned vs. actual interventions/activities organized around the components of PoW II.

4.11 **Implementation.** As was the case under PoW I, MoH/GHS collected data and reported on selected program indicators. The failure to track inputs and outputs systematically and to link them to outcomes and impacts has persisted under PoW II, making it difficult to assess the effectiveness of different interventions and approaches. Financial management and service delivery information are still not linked, which would facilitate a more comprehensive and rigorous assessment. Operational research on the cost-effectiveness of specific interventions has been under-funded and pilots have not been fully evaluated before their expansion nationwide, community-based health planning and services (CHPS) being a case in point. It has also been noted that sector-wide indicators have been inappropriate for measuring outcomes of poverty and equity-related objectives and thus are still in need of revision. Considerable investment has been made in strengthening the MIS (software, training, decentralization to the district level) and the quality and reliability of some information is likely to have improved, but there is still considerable work to be done. An assessment of the health information system was carried out as input for the 2005 annual Summit, which sought to improve performance in this regard.

4.12 **Utilization.** Thanks to the process of regular reporting and review of sector-wide indicators at all levels of the system, data and information emanating from this process are indeed used to raise issues and formulate and implement recommendations for improved sector performance. However, the inadequacy of these indicators undermines

the potential for corrective action. Performance agreements are signed between MoH and its implementing agencies, but still not used to track and ensure accountabilities.[61]

ACHIEVEMENT OF OBJECTIVES TO DATE[62][63]

Project Objective: Support the Borrower's Program to improve the health of the Borrower's population, while reducing geographic, socio-economic and gender inequalities in health and health outcomes through improvements to access, quality, efficiency, partnership and financing.

4.13 ***Health financing continued to increase under PoW II, but concerns about equity and efficiency persist***. GoG's 2006 budget for health amounts to 15 percent of total GoG budget, meeting the Abuja target.[64] Of the total GoG recurrent budget 14.5 percent was spent on health, exceeding the target of 13 percent. The proportion of the non-wage recurrent health budget spent at the district level rose to 48 percent in 2005, exceeding the target of 42 percent. However, growth in the wage budget has not been matched by an increase in the service budget and there is a persistent trend of increased funding to the hospital sector at the expense of primary health care services. Overspending on the capital and personal emoluments budgets have forced an underspending on non-wage recurrent (service and administration) budgets, causing district and subdistrict services to be underfunded. Other financing issues, which have undermined availability of funding for district and subdistrict services include: unpredictability of financial releases, timeliness of financial reporting, persistently complex disbursement procedures and consequently slow disbursement procedures. The source of revenue for health is changing in three main ways: (1) the national health insurance fund was established in 2003 and will replace internally generated funds through cost recovery; (2) some of the partners contributing to the Health Fund have shifted to budget support; and (3) there has been a reduction in partners' contribution to the Health Fund relative to earmarked funds.

4.14 ***Exemption funding has increased, but is still inadequate; and current exemption provisions are not financially sustainable.*** Health facilities have not been reimbursed for exemptions incurred. Existing exemption arrangements are estimated to

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[61] The Bank's team has pointed out that the introduction of national health insurance during PoW II (in 2005) changed the dynamics and challenges of sector management, specifically the relevance of systems and processes for performance monitoring and resource allocation. The fact remains that performance monitoring and resource allocation were repeatedly raised by many informants as critical systems which are in need of strengthening. A proposed IDA-financed Health Insurance Project (scheduled for mid-2007 approval) includes support for the development of performance-based health care provider payment mechanisms.

[62] As of end-February HSPSP II is 99% disbursed and is scheduled to close in June 2007. While a PPAR on this project will not be undertaken until an ICR will have been completed and GDHS 2008 data will be available, some assessment of this program is worth incorporating into this review as some trend data on services is available through 2005.

[63] This section provides a summary of program outcomes. More detail is provided in a matrix on program objectives and targets, prepared by IEG, and available in IEG files.

[64] In 2001 African Union countries set the Abuja target of attaining a 15 percent share of national budgets for the health sector.

cost over 600 billion cedis (US$66 million). The national health insurance scheme is slated to assume the role of protecting the poor, but this is unlikely to happen until coverage of this scheme increases beyond 50 percent. There is a need to sustain protection of the poor through exemptions, but more selectivity and precision (in the definition of beneficiaries and types of services) is warranted.

4.15 ***The expansion of community health services and the support of priority health interventions have improved availability of services. However, underfinancing of district health services and the failure to reimburse district facilities for exemptions have put them in financial difficulty and compromised the regularity of these services, as well as their accessibility to the poor.*** Under PoW II to date considerable progress was made in extending the Community-based Health Planning and Services Strategy (increasing from 19 compounds in 2001 to 270 in 2005). More effort was devoted to malaria, TB/DOTS, and nutrition than under PoW I. Nevertheless, inadequate funding of priority health and nutrition interventions was raised as an issue both in annual sector reporting as well as during field visits and district failure to accord priority to these services in district budgets and plans were raised. Measles and DPT coverage remained high at 83 and 85 percent, respectively, but have not yet met the end-of-PoW target of 95 percent. ANC coverage declined from 98 percent in 2001 to 89 percent in 2005, while the percent of deliveries attended by a skilled health worker increased modestly from 50 percent to 54 percent. A 2004 survey of women (*NetMark 2004 Survey, Insecticide Treated Nets in Ghana)* carried out in five geographically dispersed cities in Ghana revealed that 13 percent of children and 8 percent of pregnant women slept under an ITN the previous night, with still more sleeping under untreated nets and baby nets. This would indicate a favorable trend over the less than 1 percent rate documented by MoH in its 1999 annual review, but falls far short of the target of 56 percent for PoW II.

4.16 ***Annual reports provide no indication of progress in institutionalizing quality in all health facilities***. Quality management and supervision are reported to be undertaken but the nature, frequency and impact of this work has not been documented. Reports do indicate that measuring quality poses problems for the sector and that currently utilized indices are not appropriate.

4.17 ***There has not been a significant improvement in sector efficiency thus far during the program period.*** Current utilization of hospital beds indicates persistent overcapacity and inefficiency of the hospital sector, but progress has been made in the definition of a referral system that should provide the framework for more efficient utilization of health services. Furthermore, no progress has been made in resolving the inefficient functioning of MoH and GHS a decade after the GHS was created. Subjective interpretations of the roles of MoH and its agencies and duplications in structures and responsibilities across agencies continue to cause unnecessarily high overhead costs, which the sector can ill afford.

4.18 ***The ratios of medical staff to the population have improved slightly during the program period.*** In 2005 the doctor to population ratio was 1:17,929, a slight improvement over the 2001 level of 1:20,036. By the same token the nurse to population ratio in 2005 (1: 1,508) was more favorable than the 2001 level (1:1,728). Still, wide variations across regions and between urban and rural areas persist.

4.19 ***There has been continued failure to promote and exploit participation of the non-governmental sector in health service delivery.*** Private sector activities are still not taken fully into account in the planning of government services or in the monitoring of health services performance. There has been virtually no progress in signing more MoUs with the non-governmental sector to provide health services, a MoU with CHAG still being the only one in effect, despite the great number of non-governmental facilities in the country and their potential to contribute effectively to national health sector efforts. SWAp annual reports have systematically acknowledged this shortfall in performance and a specific lesson from PoW I, documented in GoG's PoW II notes that "The potential for contributions from non-governmental health service providers…remains largely untapped" (*Ministry of Health, 2003)*.

OVERALL HEALTH OUTCOMES

4.20 ***Health, fertility and nutrition outcomes will be available when the results of the planned GDHS 2008 are issued. Preliminary data on key indicators for 2006 show that infant and under-five mortality and fertility still have not changed substantially since 1998 (Figure 1-1) (UNICEF/MICS, 2006).***

5. FROM TRADITIONAL PROJECTS TO A SECTOR-WIDE APPROACH

Box 5-1 - Bank's Refined List of Expected SWAp Benefits

- Stronger country ownership and leadership
- Coordinated and open policy dialogue for entire sector
- More rational resource allocation based on priorities
- Scaling-up of benefits to entire sector
- Sector-wide accountability with common fiduciary and environmental/social safeguard standards
- Strengthening of country's capacity, systems and institutions at a feasible pace and phasing
- Reduced duplicative reporting and transactions
- Greater focus on results

Source: World Bank, Operations Policy and Country Support Guidance

5.1 Annex I presents a synopsis of the SWAp experience to date, broken down by SWAp component, and by three distinct time periods coinciding with the health sector's PoWs (and the corresponding Bank operations): Pre-SWAp (1991-1997), PoW I (1997-2001), and PoW II (2002-2007). This matrix reveals many insights about the challenges and successes of the SWAp experience, a few of which are highlighted below.

5.2 ***Ghana's evolution towards a SWAp has been a long, dynamic and incremental process, spanning more than 15 years.*** Some of the seeds of the SWAp were embedded in the HPP II design, which predates the launch of PoW I (and the Bank's first health SWAp for Ghana) by 6 years. This design envisaged: the definition of a master framework for cooperative arrangements with NGOs, the establishment of medium-term projections of resource availability and sector financing and spending plans, the conduct of annual health public expenditure reviews, the design and implementation of a health management information system and a related system of sector performance monitoring (*World Bank, 1990*). However, these actions were incorporated into the project design in the form of credit conditionality, an approach which is reported to have undermined

Government ownership and leadership. After its mid-term review and under the leadership of a new TTL who championed the preparation of a SWAp, this project was rendered more flexible. It supported critical components of a SWAp, most notably the cofinancing of the preparation of the MTHS and PoW I and some of the costs of the first three Summit Meetings. The preparation and implementation of the following two operations (the first and second SWAps) consolidated, further strengthened and added to these building blocks.

5.3 ***Technical and financial support provided by development partners[65] in support of PoW I and II implementation culminated in the building of sector management capacity and revolutionized the way Ghana and its partners act and interact in support of health sector development goals.*** Under PoW I Government assumed a leadership position in the management of the sector. The PoW 1997-2001 became the framework for mobilizing and catalyzing the technical and financial support of partners. Under this first PoW systems and processes were implemented and refined that facilitated the documentation and joint review of sector performance of the previous year and the preparation, review and approval of plans and budgets for the subsequent year. Government systems and capacities were developed at central, regional and district levels, especially in the areas of procurement and financial management. Reliance on these systems enabled the consolidated management of the public budget and pooled funding, particularly in the areas of procurement and financial management. The certification of BMCs facilitated the decentralization of sector planning, budgeting, financing, financial management, and monitoring. Conditionality was limited to actions of process rather than policy content, guiding the timely completion of the cycle of sector planning, budgeting, and monitoring. Under PoW II 2002-2007 experience was gained and refinements to the SWAp process continued.

5.4 ***Notwithstanding these successes, some capacity building objectives of the SWAp process have not been fully achieved under the two SWAp operations supporting PoW I and II.*** Established partnerships for the health sector do not yet include the adequate participation of civil society in sector reviews and planning. The formula for allocation of resources across regions and districts is not yet sufficiently developed to ensure equity as well as to reflect the different costs of doing business in different environments. A sound public expenditure framework is missing, making it difficult to ensure efficient and equitable use of funding. Various systems that have been developed (planning, financial management, procurement, performance monitoring) are not synergistic, thus undermining sector management capacity. The monitoring of process, output and outcomes is not linked with inputs and activities. Failure to define a results chain for the sector and to establish links between inputs, outputs, outcomes and outputs makes it difficult to assess the effectiveness of various approaches or to establish causality between approaches and outcomes. No real progress has been achieved: to ensure a sound institutional framework for health by rendering MoH and GHS fully operational, since the creation of GHS in 1996; to address human resources issues systematically; or

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[65] Especially those that contributed directly into the Health Fund and relied increasingly on Government systems for sector management, procurement and financial management: World Bank (through HSSP and HSPSP II), DFID, EU, The Netherlands

to develop and implement a functional performance management system that would define and monitor accountabilities for results.

5.5 ***Capacity building objectives inherent in the SWAp design may never be fully achieved, but rather are likely to be refined, or even redefined, in light of the emerging issues and challenges of a constantly changing country and sector environment*.** Two major developments in health sector financing bring to light challenges and opportunities for such refinement. *First,* the Bank and other key partners have decided to evolve their support to Ghana's health sector from pooled, sector-specific financing to budget support (Multi-donor budget support – MDBS), channeled to MoFEP for allocation to health and other priority sectors. *Second,* GoG has recently established a National Health Insurance System. Anticipated as an important and sustainable source of health financing, this system replaces the "cash and carry" cost recovery scheme and assumes responsibility for protecting the access of the poor to basic services. Together these developments demand refinements of the SWAp process, among which are: (a) the need to readjust partnerships, planning and review processes, and inter-governmental and inter-agency relationships to take into account the changing nature of health financing; (b) the need to improve and systematize public expenditure monitoring (including incidence analysis) and sector performance monitoring and accountability as a means of documenting value and results for money to establish more credibility with MoFEP and thus to attract and justify adequate budget support; and (c) the need to review and revise the cycle of sector reviews and sector planning exercises, including the Health Summits, in light of the need to engage more fully MoFEP in sector dialogue and strategic decisions.

5.6 ***Both Government officials and health partners (past and current) identified very distinct phases of their evolving partnership that were largely defined around the critical notions of trust and dialogue.*** *Phase 1* (prior to 1997), was marked by multiple, uncoordinated projects, which were characterized by donor decision-making and micromanagement, whether through heavy conditionality or donor management of implementation. Mutual trust was reported to be low and dialogue fragmented and (largely) dominated by donors. *Phase 2*, which coincided roughly with the latter years of HPP II and HSSP's support to PoW I implementation (the initiation of the SWAp), was considered the best performing phase of Ghana's health SWAp history. Donors recognized and began utilizing GoG capacity and leadership, both through the initiation of pooled health funding and through capacity building efforts. Dialogue was reported to be frank, balanced and productive. Issues identified were jointly addressed, GoG assuming very capably and professionally the leadership and donors financing or providing directly technical support as value added to GoG efforts. All of those interviewed reported that the partnership was genuine and seamless, with mutual trust and the quality of dialogue at an all-time high.

5.7 *Phase* 3 (largely coinciding with PoW II – 2002-2007) is marked by a significant deterioration in the quality and nature of the partnership, and coincides with major turnover in staff, both among MoH/GHS and its partners. A number of the most senior, experienced and skilled leaders/managers and staff of MoH left for high-level international posts, and most of those remaining left MoH to join the GHS. MoH posts were eventually filled by the appointment of more junior staff, assigned by the new Government after the 2000 elections and tensions between MoH and GHS undermined their capacity for collaboration. The group of health experts and authorities representing

the various partners which pioneered the SWAp in Ghana also left around the transition time between PoW I and PoW II; and their replacements were reported by some not to be fully briefed or convinced of the SWAp and some were reported to be more junior and less capable than those they replaced.[66] Mutual trust is reported by all actors to have deteriorated, and dialogue became more strained and adversarial. Partners reported frustration with GoG's failure to deliver on key priorities and commitments under the PoWs.[67] National health informants reported that donors were reneging on the spirit of the SWAp in two ways: (a) rather than joint problem solving, donors became more removed and critical of health sector performance; and (b) some withheld financing because of their dissatisfaction with health sector performance. This was considered by nationals to be "old-style conditionality" and further undermined performance. The transition by some partners to budget support for all sectors, including health, has also undermined the trust of national health sector stakeholders because (a) they are concerned that the level of health sector financing may not be maintained with MoEFP deciding on allocations across sectors;[68] and (b) sector dialogue has further deteriorated because (i) some donors who transitioned to budget support are withdrawing their health experts from the field; and (ii) some national informants have expressed that they see no reason further reason to dialogue with health experts as they have little leverage in the context of budget support. ***In short, the three phases have been characterized by a starting point of low trust and inadequate dialogue, followed by a significant improvement in both, and, subsequently, a serious deterioration in both.***

5.8 ***The evolution in the nature of the Bank's (and other partners') support to Ghana's health sector over the past 15-20 years has revealed a tension between the priorities of health services delivery and outcome, on the one hand, and national capacity building and utilization on the other***. Under HPP II, in the pre-SWAp phase, investments and efforts were concentrated around the immediacy of basic service delivery strengthening and expansion with a view to improving health outcomes. Capacity, where it was considered to be weak, was brought in from the outside (the establishment of a PIU, the use of parallel systems, the financing of procurement and financial management expertise and technical assistance, and pedagogical supervision and oversight) and strengthened through conditionality and project-financed training, all with a view to accelerate project implementation and the achievement of objectives. In contrast and by its very definition, a SWAp seeks to utilize and further strengthen national capacity and leadership as a primary goal, which, once achieved, is expected to contribute to improved sector performance and health outcomes. The SWAp's focus on capacity building objectives was confirmed by key Bank informants and other (Phase 1) partners, who emphasized that this evaluation of the SWAp should be against capacity building objectives only and not against the programs, services and outcome objectives and indicators articulated in Ghana's PoWs. However, given that the development

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[66] It is important to note that national informants reported that the high caliber of technical competence and support provided by the Bank has been maintained even with periodic changes in the lead health task team leader.

[67] Malaria control, reproductive health and the fight against malnutrition, for example.

[68] This is despite the fact that PRSCs have required that Government guarantee the maintenance of health financing at its SWAp levels.

objectives for the two Bank were articulated around the objectives of PoW I and PoW II, respectively they (a) are indeed accountable for the achievement of those program objectives (along with other financiers) and (b) must be evaluated against these, as well as against SWAp objectives.

5.9 ***Health indicators improved during 1993-1998 under the traditionally designed HPP II, then plateaued during 1998-2003 under the first SWAp for PoW I. New GDHS data for 2008 will provide important insight on the trends in health under the second SWAP for PoW II, but preliminary data for fertility and mortality show no improvement and are cause for concern.*** Available data on health services performance that span the timeframes of the first and second SWAps also indicate an inadequate focus of Ghana's SWAp support on results, relative to its focus on capacity building. Key service performance data reveal a stagnation in service trends and a failure to achieve 2005 objectives[69] for a number of indicators, including: utilization rates, family planning acceptors, pre-natal and post-natal care coverage, supervised deliveries by medically trained personnel. On the other hand, both immunization coverage and tuberculosis cure rates have improved. The failure to achieve more significant improvements on the bulk of key service indicators needs to be more carefully assessed once service data on the final year of PoW II and outcome data for 2008 become available. Important questions, which remain to be answered are (a) "What timeframe for capacity building is needed before such efforts should be expected to culminate in improved sector performance and outcome?" and (b) "How might a stronger results focus be achieved in parallel with, instead of subsequent to, capacity building efforts?" ***The neglect of monitoring and evaluation and performance-based management capacity building relative to the very strong and successful focus on fiduciary (procurement and financial management) capacity building is likely to have seriously undermined the results focus of the SWAp.***

5.10 ***The Bank has modified its health sector support to Ghana in two ways. Over and above its evolution of SWAp financing from (health-specific) program support to (general) budget support, it is also developing two traditional investment projects to support Ghana in its efforts to (a) implement a viable national health insurance scheme (estimated IDA support of US$15 million); and (b) accelerate child survival through interventions that have not been very successful to date under PoW I and PoW II: the fight against malnutrition and malaria control (estimated IDA support of US$25 million with US10 million from Malaria Booster Program).*** The rationale for a standalone project for health insurance is strong, given the nature of such assistance. But the rationale for supporting child nutrition and malaria prevention and control objectives outside of the Bank's SWAp support is not entirely clear in draft design documents consulted by IEG. It is possible that these traditional projects, scheduled for mid-2007 approval, will provide additional leverage for dialogue, technical support, targeted financing and a stronger results focus that may not be as assured under a SWAp. Nevertheless, this represents a change in the Bank's strategy of support to Ghana's health sector in the mid-1990s, which strongly advocated an increase in pooled sector financing and the eventual elimination of earmarked funding.

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[69] 2005 is the fourth year of PoW I and the most recent year for which service data are available.

5.11 ***Current wisdom about the theoretical differences between a "traditional project" and a SWAp do not reflect the Bank's experience in Ghana and need to be revisited*** **(Table 5-1).**

Table 5-1 Traditional Project vs SWAp: A False Dichotomy?

The Theory		**Ghana's Experience**	
Traditional Project Approach	**Sector-Wide Approach**	**Traditional Project HPP reveals false dichotomy**	**Opportunity for better balance: correcting the shortfalls of the SWAp**
"Blue print approach"	Process-oriented approach	HPP II was designed in the context of sector policy and country context	Better blend of process and substance
Narrowly-defined project	Holistic view of sector/program	HPP II was defined with the country to fill important gaps/address neglected priorities in the broader context of the sector analysis and revised sector strategy.	Holistic view of sector/program failed to sufficiently emphasize/support important public health program activities/outcomes (malaria, HIV/AIDS)
Detailed upfront planning of inputs/outputs	Agreement of program/approach w/ annual planning	HPP II was flexible, requiring only first year plans, with subsequent plans based on annual reviews, availability of other financing, changing needs/contexts. MTR strengthened support to the development of a strategic sector framework complementing other SWAp preparation financing.	Opportunities for a stronger results focus.
Short-term success of project	Sector/program performance/results	Success of traditional projects sustained a decade after project's close	Inadequate focus on results, failure to implement performance-based management system (adapted as needed to the introduction of national health insurance).
Donor-Recipient relationships	Country-led partnerships	Latter years of HPP II demonstrated that traditional projects can accommodate more balanced, respectful partnerships.	Government ownership and leadership can undermine frank sector dialogue. A SWAp does not eliminate the possibility of an erosion of trust.
Bilateral negotiation/agreement	Coordination and collective dialogue	Latter years of HPP nurtured partnerships among donors and between donors and governments.	Ear-marked funding is still prevalent and somewhat resistant to SWAp, as evidenced by donors failing to provide commitments, expenditures data in the context of annual reviews and planning.
Parallel implementation systems	Increased use of country systems	HPP II invested in the building and utilization of national capacity, but accomplishments were very modest compared to SWAp emphasis and achievements.	Importance of linking systems for planning, budgeting, financing, financial management, monitoring and evaluation.
Project management capacity	Longer-term capacity development		

6. FUTURE DIRECTIONS

6.1 The main finding of this evaluation is that the first health SWAp in Ghana has strengthened sector stewardship and sector capacity, but has not culminated in the achievement of most health service delivery and health outcome targets set by Government. Between 1998 (when the Bank's first support to SWAp became effective)

and 2003, the PoW goal of improving key health indicators was not achieved. The SWAp process took precedence over a focus on results, and sector dialogue became more deferential, even on issues of critical importance to sector performance. Had the SWAp not been undertaken, it is likely that country leadership in health sector development and oversight and the development and utilization of national capacity in procurement and financial management would not have been as strong. It is also likely that investment planning would not have been as transparent. These accomplishments, directly attributable to the SWAp, are likely to contribute to improved efficiency in the design and implementation of future PoWs. The following **lessons** point to opportunities to improve development effectiveness in the context of a SWAp:

- Success in establishing a process for sector-wide management and dialogue will not by itself ensure the achievement of health services performance and outcome targets. The absence of a strong results focus, the absence of a viable system and incentives for M&E and the failure to move towards a performance-based health system to ensure accountabilities can seriously undermine the achievement of sector objectives.
- A dialogue between Government and its health partners, which is not sufficiently rigorous or frank, can result in the neglect of critical constraints to sector performance. The institutional competition and overlap between MoH and GHS and the failure to harness the potential of the non-governmental sector for delivering health services are issues with both technical and political dimensions, which might have benefited from the technical input and leverage of outsiders.
- High priority, high-impact health programs and services risk not being implemented as planned if (a) they are financed almost exclusively by earmarked, outside funds; and (b) district/local-level autonomy and responsibility for health planning and spending are not checked or balanced with the technical and strategic knowledge of specialized staff and managers of these priority programs (located in the central and regional levels).
- Sector efficiency needs to be measured in order to be achieved. The failure to carry out annual public expenditure reviews and incidence analyses, and to define fully a program results chain and monitor progress on each link has undermined Ghana's ability to measure and fine-tune the development effectiveness of the substantial investments in the health sector.

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ANNEX A. Basic Data Sheet

SECOND HEALTH AND POPULATION PROJECT (CREDIT NO. 2193)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project cost (US$ million)	34.4	28.9	84%
Credit amount (millions of SDRs)	19.5	18.9	97%
Cancellation (millions of SDRs)		0.56	3%

Project Dates

	Original	*Actual*
Board approval	12/13/1990	12/13/1990
Signing	12/21/1990	12/21/1990
Effectiveness	03/21/1991	06/18/1991
Closing date	12/31/1995	12/31/1997

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*US$('000)*
Preparation to appraisal	10.2	21.4
Appraisal	30.1	69.1
Negotiations	34.1	82.5
Supervision*	144.5	280.4
Completion*	7.8	17.0
Total	226.7	470.4

*Information available from FACT only for FY96–FY98.

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance Rating	
				Implementation Progress	Development Objective
Preparation through effectiveness	04/1989	3	Senior Planner; Task Manager; Health Specialist		
	06/1989	1	Task Manager		
	08/1989	1	Task Manager		
	10/1989	4	Task Manager; Senior Planner; Health Specialist; Pharmaceuticals Specialist		
	01/1990	1	Task Manager		
	06/1990	2	Task Manager, Health Specialist		
Supervision	03/1991	4	Pharmaceutical Specialist; Senior Planner; Operations Analyst; Task Manager		
	11/1991	3	Pharmaceutical Specialist; Task Manager; Senior Planner	3	2
	03/1992	3	Senior Planner; Task Manager, Project Officer		
	06/1992	2	Senior Planner; Project Officer	3	3
	02/1993	2	Senior Planner, Project Officer	3	3
	08/1993	3	Public Health Engineer; Health Economist; Sr. Public Health Specialist	2	3
	09/1993	3	Public Health Specialist (2); Health Economist		
	06/1994	3	Project Officer; Senior Planner; Health Economist		
	10/1994	2	Health Economist, Senior Planner		
	05/1995	3	Public Health Specialist; Project Officer; Health Economist		
	02/1996	3	Project Officer, Public Health Specialist; Sr. Operations Officer		
	06/1996	3	Public Health Specialist; Project Officer; Operations Analyst	S	S
	10/1996	3	Public Health Specialist; Project Officer; Operations Analyst	S	S
	03/1997	3	Public Health Specialist (2); Project Officer	S	S
Completion	09/1997	3	Public Health Specialist; Project Officer; Public Health Engineer	S	S
	04/98	2	Sr. Public Health Specialist; Project Officer		

HEALTH SECTOR PROGRAM SUPPORT PROJECT (CREDIT NO. 2994)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project cost (US$ million)	773.4	689.5	89%
Credit amount (millions of SDRs)	25.1	24.9	99%
Cancellation (millions SDRs)		0.14	1%

Project Dates

	Original	*Actual*
Board approval	10/21/1997	10/21/1997
Signing	04/03/1998	04/03/1998
Effectiveness	07/02/1998	06/18/1998
Closing date	06/30/2002	06/30/2002

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*US$('000)*
Identification/Preparation	108.9	378.2
Supervision	264.3	601.1
ICR	12.5	49.0
Total	385.7	1,028.3

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance Rating	
				Implementation Progress	Development Objective
Identification/ Preparation	11/1993	4	Public Health, TTL (1); Health Economics (1); Nutrition (1); Nutrition Officer (1)		
	03/1994	4	Public Health, TTL (1); Population (1); Nutrition (1); Implementation Officer (1)		
	03/1995	4	Public Health, TTL (1); Health Economics (1); Sociologist (1); Public Health (1)		
	09/1995	4	Public Health, TTL (1); Health Economics (1); Sociologist (1); Financial Management (1)		
	11/1995	4	Public Health, TTL (1); Health Economics (2); Public Health (1); Public Health (1)		
Appraisal/ Negotiation	07/1997	7	Public Health, TTL (1); Health Economics (1); Public Health (1); Financial Management (1); Disbursement (1); Lawyer (1); Procurement (1)		
Supervision	04/30/1998	5	Public Health, TTL (1); Health Economics (1); Financial	HS	HS
	09/30/1998	4	Public Health, TTL (1); Health Economics (1); Procurement Specialist (1); HNP Specialist (1)	HS	S
	05/13/1999	5	Public Health, TTL (1); Financial Management (1); Procurement (2); HNP Specialist (1)	HS	S
	10/01/1999	3	TTL (1); Project Officer (1); Procurement Specialist (1); LSR. Proc. Specialist (1); Proc. Specialist (1); Fin. Mgt. Specialist (1); Project Officer (1)	HS	S
	06/15/2001	6	Task Team Leader (1); Health Specialist (1); Assistant (1); Procurement Specialist (1); Fin. Mgt. Specialist (1); Sr. Proc. Specialist (1)	HS	S
Completion	12/07/2002	2	TTL (1); HNP Specialist (1)	S	S

ANNEX B. Persons and Organizations Consulted[70]

Ghana

Accra

Ministry of Health

Mrs. Salimata Abdul-Salim, Chief Director
Dr. Edward Addai, Director, Policy, Planning, Monitoring and Evaluation
Mr. George Dakpallah, Head of Budget Unit
Mr. Sam Boateng, Head of Procurement Unit
Mr. Herman Dinsu, Financial Controller
Mr. Emmanuel Longi, Acting Director, Administration
Mr. Peter Ekow Gyimah, Head of Central Medical Stores
Mrs. Joyceline Azeez, Head of Procurement and Supplies

Ghana Health Service

Dr. George Amofa, Director, Public Health Division
Dr. Gloria Q. Asare, Reproductive and Child Health Unit
Dr. Nii Akwei Addo, Manager, National AIDS Control Program
Mr. Joseph Adu, Head of Procurement Unit
Mr. Jacob Armah, Head of Nutrition Unit
Mrs. Rosanna Agble, former Head of Nutrition Unit
Mrs. Hanna Adjei, Program Manager, Community-Based Food Security and Nutrition Project, Nutrition Department
Mr. Frank Bonsu, Head of Disease Control
Mr. Emmanuel Tidakbi, Acting Director, Health Administration and Support Services
Mr. Daniel Darko, Chief Biostatistics Officer, Center for Health Information Management
Mr. Dan Osei, Policy, Planning, Monitoring and Evaluation
Mr. Isaac Adams, Monitoring, Evaluation and Research

Ministry of Finance

Mr. Patrick Nomo, Director-General, Internal Audit Agency, formerly Director of Finance, Ministry of Health

Non-Governmental Sector/Civil Society

Mrs. Eden Anuwa-Amarh, Operations Manager, Catholic Relief Services
Mr. E. Kumodzie, Catholic Relief Services, Accra
Dr. Richard E. Killian, Director, Quality Health Partners/EngenderHealth

Bilateral and International Partners

Marius de Jong, Dutch Embassy and Representative of DfID
Dr. Koma S. Jehu-Appiah, Embassy of the Kingdom of the Netherlands
Dr. Morkor Newman, National Professional Officer, HIV/AIDS, WHO Country Office, Accra
Mr. Warren Naamara, Country Coordinator, UNAIDS
Mrs. Matilda Oronsu-Ansah, HIV/AIDS Advisor, DfID
Mrs. Helen K. Dzikunu, Senior Programme Officer, DANIDA Health Sector Support Office

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[70] The health evaluation mission also benefited from exchanges with regional and district AIDS Committees. A list of the individual members of these committees, with whom the mission met, but can be found in Annex B of the GARFUND PPAR (*World Bank, IEG, 2007*).

Mr. Peter Wondergem, HIV/AIDS Team Leader, United States Agency for International Development
Ms. Liv Elden, Programme Coordinator, UNICEF
Mrs. Ute Moehring, Programme Officer Governance and Civil Society, European Union
Mr. Jakob Rogild Jakobsen, First Secretary, Royal Danish Embassy
Mr. Taavi Erkkola, Monitoring and Evaluation Adviser, UNAIDS
Dr. Rosalinda Hernandez, Country Officer, World Health Organization

World Bank Office
Mr. Mats Karlsson, Country Director
Ms. Laura Rose, Senior Health Economist
Ms. Evelyn Awittor, Senior Operations Officer
Mr. Fred Yankey, Senior Financial Management Specialist

Upper West Region

Regional Health Team, Wa
Mr. Manfred Yaw Onsu-Ansah, Regional Health Information Officer
Mr. Kuubetienre George, Health Services Administrator
Mr. Ralph K.S. Hadai, Deputy Director of Pharmaceutical Services (Regional Pharmacist)
Mrs. Josephine Ahorse, Regional Training Coordinator
Mrs. Genevieve Yiripare, HIV/AIDS and TB Coordinator
Mr. Lazarus Dery, Pharmacist, Manager RMS
Mr. Johas Firina, Procurement Officer, RHA

District Health Team, Nadowli
Mrs. Melany Bokuma, District Health Director
Mrs. Perpetua D. Mornah, Reproductive and Child Health Coordinator
Mrs. Alijata Issaka, Reproductive and Child Health Focal Person (Global Fund, reproductive health, HIV/AIDS and malaria)
Mr. Ahmed Farouk, Accountant
Mr. Emmanuel K. Sanowok

Upper East Region

Regional Health Team, Bolgatanga
Dr. Joseph A. Amankwa, Director, Regional Health Directorate
Mr. Dela Asamany, Regional Health Information Officer
Mr. Lucio G. Gery, Deputy Director, Administration

Kassena-Nankana District Assembly, Navrongo

Northern Region

Regional Health Team, Tamale
Dr. Akwasi Tsumasi, Senior Medical Officer, Public Health Physician, SMO-PH
Dr. Seidu Korkor, SMO-PH
Mr. Ibrahim Issah, Deputy Director Administration

District Health Team, Tolon
District Director, Public Health Nurse
Assistant District Director, Public Health Nurse

Ashanti Region

Regional Health Team, Kumasi

Dr. Kofi Asare, Director, Ashanti Regional Health Directorate, Kumasi
Mr. Michael Boamey, Regional Coordinator, HIV/AIDS/STIs and National Trainer
Mr. Kwabana Agirhie Ennis, Acting Regional Accountant
Mr. Kofi Opoku, Deputy Director, Administration
Mrs. Abewaa Akuamoa-Boateng, Regional Nutrition Officer

Belgium, Brussels

Dr. Francois Decaillet, Lead Public Health Specialist, World Bank, former TTL for Ghana

Scotland, Aberdeen

Dr. Sam Adjei, Public Health Specialist, former Deputy Director General, Ministry of Health

Switzerland, Geneva

Dr. Delanyo Dovlo, World Health Organization, former manager

United States of America

World Bank, Washington, D.C.

Dr. Alexandre Abrantes, Former Sector Manager for Ghana Human Development
Dr. Alexander Preker, Lead Health Economist for Ghana Human Development
Dr. David Peters, Senior Public Health Specialist, former TTL for Ghana Health
Ms. Katja Janovsky, Consultant, formerly of World Health Organization
Dr. Bernhard Liese, Public Health Consultant

UNDP, New York

Dr. Joseph Annan, former Head of JSA Consultants, Ltd., Accra

ANNEX C. Timeline of World Bank Support to Ghana's Health Sector 1986-2006

Year	Health Sector-Specific	Macro-economic and Cross-sectoral
1986	**Health and Education Rehabilitation Project (Credit 1653-GH)** (effective: 4/86, closed: 12/31/91) – (US$15 million total – US$10 million for health) ***Objectives:*** to provide emergency assistance to the health and education systems and to the Management Development and Productivity Institute (MDPI); to rehabilitate service delivery at the peripheral level of the public health system, with special emphasis on immunization, family planning and nutrition; and to strengthen MoH and MoE management and planning capacity ***Health inputs:*** emergency drugs, physical rehabilitation, furniture and equipment for two hospitals, mopeds and basic equipment for community health workers, policy/management studies, and training. *Outcome:* Satisfactory	
1989	**Ghana: Population, Health and Nutrition Sector Review** (effective: 3/31/2007) ***Medium-term recommendations:*** *Population*: expand family planning outreach beyond existing service delivery points, increase NGO involvement and capacity building; expand contraceptive methods offered; implement an IEC plan *Health:* continue focus on primary health care to reduce mortality and morbidity especially of children and women; address regional inequities of health services and resource allocation; encourage NGO and private sector involvement; strengthen MoH organization and management, including establishment of a management services unit; take actions to ensure critical inputs: human resources; drugs; logistics; financing and financial allocations (favoring primary health care); review/revise service charges to improve incentives for proper utilization; set up health insurance scheme independent of MoH. *Nutrition:* give policy recognition to malnutrition and articulate national goals for its reduction; implement a new community-based strategy; expand clinic-based surveillance to cover all regions; revise nutrition education based on research; expand weaning-food program; build micronutrients into current programs; consolidate/shorten nutrition training; evaluate regularly. ***Long-term Targets for Population, Health and Nutrition:*** • Scale back existing targets and set more realistic ones • Prepare a first set of annual and medium-term rolling plans • Install a health management information system	
1991	**Health and Population II** (effective: 6/18/91, closed: 12/31/97) – (US$27 million) ***Objectives:*** To improve the quality and coverage of health services and increase the availability and accessibility of family planning services, with a focus on the three northernmost regions of Ghana. ***Components:*** drug and vaccine supplies and drug infrastructure rehabilitation; MoH institution building; district and regional hospital equipment in northern regions; primary health care; population/family planning; prizes fund.	
1995		***Country Assistance Strategy (CAS),*** April 17, 1995 ***Objectives:*** poverty reduction (including support to social services); restoring and maintaining macroeconomic stability; capacity building; private sector development; environmentally sustainable development.

Year	Health Sector-Specific	Macro-economic and Cross-sectoral
1997		***CAS***, August 14, 1997 ***Objectives:*** (a) support Government's proximate development objectives of restoring macroeconomic stability, promoting higher private investment, ensuring broad-based social and rural development and implementing direct poverty-alleviation measures; (b) allocate an increasing share of Bank's administrative budget in favor of more non-lending services; (c) move away from infrastructure investment while providing greater non-lending support to private participation in these sectors; (d) coordinate enhanced IFC and MIGA lending and non-lending assistance; (e) appoint a Country Director to the Bank's Accra office; (f) increase partnership with NGOs, UN agencies and other donor agencies; and (g) measure the impact of Bank assistance and Government efforts based on results indicators.
1998	**Health Sector Support Project** (effective: 6/18/98, closed: 6/30/02) – (US$35 million) ***Objective:*** to assist the Borrower in implementing the PoW I to (a) provide universal access to basic health services and improve the quality and efficiency of health services; and (b) foster linkages with other sectors in the Borrower's economy to reduce the population growth rate, reduce the level of malnutrition, increase female education, increase access to water and sanitation and reduce poverty. ***Components***: strengthen district health services; reorient secondary and tertiary services; human resources development; capacity building in policy analysis, performance monitoring and evaluation and regulation; strengthen central support systems for management; promote private sector involvement; and strengthen inter-sectoral collaboration.	
2000		***CAS,*** June 29, 2000 ***Objectives:*** The overriding goal of the GoG's Development Strategy for Poverty Reduction and the support of the World Bank Group are to eliminate hard-core poverty. The proposed business strategy of the Bank would help the Government to: (i) raise the growth rate of the economy; (ii) redefine the role of the state to provide public goods and services and ensure equitable distribution of the benefits of development (including ongoing HSSP); and (iii) implement their strategy more effectively on the ground.
2001		**Community-Based Poverty Reduction Project (LIL**) (Effective: 10/23/2001; Closed: 12/31/2005) Overall US$5 million, US$1.8 million to relevant component Project included health-relevant objectives or components. ***Objectives:*** Test approaches and mechanisms for delivering, coordinating, monitoring and evaluating community-based poverty reduction actions through community nutrition and food security interventions and activities to assist street children; and build capacity, at national and local levels, for designing, coordinating, monitoring and evaluating community-based poverty reduction programs.
2002	**AIDS Response Project (GARFUND)** (effective: 5/08/02, closed: 12/31/05) – (US$25 million) ***Objective:*** to intensify multisectoral activities designed to combat the spread of HIV/AIDS and reduce its impact on those already affected by HIV/AIDS.	**HIPC Debt Initiative Decision Point ,** February 26, 2002 Health triggers for floating completion point: • The percentage of households with access to safe water has increased from 50% in 2000 to 46% in rural areas • Recurrent health expenditures at district and lower level governments have risen from 42% of the recurrent health budget in 2000 to 45%.
2003	**Second Health Sector Program Support Project** (effective: 5/22/03, closing: 6/30/07) – (US$90 million) ***Objective:*** to support the Borrower's Program to improve the health of the Borrower's population, while reducing geographic, socio-economic and gender inequalities in health and health outcomes. ***Components*** *(11 key program components of PoW II):* priority health services; human resources; infrastructure; partnerships for health; private sector participation; regulation; organizational reform, health financing; management systems; management information systems and performance monitoring; links/synergies with traditional medicine.	**PRSC I** (effective: 6/25/03, closed) - (US$125 million IDA financing of which US$88 million credit and US$37 million grant) ***Objective:*** To support the Government's Poverty Reduction Strategy, focusing on (i) growth and employment promotion, (ii) human service delivery improvement, and (iii) governance and public sector management strengthening. Health-specific components (i) expanding access to health services (particularly in most deprived regions) and enhancing quality; and (ii) improving the efficiency and equity of health services and ensuring sustainable financing arrangements that protect the poor. Health-specific policy actions (achieved): launching implementation of national policy of community-based health planning services that emphasizes basic primary services; and adoption of fee exemption policy for maternal deliveries for deprived regions.

Year	Health Sector-Specific	Macro-economic and Cross-sectoral
2004	**Regional HIV/AIDS Treatment Acceleration Project** (effective: 11/23/ 04, closing: 09/30/07) – (Multi-Country project overall: US$60 million, US$15 million to Ghana (Grant)) ***Objective:*** to scale-up access to HIV/AIDS Treatment in Burkina Faso, Ghana and Mozambique.	***CAS,*** February 20, 2004 ***Objectives:*** Ghana's poverty reduction Strategy (approved in 2003) outlines five pillars: ensuring sound economic management for accelerated growth; increasing production and promoting sustainable livelihoods; direct support for human development and the provision of basic services; providing special programs in support of the vulnerable and excluded; and ensuring good governance and increased capacity of the public sector. The Bank's strategy to support the GPRS rests on three pillars: (i) sustainable growth and jobs creation; (ii) service provision for human development; and (iii) governance and empowerment. **HIPC Debt Initiative Completion Point** (June 15, 2004) Both triggers were met: • The percentage of households with access to safe water has increased from 40 percent in 2000 to 46.4 percent in 2003 (target: 46 percent). • Recurrent health expenditures at district and lower level governments have risen from 42 percent of the total recurrent health budget in 2000 to 49.6 percent in 2003 (target: 45 percent) Estimated debt relief: US$1,102 million in 2000 NPV **PRSC II** (effective: 7/15/04, closed) (US$125 million of which $85 million IDA credit and US$40 million IDA grant) *Objective:* To support the implementation of the Ghana Poverty Reduction Strategy aimed at improving the living conditions of the population by promoting growth, incomes and employment; accelerating human resource development; and strengthening governance and public sector management. Health-specific actions: bridging the equity gaps in access to health care services in deprived regions; and reducing the spread of HIV. Health-specific outcomes: supervised deliveries rose from 49 percent in 2002 to 53 percent in 2004. HIV/AIDS prevalence among pregnant women declined from 3.6 percent in 2003 to 3.1 percent in 2005. **Community-Based Rural Development Project** (Effective: 11/02/2004, closing: 2/15/2009) – (US$60 million total; US$21.97 million to relevant component) ***Health-specific objectives***: The overall goal of the project is to reduce poverty and enhance the quality of life of beneficiary rural communities. One component, Infrastructure for Social and Human Development, attempts to rehabilitate existing schools, construct community health compounds and nutrition centers, and improve access to potable water for communities to enhance well-being and reduce water borne diseases.
2005		**PRSC III** (effective: 8/30/05, closed) - (US$125 million IDA Credit) ***Objective:*** to support implementation of the GPRS in line with the 2004 CAS, focusing: (i) the promotion of growth, income and employment; (ii) improvements in the delivery of services for human development; and (iii) strengthening of governance and public sector management. A particular focus on outcome indicators. Health-specific: Bridging the equity gaps in the access to health care services in deprived regions (Northern, Upper East, Upper West and Central) ; and ensuring sustainable financing arrangements for the health sector that protect the poor. Monitorable actions: (i) establishing the HR M&E system, piloting agreed recommendations of the options paper for the decentralization of personnel emoluments, and developing a draft revised HR policy; (ii) registering the eligible poor at the District-wide Mutual Health Insurance Schemes (DMHIS), while, in parallel, the National Health Insurance Council (NHIC) transfers the insurance subsidy to these district schemes, and the 2006 budget proposal keeps the funding for exemptions at the same levels as in 2004.

Year	Health Sector-Specific	Macro-economic and Cross-sectoral
2006	**Multisectoral HIV/AIDS Program** (effective: March 2006, ongoing) – (US$20 million) ***Objectives:*** to reduce new infection among vulnerable groups and the general population; mitigate the impact of the epidemic on the health and socio-economic systems as well as infected and affected persons; and promote healthy life-styles, especially in the area of sexual and reproductive health. ***Components:*** policy, advocacy and enabling environment; coordination and management of the decentralized multi-sectoral response; mitigating economic, socio-cultural and legal impacts; prevention and behavior change communication; treatment, care and support; research, surveillance, monitoring and evaluation; resource mobilization and funding arrangements.	**PRSC IV** (effective: 6/20/06, closed) - (US$140 million credit) ***Objective:*** in the framework of Multi-Donor Budgetary Support (MDBS) and in support of GPRS II (2006-09) this operation focused on three broad components: (i) accelerated private sector-led growth; (ii) vigorous human resource development; and (iii) good governance and civic responsibility. Special attention given to: (i) broadening the scope of the budget to include internally generated funds, donor funds and the proceeds of the HIPC debt relief; (ii) supporting the implementation of the new regulatory framework for public financial management; and (iii) operationalizing the government's computer-based financial and accounting information system: Budget and Expenditure Management System – BPEMS). Also attention given to monitoring outcomes and ensuring that sector programs deliver results in terms of human development indicators.

Source: World Bank Internal Documents and Records Management System, January 2007

ANNEX D. Second Health and Population Project: Costs

Table D 1 – Planned versus Actual Expenditure by source (US$ million equivalent)

Financier	Planned	Actual	Actual as % of Planned
Government	7.0	1.5	21
Planned Parenthood Association of Ghana	0.3	-	-
International Planned Parenthood Federation	0.1	-	-
IDA	27.0	27.4	102
Total	**34.4**	**28.9**	**84**

Source: World Bank 1990 (p.ii); World Bank 1998.

Table D 2 - Use of IDA Credit by Disbursement Category (Planned vs. Actual, millions of SDR)

Disbursement Category	Initial Allocation	Final Allocation by DCA Amendment	Actual	Actual as % of Initial Allocation
MoH	**15.16**	**17.47**	**17.06**	**113**
Civil Works	1.48	4.50	4.24	287
Drugs	2.44	2.50	2.78	114
Hospital equipment and spare parts	2.06	2.40	2.49	121
Contraceptives	1.41	0.07	0.07	5
Other equipment, spare parts, vehicles, furniture, building materials, office supplies and vaccines	5.69	5.40	5.18	91
Consultants' services and training	2.08	2.30	1.98	95
Operating Costs	0	0.30	0.32	-
Planned Parenthood Association of Ghana (PPAG)	**1.87**	**2.00**	**1.85**	**99**
Equipment, furniture, spare parts, office supplies and vehicles	0.40	0.20	0.13	33
Contraceptives	1.23	1.60	1.55	126
Training	0.24	0.20	0.17	71
National Catholic Secretariat of Ghana (NCS)	**0.54**	**0.03**	**0.03**	**6**
Hospital equipment, spare parts and maintenance equipment	0.54	0.01	0.01	2
Civil works	0	0.02	0.02	-
Unallocated	**1.93**	**0**	**0**	**-**
Total	**19.50**	**19.50**	**18.94**	**97**

Source: Development Credit Agreement, 1990; World Bank disbursement data, January 2007.

ANNEX E. Health Programs I and II: Costs, Public Spending and Indicators

I – Health Sector Support Program (1997-2001)

Table E 1 - Financing Plan (Planned versus Actual) (US$ million equivalent)

Financier	Planned PoW I (8/96)	Planned PAD (9/97)	Actual	Actual as % of Planned/PoW I
Government	537.2	500.6	349.2	65
Commercial Loans	0	77.0	98.5	-
Internally Generated Funds (cost recovery)	36.2	48.8	82.9	229
External Aid	200.0	197.6	161.8	81
Total	**773.4**	**823.9**	**689.5**	**89**

Source: MoH financial data

Table E 2 – Use of IDA Credit by year (millions of SDRs)

Credit	Planned	1999	2000	2001	2002	2003	Total	Actual as % percentage of planned
HSSP	25.1	4.8	4.4	11.5	3.5	0.6	25.0 [a]	99

Source: World Bank Loan/Credit database, February 26, 2007

a. of the total credit disbursed, about 77 percent was deposited to the Health Fund and 23 percent for advance payments to UN agencies for vaccines, drugs, equipment, and direct payments to international supplies.

Table E 3 – Public Spending Outcomes, 1997-2001

Indicator	1997		1998		1999		2000		2001	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Public health exp (US$ mil.)	127	159	139	155	155	129	167		184	
Investment	40	70	43	47	48	23	48		48	
Recurrent	87	89	96	108	107	106	119		136	
Spending shares (%)										
MoH as % GoG total expend.	5.9	3.9	6.2	5.5	6.9	5.9	6.9		7.3	8.7 [a]
Recurrent as % of total health expenditure	69	56	69	70	69	82	71		74	
IGF as % of total health expenditure	4.9	8.5	4.8	9.1	4.6	14.2	4.6		4.5	14.0 [b]
Non-salary as % of MoH recurrent budget	62	58	65	64	67	59				
Health Aid										
As a % of total health expend.	32	17.4	29	14.9	26	25.6	24		22	
As a % of total aid to Ghana	9		10	5	11	6.8	11		11	
Health expenditures per capita (US$)										
Including aid	6.90	8.10	7.40	7.80	8.00	6.83	8.40		9.00	6.30 [a]
Excluding aid	4.80	4.20	5.30	4.90	5.90	4.82	6.40		7.00	

MoH, 2001; data in italics calculated on the basis of MoH financial data
a. MoH, April 2006
b. Calculated on the basis of MoH financial data

Table E 4 – Distribution of Health Sector Revenues by Source (percent), 1997-2001

Source	1997	1998	1999	2000	2001
GoG	43	55	54	55	49
Financial Credits	31	21	8	5	2
IGF	8	9	12	12	14
Health Fund	} 18	} 15	} 26	8	13
Earmarked Funds				20	22
Total	100	100	100	100	100

Source: for 1997-99, Calculated from MoH 2001 data. For 2000-2001, MoH 2006

Table E 5 – Distribution of recurrent expenditure by level

Level	1996	1997	1998	1999	2000	2001	2001 Target
HQ	28	29	5	14	22	25	17
Tertiary institutions	32	22	22	21	14	16	24
Regional	17	15	13	24	20	16	17
District	23	34	39	41	44	43	42
Total	100	100	100	100	100	100	100

Source: For 1996-1998, Planning and Budget Unit (PPME/GHS); For 1999-2001, MoH 2002, Annual Review 2001 (p. 14)

Table E 6 – Distribution of non-salary recurrent budget by level (percent)

	1997		1998		1999		2000		2001	
Level	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
HQ MoH, GHS	18	36	18	13	17	14	16	22	16	25
Tertiary	22	16	21	12	20	21	20	14[a]	19	16[a]
Regional	24	13	24	24	24	23	23	20[a]	23	16[a]
District	37	34	38	50	39	42	41	44[a]	42	43[a]
Total	100	100	100	100	100	100	100	100	100	100

Source: MoH 2001, Health of the Nation

a. MoH 2002, Annual Review of 2001

Table E 7 – Distribution of capital expenditure by level (percent)

Level	1997	1998	1999	2000	2001
HQ	53	25	-	-	-
Tertiary Institutions	11	20	-	-	-
Regional	34	27	-	-	-
District	2	28	-	-	-
Total	100	100	-	-	-

Source: MoH, 2002, Annual Review of 2001 (p. 15). Note: Data for blank cells were not available.

Table E 8 - Amount spent on exemptions by exemption category (millions of cedis)

Exemption Category	1997	1998	1999	2000
Paupers		390	577	386
Antenatal services	2,600	1,515	3,331	3,460
70+ years	700	429	1,336	1,339
< 5 years		54	2,083	2,993[a]
Psychiatry/leprosy	2,800			
Emergency cases		153	96	116[b]
Others	400	191	380	155

Source: MoH, 2002, Annual Review of 2001 (p. 18)

a. Excludes GAR

b. Excludes GAR, Kbu, UER, UWR

II – Health Sector Support Program II

Table E 9 – Planned Project Costs by year, POW II ($US million equivalent)

	2002	2003	2004	2005	2006	Total
POW II	177.35	206.39	222.49	241.77	264.86	1,112.86

Source: MoH 2003.

Table E 10 – Use of IDA resources by year (millions of SDRs)

IDA Operation	Planned	Actual Disbursements					Actual as % of planned
		2004	2005	2006	2007	Total	
IDA Credit	43.5	-	37.8	5.5	0.03	43.3	100
IDA Grant	24.5	20.7	1.6	1.9	-	24.2	99
IDA Grant	68.0	20.9	39.4	7.4	0.03	67.5	99

Table E 11 – IDA Supplemental Letter No. 2 Key Performance Indicators for Health Sector Program Support Project Cr 2994-GH, April 3, 1998; and SAR, Annex 10, pp. 1-2

Indicator	Baseline Level (1996)	How Measured
1. % of GOG budget spent on health	4.9% of total GOG 7.0% of recurrent GOG, excluding debt	MoH Expenditure Reports
2. Recurrent (wage and non-wage) and capital expenditure by level, and by source of financing	Recurrent expenditure: HQ: 17% Tertiary: 24% Regions: 17% Districts: 42%	MoH Expenditure Reports
3. % of Budget and Management Centers (BMCs) with 1998 budgets and plans following an agreed format where all sources of funding are used to link budgets and activities	95% of those reporting (81%) have budget and plans for GOG only	Regional Quarterly Reports
4. Contracts for mission hospitals, NGOs, and private service providers developed for 1998 use	Not yet started	MoH Report
5. % of BMC's with timely quarterly income and expenditure returns (within 3 months) on all sources of financing (GOG, IGF, and common funds)	63%	MoH Quarterly District and Regional Reports
6. Agreement on a single set of procurement procedures, thresholds, bidding documents, evaluation criteria, and contracts, covering civil works, goods, and technical assistance	Bidding document only developed	Report
7. Completion of staffing establishments for BMCs	Establishments for technical staff only completed	Report
8. % of districts with timely (within 3 months) Communicable Disease Surveillance Reports	70% (estimated)	MoH Quarterly District and Regional Reports
9. % of district, regional and teaching hospitals that undertake and report on patient satisfaction surveys in the last quarter	Teaching Hospitals: 0% Regional hospitals: 22% District hospitals: 13% (2 regions only)	MoH Quarterly Reports
10. Outpatient visits per capita, per staff, and by sex	0.39 per capita nationally (17.8 million pop.)	MoH Quarterly Reports
11. Hospital admissions, average bed occupancy and length of stay for district, regional, and teaching hospitals	Total adm: 567,065 Bed occupancy: 70% (nationally) ALOS: NA	Quarterly Reports
12. DPT3 & OPV3 coverage for 1 year olds	DPT3: 49.6% OVP3: 49.0%	Quarterly District and Regional Reports
13. Couple-years of contraceptive protection	251,762 CYP	UNFPA Report
14. % of children using bednets	< 1% (estimated from 1995)	Sample Household Survey
15. % households using iodized salt	0.3% (1995)	Sample Household Survey
16. % drugs from an indicator list of drugs in stock at all times in the last quarter	NA (80% at CMS)	Sample Survey of Facilities
17. Medical Equipment Performance Index at hospitals (precise definition required)	60%	Sample Survey of Hospitals
18. Average cost per in-patient day at district, regional and tertiary hospitals	District: C1500 Region: C2000 Tertiary: C3000 (Hotel costs only)	Quarterly District and Regional Reports; Expenditure Reports
19. Amount of funds spent on exemptions by exemption category	C827,000,000 (vote for paupers and psychiatric patients only)	Quarterly District and Regional Repots
20. Number of outreach clinics per subdistrict, by Region	Greater Accra: 9 Brong Ahafo: 6 Central: 10 Eastern: 8 Ashanti: 5 Northern: 11 Upper East: 5 Upper West: 8 Western: 6 National Average: 7	Quarterly District and Regional Reports

ANNEX F. Health Status and Health Care Utilization Outcomes, 1990-2005[1 2]

Table F 1 – Health and nutrition outcomes, 1993-2007

Health Outcome	1988[1]	1993[1]	1998[1]	HSSP Target 2002[2]	2003[1]	2006[3]	HSSPII Target 2007[4]
Mortality/life expectancy							
Infant mortality rate (5 year)	77.2	66.4	56.7	50	64	71	50
[Confidence interval]					[55.4- 73.1]		
Under-5 mortality rate (5 year)	154.7	119.4	107.6	100	111.2	111	95
[Confidence interval]					[99.3-123.0]		
Nutrition							
Underweight (children < 3 years)	30.3	27.3	24.9		23.5	18	20
Stunting (children < 3 years)	29.4	25.9	20.0		26.7		
Wasting (children < 3 years)	8.0	11.3	12.9		9.5		

Source: [1] GDHS reports for IMR and Under 5 mortality, DHS Stat Compiler for nutrition indicators*;* [2*] HSSP PAD; [3]Ghana Multiple Indicator Cluster Survey (MICS), preliminary results, February 2007; [4*]SHPP II PAD. (* The definitions of indicators in PADs are not clear, yet provide targets for comparison.)

Table F 2 – Population Outcomes, 1998-2003

	1988[1]	1993 [1]	1998 [1]	HSSP Target 2002[2]	2003 [1]
Total fertility rate	6.4 [a]	5.5 [a]	4.6 [a]	5.0	4.4 [b]
[Confidence interval]			[4.3- 4.8]		[4.2- 4.7]

Sources: [1]GDHS; [2*] HSSP PAD.

a. Rates are for the period 5 years (1-60 months) preceding the survey for women age 15-49, expressed per woman.
b. Rates are for the period 3 years (1-35 months) preceding the survey for women age 15-49, expressed per woman.

Table F 3 - Infectious diseases/ parasites

	1996	1998	2000	2001	2002	2003	2004	2005	HSSPII Target 2007[4]
TB cure rate (%)[5]	16.9	43.8		47.9	55.1	61.0			63
Malaria prevalence per 100,000 [6]	10,697	11,191	13,590	15,667	15,726	16,363	16,015		
Guinea worm cases [7]				4,738	5,545	8,290	7,275	3,944	0

Sources: [4*]SHPP II PAD; [5]National TB Programme; [6] Centre for Health Information Management,/ Policy Planning Monitoring and Evaluation- Ghana Health Service; [7]Guinea World Eradication Programme

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[1] Source: GDHS 1988, 1993, 1998, 2003

[2] Confidence intervals which are available through the GDHS are reflected in Annex tables. Many are missing for the earlier surveys. Still others (on mortality) were cited in the earlier surveys for data on 10-year averages, but not for five-year averages. IEG has used five-year averages for mortality as the basis of its analysis, as they are more appropriate for the purposes of this evaluation.

Table F 4 - Health System Output Indicators

Health system output	1988 [1]	1993 [1]	1998 [1]	2001[8]	2003 [1]	2005[8]	2006[3] MICS	HSSPII Targets 2007[4]
Percent of deliveries supervised by skilled workers	40.2 [a]	43.8 [b]	44.3 [a]					60
Percent of deliveries supervised by skilled workers [c]					47.1			
Percent of deliveries supervised by skilled workers [d]							49.7	
Percent of tracer drugs available				70		85.7		80
Percent of maternal deaths audited				10		89.6		

Sources: [1]GDHS; [3]Ghana Multiple Indicator Cluster Survey (MICS), preliminary results, February 2007; [4*]SHPP II PAD.
MoH 2001, 2005. [8]MOH.

a. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse or midwife.
b. Percent of births 3 years (1-35 months) before the survey attended by a doctor, nurse or midwife.
c. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse, midwife or auxiliary nurse.
d. Percent of births 2 years before the survey attended by a doctor, nurse, midwife, auxiliary nurse, or community health worker.

Table F 5 - Use of health services

	1988[1]	1993[1]	HPP2 Target 1997[9]	1998[1]	2003[1]	2006 MICS[3]	HSSP II Target 2007[4]
DPT3[a]	89.5						
DPT3[b]		62.4	80	72.2	79.5	83.5	95
[Confidence interval DPT3]		[58.2-66.5]		[68.0-76.4]	[76.3-82.7]		
Measles[a]	60.3						
Measles[b]		64.4	80	72.6	83.2	85.4 [c]	95
[Confidence interval]		[60.2-68.5]		[68.4-76.9]	[80.0-86.4]		
BCG[a]	69.8						
BCG[b]		83.1		87.8	91.1	94.3	
[Confidence interval]		[79.9-86.3]		[84.8-90.9]	[88.7-93.5]		
Full[a,d]	46.7						
Full[b,d]		54.8		62	69.4	73.4	
[Confidence interval]		[50.6-59.1]		[57.4-66.6]	[65.6-73.2]		

Sources: [1]GDHS; [3]Ghana Multiple Indicator Cluster Survey (MICS), preliminary results, February 2007; [4*]SHPP II PAD.
[9*]HPP2 PAD.

a. Percent of children aged 12-23 months at the time of the survey vaccinated any time prior to the survey according to vaccination card.
b. Percent of children aged 12-23 months at the time of the survey vaccinated any time prior to the survey according to vaccination card or mother's report.
c. MICS survey specifies that this is the measles, mumps, rubella (MMR) vaccination.
d. Full vaccination includes BCG, 3 doses of DPT and polio (not including Polio 0), and one dose of measles. Beginning in 2002, the three doses of DPT were replaced with DPT/HepB/HiB, and thus this series replaced the 3 doses of DPT in 2003.

Table F 6 - Health care utilization

	1988[1]	1993[1]	1996[8]	1997[8]	HPP2 Target 1997[9]	1998[1]	2001[8]	2002[8]	HSSP Target 2002[2]	2003[1]	2005[8]	2006[3]	HSSP II Target 2007[4]
Outpatient visits/capita[10]							0.49				0.52		0.6
Bed occupancy rate %[10]			70		80-90		58.9	59.4		57.6	56.8		80
Family planning/MCH													
Contraceptive prevalence--modern method (as defined in '88) [a]	5.2	10				12.6				17.4		11.5 [b]	
Contraceptive prevalence—any modern method	5.2 [a]	10 [a]				13.3[c]				18.7[d]		13.6 [e]	
Couple-years of protection				278,952			597,273						
Women receiving ANC	82.4 [f]	85.7 [g]				87.5[f]							
Women receiving ANC [h]										91.9			
Births at a facility		42.2[i]				43 [j]				45.7 [k]		48.7 [l]	
Use of ORS or RHF to treat diarrhea [m]	36.6	37.1				32.5				48.3			
Use of ORT to treat diarrhea (2003 definition includes ORS, RHF and increased liquids)[n]		45.6				66.8				64.4			

Sources: [1]GDHS (treatment of diarrhea statistics from STATcompiler); [2] HSSP PAD; [3]Ghana Multiple Indicator Cluster Survey (MICS), preliminary results, February 2007; [4*]SHPP II PAD; [8]MOH; [9*]HPP2 PAD; [10]Centre for Health Information Management,/ Policy Planning Monitoring and Evaluation- Ghana Health Service.

a. Percent of currently married women aged 15-49 using a modern contraceptive method, including: pill, IUD, injection, diaphragm, foam/jelly, condom, or female sterilization.
b. Percent of currently married women or women in union aged 15-49 using a modern contraceptive method including: pill, IUD, injection, diaphragm, foam/jelly, condom, or female sterilization.
c. Percent of currently married women aged 15-49 using a modern contraceptive method including: pill, IUD, injectables, diaphragm/foam/jelly, condom, female sterilization, or implant. Same as 1988 and 1993 definition with the addition of implant, male sterilization and Lactational Amenorrhea Method (LAM).
d. Percent of currently married women aged 15-49 using a modern contraceptive method including: pill, IUD, injectables, diaphragm/foam/jelly, condom, female sterilization, or implant. Same as 1998 definition with the addition of male condom, and exclusion of male sterilization.
e. Percent of currently married women or women in union aged 15-49 using a modern contraceptive method including: pill, IUD, injection, diaphragm, foam/jelly, female condom, male condom, female sterilization, or LAM.
f. Percent of women who gave birth 5 years (1-59 months) preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy. Asked for all live births.

g. Percent of women who gave birth 3 years (1-35) months preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy.
h. Percent of women who gave birth 5 years (1-59 months) preceding the survey who consulted a doctor, nurse, midwife, or auxiliary nurse at least once during pregnancy. Asked only for most recent birth.
i. Births in the 3 years (1-35 months) prior to the survey in a public or private facility.
j. All live births in the 5 years (1-59 months) prior to the survey in a public or private facility.
k. Most recent births in the 5 years (1-59 months) prior to the survey in a public or private facility
l. Births in the 2 years (1-23 months) prior to the survey in a public or private facility.
m. Percent of children under 3 who have had diarrhea in the two weeks preceding the survey who received oral rehydration salts (ORS) or recommended home fluids (RHF). .
n. Percent of children under 3 who have had diarrhea in the two weeks preceding the survey treated with ORT; according to the 2003 DHS definition ORT includes (ORS), recommended home fluids (RHF), or increased liquids. This number was found using the STATcompiler and subtracting the percent who received “no ORS, RHF or increased liquids” from 100.

Table F 7 - Targets/Indicators (1997-2001): PoW I *(Source: Ministry of Health, 1996)*

		PoW I Estimates (*MoH, 1996*)		GDHS Actuals		
	Impact Measures	**1997** *Estimated Baseline*	**2001** *Targets*	**1998 GDHS** *Actual Baseline*	**2003** *Actual Outcome*	
Health Status	IMR per 1000 (5yr)	66	50	57	***64*** ***[CI: 55-73]***	***Not achieved.*** No real change in IMR.
	U5MR per 1000 (5 yr)	132	100	108	***111*** ***[CI: 99-123]***	***Achieved, but with caveats.**** No real change in U5MR. Target of 100 was based in an incorrect baseline estimate of 132, which was never updated based in GDHS 1998 data.
Fertility	Total fertility rate (TFR)	5.5	5.0	4.6 (5-year rate) [CI: 4.3 – 4.8]	***4.4*** ***(3-year rate)*** [CI: 4.2 – 4.7]	***Exceeded, but with caveats.**** Target of 5.5 was exceeded already in 1998. Baseline and targets were never updated on the basis of GDHS 1998 data.
Nutrition Status	% with severe malnutrition	12	8			***Not achieved.*** The definition of the "severe malnutrition" indicator was not provided. Relevant DHS indicators reveal no significant change in severe malnutrition of children under five.
	% children under 5 severely stunted			9	11	
	% children under 5 severely underweight			5	5	
	% children under 5 severely wasted			1.4	1.3	
Health Services						
(a) clinical services	Per capita OPD attendance (pa) at public institutions	0.3	0.5	0.39 *(MoH/GHS, 1996)*	0.49	***Achieved.***
	TB cure rate (%)	15	85		64 *(MoH/GHS, 2004)*	***Not achieved***
(b) public health services	% Iron deficiency anemia in pregnancy	50	40		65	***Not achieved.*** (mild: 37%, moderate 26.7%, severe 1.2%) (*GDHS 2003*) ***not achieved***
	% supervised delivery	40	60	44 (births in previous 5 years attended by doctor, nurse or midwife)	47 (births in previous 5 years attended by doctor, nurse, midwife or auxiliary nurse)	***Not achieved.***
	% DPT3 coverage	49	75	72	80	***Achieved, but with caveats.****Actual baseline was almost equal to the target. (GDHS data for children 12-23 months.)
	%OPV3 coverage	49	75	72	79%	***Achieved, but with caveats.**** Actual baseline was almost equal to the target. (GDHS data for children 12-23 months.)
	% TT2 coverage	64	80	50	52	***Not achieved.*** No significant improvement in coverage. (GDHS data for pregnant women receiving 2 or more doses.)
	% households using Iodised salt	30	100	28	28	***Not achieved.*** No improvement in coverage.
	% Vitamin A supplement	20	80			

		PoW I Estimates (*MoH, 1996*)		GDHS Actuals		
	Impact Measures	**1997** *Estimated Baseline*	**2001** *Targets*	**1998 GDHS** *Actual Baseline*	**2003** *Actual Outcome*	
	% children who took supplement in 6 months preceding the survey % women who had taken supplement w/in 2 months of last birth			24 28	75 43	***Almost achieved for children.*** ***Not achieved for women.***
	% Use of Insecticide Treated Bednets (ITNs) % children under 5 who slept under an ITN the night before the survey % pregnant women who slept under an ITN the night before the survey	10	40	< 1 percent *(MoH/GHS data)*	 3.5 2.7	***Not achieved.***
	% Children w/ Diarrhea receiving oral rehydration therapy (ORT) % children under 3 with diarrhea treated with oral rehydration salts (ORS), recommended home fluids (RHF) or increased liquids (GDHS 2003 definition of ORT) % children with diarrhea treated with either ORS or RHF % children with diarrhea receiving no treatment	24	80	 67 33 8.1	 64 48 13.1	***Not achieved.***
	% Children exclusively breastfed (4 months) % children 2-3 months % children 4-5 months	19	80	 31 22	 65 39	***Not achieved.***

* *Note:* These targets were achieved, but real baselines (drawn from 1998 GDHS) were almost equal to, or already exceeding, the 2001 targets. Differences between the real baseline values and actuals reveal very modest changes that may not be statistically significant. Targets should have been adjusted when GDHS 1998 data became available.

ANNEX G. Equity in Health Outcomes and Use of Services, 1993-2003

Table G 1 - Changes in health status and use of services by wealth quintile

Indicator	Poorest Quintile			Richest Quintile			Poor/Rich Ratio		
	1993	1998	2003	1993	1998	2003	1993	1998	2003
Health outcomes									
Moderate Stunting [a]	21.9	20.3	25.4	9.2	9.1	8.9	2.4	2.2	2.9
Moderate Underweight [b]	22.8	23.6	22.2	10.8	11.0	9.8	2.1	2.1	2.3
Total fertility rate	6.7 [c]	6.3 [c]	6.4 [d]	3.4 [c]	2.4 [c]	2.8 [d]	2.0	2.6	2.3
Service utilization (%)									
Measles immunization [e]	47.8	60.5	74.0	89.2	87.2	88.4	0.5	0.7	0.8
Full immunization [f]	37.5	49.6	53.0	54.8	79.3	78.3	0.5	0.6	0.7
Use of ORT to treat diarrhea (including ORS, RHF or increased liquids)[g]	40.9			62.0			0.7		
Use of ORT to treat diarrhea (including ORS, RHF or increased liquids)[h]		62.1	59.6		78.9	78.3		0.8	0.8
Ante-natal visit	75.8 [i]	76.4 [j]		97.3 [i]	98.3 [j]		0.8	0.8	
Ante-natal visit [k]			83.4			98.2			0.9
Delivery by trained staff	25.3 [l]	17.9 [m]		85.3 [l]	86.1 [m]		0.3	0.2	
Delivery by trained staff [n]			20.6			90.4			0.2
Contraceptive prevalence, modern methods [o]	5.4			19.1			0.3		
Contraceptive prevalence, modern methods [p]		7.5			17.9			0.4	
Contraceptive prevalence, modern methods [q]			8.6			26.3*			0.3

Source: DHS 1993, 1998, and 2003, as analyzed by Gwatkin et al 2000 and 2006. Note that some of the data vary from original DHS data.
*Increase from 1993 to 2003 is statistically significant; however, there is a change in the methods included as "modern methods" between surveys.

a. Percent of children under 5 (1-59 months) between -2 and -3 SD from the median height for age of the reference population.
b. Percent of children under 5 (1-59 months) between -2 and -3 SD from the median weight for age of the reference population.
c. Rates are for the period 5 years (1-59 months) preceding the survey for women age 15-49, expressed per woman.
d. Rates are for the period 3 years (1-35 months) preceding the survey for women age 15-49, expressed per woman.
e. Percent of children age 12-23 months who have received the measles vaccination at any time before the survey according to vaccination card or mother's report.
f. Percent of children 12-23 months who have received BCG, 3 doses of DPT and polio, and 1 dose of measles vaccine anytime before the survey according to vaccination card or mother's report.
g. Percent of children under 3 (1-35 months) with diarrhea in two weeks prior to survey treated with oral rehydration salts, recommended home fluids, or increased liquids. Note this is the definition of ORT according to the 2003 DHS and used by Gwatkin et al.
h. Percent of children under 5 (1-59 months) with diarrhea in two weeks prior to survey treated with oral rehydration salts, recommended home fluids, or increased liquids. Note this is the definition of ORT according to the 2003 DHS and used by Gwatkin et al.
i. Percent of women who gave birth 3 years (1-35 months) preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy.
j. Percent of women who gave birth five years (1-59 months) preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy. Asked for all live births.
k. Percent of women who gave birth five years (1-59 months) preceding the survey who consulted a doctor, nurse, midwife, or auxiliary nurse at least once during pregnancy. Asked only for most recent birth.
l. Percent of births 3 years (1-35 months) before the survey attended by a doctor, nurse or midwife.
m. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse or midwife.
n. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse, midwife or auxiliary nurse.
o. Percent of currently married women aged 15-49 using a modern contraceptive method, including: pill, IUD, injection, diaphragm, foam/jelly, condom, or female sterilization.
p. Percent of currently married women aged 15-49 using a modern contraceptive method including: pill, IUD, injectables, diaphragm/foam/jelly, condom, female sterilization, or implant. Same as 1993 definition with the addition of implant, male sterilization and Lactational Amenorrhea Method (LAM).

q. Percent of currently married women aged 15-49 using a modern contraceptive method including: pill, IUD, injectables, diaphragm/foam/jelly, condom, female sterilization, or implant. Same as 1998 definition with the addition of male condom, and exclusion of male sterilization.

Table G 2 - Changes in health status and use of services in rural and urban areas

	Rural areas				Urban areas				Rural/urban ratio			
Indicator	**1988**	**1993**	**1998**	**2003**	**1988**	**1993**	**1998**	**2003**	**1988**	**1993**	**1998**	**2003**
Health outcomes												
Stunting	31.7[a]	30.1[b]			25.6[a]	15.7[b]			1.3	1.9		
Stunting[c]			29.7	34.5			14.3	20.5			2.1	1.7
Wasting[a]	8.3[a]	12.6[b]			7.1[a]	8.6[b]			0.7	1.5		
Wasting[c]			10.5	7.4			6.5	6.6			1.6	1.1
Underweight[a]	32.8[a]	31.4[b]			25.6[a]	17.5[b]				1.8		
Underweight[c]			27.9	25.4			15.6	15.4			1.8	1.6
Total fertility rate[d]		6.4	5.4			4.0	3.0			1.6	1.8	
Total fertility rate[e]				5.6				3.1				1.8
Service utilization (%)												
Measles immunization	66.7[f]	57.5[g]	69.2[g]	81.8[g]	74.6[f]	80.2[g]	81.5[g]	85.8[g]	0.9	0.7	0.8	1.0
Full immunization	37.6[h]	47.8[i]	58.0[i]	66.0[i]	60.3[h]	71.1[i]	72.3[i]	75.5[i]	0.6	0.7	0.8	0.9
Use of ORS or RHF to treat diarrhea[j]	32.1	32.1	38.9	52.3	48.4	53.0	30.6	32.3	0.7	0.6	1.3	1.6
Use of ORT to treat diarrhea (2003 definition includes ORS, RHF or increased liquids)[k]		40.4	66.4	53.5		62.0	66.9	62.9		0.7	1.0	0.9
Ante-natal visit	78.1[l]	81.5[m]	85.2[l]		93.6[l]	96.7[m]	94.5[l]		0.8	0.8	0.9	
Ante-natal visit[n]				88.6				97.9				0.9
Delivery by trained staff	28.9[o]	29.5[p]	34.1[o]		70.3[o]	81.2[p]	76.3[o]		0.4	0.4	0.5	
Delivery by trained staff[q]				30.9				79.7				0.4
Contraceptive prevalence, modern methods (as defined in 1988)[r]	3.8	7.4	10.9	13.9	8.1	15.9	16.4	22.7	0.5	0.5	0.7	0.6
Contraceptive prevalence-- any modern method	3.8[r]	7.4[r]	11.4[s]	14.9[t]	8.1[r]	15.9[r]	17.4[s]	24.2[t]	0.5	0.5	0.7	0.6

Source: DHS 1988, 1993, 1998, and 2003. (Treatment of diarrhea statistics from STATcompiler)

a. Percent of children 3-35 months less than -2 SD from the median of weight for age (underweight), height for age (stunting) and weight for height (wasting) of the reference population.

b. Percent of children under 3 (1-35 months) less than -2 SD from median of weight for age (underweight), height for age (stunting) and weight for height (wasting) of the reference population.

c. Percent of children aged under 5 (1-59 months) less than -2 SD from median of weight for age (underweight), height for age (stunting) and weight for height (wasting) of the reference population.

d. Rates are for the period 5 years (1-60 months) preceding the survey for women age 15-49, expressed per woman.

e. Rates are for the period 3 years (1-35 months) preceding the survey for women age 15-49, expressed per woman.

f. Percent of children aged 12-23 months who received measles vaccine prior to survey according to vaccination card.

g. Percent of children aged 12-23 months who received measles vaccine prior to survey according to vaccination card or mother's report.

h. Percent of children who age 12-23 months who have received BCG, 3 doses of DPT and polio, and 1 does of measles vaccine any time before the survey according to vaccination card.

i. Percent of children who age 12-23 months who have received BCG, 3 doses of DPT and polio, and 1 does of measles vaccine any time before the survey according to vaccination card or mother's report. For the 2003 survey, the three doses of DPT were replaced with the DPT/HepB/HiB.

j. Percent of children under 3 who have had diarrhea in the two weeks preceding the survey treated with oral rehydration salts (ORS), or recommended home fluids (RHF).

k. Percent of children under 3 who have had diarrhea in the two weeks preceding the survey treated with ORT; according to the 2003 DHS definition ORT includes (ORS), recommended home fluids (RHF), or increased liquids. This number was found using the STATcompiler and subtracting the percent who received "no ORS, RHF or increased liquids" from 100.
l. Percent of women who gave birth five years (1-59 months) preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy. Asked for all live births.
m. Percent of women who gave birth 3 years (1-35 months) preceding the survey who consulted a doctor, nurse or midwife at least once during pregnancy.
n. Percent of women who gave birth five years (1-59 months) preceding the survey who consulted a doctor, nurse, midwife, or auxiliary nurse at least once during pregnancy. Asked only for most recent birth.
o. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse or midwife.
p. Percent of births 3 years (1-35 months) before the survey attended by a doctor, nurse or midwife.
q. Percent of births 5 years (1-59 months) before the survey attended by a doctor, nurse, midwife or auxiliary nurse.
r. Percent of currently married women age 15-49 using a modern contraceptive method (pill, IUD, injectables, diaphragm, foam/jelly, condom, female sterilization).
s. Percent of currently married women age 15-49 using a modern contraceptive method (pill, IUD, injectables, diaphragm, foam, jelly, condom, implant, female sterilization, male sterilization, or LAM). Same methods included as 1993 with the addition of LAM.
t. Percent of currently married women age 15-49 using a modern contraceptive method (pill, IUD, injectables, diaphragm, foam, jelly, male condom, female condom, implant, female sterilization, or LAM). Same methods included as 1998, except that male sterilization is excluded and male condom was added.

Table G 3 - Changes in health status and use of services in Northern regions and nationally

	Northern Regions*			**National**			**Nothern/National Ratio**		
Indicator	**1993**	**1998**	**2003**	**1993**	**1998**	**2003**	**1993**	**1998**	**2003**
Full Immunization [a]	47.3	58.7	57.2	54.8	62.0	69.4	0.9	0.9	0.8
Deliveries attended by skilled worker [b]	17.5	16.5	22.4	43.8	44.9	46.5	0.4	0.4	0.5
Contraception prevalence-- any modern method [c]	5.7	7.1	10	10.1	13.3	18.7	0.6	0.5	0.5
Antenatal visit [d]	72.9	74.2	84.6	85.6	88.6	91.9	0.9	0.8	0.9
Use of ORS or RHF to treat diarrhea [e]	35.1	29.7	51.4	37.1	32.5	48.3	0.9	0.9	1.0
Use of ORT to treat diarrhea (2003 definition includes ORS, RHF or increased liquids) [f]	46.6	64.6	65.3	45.6	66.8	64.4	1.0	1.0	1.0

*Northern Regions include Northern, Upper West and Upper East regions.

Source: MEASURE DHS STATcompiler (www.stacompiler.com). Note that the STATcompiler provides broad definitions for indicators that may not reflect changes in indicator definitions between DHS surveys.

a. Percent of children who age 12-23 months who have received BCG, 3 doses of DPT and polio, and 1 does of measles vaccine any time before the survey according to vaccination card or mother's report.
b. Percent live births attended by a doctor or other health professional in three years preceding survey.
c. Percent of currently married women age 15-49 using a modern method of contraception.
d. Percent of women who gave birth 3 years preceding the survey who consulted a doctor or other health professional.
e. Percent of children under 3 with diarrhea in the two weeks preceding the survey treated with oral rehydration salts (ORS) or recommended home fluids (RHF). .
f. Percent of children under 3 with diarrhea in the two weeks preceding the survey treated with ORT; according to the 2003 DHS definition ORT includes oral rehydration salts (ORS), recommended home fluids (RHF), or increased liquids. This number was found using the STATcompiler and subtracting the percent who received "no ORS, RHF or increased liquids" from 100.

ANNEX H. Trends in Health Outcomes, Water and Sanitation, Based on Household Surveys, 1988-2003

This annex presents trends in indicators of health outcomes (nutritional status of children) and service use or coverage (immunization, contraceptive use, household sources of drinking water and sanitation), using data from the Ghana Living Standards Surveys (GLSS) conducted in 1988/89, 1991/92, and 1998/99. In addition, in 2003 IEG conducted a re-survey of households in 81 clusters from the 1988/89 GLSS with a nearly identical questionnaire, for the purpose of examining changes in those same clusters over the period 1988-2003. While the 1988/89 clusters were nationally representative in that year, when re-interviewed as part of a cluster-level panel in 2003, they were not nationally representative of Ghana. The 1988/89 and 1991/92 surveys were self-weighted; results for the 1998/99 surveys have been weighted.

Selected results are presented by poverty group: rural and urban groups; the lowest and highest quintile of household per capita consumption expenditure; and the "poor" and "non-poor", defined as all individuals or households below the median value of household per capita consumption expenditure of the first of any two surveys, adjusted for inflation. This latter category compares individuals or households with similar absolute levels of welfare across two adjacent surveys, while the quintile analysis measures relative welfare (the lowest and highest 20 percent of individuals or households). However, because the GLSS fundamentally changed the way that consumption expenditure was collected in 1991/92 and thereafter (shifting from recall to a diary method), absolute levels of welfare (the poor/non-poor categories) are not strictly comparable between 1988/89 and the two GLSS surveys that followed (Ghana Statistical Service, 2000), though they are comparable with the 2003 IEG household survey. In addition, some of the variables were not collected by all four surveys or were defined differently by the questionnaire, and thus not strictly comparable.

Table H 1 - Trend in nutritional status of children <3, 1988-2003

	Stunted[a]		Wasted[b]		Underweight[c]		Sample size	
Sample	**1988/89**	**2003**	**1988/89**	**2003**	**1988/89**	**2003**	**1988/89**	**2003**
Rural	27.3	27.6	5.9	16.2	26.0	33.2	439	265
Urban	15.9	21.7	6.0	9.8	18.1	20.7	182	184
Lowest quintile[d]	28.7	31.5	5.6	18.2	28.7	35.4	216	181
Poor[e]	28.0	41.8	7.0	19.4	27.4	40.3	382	67
Non-poor	19.9	22.3	4.9	12.6	*19.9*	*25.9*	307	382
All children	24.0	25.2	6.0	13.6	*23.7*	*28.1*	621	449

Source: IEG analysis of GLSS 1988/89 and the 2003 IEG household survey

Note: Shaded cells denote statistically significant trend at p<=.05. Italics indicate statistically significant trend at p<=.10.

a. Percent <-2 SD below the median height for age of the reference population.
b. Percent <-2 SD below the median weight for height of the reference population.
c. Percent <-2 SD below the median weight for age of the reference population.
d. The number of children in the sample for the highest quintile households was too small to yield meaningful results.
e. Children in households with per capita consumption expenditure less than the median in 1988/89.

Table H 2- -Trend in vaccination and contraceptive prevalence rates, 1991-1999

Sample	Percent of children <5 years ever vaccinated		Percent of women 15-49 using a modern method of contraception	
	1991/92	1998/99	1991/92	1998/99
Rural	77.3	90.9	5.3	12.4
Urban	94.2	97.2	8.5	11.6
Lowest quintile	77.4	90.8	4.2	9.8
Highest quintile	95.2	95.4	*8.1*	*12.8*
Poor	78.4	90.5	5.4	10.5
Non-poor	85.6	93.9	7.7	13.1
All	82.0	92.6	6.5	12.1
Sample size	3,167	3,337	4,475	5,937

Source: IEG analysis of GLSS surveys.
Note: Shaded cells denote statistically significant trend at p<=.05. Italics indicate statistically significant trend at p<=.10.

Table H 3 - Trend in source of drinking water, 1988-1999

Source of drinking water	Percent of households		
	1988/89	1991/92	1998/99
Piped inside[a]	12.2	15.1	14.7
Piped outside[b]	12.0	14.7	21.1
Well[c]	23.8	28.7	30.4
Surface source[d]	46.0	34.7	24.8
Other[e]	6.0	6.9	9.0
Sample size	3,193	4,493	5,998

Source: IEG analysis of GLSS surveys.
Note: The response "neighboring household", which is included in "other", does not indicate the source of the neighbor's drinking water, which could be any of the other categories.

a. Indoor plumbing or inside standpipe.
b. Private outside standpipe or public standpipe.
c. Well with or without a pump.
d. River, lake, spring, rainwater.
e. Water vendor, truck/tanker, neighboring household, "other".

Table H 4 - Trend in percent of households obtaining drinking water from surface sources, by poverty group, 1988-1999

Group	Percent of households		
	1988/89	1991/92	1998/99
Rural	61.1	48.0	35.2
Urban	*12.3*	*9.9*	6.8
Lowest quintile	57.5	45.8	35.0
Highest quintile	31.3	25.2	15.1
Poor	[a]	41.2	33.3
Non-poor	[a]	28.1	18.3
All	46.0	34.7	24.8
Sample size	3,193	4,493	5,998

Source: IEG analysis of GLSS surveys.
a. Absolute levels of consumption expenditure cannot be compared between 1988/89 and the two surveys that followed because of a change in the way that the data were collected.

Table H 5 - Trend in percent of households obtaining drinking water from wells, by poverty group, 1988-1999

	Percent of households		
Group	**1988/89**	**1991/92**	**1998/99**
Rural	26.7	37.2	42.7
Urban	17.4	13.0	9.2
Lowest quintile	28.7	36.1	46.3
Highest quintile	*19.0*	*24.0*	*20.2*
Poor	[a]	32.6	40.4
Non-poor	[a]	*24.9*	*22.8*
All	23.8	*28.7*	*30.4*
Sample size	3,193	4,493	5,998

Source: IEG analysis of GLSS surveys.

a. Absolute levels of consumption expenditure cannot be compared between 1988/89 and the two surveys that followed because of a change in the way that the data were collected.

Table H 6 - Trends in household sanitary facilities, 1988-1999

	Percent of households		
Type of toilet	**1988/89**	**1991/92**	**1998/99**
Flush toilet	5.1	7.1	6.6
Pit latrine	56.6	50.2	35.4
KVIP[a]	[b]	6.8	29.1
Pan/bucket	11.5	11.3	6.8
None/Other	26.9	24.7	22.1
Sample size	3,192	4,495	5,998

Source: IEG analysis of GLSS surveys.

a. Kumasi VIP (KVIP) – communal double vault composting toilet.

b. KVIP was not a response code on the 1988/89 questionnaire.

Table H 7 - Trend in percent of households using pit latrines by poverty group, 1988-1999

	Percent of households		
Group	**1988/89**	**1991/92**	**1998/99**
Rural	*64.5*	*61.2*	45.3
Urban	39.0	29.6	18.2
Lowest quintile	*56.7*	*52.8*	35.1
Highest quintile	*48.6*	*48.5*	29.3
Poor	[a]	53.7	39.3
Non-poor	[a]	46.7	32.3
All	56.6	50.2	35.4
Sample size	3,192	4,495	5,998

Source: IEG analysis of GLSS surveys.

a. Absolute levels of consumption expenditure cannot be compared between 1988/89 and the two surveys that followed because of a change in the way that the data were collected.

Table H 8 - Trend in percent of households using KVIP by poverty group, 1988-1999

Group	Percent of households		
	1988/89	1991/92	1998/99
Rural	[a]	3.7	19.9
Urban	[a]	12.6	45.2
Lowest quintile	[a]	4.6	17.2
Highest quintile	[a]	8.9	38.0
Poor	[a]	5.3	22.1
Non-poor	[a]	8.3	34.6
All	[a]	6.8	29.1
Sample size	3,192	4,495	5,998

Source: IEG analysis of GLSS surveys.
a. KVIP was not a response code on the 1988/89 questionnaire.

Table H 9 - Trend in percent of households with no toilets/other, by poverty group, 1988-1999

Group	Percent of households		
	1988/89	1991/92	1998/99
Rural	28.5	29.7	29.8
Urban	23.1	15.2	8.8
Lowest quintile	37.0	35.3	44.4
Highest quintile	*19.5*	*15.5*	*12.3*
Poor	[a]	*28.7*	*32.5*
Non-poor	[a]	20.5	14.1
All	*26.8*	*24.7*	22.1
Sample size	3,192	4,495	5,998

Source: IEG analysis of GLSS surveys.
a. Absolute levels of consumption expenditure cannot be compared between 1988/89 and the two surveys that followed because of a change in the way that the data were collected.

Reference

Ghana Statistical Service. 2000. *Poverty Trends in Ghana in the 1990's*. Ghana Statistical Service, Accra, Ghana. Accessible on www.worldbank.org/lsms.

ANNEX I. SWAp: A Long, Dynamic and Incremental Process

(conditionalities shown in italics)

Characteristic of the Sector-Wide Approach[a]	HPP II (1991-1997)	PoW I (1997-2001)	PoW II (2002-2007)[b]
A sustained partnership			
(a) involving different parts of government, groups in civil society, and one or more donor agencies.	MoH's partnership with its partners, including the Bank, was largely of a bilateral nature until the end of the project. Civil society partnerships in strategic sector management were limited.	MoH's relationship with development partners expanded and became more dynamic, especially with the core group of partners contributing to the health fund, which were the only partners to sign Joint Aides-memoire. Civil society partnerships in strategic sector management were limited.	At the end of this program period, all development partners (including those not contributing to health fund) were permitted to sign Joint Aides-memoire. Civil society not yet included in partnerships. Partnership with MoFEP likely to be even stronger in light of evolution to budget support by some partners.
(b) led by national authorities w/ the goal of achieving improvements in people's health and contributing to national human development objectives	Government complying with Bank conditionalities and implementing in project mode.	Government in leadership position.	Government in leadership position.
A coherent sector, defined by			
(a) an appropriate institutional structure	A vision of strong central institutions supporting strong regional and district health teams has underpinned the objective of institution building throughout the period under review. The extent to which this vision was realized is discussed below under "institutional reform and capacity building."		
(b) a national financing program		PoW I financing plan established. Creation of a Health Fund for pooling the resources of (some) development partners for health and blending these funds w/ GoG funds, using government systems both for channeling resources to implementing agencies and decentralized levels and for their financial management. Earmarked funds to contribute directly to PoW implementation.	PoW II financing plan established. Health Fund initially continued, but in later years of program a number of core funders have transitioned to budget support. Most recent summit (2006) was the first time that the budget was discussed with (and somewhat influenced by) partners and has been noted as an important advance. It also reveals an important deficiency of previous annual summits on annual plans and budgets. Financing system is changing with the successful establishment of NHIS (which will increasingly assume responsibility for a large portion of sector financing, including protection of the poor) and the move away from pooling to budget support.
A collaborative program of work focusing on:	*MoH to prepare a program for the extension of PHC coverage, staffing norms, manpower master plan, master training program.* PoW I prepared (1997-2001)	PoW I is the basis for all financing and for health sector implementation and monitoring.	PoW II is the basis for all financing for health sector implementation and monitoring.
(a) the development of **sectoral policies and strategies** that			
(i) define the roles of the public and private sectors in relation to the financing and provision of service and	*Contract w/ PPAG for FP provision; use of additional funds to finance other NGOs to provide FP.* *Government to prepare master framework agreement for governing relationship between MoH and NGOs in the areas of health and*	Envisaged under PoW I, but not realized.	Envisaged under PoW II, but not realized.

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	population service delivery. Cooperative arrangements w/ NGOs not fully developed or exploited.		
(ii) provide a basis for prioritizing public expenditures		*Government to ensure that contracts for capital investments are awarded in accordance with the Process for the Definition and Review of Capital Projects.*	*MoH to ensure that contracts for capital investments are awarded in accordance with the Process for the Definition and Review of Capital Projects.* Formula for allocation of resources across regions, districts not yet right (in terms of equity and in terms of costs of doing business). Evidence base is missing: need for a review/update, a sector status report to look at burden of disease, determinants, cost-effectiveness of interventions, health systems issues, etc...; also need for operational research on cost-effectiveness of interventions.
(b) **medium-term projections of resource availability and sector financing and spending plans**, consistent with a **sound public expenditure framework**	*Government to provide annually MoH recurrent budget and 3-year rolling public investment program. Recurrent budget to be based increasingly on service delivery plans with emphasis on primary health care and full financing of critical inputs. Investment program to be prioritized w/ transparent criteria and coherent w/ strategy to extend PHC coverage. Budget to be based on actual expenditure.* Support for development of MTHS and PoW	*Annual MoH budget to be submitted by MoH to the Ministry of Finance no later than October 1 of each year and to Parliament no later than January 1 of each year.*	Performance indicators (results) not linked to planning/budgets (inputs) or to expenditures. PER is planned. *Annual MoH budget to be submitted by MoH to the Ministry of Finance no later than October 1 of each year and to Parliament no later than January 1 of each year.* Increasing resources are not equitably or efficiently used. Trend of increasing expenditures on personnel and capital investments and decreasing expenditures on service and administrative budgets. Also a trend of increasing expenditures on the hospital sector to the detriment of primary health care spending. Criteria for resource allocation to lower levels is not clear and regions and districts rated as high poverty areas do not automatically receive additional resources.
(c) **management systems** by national governments and donor agencies that facilitate **common arrangements** for :		Common management arrangements (CMA) prepared in the context of SWAp preparation and implemented under PoW I.	CMA II prepared and in effect. Various systems established and functioning but not inter-linked.
(i) disbursement and accounting of funds		*Government to maintain a system which shall provide for the flow of funds to the BMCs; to audit use of GoG budget and Health Fund; to furnish to partners: quarterly financial statements showing all revenues and expenditures for each level of BMC (all sources of funds).* Financial management and financial reporting guidelines, capacity building (training/supervision), decentralization.	*Government to maintain a system which shall provide for the flow of funds to the BMCs; to audit use of GoG budget and Health Fund; to furnish to partners: quarterly financial statements showing all revenues and expenditures for each level of BMC (all sources of funds).*
(ii) procurement of goods and services		*Government to establish a procurement unit within MoH to coordinate procurement under the PoW* Procurement unit established and guidelines prepared. Procurement staffing and training to prepare	*Government to appoint a procurement auditor for reviewing the procurement of goods, works and services financed under the PoW, including the reviewing of procurement procedures and processes.*

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		BMCs to take on responsibilities. Drugs supply and management system strengthened.	
(iii) monitoring of sectoral performance	*Government to undertake annual health public expenditure review. Government to design and implement a MIS to generate key indicators and related system of regular performance monitoring at different levels.*	Periodic reviews of sector performance at district, regional and national levels against 20 performance indicators. Performance contracts prepared, but not used as management tool for accountability.	Major study undertaken to assess MIS and recommend improvements carried out in the context of 2005 Annual Sector Review. Simplification and computerization of information collection, reporting and consolidation is ongoing. Even with some adjustment to 20 performance indicators. For PoW II, sector-wide indicators are not fully adequate in measuring sector performance, including (but not limited to) their inability to measure outcomes of poverty and equity-related objectives. Sector logframe needs to spell out results chain and links (inputs, outputs, outcomes, impacts). M&E not facilitating learning/evidence-base of strategies and programs. No systematic review of sector costs, financing, expenditures (series of public expenditure reviews, incidence analyses). No health sector analysis, little operational research to update policy, strategy, program priorities.
(d) institutional reform and capacity building, in line with sectoral policy, and the need for systems development	Support to reorganization of MoH, assistance to National Health Advisory Board and to 6 new divisions of MoH; District-level planning and implementation support; training for DHMT in planning, supervision, management. *MoH to continue appointing full-time heads of DMTs.*	Support to render operational the split of central level functions between MoH (policy, regulation) and a newly created GHS (service delivery). But not fully achieved. Certification of BMCs to ensure their capacity to assume fiduciary responsibilities (financial management, procurement).	Support to MoH/GoH institutional set-up and functioning envisaged, but still not fully achieved. Strengthen/consolidate/update regulatory institutions, legislation: in process SWAp process has documented this issue repeatedly, but has not been successful in resolving it since 10 years.
Established structures and processes for :	Primarily bilateral dialogue; common management arrangements prepared at end.	CMA I implemented.	CMA II implemented.
(a) negotiating strategic and management issues,	Strengthening of external aid coordination and project management.	Nature of dialogue, candid, transparent, inquisitive, technical, collegial: joint identification and resolution of issues/constraints to sector performance. Special studies commissioned to analyze/address key issues.	Nature of dialogue became more tense, less productive, with major turnover of key actors, both on Ghana's and partners' sides. Some partners withheld/delayed financing when dissatisfied with GoG performance on some issues. Special studies commissioned to analyze/address issues, but some not culminating in resolution of issues. Issue about how polite vs. how rigorous the exchange is/should be. Some donors have expressed concern that the system is breaking down, no longer working.
(b) reviewing sectoral performance against jointly agreed milestones and targets.	First three summit meetings (1996-1997) take place to review/approve PoW I and to review initial performance for 1997. *MoH to design a regular performance monitoring system at different levels, linked to MIS.*	Two summit meetings/year: one to review performance of past year and agree on improvements; the other to review plans/budget for the following year (including donor commitments). *Quarterly financial statements to be submitted to partners should report on performance indicators linked to performance indicators agreed with partners* *No later than April of each year an annual report integrating the results of monitoring and*	Process of semi-annual summit meetings at national level and regular meetings at decentralized levels continued. However, a significant number and large range of informants questioned the utility of annual reviews, which were found to be very expensive (both in terms of financial resources spent and in terms of the opportunity costs of time spent at these meetings), more focused on process vs. substance, and, on an increasing basis, stale and less likely to lead to concrete decisions/improvements. Preparation of recent summits has been lax compared to

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		evaluation activities should be prepared on the progress achieved and on measures recommended to ensure the efficient implementation of the program and achievement of objectives and the report of actual expenditures against the budget for the previous year.	earlier ones, with a number of background documents not available or available in draft form. Some recommendations not fully followed through: MoH/GHS organizational set-up; human resources; performance-based management. Strong calls made to establish a viable performance management system that would render managers and service delivery staff accountable for results. *Quarterly financial statements to be submitted to partners should report on performance indicators linked to performance indicators agreed with partners* *No later than April of each year an annual report integrating the results of monitoring and evaluation activities should be prepared on the progress achieved and on measures recommended to ensure the efficient implementation of the program and achievement of objectives and the report of actual expenditures against the budget for the previous year.*

a. Cassels 1997.
b. Progress to date and emerging issues and opportunities.