GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Ghana Desk-based Case Study

Final Version – August 2009

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Submitted by

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Acronyms and abbreviations

APR	Annual Progress Report
CHO	Community Health Officer
CHPS	Community Health Planning and Service
CTT	Country Task Team
DDHS	District Director of Health Services
DHAP	District Health Analysis and Planning
DSS	Demographic Surveillance Site
DWIMS	District Wide Information Management System
DHMT	District Health Management Team
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
HPCG	Health Partners Coordination Group
IRC	Independent Review Committee
MBB	Marginal Budgeting for Bottlenecks
MOFEP	Ministry of Finance and Economic Planning
NDPC	National Development Planning Commission
NHIS	National health Insurance Scheme
PDA	Personal Data Assistant
PPMED	Planning Policy Monitoring and Evaluation Division (of the GHS)
SDHMT	Sub-District Health Management Team

Summary of key findings

The GAVI HSS programme is country driven and responds to real weaknesses in service delivery. It focuses mostly on district and sub-district interventions to:

- strengthen leadership, management and teamwork skills and capacities
- develop and introduce protocols to assist local planning and resource allocation
- provide better transportation and supplies
- improve data collection and reporting, monitoring and evaluation systems, and undertake operational research on delivery effectiveness.

The programme appears sensible, relevant and achievable, and is likely to help strengthen primary care delivery across the board. Ghana appears to have had good prior understanding of some weaknesses in relevant services delivery and was able to identify quickly how GAVI HSS funding could help – and GAVI HSS funding is sufficiently flexible in application to respond.

Some issues that arise from this desk evaluation include the following:

- some confusion over where and when GAVI HSS funding was sent resulted in a six-month delay in start up – the key recipient was not properly informed

- the flexibility of GAVI HSS funding is very useful to Ghana in filling key gaps in delivery but, at the same time, the grant design and application process relies heavily on information selected by the applicant that cannot be verified adequately by the IRC during evaluation – sign off by partners is often perfunctory and last minute

- the GAVI HSS APR process is significantly inadequate to assess what is actually happening on the ground and whether it is effective or efficient – HSS assessment requires much more knowledge of how health care delivery works in the country than can be gleaned from HSS documents by a team assembled once a year

- ways must be sought by GAVI to both reduce the burden of programme reporting on implementers and make it more responsive – possible ingredients here include more assessment undertaken in-country by an external assessor, and the use of HSS funding to support the production of costed plans for strengthening services that, with simple quarterly reporting, would provide the basis for performance review without further excessive effort by government

- whilst output indicators are simple, clear and related to objectives and activities, it is highly doubtful if it would ever be possible to relate these to improved outcomes, and it should be noted that GAVI HSS funding is not geared to results but is front-loaded.

1 Scope and methodology

The GAVI HSS Evaluation 2009 conducted 11 in-depth case studies in the following GAVI HSS recipient countries, Burundi, Cambodia, Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were subject to desk studies that did not involve country visits but were limited to a review of available documentation combined with email/phone interviews.
These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

The overall evaluation methodology (framework, key questions, study components, guidelines for data collection, sampling method, etcetera) is discussed in the main body of the evaluation report and is not reproduced here.

2 The Ghana GAVI HSS proposal – inputs, process and progress

This section describes the process of design, application, progress and review. Section 3 evaluates the process in practice against GAVI principles.

Contextual factors

A new National Health Policy "Creating Wealth through Health" was launched by MOH in November 2006, replacing the Medium Term Health Strategy (1997-2001). The National Health Policy was intended to guide the sector development until 2015. The policy claims to be in line with the Developmental Agenda of Ghana – the Growth and Poverty Reduction Strategy II.

Within this policy framework, Ghana is currently in its 3rd Five Year Programme of Work outlining implementation for the period 2007-2011, and subject to annual programmes of work. This is taking place within the context of the health sector reforms that include a mechanism for periodic health sector assessments: the institutionalization of yearly sector review by independent external reviewers and of two Health Summits each year with external development partners to assess performance, to plan for the subsequent period and to define this in a signed Aide-mémoire.

2.1 HSS proposal design

Who was involved, how and in what time periods

Proposal design was led by the Director of the Planning Policy Monitoring and Evaluation Division (PPMED) of the Ghana Health Service (GHS), the agency for the Ministry of Health. Key steps included:

- December 2006: The Health Partners Coordination Group (HPCG) was informed of the potential for GAVI HSS support. The HPCG is explained in section *HSS application, review and approval* below.
- January 2007: Initial discussion on the GAVI HSS proposal took place during the meeting of the HPCG. A Country Task Team (CTT) was convened and charged

with coordinating the development of the proposal. PPMED in GHS was used as the secretariat during the process of developing the proposal.

- April 2007: Discussions were held with Regional and Headquarters Heath Directors during their bi-annual senior managers meeting, focusing on areas of support, criteria for targeting districts and getting buy-in from regional managers.
- June 2007: The team met with all the 138 District Directors of Health Services (DDHS) during their annual conference. During the discussions, the areas of support and selection of districts were discussed and the specific areas were agreed.
- July/August 2007: Four main drafting meetings were held to formulate objectives and develop the areas of focus for the proposal based on the consultations.
- August/September 2007: Drafts were discussed via email with the HPCG members.
- October 2007: The application was approved at the monthly HPCG meeting.

What technical support was provided

Technical Assistance was contracted from two in-country health systems experts using the GAVI HSS $50,000 grant facility. The individuals were ex Directors of Medical Services and had good knowledge of district level functions and needs. The grant was channelled through WHO, and used to pay the consultants directly and for the relevant consultative meetings. PPMED feels that it had adequate control over how the money was spent.

The application claims that the WHO NPO for Health Systems was a core team member from preparation to completion stages, that the WHO NPO for EPI provided technical support, and that HPCG representatives from UNICEF, Danida and Netherlands played key roles in reviewing documents. WHO regional support was provided in the form of a workshop on the GAVI HSS process resourced by WHO regional and HQ staff.

What components were identified

The application identified a number of key barriers to improving immunisation coverage based on recent assessments. It then identified which of these were being addressed with available resources, in order to identify areas where GAVI HSS would focus. It states that these weaknesses have been articulated in most of the

yearly external Health Sector Reviews and captured in the various Aide-mémoires. They include:

- The performance of District Health Management Teams have not been optimal: they do not function as teams and do not provide supportive supervision to their Sub-District Health Management Teams.

- Service delivery is not efficient and resources are not well prioritised to achieve the MDG's, and the poorest regions in the north have been underserved by health services.

- Accountability for delivering results has not been well defined and performance has not been adequately tracked.

- Communities have not been involved in the planning, management and monitoring of local health services.

Thus key areas that require additional support include:

1. Increasing geographical access to and innovation in service delivery
2. Strengthening management, teamwork and leadership capacity
3. Strengthening financial and procurement management
4. Improving the use of tools in planning, prioritization and performance skills
5. Strengthening supportive supervision
6. Improving information management, monitoring and evaluation
7. Using operational and implementation research at the district level.

What objectives, activities, indicators and targets were specified

In focusing on strengthening capacity and operations at the district level, the proposal is in line with the new overall health sector policy to strengthen health systems. Its four main objectives are:

1. Strengthening district and sub-district systems to support service provision by building managerial capacities and fostering teamwork within the duration of the 3rd Five Year Programme of Work.

2. Expanding functional Community Health Planning and Service (CHPS) coverage to deliver essential services focusing on MDG4 and MDG5 in 50 Districts.

3. Strengthening sub-district Health Information Systems especially at the CHPS zone level to inter-phase with current computer based District Wide Information Management System (DWIMS) in the target Districts.
4. Conducting district operational and implementation research in specific subject areas.

The main activities under each are:

OBJECTIVE 1: To Strengthen district and sub district managers and health teams to support service provision by the year 2011

Sub-Objective 1.1: To strengthen the capacity of Directors in leadership and DHMTs and SDHMTs in management and team building at the district and sub-district levels by 2011

Activities

1. Equip national and regional in-service training units to improve the quality of in-service training programmes organised by 2011.
2. Provide leadership training for selected Directors, Deputy Directors and managers in MoH, NGOs, Regional Coordinating Directors and District Chief Executives by 2011.
3. Train DHMTs and SDHMTs in management and team building using the SDHS training module by 2011.
4. Develop simplified financial management and procurement operational manual for sub districts, CHOs and NGOs.
5. Train District, and Sub-District Managers and Community Health Officers (CHOs) in procurement and financial management.

Sub-Objective 1.2: Strengthen district health planning, resource allocation, management and monitoring and evaluation at all levels by 2011

Activities

1. Provide logistics and support to the Navrongo Research Centre to develop Demographic Surveillance Site (DSS) data each year to provide evidence for planning and resource allocation by 2011.

2. Train senior managers including National, Regional and District Directors in the use of District Health Analysis and Planning (DHAP) and Marginal Budgeting for Bottlenecks (MBB) for resource allocation, priority setting and decision-making by 2011.

Sub-Objective 1.3: Strengthen the support and supervision systems in 50 districts by 2011

Activities

1. Provide orientation and support to 1600 persons in 50 districts (district, sub districts and NGOs) in supportive supervision by 2011.

2. Provide fuel and stationery to 50 districts (district and sub districts levels and NGOs) to undertake supportive supervision by 2011.

OBJECTIVE 2: Improve on the quality of MDGs 4 and 5 services by CHO to households in 50 districts by 2011

Activities

1. Procure 1500 motorcycles for CHOs by 2009
2. Procure 1500 service delivery kits for CHOs by 2009.

OBJECTIVE 3: Strengthen the quality and timeliness of reporting data by CHOs in 500 zones (50 districts) by 2011.

Activities

1. Procure 500 PDA (palmtops) for CHOs by end of 2008
2. Train CHOs in 500 zones in the use of PDA equipment by 2009.

OBJECTIVE 4: Strengthening information management, M&E and operational and implementation research by 2011.

Activities

1. Support national and regional level monitoring and support visits to districts.
2. Undertake yearly evaluation of the effect of decentralizing of resources to the sub-district level
3. Undertake mid- and end-term evaluation of effectiveness of GAVI and other HSS support to the health sector.

Impact and outcome indicators

Indicator	Data Source	Baseline Value	Source	Date of Baseline	Target	Target date
1. National DTP3 coverage (%)	EPI report	85%	EPI Report / Sector Review Report	2005	90%	2011
2. Percentage of districts achieving ≥80% DTP3 coverage	EPI Report	77%	EPI Report	2006	80%	2011
3. Under five mortality rate (per 1000)	DHS	111	DHS	2003	95	2006
4. % Maternal Death Audited	2005 MoH Annual review report	89.6	2005 MoH Annual review report	2005	95%	2008
5. % Tracer Drug Availability	2005 MoH Annual review report	85.7	2005 MoH Annual review report	2005	95%	2011
6. Proportion of births attended by skilled health personnel	RCH Report	54.1	Annual Review Report	2005	85%	2011

Output indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Target date
1. Proportion of Regional and District Directors trained in management and leadership	Number of Regional & District Directors Trained	Total number of Regional & District Directors	Training Report	6.7%	Training report/quarterly Reports	2005	100%	2011
2. Number of health teams trained in team building skills	Number of 'District Heath Management Teams'	138 DHMT's	Training Report	0%	Training Report	2007	100%	2011
3. Proportion of functional CHPS zones with full complement of service delivery kits	Number of CHOs supplied with service delivery kits	Total number of functional zones in the target Districts (50)	CHPS and M&E	11%	CHPS and M&E	2007	72%	2011
4. Proportion of Districts using DHAP and MBB Tool	Number of Districts with Budgets in DHA format	Total number Districts trained in the use of DHA and MBB	M&E Reports	12%	M&E Reports	2007	100%	2011

		Tools						
5. Number of CHOs using PDAs	Number of CHOs using PDA for primary data collection	Total number of CHOs in functional CHPS zones in targeted districts	Routine Reports	7%	Routine Reports	2007	100%	2011
6. Number of NGOs participating in district performance review	Number of NGO's reported by Districts participating in District Reviews	Number of NGO's determined by the Mapping	DHMT Annual Report	25%	DHMT Annual Report	2007	80%	2011

2.2 HSS application, review and approval

What country coordination and approval mechanisms were used?

Coordination was provided by the national level Health Partners Coordination Group (HPCG) which was formed in 1996. It meets monthly, with quarterly business meetings and summit meeting twice a year. Membership includes representatives of all development partners in health, the Ministry of Health, NGOs, Ministry of Finance and Economic Planning (MOFEP), and the National Development Planning Commission (NDPC). Sub-committees are formed on an ad-hoc basis to deal with critical issues and, in turn, report to the main group. It is chaired by the Policy Planning Monitoring and Evaluation Division of the Ministry of Health (PPMED) that also provides the Secretariat function.

The HPCG aims to provide oversight and coordination for the implementation of the yearly Aide-mémoire that guides the health sectors yearly Programme of Work, and to provide a forum for discussion of critical issues affecting the implementation of the sector reforms and partner coordination and harmonization.

The Minister of Health, the Minister of Finance Economic Planning, and the HPCG provided final approval and endorsement of the GAVI HSS application.

2.3 HSS start up measures

Financial arrangements

GAVI HSS funds are deposited into an existing account at the national level used to receive all non-GoG budgetary funds. They will be transferred to districts using existing channels via regional accounts and deposited in the DDHS account, controlled by the DDHS and the District Accountant.

GAVI funds will be disbursed to the level of implementation quarterly, based on approved quarterly workplans and budgets, prepared and submitted together with MTEF workplans. To access funds at the implementation level, a request must be submitted to the approving authority at that level. Each request for funds is reviewed by an internal audit team and, on a monthly basis a sampled audit is carried out by the local office of the Government Audit Service. A team of external auditors carries out an annual audit jointly with the Ghana Audit Service, and the results shared and discussed with all stakeholders annually during a Health Summit.

Management and reporting arrangements

GAVI HSS implementation is managed by PPMED reporting to the monthly meetings of the HPCG and through quarterly and half-yearly progress reports. The annual review of the health sector provides an in-depth assessment of major initiatives and support to the health sector. The APRs required by GAVI are submitted after HPCG endorsement. The PPMED is also part of the task teams working on HSS supported by GFATM and others, working alongside Development Partner representatives and others, and in a position to synchronise these various support efforts. Procurement of goods and service is under the Public Procurement Act of Ghana, and the GAVI HSS proposal includes procurement of technical assistance to develop tools and provide training.

2.4 Annual progress reporting (APR)

Reports submitted – dates

The first relevant APR was for 2008, submitted 15 May 2009.

Who was involved?

The process is not detailed in the APR, but appears to have been undertaken by PPMED with some assistance from the WHO country office.

Sources of data

PPMED has a routine Monitoring and Evaluation data collection system, and this information was collated from those reports, but no detailed information is provided on how this works.

Quality of reporting on HSS activities, finance and results

As required, the APR provides charts of activities and expenditure for the year under review (2008), for January to April 2009, and as planned for 2010. It is not possible from these charts to know what funding was actually used for within each activity or whether these are reasonable sums. Indeed, even if such detailed information were requested and provided, it would not be possible to assess the relevance and validity of this from outside the country and without some on-the-spot review and interrogation.

The GAVI format provided for Table 4.3 on activities and expenditure for 2008 requests information on sources of data and on support functions involved. The Ghana APR for 2008 does not provide these, and it is hard to see how such information could be incorporated into this table format.

A short narrative of progress and problems is provided but is limited to an explanation for:

- A slow start (late arrival of funding);
- a change in the number of districts to be covered, and;
- an alert about the need for reprogramming some funds as items had already been procured using other funding.

This is not adequate to make any real assessment of what is happening on the ground in relation to money spent, quality of programme management or prospects of future achievements. Some sympathy can be extended to PPMED in that the work required for detailed reporting is just another burden on an already over burdened government agency responding to external grant providers. Even with such detailed reporting by the implementers, however, it would not be possible for GAVI – through the IRC monitoring process - to evaluate its veracity and relevance. An alternative

solution is needed for reporting and review, and it is difficult to see one much different from a short external review by an independent individual able to probe issues, spread the burden of answering questions and providing information across the several levels involved in implementation and monitoring, and removing the burden of report writing from the programme coordinators or implementers.

In any case, the once-a-year APR process is not conducive to smooth planning and spending in country including some uncertainty about whether procurement decisions can go ahead pending IRC review and comment. Ghana has mentioned that a simple quarterly reporting to GAVI might be preferable based on the data being generated, and that this would keep GAVI much better informed and reduce delays in programme management decisions and spending. Another cause of delay is the requirement for ministers of health and finance to sign the APR when this could be done more meaningfully by the programme technical head and the partners in the HPCG that meets monthly.

Quality of IRC review

The IRC monitoring review report is not yet available. The points made in the sub-section immediately above raise the issue of whether it might be preferable for programme assessment to be undertaken more frequently and by GAVI in-house in order to develop more institutional knowledge and in-depth knowledge of country programmes, and to respond more smoothly to country needs for lanning and spending.

What technical support was provided?

This is not detailed in the APR but appears to have been limited to participation by WHO country office as team member.

2.5 HSS implementation progress

Detectable changes in outputs and outcomes

The APR reports that as a result of a delay in formal notification of award of the HSS grant and in confirming the transfer of funds from GAVI into the Ghana MoH account, funds were not received until June 2008. In addition much time was taken to document and to build consensus on the implementation especially with the district levels.

Implementation was thus delayed, only US$207,480 of the US$1,035,500 received for 2008 was spent, and many activities are slipping into 2009. But the APR reports that several preparatory activities were completed and that these form the base for implementation of activities at regional, district and community level, and activities are now on track and all regional activities schedules in 2008 are taking place within the first quarter of 2009.

Specifically, for 2008, most progress is claimed in the development or upgrading of manuals and tools for training and to guide procedures, and some limited training of trainers (Activities 1.1.2, 1.1.3, 1.1.4, 1.2.1, 3.1 - see section 2.1 on objectives and activities above), and for some M&E support visits to regions and districts (Activity 4.2). The mapping between these activities in the APR and those in the proposal are, however, very imprecise and not explained in the APR.

What technical support was provided?

It is not known whether technical support (external to the implementers) is involved in implementation, or whether it is needed.

2.6 End of HSS assessment

The APR offers assurances that progress will accelerate in 2009, but it has not been possible to make a verifiable assessment of the extent to which Ghana GAVI HSS is likely to meet its targets. In general terms, the proposal and APR have clearly been prepared and assessed in-country by competent people, and there appears a good chance that all major activities planned can be implemented, albeit to a slower timetable than originally specified, and that these will result in the achievement of the output indicator targets. It is not possible to assess the extent that this is likely to result in detectable improvements in the outcome/impact indicators targets since there is no clear causality chain, but it must be assumed that improved management, training, planning tools and supplies will have a positive effect even if this remains unmeasurable.

The district level data collection may allow for some outcome indicator comparisons between GAVI HSS supported districts and others, and although it may still not be

possible to attribute any improvements to specific GAVI HSS interventions, this may provide some insight into the effects of a package of interventions.

2.7 Support systems for GAVI HSS

This has been covered where possible under each relevant section above. Documentation mentions nothing about any regional level support, or about supporting contact with GAVI. Technical support appears to have consisted of help from in-country WHO and some development partners during design and pre-application stages. It is not possible in a desk case study to assess the quality of that support, or indeed to assess the extent to which it was needed.

3 Assessment against GAVI HSS principles

3.1 Country driven

There seems little doubt that the GAVI HSS proposal was country driven in the sense that its content follows on from consistent statements on key weaknesses and that the proposal addresses them. From available documents and phone conversations, however, it appears that WHO and UNICEF played substantial roles that may have ventured beyond support into a more pro-active position.

3.2 Aligned with national plans and processes

i. with broader development policies

The objectives and activities of the proposal appear to be consistent with national development policies and with the health sector current Programme of Work. They appear to respond to problems that have long been identified, particularly district level weaknesses in management and systems for which the GAVI HSS programme focuses on producing standards, guidelines and procedures and on training in the use of them. The design and application process seems to have benefited from the relatively strong sector review process in Ghana involving the active and sustained participation of partners.

An issue here, however, is why there was not a suitable national document on the sector plan that would have obviated the need for elaboration in the application process and that would have formed the basis for integrating all sector assistance especially that for HSS. Participants in Ghana have also pointed out the advantages of such a plan, costed and timetabled, and revised annually, and that would form the basis for all external funding including GAVI HSS. It was suggested that GAVI support could be used to support the production of such a plan, of which a detailed immunisation plan would be part including delivery systems strengthening.

ii. with budget and reporting mechanisms and cycles, and M&E

Finance

Financing arrangements appear to be fully integrated into existing country mechanisms, although the grant application is not clear on exactly how these work.

For ISS, it appears that since funding is based on reward and therefore not predictable, it cannot be included in the national budget (MOFEP/MOH) but is treated as extra-budgetary earmarked funding. Thus, MOFEP is aware of these resource flows into the health sector, although they are not reflected in the MOFEP budget or the MTEF.

M&E data collection, analysis and use

Data is generated largely through existing reporting sources and mechanisms, and through the DHS.

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Routine Monthly returns	Data analysed by EPI using SPSS/Epi Info/spreadsheet	To be used to compare district and regional performance and share with all stakeholders during meetings with DPs.
2. Percentage of districts achieving ≥80% DTP3 coverage	Routine Returns	Analysed at regional and national levels	Information is shared with districts for benchmarking and with DPs for advocacy
3. Under five mortality rate (per 1000)	GDHS	Survey results analysed by Ghana Statistical Service	Disseminated to all stakeholders
4. % Maternal Death Audited	RCH	Data analysis is done at district, regional and national levels	Data is shared with all stakeholders during quarterly, mid-year and annual review meetings with MoH agencies and DPs
5. % Tracer Drug Availability	Data collected routinely on quarterly, mid-yearly and during annually	Data analysis is done at district, regional and national levels	Data is shared with all stakeholders during quarterly, mid-year and annual review meetings with MoH agencies and DPs
6.Proportion of births attended by skilled health personnel	RCH	Data analysis is done at district, regional and national levels	Data is shared with all stakeholders during quarterly, mid-year and annual review meetings with MoH agencies and DPs
Output			
1. Proportion of Regional and District Directors Trained	Training Reports	Reports from M&E system will be analysed manually	Results will be disseminated through quarterly, mid-year and annual reviews at district, regional and national levels
2. Number of health Teams trained in Team Building skills	Training Report	Data will be analysed manually	Results will be used to assess performance of districts in working with each other
3.Completed CHC with full	CHPS M&E /Target	Reports from M&E	Results will be disseminated

complement of service delivery kits	District Routine reports	system will be analysed using spreadsheet	through quarterly, mid-year and annual reviews at district, regional and national levels
4. 4.Proportion of NGOs involved in supportive supervision	Target District Routine Reports/Survey	Survey data will be analysed using SPSS/Epi Info	Results will be disseminated through quarterly, mid-year and annual reviews at district, regional and national levels
5. Proportion of CHOs using PDAs for primary information.	CHPS M&E Monthly/Quarterly and Yearly reports	Reports from M&E system will be analysed manually	Results will be disseminated through quarterly, mid-year and annual reviews at district, regional and national levels
6.Number of Sub-districts visited at least 4 times in the last 12 months	Target District Annual Reports/ survey	Survey data will be analysed using SPSS/Epi Info	Results will be disseminated through quarterly, mid-year and annual reviews at district, regional and national levels

3.3 Harmonised with other funding and support

At the time the GAVI HSS application was prepared, a number of other proposals were also being developed which included some support for HSS activities. Members of the GAVI HSS team were involved in these proposals (Global Fund Round 7 for malaria, Rolling Continuation Channel for malaria, Nutrition and Malaria for Child Survival project and National Health Insurance Project) and therefore were in a position to ensure synchronisation in areas of support and geographical coverage at the district level. The selection of districts was also guided by the strategic direction of MoH and its Development Partners in line with how budget support is being targeted. Overall, it appears that there was a reasonable harmonisation with other relevant funding.

3.4 Providing predictable funding

Funding is based on cost estimates provided, and agreed for each of the years of its duration. To this extent, it is predictable. But in practice it was not available in time to start expenditure in 2008 as specified. Furthermore, in terms of longer term planning, Ghana needs to know if similar funding will be available beyond 2011

3.5 Accountable, inclusive and collaborative

Since Ghana has reasonable mechanisms for accountability, and existing government channels are being used, accountability within the traditional public service model appears to be reasonable i.e. someone knows that the money went

where it was supposed to and was spent more or less on what it was supposed to be spent on.

The process of design appears to have involved all levels of the government service and WHO and UNICEF but not so much beyond that. It cannot be assumed that the act of simply signing off by higher levels of government and more notably by members of the HPCG represents real participation by them even where, as in Ghana, this appears to be a relatively well functioning committee.

3.6 Having a catalytic effect

No information is available on this.

3.7 Results oriented

The specified output indicators are relevant to strengthening district and sub-district service delivery, and to reducing the specific weaknesses identified as barriers. But the front loading of GAVI HSS funding would appear to work against the principle of 'results oriented' funding.

3.8 Sustainable

The activities focus on strengthening protocols, raising standards and improving management skills and do not appear to result in significant increases in recurrent budget requirements. In the wider context, efforts in financing reforms, including NHIS, and in efficiency in resource allocation and utilisation should ensure the sector maintains any gains made under GAVI HSS.

3.9 Improving equity

The selection of districts for GAVI HSS support attempted to ensure a focus on poorer performing areas of the country.

Annex 1 Documents available

Ghana GAVI HSS Task Team, GAVI HSS application, October 2007

Ghana GAVI HSS Task Team, Response to the IRC Report, 2007

Review of the 2007 APR (June 2008)

APR for 2008 (submitted May 2009)

Annex 2 Telephone conversations

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Annex 3 Description of the study approach

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.