

**Health System Strengthening (HSS) Cash Support**

**Application Package –Proposal Form**

This proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organisations, in the development of HSS proposals prior to submission of this application for funding.

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| PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION | |
| 1. Applicant Information | |
| **Applicant:** | The Ministry of Health (MoH) of the Republic of Ghana |
| **Country:** | Ghana |
| **Proposal title:** | The Health Sector of Ghana Health System Proposal to Global Alliance for Vaccine and Immunisation |
| **Proposed start date:** | July/2014 |
| **Duration of support requested:** | Five (5) Years |
| **Total funding requested from GAVI:** | US$18,059,296 |
| **Contact Details** | |
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| 2. THE PROPOSAL DEVELOPMENT PROCESS |
| The Ministry of Health (MoH) indicated its desire to apply for the next tranche of GAVI/HSS funding in 2012 during the discussion on the newly introduced Health System Funding Platform (HSFP) which did not materialise and other modalities by GAVI and Global Fund for AIDS, Tuberculosis and Malaria (GFATM). This intention was further discussed prior to the 2012 APR submission to GAVI.  The development of the GAVI/HSS proposal was discussed at a number of health sector forums. This included Health Sector Working Group[[1]](#footnote-2) (HSWG) monthly meetings and GHS Senior Managers (Regional and Headquarter Directors) Meeting of May 2013. Senior managers in turn briefed their peripheral level heads (216 District Directors of Health Service) during their 2013 annual conference to get their buy-in and better participation in consolidating the priorities. The proposal development period (synthesis stage) took advantage of the annual review period of the health sector where there were Regional and District Performance Hearings at all ten administrative regions and District Health administration levels.    The formalization of the proposal development process was consolidated at the Health Sector Working Group (HSCC) meeting in April 2013. At that meeting the HSCC was informed of the government’s intention to apply for GAVI/HSS Cash Support. Members were informed that a technical working group (TWG) would be formed and representation was expected from all stakeholder interest groups, especially Development Partners (DPs) and Ghana Coalition of NGOs in Health (GCNH).    The proposal development technical working group (TWG) was chaired by the Chief Director of the MoH and coordinated by the Policy Planning Monitoring and Evaluation Division (PPMED) of MoH. The membership of the TWG includes representatives from the following divisions of MoH- PPME, HRHD, Finance, RSIM; GHS- PPME, Finance, and EPI; Christian Health Association of Ghana (CHAG), GCNH, and DPs representatives (WHO and UNICEF). A two-member team from GAVI Secretariat participated in the inaugural meeting of the TWG in July 2013 and shared the new proposal format for the HSS Cash Support.    Progress on the proposal was reported during the weekly MOH and GHS Directors and PPME divisional meetings respectively. Updates were also provided at EPI weekly meetings and at HSCC monthly meetings in June to December 2013 for comments and inputs.  GCNH represents NGOs and participated in all events and meetings for the development of the proposal. GCNH was represented by its Vice National Chairperson and National coordinator at each of the HSCC and ICC meetings. Private Health Association of Ghana which is an umbrella group for private health sector is also represented on the HSCC and also participated in all deliberations including those of the proposal development.  Two officers (EPI and Health Economist) from WHO and Health Officer from UNICEF participated in the proposal development. WHO being the Deputy Lead for Development Partners (DPs) also shared progress reports on the development process with DPs. WHO provided technical assistance to address comments from GAVI Secretariat for re-submission.  The proposal development took six months from June to December 2013. The process commenced with the consultations and desk reviews (APR 2012, HSMTDP 2010-2013 review report, cYMP 2010-2014 etc). The proposal development period coincided with the preparatory work for the development of the Ghana Shared Growth and Development Agenda 2014-2017 which is the National Medium Term Development Plan and the next Health Sector Medium Term Development Plan (HSMTDP II) 2014-2017. These helped in the synthesis of the bottlenecks and priorities identified in this proposal.  The most challenging element during the proposal development was the difficulty in managing the several priorities. Most MOH and GHS divisions at national, regional and district levels, and GCNH submitted several and varied priorities. This challenge was mitigated by further review of regions, districts and divisional performance reports. Another challenge was ensuring better alignment with existing and potential future programmes and projects. To resolve this issue, the TWG engaged all coordinators of existing and potential future HSS projects and programmes in order to discuss details of the activities to ensure harmonisation, alignment, coherence and integration.  Roles and responsibilities of key partners (HSCC members and others)- Refer to Annex 1 |

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| **Signatures: Government endorsement** |
| Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Ministers of Health & Finance and their delegated authority  Minister of Health Minister of Finance:  Name: Hon. Hanny-Sherry ARYITEY Name: Hon. Seth Emmanuel TEKPER  Signature: Signature:  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tel: +233-302665323 Fax: +233-302663810 Tel: +233-302665132 Fax:…………………………… |

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| **Signatures: Health Sector Coordinating Committee endorsement** | | | | |
| We the members of the HSCC, or equivalent committee met on the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application. | | | | |
| Please list all ICC members | Title / Organisation | Name | Please sign below to indicate the attendance at the meeting where the proposal was endorsed | Please sign below to indicate the endorsement of the minutes where the proposal was discussed |
| Chair | Chief Director/MOH | Salamatu Abdul Salaam |  |  |
| Secretary | Director PPME/MOH | Dr. Afisah Zakariah |  |  |
| Members | Senior Health Advisor/DFID  Lead, Health Development Partners | Susan Elden |  |  |
| Officer In Charge/WHO  Deputy Lead, Health Development Partners | Dr. Patrick Kabore |  |  |
| Vice National Chairperson, Ghana Coalition of NGOs in Health | Cecilia Lodonu Senoo |  |  |

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| Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes √ No 🞎  Individual members of the HSCC may wish to send informal comments to: [gavihss@gavialliance.org](mailto:HSFP@gavialliance.org)  All comments will be treated confidentially. |

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| 3. EXECUTIVE SUMMARY |
| **Introduction**  Ghana has made positive strides in improving the health status of children. The achievements with regards to immunisation have contributed to the reduction in infant mortality rate over the years from 80/1000LB (DHS 2003), 50/1000 LB (DHS 2008) to 53/1000LB in (MICS 2011). Under five mortality rate has also improved from 110/1000LB (DHS 2003), 80/1000 LB (DHS2008) to 82/1000LB in (MICS2011). The country was the First GAVI eligible country to introduce two new vaccines (pneumococcal and rota virus vaccines) concurrently in 2012 and won 2 out of 8 awards at the GAVI Partners meeting. The country has not recorded any documented death from measles since 2003 and since November 2008 there has not been any report of wild polio virus.  Despite the improvements, there exist wide variations in health status between the poor and rich Ghanaians. According to MICS 2011, it was estimated that there are twice as many under-fives dying per 1,000 live births in the poorest wealth quintile compared to the richest. It was also noted that under-five mortality inequality gap between the richest and poorest has been widening with a projection that those within the richest quintile are more likely to reach the MDG target. There was also geographical disparity with under five mortality in urban being 72/1000 live births and that of the rural being 94/1000 live births.  The bottlenecks to improving and sustaining high immunisation coverage are systemic encompassing poor access to services in hard to reach districts (especially, islands and lake communities), inadequate health staff to provide required services, inadequate cold chain capacity at lower levels (about 41%of fridges and freezers are over 10 years), weak community engagement and involvement in immnunisation services, weak capacity for micro planning and logistics management at the sub-district and CHPS zone level, poor documentation of primary data which impacts on data quality and inadequate infrastructure among others (See Ghana Immunisation Service Review, 2012; Effective Vaccine Assessment Report 2010; the Policy on immunisation 2011; and the Holistic Assessment of the Health Sector Programme of Work 2012).  **Vision**  The vision of the health sector is to have a healthy population for national development.  **Goal**  The goal is to have a healthy and productive population that reproduces itself safely.  The current proposal covers an implementation period of five years 2014 - 2018. The important outcome and impact indicators include; achieving an increase in PENTA 3 coverage from 88% to 92% by 2018 (country administrative data, 2012), increase MCV1 coverage (% of surviving infants receiving first dose of measles containing vaccine) from 88% to 95% by 2018 (2012 country administrative data). The proposal further aims at addressing Geographic equity of PENTA 3 coverage – (% of districts that have at or above 80% PENTA 3 coverage) from 74% to 90% by 2018 (2012 country administrative data). The proportion of children fully immunised (% of children aged 12-23 months who receive all basic vaccinations in a country’s routine immunisation program) will also increase from 77% (MICS, 2011) to 83% by the end of the proposal interventions in 2018 and finally the Dropout rate (percentage point difference between PENTA 1 and PENTA 3 coverage) is expected to drop from 4.6% to 4% by 2018. It is envisaged that the implementation of the proposal will contribute towards the national effort to achieving Under five mortality rate of >50 (per 1000 live births) by 2015 (Ministry of Health, Annual Report, PoW).  **Objectives**  In order to achieve the goals from a system perspective, five objectives have been identified for this proposal.   1. To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services (Service Delivery) 2. To strengthen health worker capacity and distribution so as to address equity issues at the district level. (Workforce and Human Resources) 3. To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices (Procurement, Logistics and Health Technologies) 4. To empower civil society for increased demand creation for health services at the community level (Empower Communities and local actors) 5. To strengthen governance and health information management for improved health service delivery   **Budgets for objectives**  The total proposed budget for the funding support from GAVI is US$18,059,296 for a period of five years from 2014 -2018. A total amount of US$11,269,516 (62%) has been allocated for implementation of activities related to objective 1 (service delivery), objective 2 (workforce and human resource), US$108,500 (1%), objective 3 (logistic and supply chain management) US$455,000 (3%), Objective 4 (community support and civil society organisation) US$2,005,800 (11%), and objective 5 (governance and health information management for improved health service delivery) US$4,220,480 (23%).  **Proposed Implementation Arrangements including the role of government departments and Civil Society Organisations (CSOs)**  The Policy Planning Monitoring and Evaluation Division of Ministry of Health which oversees the implementation of the heath sector’s Common Management Arrangement (CMA) will coordinate implementation of the GAVI/HSS grant. The CMA establishes some of the working relationships between the Ministry and its agencies and how it collaborates with its development partners and other key stakeholders including CSOs. At the operational level, the Ghana Health Service will coordinate the implementation of activities that will be undertaken at the regional, district and sub-district levels. All procurement and financial administration activities will be conducted in accordance with the principles enshrined in respective public sector governing laws.  Monitoring of the implementation of the GAVI/HSS support will be an integral part of the overall Monitoring and Evaluation Framework of the Ministry. The Ministry of Health has developed an integrated checklist for monitoring and evaluating the performance of the health sector. The indicators are comprehensive and capture the key immunisation performance assessment measures of the health sector including that of the CSOs. The HSCC monthly and quarterly Business Meetings as well as Annual Summits will provide mechanism for periodic review of the performance of the GAVI/HSS implementation. Ghana Health Service and implementing CSOs will submit quarterly, bi-annual and annual reports to the HSCC as part of the agreed monitoring and reporting mechanisms within the sector. The HSCC endorsed annual reports will be shared with the GAVI Secretariat. |

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| 4. ACRONYMS | | | |
| *→ Please detail the full version of all acronyms used in this proposal, including in the HSS M&E Framework (Attachment 3) and in the Budget, Gap Analysis and Workplan Template (Attachment 4).* | | | |
| **Acronym** | **Acronym Meaning** | **Acronym** | **Acronym Meaning** |
| AEFI | Adverse Effects Following Immunisation | HSFP | Health System Funding Platform |
| ANC | Antenatal Care | HSCC | Health Sector Working Group |
| APOW | Annual Programme of Work | ICC | Inter- Agency Coordinating Committee |
| APR | Annual Progress Report | IGF | Internally-Generated Funds |
| ATF | Accounting Treasury and Finance | IMR | Infant Mortality Rate |
| BMC | Budget Management Centre | KAP | Knowledge Attitude and Practice |
| BPEMS | Budget and Public Expenditure Management System | LMIS | Logistics Management Information System |
| CHAG | Christian Health Association of Ghana | M&E | Monitoring and Evaluation |
| CHMC | Community Health Management Committee | MAF | Millennium Acceleration Framework |
| CHOs | Community Health Officers | MDA | Ministries, Departments and Agencies |
| CHPS | Community-based Health Planning and Service | MICS | Multi-Indicator Cluster Survey |
| CHV | Community Health Volunteer |  |  |
| CMA | Common Management Arrangements | MLM | Middle Level Management |
| CSO | Civil Society Organisation | MMR | Maternal Mortality Rate |
| cYMP | Country Multi Year Plan | MOFEP | Ministry of Finance and Economic Planning |
| DfID | UK Department for International Development | MOH | Ministry of Health |
| DHIMS | District Health Information Management System | NGO | Non-Governmental Organisation |
| DHMT | District Health Management Team | NHIS | National Health Insurance Scheme |
| DMHIS | District Mutual Health Insurance Schemes | PBF | Performance Based Financing |
| DP | Development Partners | PFM | Public Financial Management |
| DVD-MT | District Vaccination Management Tool | PHC | Primary Health Care |
| EPI | Expanded Programme On Immunisation | PIE | Post Introduction Evaluation |
| EU | European Union | PPMED | Policy, Planning, Monitoring and Evaluation Department |
| EVMA | Effective Vaccine Management Assessment | RHMT | Regional Health Management Team |
| FMIS | Financial Management Information System | SARA | Service Availability and Readiness Assessment |
| GCNH | Ghana Coalition of NGOs in Health | SBS | Sector Budget Support |
| GDHS | Ghana Demographic Health Survey | TA | Technical Assistance |
| GDP | Gross Domestic Product | TWG | Taskforce Working Group |
| GHS | Ghana Health Service | U5MR | Under Five Mortality Rate |
| GIFMIS | Government Integrated Financial Management Information System | UNICEF | United Nation Children Fund |
| GOG | Government Of Ghana | USAID | United States Agency for International Development |
| HRHD | Human Resource For Health Development | VPD | Vaccine Preventable Diseases |
| HRHPS | Human Resource Policies And Strategies for the Health Sector | WHO | World Health Organization |

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| SITUATIONAL ANALYSIS | | | | | | | |
| 5. Key relevant health and health system statistics (3 pages Maximum) | | | | | | | |
| **Indicator** | **Source** | **National Average** | **Percentage difference between highest & lowest quintiles** | **Sex**  ***(Please provide disaggregated data where available)*** | | | **Year** |
| **M** | **F** | **Total** |
| PENTA3 coverage[[2]](#footnote-3) | Administrative Data (DHIMS) | 92.2% | NA | NA | NA | NA | 2012 |
| UNICEF/WHO Estimate | 92% |  |  |  |  | 2012 |
| Other\*  (MICS-Ghana)[[3]](#footnote-4) | 92.1% | 1.4% | 92.7% | 93.0% | 92.1% | 2011 |
| Measles 1st dose coverage | Administrative Data | 93.3% | NA | NA | NA | NA | 2012 |
| UNICEF/WHO Estimate | 88% |  |  |  |  | 2012 |
| Other\*  (MICS-Ghana) | 88.5% | 7.4% | 93.3% | 94.1% | 88.5% | 2011 |
| Drop-out rate between PENTA1 & PENTA3 | Administrative Data | 4.6% | NA | NA | NA | NA | 2012 |
| UNICEF/WHO Estimate |  |  |  |  |  |  |
| Other\*  (MICS-Ghana) | 5.7% | NA | NA | NA | NA | 2011 |
| Percent of districts with PENTA3 coverage ≥80% | Administrative Data | 80.0% | NA | NA | NA | NA | 2012 |
| UNICEF/WHO Estimate |  |  |  |  |  |  |
| Other\*  (JRF-Ghana) | 80.0% | NA | NA | NA | NA | 2012 |

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| **Situational Analysis** | | | | | | | |
| **5. Key relevant health and health system statistics (3 pages Maximum)** | | | | | | | |
| **Indicator** | **Source** | **National Average** | **Percentage difference between highest & lowest quintiles** | **Sex**  *(Please provide disaggregated data where available)* | | | **Year** |
| **M** | **F** | **Total** |
| PENTA3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile | Administrative Data |  |  |  |  |  |  |
| Other\*  (state source) | NA | NA | NA | NA | NA | NIL |
| Fully immunised child coverage (%) | Administrative Data (DHIMS) |  |  |  |  |  |  |
| Other\*  (MIC) | 77.3% |  |  | GHS |  | 2011 |

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| **Additional Health System Statistics** | | | |
| **Indicator** | **Source** | **Value** | **Year** |
| Under Five Mortality | Other\* (MICS-Ghana)  (state source) | 82 (MICS) | 2011 |
| Administrative  Data |  |  |
| Total Expenditure on Health (THE) as percentage of GDP | Other\* Ghana National Health Account 2005 & 2010, 2012 | 3.3 | 2010 |
| Administrative  Data (2012 PoW) | 35.8 (Public sector expenditure) | 2012 |
| Per capita expenditure on health | Other\* World Health Report, 2012 | 54 | 2012 |
| Ghana National Health Account 2005 & 2010, 2012 | GHS57.66  US$39.12 | 2010 |
| Total health sector budget for the year of application | Other\*  (state source) |  |  |
| Administrative  Data ((MoH, 2013 Annual Programme of Work) | GHS 3,529.44 MILLION | 2013 |
| Percent of the health sector budget funded by the government from domestic sources | Other\*  (state source) | N/A | N/A |
| Administrative  Data | N/A | N/A |
| Budget of EPI programme for the year of application | Other\*  (state source) | N/A | N/A |
| Administrative  Data | N/A | N/A |
| Percent of sub national level facilities with cold chain capacities fit for purpose (based on WHO definition “fit for purpose”) | Other\* Cold Chain Utilization Analysis: By ACCEMTURE Project, Bill and Melinda Gates Foundation  (state source) | 65% | 2013 |
| Administrative  Data | N/A | N/A |
| Timeliness and completeness of facility and district (or equivalent) reporting | Other\*  (state source) | N/A | N/A |
| Administrative  Data (2012 PoW Performance**)** | 82 | 2012 |

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| 6. DESCRIPTION OF THE NATIONAL HEALTH SECTOR |
| **The National Health Sector**  The health sector of Ghana is decentralized with established mechanisms to ensure coordination of policy formulation, resource mobilization, implementation, monitoring and evaluation of activities (CMAIII, 2010: pp 9). Health workers are recruited; trained, posted and remunerated at the central level. Key commodities for service delivery are procured centrally and distributed through the Regional Medical Stores to the District and health facilities. Financial management is decentralised up to the district level with sub districts and CHPS zones managed by the DHMTs  Ministry of Health  Service Delivery  Health Financing  (National Health Insurance Authority  Civil  Society Organisations  Regulatory Authorities  e.g. NMC, MDC  Other Subvented Organisations e.g. Quasi Govt Health Institutions  Mental Health Service  Ghana Health Service  Private Sector  Regional Level  District Level  Figure 1: The Structure of Ghana Health Sector  CHAG  Teaching Hospitals  The MoH has oversight responsibility over all agencies within the health sector. GHS, Teaching hospitals, Christian Health Association of Ghana (CHAG), Quasi Government Health Institutions and private sector are responsible for service delivery. CHAG and private sector provide about 40% of service delivery. The regulatory agencies ensure that health care providers practice within agreed standards and their services are accessible to the whole population. There are both public and private health-training institutions producing trained health professionals for the health sector. CSOs also play a considerable role in delivering health services to communities. They are effective medium for community mobilisation for immunisation service delivery.  **Health Service Delivery**  Service delivery within the health sector is organised at four main levels; (1) tertiary services - mainly provided by the 4 teaching hospitals, 3 psychiatry and other specialised hospitals. (2) At the secondary level there are 9 regional hospitals in the country which serve as referral centres to the lower levels. (3) The country has 216 administrative districts with 109 district hospitals. (4) At the sub-district level, there are 1005 health administrative sub-districts with 789 health centres and 1,676 Community Based Health Planning and Services zones (CHPS). There is an average of 5 CHPS Zones in each sub district. A Zone is a geographical area covering a population of about 5000 people. It is made up of about 5-8 communities and is managed by two Community Health Officers. There are also 969 clinics, 263 hospitals, 348 maternity homes, 20 polyclinics and 2 University Hospitals. There are over 3000 immunisation centres in the country. There are plans to increase functional CHPS zones to cover all 6500 electoral areas by 2018.  The private health sector in Ghana is large hence, an important actor in the health industry for health-related goods and services. The private self-financing sector is concentrated in the urban and peri-urban areas, with low rural penetration. Private self-financing health providers in rural areas face more challenges given the higher poverty rate of the population.  **Mechanisms for ensuring quality of service delivery**  The mechanisms to ensure good quality service delivery include policy dialogue and performance monitoring at all levels. Structures put in place to enforce the implementation of these mechanisms include: Inter Agency Leadership Committee, Health Sector Working Group, Inter-Agency Coordinating Committees, Business Meetings, Annual health summit, Decentralised sector dialogue, supportive supervision and engagement with the private sector and civil society *(see CMA III, 2010:pp.8-15).*  **Workforce and Human Resource**  The draft Human Resource Policy and Strategies for the Health Sector 2014 – 2017 identify priority areas and challenges with a four-fold thrust to increase the production of quality health professionals, ensure equitable distribution of health workers, improve health worker productivity and cross-cutting issues affecting health workforce.  The health workforce includes those offering clinical services and health support services respectively. The clinical staff include medical, nursing and other health professional whose work impact directly on service delivery. The doctor-population ratio has not changed significantly within the last three years (1:11,698 in 2010 to 1:10,452 in 2012). Large regional variations however persist with Greater Accra Region, which has the capital city, having 11 times more doctors per population compared to Upper West Region. The nurse-population ratio has improved from 1:1,497 (2009) to 1:1,251 (2012.). The number of midwives reduced from 4,034 in 2011 to 3,863 midwives in 2012. (Human Resource Annual Report, MoH, 2012). The training and deployment of midwives is not keeping pace with those going on retirement. There are 11,056 community health nurses offering primary health care services (See Annex 2 for Trend of Sector-wide Indicators).  **Procurement and Supply Chain Management**  EPI vaccines are procured from international manufacturers and bundled with safe injection equipment through UNICEF. There is no local production of vaccines and safe injection equipment. The procurement of cold chain equipment and vehicles follow the legal and regulative process outlined in the Procurement ACT, 2003 (ACT 663) of the Republic of Ghana and the Common Management Arrangement III (CMAIII: pp.30-31). Ghana practices a mixture of “push and pull” systems for vaccines and logistics supply chain system. The national level “pushes” vaccines and diluents to regions based on their target population and previous consumption patterns on quarterly basis. The devices are however “pulled" by the regions. The districts also pull their vaccines and logistics from the regions in much the same way that facilities also pull them from the districts. In all these, the principles of bundling vaccines and logistics are followed. In terms of storage and distributing to facilities, particularly for vaccine products, all the regions have walk-In Cold Rooms (WICRs) with adequate storage capacities. However, there is the need to increase the storage capacity of the national cold room to an additional 40m3 capacity WICR.  **Health Information Management System**  The District Health Information Management System (DHIMS) which is a web-based application is the main database information software for recording and reporting health indicators in Ghana. Most primary data are collected using community registers and this is aggregated and entered into DHIMS at the district level and reviewed electronically by the regional and national levels. Strategies to improve data quality include the introduction of electronic registers to gradually replace the manual community registers and institutionalising data quality audit. Data validation is conducted monthly by EPI. The MOH’s Integrated Monitoring and Evaluation Framework provides the levels and frequency of data reporting as well as key performance assessment indicators; which also focuses on EPI. The timeliness and completeness of health information has significantly improved with the upgrading of DHIMS-I to DHIMS-II. Ghana conducts Demographic and Health Survey (DHS) every five years and Multiple Indicator Cluster Survey (MICS) in between DHS. The EPI undertakes periodic performance reviews which are in tandem with the overall health sector performance review and reporting requirements. Additionally, specific reports and assessment are undertaken periodically, which are quarterly reported to the Inter Agency Coordinating Committee (ICC). In addition, assessments such as the Effective Vaccine Management Assessment (EVMA), Ghana Immunisation Service Review and Coverage surveys provide an indication of EPI performance; which enables identification of strength and weaknesses and strategies for redress.  **Legal, Policy and Regulatory Environments**  The Public Health Act of Ghana sets out the framework for vaccination in Ghana including the responsibilities of health professionals and the general public. The Policy for Immunizations in Ghana (2011) provides guidelines and standards for the EPI Programme.  The sector maintains a participatory approach involving key stakeholders in planning, budgeting and implementation of activities including that of HSS and immunisation interventions. This includes representatives from the MoH and its agencies (GHS and Teaching Hospitals, Regulatory agencies, Development Partners (DPs) and CSOs).Planning and budgeting for sector programmes including that of HSS and immunisation services is done at the sub-district level. Cross-sectional discussions at various health sector forums, including HSCC monthly meeting and other senior managers meetings are used to review the proposal and its implementation. All sub-districts prepare micro plans at least once in a year in conjunction with key stakeholders like District Assembly, Opinion leaders and NGO’s. Micro plans address specific challenges like hard to reach areas and special populations. These micro sub-districts plans are aggregated into the district, regional and national plans and funded by the sector budget and other funding sources. The aggregated plans and budgets are approved by HSCC.  **Health Systems Financing**  The Government of Ghana (GoG) is the major source of funding of the health sector, with substantial resources also coming from DPs, mainly bilateral donors. A total of GHC 3,353.70m has been allocated to the health sector for 2014 (Budget Statement and Economic Policy of Ghana government as presented to the Parliament on 19th November 2013). This comprises the discretionary budget: GOG (36.4%), IGF (40.66%), DP (23.30%). An amount of GH¢926.6m is estimated to be transferred into the National Health Insurance Fund. The trend of budgetary allocation to the health sector shows improvement from GHC 1,805.25m in 2011, GHC 2,287.50m in 2012 to GH 3,529.44m in 2013 (MoH, 2013 Programme of Work:pp.19) but fell nominally by about 5% in 2014.  The National Health Insurance Act (Act 650) was revised into Act 852 and passed in 2012 to improve coordination in the Health Insurance System throughout the country. The scheme was initiated to address the problem of financial barrier to health care posed by “out-of-pocket” payment at the point of service delivery in both private and public facilities. Enrolment of new members has increased from 8.16 million in 2010 to 8.30 million in 2011 and 8.65 million at the end of 2012. This represents about 33.4% of the population registered for health Insurance. |

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| 7. NATIONAL HEALTH STRATEGY AND JOINT ASSESSMENT OF NATIONAL HEALTH STRATEGY (JANS) |
| The Ministry of Health has completed the implementation of its HSMTDP 2010-2013. Currently, the HSMTDP 2014-2017 is being developed and a timetable for its completion has been provided as part of section 2 (and attached). The HSMTDP 2010-2013 was assessed by JANS and the recommendations used to complete the plan (see attached; JANS 2010).  The current plan which is in draft, acknowledges the need to articulate issues from the previous JANS to strengthen the resolve of the Ministry to improve health care delivery from a system perspective. The attributes of JANS will be used in assessing the quality of the HSMTDP 2014-2017.  In the draft HSMTDP 2014-2017, the importance of improving child health was explicitly an integral part of health sector objectives. One objective focuses on bridging equity gaps in geographical access to health services of which strengthening the district and sub-district health systems is the bedrock of the national primary health care strategy. Another objective aims at improving efficiency in governance and management of health systems of which one of the key strategies is to deepen stakeholder engagement and partnership (public, private and community for health care delivery). Additionally, intensifying the prevention and control of non-communicable and communicable diseases is another objective. Under this objective, intensification and sustaining of EPI, the certification and eradication of polio are key components. |

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| 8. MONITORING AND EVALUATION PLAN FOR THE NATIONAL HEALTH PLAN |
| The national M&E framework states that all agencies and institutions at all levels will report to a central level. Service delivery BMCs are expected to report through the DHIMS. This is managed by the Ghana Health Service on behalf of the MoH. Data generated at source are collated manually using registers, aggregated and inputted by data entry officers. The data entered in the DHIMS can be assessed by designated officers at all levels. The DHIMS reports the health sector indicators from the data entered from the registers.  Data flow from the primary source is aggregated to the national level and the process is guided by timelines. Data from all reporting agencies (DHMTS, CSOs, NGOs and the private sector) flow through the regions to GHS headquarters and further to MOH. Agreed timelines are aligned to the statutory reporting requirement from the agencies to the Ministry to the government and other organizations including development partners.  There is a set of agreed sector-wide indicators amongst members of HSCC (Annex 2). These indicators are used to monitor the implementation of the HSMTDP. Other tools used include the holistic assessment which measures health system performance based upon basket of indicators. The holistic assessment is usually used as part of the annual review process to determine whether the sector has performed or under-performed. Periodic reviews are organized to assess performance in the health sector. Reviews start from the district level of the health delivery system to national level. MoH in conjunction with HSCC conducts quarterly joint monitoring visits to BMCs and meet half yearly to review key policy decisions, strategies and activities in the Annual Programme of Work (PoW). Joint field visits with DPs to validate data quality and performance of the sector at service delivery points are organized on regular basis. Inputs from the HSCC meetings inform the agenda of the joint monitoring visits. Decentralised departments from other MDAs at the districts and regions in addition to CSOs, private sector and other stakeholders like chiefs and opinion leaders participate in the district and regional reviews. The standard review of the health sector starts in December with district reviews, followed by regional and national reviews. It ends with a health summit which culminates in the signing of aide memoire between MoHand DPs by the second quarter of each year. A Common Management Arrangement requires that, HSCC holds monthly meetings and quarterly business meetings to discuss the progress in the implementation of the annual aide memoire.  There is EPI bi-annual review conducted at the national level with participation from MOH, GHS (divisions, regional and district health directorates), DPs, CSOs, and private sector providers. The sources of information are DHIMS, surveys (MICS, DHS), and specifics studies (EVMA, PIE). Findings and recommendations are discussed at HSCC monthly meetings, sector quarterly business meetings, and at periodic ICC meetings and annual health sector reviews. |

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| 9. HEALTH SYSTEM BOTTLENECKS TO ACHIEVING IMMUNISATION OUTCOMES |
| The country has made steady progress in improving health outcomes over the past two decades. The total fertility rate (TFR) declined from 6.4 children per woman in 1988 to 4.3 children per woman in 2011 (MICS4, 2011). In spite of the progress, there are large disparities between women in urban areas (3.3 births) and those in rural zones (5.5 births) with the Northern region having the highest rates (6.2 births) (MICS4, 2011). Ghana has also experienced a marked decline in childhood mortality over the past decades, reaching a rate of about 82 deaths per 1,000 live births in 2011(MICS4, 2011) from 145 deaths per 1,000 live births in 1998. Over two-thirds of deaths occur in the first year of life with Ghana’s infant mortality dropping to 53 deaths per 1,000 live births (2011) from 80 deaths per 1000 live births in 2003. (MICS4, 2011). Although Maternal Mortality Ratio dropped from a high of 600 deaths per 100,000 live births in 1990 to about 451 deaths per 100,000 live births in 2007 it still remains high. (Ghana Maternal Health Survey, 2007).  One of Ghana’s key strategies to address the disparities in access to maternal and child health services is to strengthen and accelerate the CHPS implementation to complement other efforts on service delivery and health financing. The GAVI/HSS support will build on efforts initiated by the MoH in using the CHPS strategy to reduce geographical barriers to health care. With a focus on deprived and remote areas, the strategy brings services closer to clients and uses community-based health structures that are familiar with the socio-cultural environment. The CHPS strategy has a number of key features: (i) a bottom up planning process (micro planning) which fosters a dialogue between community representatives and service providers; (ii) greater involvement of traditional community leaders who are well respected and can effectively transmit messages about health seeking behaviour (iii) structured training and mentorship programme, whereby DHMT ensures that community health workers have the requisite skills to deliver a set of high impact interventions (e.g. immunisation, assisted deliveries, postnatal care, family planning); and (iv) reliance on personnel who are knowledgeable with the local context as they come from the local community and are able to communicate effectively on sensitive matters.  **Major Analytical work to identify Health System Bottlenecks**  A number of engagements with managers in the health sector and literature review were undertaken to inform the synthesis of the systemic bottlenecks to achieving and sustaining high immunisation coverage. The key health system challenges confronting the Ghanaian health sector are in the areas of governance (weak coordination, ineffective inter-sectoral collaborations, participation and integration); gaps in geographical and financial access to quality health care, inadequate and inequitable distribution of critical staff mix, Specific to immunisation the number of documents reviewed included: (i) Effective Vaccine Management (EVM) Assessment (2010), (ii) Ghana Immunisation Service Review (2012), (iii) Post Introduction Evaluation (PIE) report for the two new vaccines (2013), (iv) cYMP (2010-2014), (v) Review of HSMTDP (2010-2013), (vi) MDG Accelerated Framework (2010) and Technical Reports. The summarised priority bottlenecks and referenced documents have been attached as annexed two (2).  **The EVM** A**ssessment** (2010) was an integral part of the process to unravel the systemic constraints to the introduction of the two new vaccines (pneumococcal and rotavirus). The assessment noted among other things the need to improve temperature monitoring systems, expansion/rehabilitation of the cold chain capacity at all levels, implement computerized stock inventory system and improve supportive supervision, including vaccine management.  **The Ghana Immunisation Services Review** (2012) had the overall goal to document successes and shortfalls of EPI and to inform the next cYMP. The challenges from the review were: poor quality micro-planning at the sub-district levels, inadequate data analysis and use for decision-making, inadequate supportive supervision, untapped potentials of CHPS to achieve maximum immunisation coverage, weak capacity of district staff in areas of communication for behavioural change, weaknesses in vaccine distribution and management, inadequate transport to ensure outreach visits, routine vaccination not conducted daily in most facilities and inadequate staff at the grassroots, especially deprived and hard to reach communities (pp.6).    The **Immunisation Programme Comprehensive Multi Year Plan (**2010-2014), also underscored the challenges above and further noted the inadequacy of resources for regular outreach services to islands and lake communities, poor cold chain maintenance, injection safety and weak community involvement among others. The plan therefore sought to reduce infant and child mortality and morbidity associated with vaccine-preventable diseases (VPD).  **Technical Report: Peer Monitoring of Measles Second Dose Pneumococcal and Rotavirus Vaccines Introduction into the EPI Programme (2013; pp.6).** The key challenges identified were: inadequate child health record books and the usage of old tally sheet books which do not contain column for recording new vaccines.  **A recent analysis of the EPI cold chain system (2013)** in Ghana revealed significant challenges. At the operational level, there are high numbers of over aged fridges and freezers, coupled with erratic power supply resulting in frequent breakdowns. The policy to replace old fridges after 10 years is also not being achieved due to inadequate funding. Additionally, there is the need to strengthen cold chain maintenance system to improve uptime. At the sub district and CHPS zone level, there are inadequate cold boxes and vaccines carriers for delivering immunisation services at the community level.  In addition to the bottlenecks associated with immunisation there are health system challenges which affect the country adversely in achieving the MDGs 4, 5 and 6. The main persisting immunisation/HSS bottlenecks which are prioritised to be addressed under the GAVI/HSS categories are as follow (see also annexed 2):  **Service Delivery:**   * **Inadequate cold chain capacity at district level and below**: According to 2013 cold chain inventory about 41% of fridges and freezers were over 10 years, 1 out of every 4 units is not functioning. Also forty six new DHMTs have been created that need cold chain equipment. New health facilities are being set up and hence need support to provide immunisation services. There is also frequent breakdown of cold chain equipment due to poor maintenance culture and erratic power supply (EVM 2010, pg 18, 19; cMYP 2010-2014, pg 17, 28) * **Inadequate access of immunisation service in riverine and island communities**:   There are 23 districts which lie in the Volta lake basin whose services can only be provided by use of boats. To improve access to immunisation services in these hard-to-reach communities, there will be the need to procure fibre boats.   * **Inadequate infrastructure:** Many of the existing district cold rooms are in deplorable states, while most of the newly created 46 districts do not have cold rooms. Construction of cold rooms was not planned for these 46 new districts in the cMYP 2010-2014. ( attach list of newly created districts by region and number) * **Inadequate data collection tools:** inadequate funds to procure EPI stationery (tally sheet books, child health records vaccine ledger etc) (EVM 2010, pg 17. PIE 2013, pg 9; HSMTDP 2014-2017 pg9, 17, 23) * **Waste management is a challenge:** In a bid to ensure adequate and safe waste management at health facility level it is recommended that each district should have a suitable incinerator in addition to the training of staff. This has become necessary in view of the increasing number of vaccination and new district that have been created (Ghana EPI Review 2012 pg 94, PIE, 2013, pg. 6, cYMP, 2010-2014 pg. 42). * **Inadequate Outreach Services:** There are inadequate resources for districts to undertake planned outreach service. These affect routine immunisation and vaccine preventable diseases surveillance. The Ghana EPI Review 2012 pg 71, 118, mentions one main constraint at district level was inadequate transport services for required outreach and recommends the procurement of four-wheel drives and adequate and accurate (i.e. durable and gender-friendly) motorbikes. * **Inadequate Supportive Supervision:** There exists low capacity and resources for supportive supervision at all levels (Ghana EPI Review 2012, pg 27, 62) * **Inadequate demand creation:** There is poor community mobilisation and engagement as a result of inadequate resources and capacity.( Ghana EPI Review 2012 pg 54)   **Health Workforce**   * There is a weakness in deployment and retention of health workforce especially CHOs in deprived and hard-to-reach communities hence the need for clear policy guidelines to address the issues (Review of HSMTDP, 2010- 2013. pg. 7, HSMTDP 2014 -2017 pg 13,14). * **Weak performance management**: There is absence of clearly defined system for measuring health worker force productivity. There is therefore the need to develop a framework/tool to measure health workforce productivity which can be linked to improvement in service delivery (Review of the HSMTDP 2010-2013, pg 24) * The need to scale-up management training was reiterated in the Review of the HSMTDP 2010-2013, pg 29). The creation of new districts has resulted in increased number of management positions and therefore the need to expand management training.   **Procurement and Supply Chain Management**   * Inadequate capacity and support to monitor procurements at district and sub-district levels (HSMTDP 2010-2013, pg 42-43; HSMTDP 2014-2017, pg 24, 29) * Weak interconnectivity of logistics management information system at central, regional medical stores and district hospitals * Weak infrastructure of regional and district medical stores coupled with low availability of transport and other logistics for timely distribution (HSMTDP 2010 -2013, pg 42)   **Health Information System**  **Poor data quality:** There is poor documentation and data management for effective planning and decision making at the operational level. Prior to the introduction of DHIMS2. The DVD-MT was the primary tool for EPI data management (cMYP p19) recording 100% completeness and above 85% completely for consecutive years. In 2012 following national adoption and rollout of DHIMS2, data completeness and timeliness of reporting has dropped (in the DHIMS were 88.5% and 37.8% respectively). To strengthen national health system in a comprehensive manner, there is the need to improve capacities in DHIMS2 and integrate it with DVD-MT which is currently being used by EPI to reconcile data quality.   * **Inadequate operational research to inform policy and decision-making:** The health sector remains challenged at all levels in analyzing and using available data for decision making (HSMTDP, 2010-2013). EPI operational research activities in the health sector are inadequate and uncoordinated. * Lack of integration of district vaccination data management tool (DVD-MT) and LMIS into DHIMS ( Ghana EPI Review 2012, pg 40, 72, 84)   **Legal, Policy and Regulatory Environment:**   * **Weak micro planning at the operational level:** Weak capacity for micro planning and budgeting at the sub district and CHPS zone levels.( Ghana EPI Review 2012, pg 26-27; cMYP pg 17)   **Financial Management**   * Weaknesses in prioritisation, disbursement and financial resources tracking at all levels (Ghana EPI Review 2012, pg 7). * Inadequate funds at the operational level service delivery (Ghana EPI Review pg 36; HSMTD Strategy, pg 9, 20, 23) * Weak financial management practices at sub district level (HSMTDP   **Community and Local Actors**   * **Poor mobilisation and engagement of communities in health service delivery especially for routine immunisation:** There is weak CSO role in the engagement of communities for demand creation, sensitisation and advocacy. (The Ghana Immunisation Services Review, 2012:pp.7). This is due to the following: * Inadequate funding to undertake impact-oriented community level interventions by CSOs (cMYP, pg 17) * Poor incentive support for working in hard-to-reach areas (cMYP, pg 31-36)   **Low coverage of key essential health interventions (including immunisation) in some population:** Districts showing high percentage of un-immunized children have been identified based on EPI 2012 administrative data. Also, districts with riverine and island communities have been targeted for support. About 10 communities per district will be selected from 20 of such districts and targeted for community mobilization and demand creation.  **Gender Inequalities in Service Delivery and Effects on Immunisation**  There are no significant differences in immunization uptake among various wealth quintiles, and gender (MICS, 2011). The administrative data for immunisation is not disaggregated by sex. However, there are steps which have been initiated through the child growth promotion session to disaggregate data by sex. This will also be introduced into routine immunize data to strengthen data reporting and analysis by gender. There is therefore the need to adapt existing data collection tools to be able to capture immunisation data by sex. The MoH has a gender policy that aims at mainstreaming gender in the health sector.  **Other national programmes addressing bottlenecks**   * **Ghana essential health intervention project (GEHIP) in Upper East:** It seeks to influence the health system through various activities that will lead to increase access to technologies, increase service availability and care and improve quality and efficiency of service. It is being integrated with the normal sector programme. * **Project Five Alive:** It is a five-year initiative to accelerate Ghana’s effort to achieve MDG 4 for reducing under-five mortality rate by 67 percent, from 110 per 1,000 live births in 1990 to less than 40 per 1,000 live births by 2015 through the application of quality improvement strategies. * **MAF:** Ghana is implementing the MAF, which identifies and prioritises the bottlenecks of the effective implementation of the most important intervention to reduce maternal death and propose solutions for accelerating progress for MDG 5. The European Union is providing support for MAF to address maternal and child health issues over the period 2013 to 2015. This includes activities focusing on skilled attendant at birth, emergency obstetric care and family planning, strengthen monitoring and evaluation, health management information system and financial management. * **Free maternal health care:** The GoG though the NHIA is providing free maternal care to all pregnant women. This service covers antenatal, delivery and post natal. |

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| 10. LESSONS LEARNED AND PAST EXPERIENCE | |
| While the immediate past GAVI HSS support has not been evaluated, however Annual reports including the current APR has evidence of performance related to the GAVI Support. Three key areas of best practice and lessons learns are 1) Ensuring cash disbursement to the sub-district level, 2) flexibility for re programming the GAVI funds and 3) provision of vehicles(pick-ups) to100 districts to support health service delivery. | |
| Current GAVI/HSS Objectives | Example of lesson learned, highlighting both successes and challenges |
| 1. To strengthen and scale-up community health interventions aimed at improving access and quality of primary health care services | The budget management centre concept requires a cost-centre to have a certain level of capacity to receive and manage funds. This has been a challenge because the CHPS concept which places a CHO at the community-level will not qualify for direct funds and management.  During implementation of the previous GAVI HSS, an accountable imprest system was created to enable cash to be transferred to sub-districts to enable them to pay for small expenditure *such a*s fuel, repair of motorbikes, stationery, etc. Though there were challenges in ensuring that districts transferred funds to sub-districts, some regions *such as* UER were able to open accounts for all sub-districts and transfer funds. This helped improve financial access to funds for service delivery.  The previous GAVI HSS procured 100 4X4 pick-ups for 100 districts out of a total of 170. This enhanced outreach services in all resourced districts especially in the newly created districts. For the already existing districts that had at least one vehicle, the new vehicle was scheduled to serve the number of sub-districts in turns for outreach services especially to remote and hard-to-reach areas that were inaccessible with motorbikes. |
| 1. To address capacity and equity gaps in health worker distribution in targeted districts and communities | The Government created Community health training institutions in each region, increased intake and passed a Policy to retain 70% of community health nurses trained in the regions. This rapidly increased the number of CHNs available in each region and deployed to communities. |
| 1. To empower civil society for increased demand for health services at the community | There is improved collaboration between MOH and CSOs such that they are recognized as partners and their involvement in the health sector policy decisions. From the CSO mapping, active CSO participation has been linked with DHMTs in districts where they are operational. This leadership role of the MOH and GHS has promoted the relationship of CSOs in DHMTs.  CSO activities have so far been concentrated in 2 districts covering 100 hard-to-reach communities, where they have been able to improve immunization uptake between 9.2% and 27.3% (between 2012-2013, respectively) GAVI Project Fact File 2013. Some CSOs have offices within the DHMTs (Twifo-Praso District). |
| 1. To strengthen governance and health information management for improved health service delivery | The flexibility of HSS support enabled Ghana to re-programme funds for the procurement of motorbikes to vehicles (because Government was procuring 4000 motorbikes). Such flexibility promoted the integration of GAVI HSS activities into other government activities. |

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| PART D - PROPOSAL DETAILS |
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| 11. OBJECTIVES OF THE PROPOSAL |
| The objectives of this proposal address prioritised health system and immunisation bottlenecks which are specifically aligned to HSMTDP (2014-2017). The alignment between this GAVI/HSS proposal objectives and cYMP (2010-2014) with the HSMTDP (2014-2017) is depicted in the table below:   |  |  | | --- | --- | | **HSMTDP POLICY OBJECTIVE& STRATEGIES** | **OBJECTIVES OF cYMP AND GAVI HSS** | | **OBJ 1: Bridge the equity gaps in geographical access to health services** | GAVI HSS - Objective1.  To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services | | **OBJ 2: Ensure sustainable financing for healthcare delivery and financial protection for the poor** |  | | STR 2.2 Improve efficiency and effectiveness of health service delivery including the NHIS | cYMP - Objective 4: Improve programme management and integration with health systems | | **OBJ 3         Improve efficiency in governance and management of the health system** | GAVI HSS - Objective 5.     To strengthen governance and health information management for improved health service delivery | | STR 3.1     Review and restructure of the health sector leadership development and management programs | cYMP - Objective 4: Improve programme management and integration with health systems | | STR 3.3  Deepen stakeholder engagement and partnership (public, private and community) for health care delivery | GAVI HSS - Objective 4: To empower civil society for increased demand for health services at the community | | STR 3.5 Implement the human resource development strategy to improve production, distribution retention of critical staff and performance management | GAVI HSS - Objective 2: To strengthen health worker capacity and distribution so as address equity issues in districts levels. | | STR 3.6     Improve health information management systems including research in the health sector | GAVI HSS - Objective 5.     To strengthen governance and health information management for improved health service delivery | | **OBJ 4Improve quality of health services delivery including mental health services** |  | | STR 4.4 Improve supply chain, ensure commodity security and availability of quality medicines | GAVI HSS - Objective 3. To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices | | **OBJ 5 Enhance national capacity for the attainment of the health related MDGs and sustain the gains** |  | | STR 5.3 Intensify and sustain Expanded Programme on Immunisation(EPI) | cYMP- Objective 1: Reach everyone targeted for immunisation to achieve and sustain by 2014, 94% coverage in all childhood immunizations and 85% for Tetanus Toxoid for Pregnant women | | OBJ 6  Intensify prevention and control of non-communicable and other communicable diseases |  | | STR 6.8     Strengthen Integrated Disease Surveillance and Response (IDRS) at all levels and implement fully the International Health Regulations (IHR | cYMP Objective 3: Strengthen surveillance system |   **Vision**  The vision of the health sector is to have a healthy population for national development.  **Goal**  The goal is to have a healthy and productive population that reproduces itself safely  The proposal will contribute towards the national effort to achieve Under five mortality rate of less than 50 per 1000 live births by 2015  The overall targeted immunisation outcomes are as follows:   1. Increased Penta 3 coverage from 92% in 2012 to 95% by 2018, 2. Increased MCV1 coverage (% of surviving infants receiving first dose of measles containing vaccine) from 93% in 2012 to 95% by 2018. 3. Geographic equity of Penta 3 coverage – (% of districts that have at least or above 80% Penta 3 coverage) from 80% in 2012 to 90% by 2018. 4. Proportion of children fully immunised (% of children aged 12-23 months who receive all basic vaccinations in a country’s routine immunisation program) increased from 77% in 2011 (MICS) to 83% by 2018. 5. Dropout rate - (percentage point difference between PENTA 1 and PENTA 3 coverage) from 4.6% in 2012 to 4% in 2018.   The scope of this proposal focuses on addressing geographical inequities by resourcing and building capacities in newly created districts and hard to reach areas to uptake and sustain high immunisation coverage.The expected specific contribution to the above outcomes from of each of the objectives are as follows:  **Objective 1: To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services:** This objective addresses bottlenecks associated with inadequate logistics to support service delivery, and to build capacity for service delivery and demand creation for immunisation service. The objective contributes directly to the attainment of all targeted immunisation outcomes.  **Objective 2: To strengthen health worker capacity and distribution so as to address equity issues at district level**: This will address inequity in health workforce distribution and retention and address workforce performance. The objective contributes directly to the attainment of all targeted immunisation outcomes.  **Objective 3: To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices**: This objective is expected to address logistic management challenges and ensure availability of safe vaccines and related commodities. The objective contributes directly to the attainment of all targeted immunisation outcomes.  **Objective 4: To empower civil society for increased demand for health services at the community:** This will enhance collaboration among various partners for effective service delivery at the community level. The objective contributes directly to the attainment of all targeted immunisation outcomes.  **Objective 5: To strengthen governance and health information management for improved health service delivery:** This will address issues pertaining to improving data quality to enhance evidence-based decision making, effective resource allocation and management. This objective will strengthen the health system and contribute indirectly to the attainment of all targeted immunisation outcomes. |

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| 12. DESCRIPTION OF ACTIVITIES | |
| **Objective / Activity** | **Explanation of link to improving immunisation outcomes** |
| **Objective 1:** To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services | |
| 1.1 Procure needed logistics and improve transport capacity to support service delivery | This activity will ensure availability of essential logistics for immunisation services. |
| 1.2 Strengthen capacity and provide resources needed to undertake outreach services at the district and sub district levels | This activity will improve access and utilisation of immunisation services. |
| 1.3 Support National, Regional, Districts and Sub District team Supervision and monitoring | This will ensure quality of immunisation services. |
| 1.4 Construct and renovate cold chain infrastructure and equipment: | This will improve availability and quality of immunisation services. |
| 1.5 Train CHMCs and CHVs for CHPS implementation including routine immunisation services, Middle Level Managers (MLM) for EPI staff, EPI equipment Technicians, Waste Management focal persons, Cold Chain and logistics Management and quality assurance | This activity will improve access, availability and quality of immunisation services. |
| **Objective** 2. To strengthen health worker capacity and distribution so as to address equity issues in districts levels. (Workforce and Human Resources) | |
| 2.1 Develop HR productivity measuring framework/tools  2.2 Train CHOs and SDHMTs in Management | This activity will address management capacity needs as well as the instrument to determine productivity, hence, affecting service delivery positively |
| 2.2 Scale-up Management capacity building at district and sub district levels | This activity will ensure the quality of immunisation services. |
| **Objective** 3. To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices | |
| 3.1 Reorganise the national and district stores to improve logistics management | This will ensure the availability of quality and essential logistics for immunisation services. |
| 3.2 Build capacity, support and monitor procurements at district and sub district levels |
| 3.3 Improve the use of the central logistics management information system at regional medical stores and expand to regional and district hospitals to respond to demand |
| 3.4 Rehabilitation of Regional Medical Stores in Volta and Northern Region | This activity will expand storage capacity for effective logistic management for immunisation services. |
| Objective 4: To empower civil society for increased demand for health services at the community | |
| 4.1  Strengthen the national level (GCNH) to coordinate CSOs activities in health | This activity will ensure effective coordination of CSO activities for immunisation services. |
| 4.2  Develop capacity of CSOs to better support community level services, including mainstreaming gender (Male involvement) | This activity will promote community engagement and male involvement in immunisation services. |
| 4.3 Establish and build the capacities of five satellite sites for CSOs to support community service delivery | This will improve demand creation for immunisation services. |
| 4.4  Recruit/train retired Community Health Nurses and Midwives to partner CSOs to operate in the established satellite sites in hard to reach communities | This will improve collaboration among CSOs, health service providers and communities for immunisation services. |
| 4.5 Undertake community outreach activities in partnership with DHMTs and retired Midwives in hard-to- reach communities in the selected 20 districts (See annex 3 for list of selected districts by CSOs). |
| Objective 5: To strengthen governance and health information management for improved health service delivery | |
| 5.1 Upgrade management information system (DHIMS, FMIS and LMIS) | This will harmonize the existing tools to ensure standardization in reporting of immunisation data. |
| 5.2 Build the capacity of health information officers and CHOs and undertake quarterly technical and financial data validation at district and sub-district levels | This will ensure effective implementation and enhance data quality and timely reporting of immunisation data. |
| 5.3 Improve capacity of sub-district and CHPS Zones staff in micro-planning and develop micro-plans at these levels |
| 5.4 Support the development of health accounts and joint annual performance review | This will lead to use of data for effective decision making at the at national and regional levels |
| 5.5 Strengthen data management and M&E systems | This will ensure effective planning, monitoring and evaluation of immunisation services. |

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| 13. RESULTS CHAIN | | | | | | |
| ***Objective 1: To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services*** | | | | | | |
|  | **Key Activities:**  1.1 Procure needed logistics and improve transport capacity to support service delivery  1.2 Strengthen capacity and provide resources needed to undertake outreach services at the district and sub district levels  1.3 Support National, Regional, Districts and Sub District team Supervision and monitoring  1.4 Construct and renovate cold chain infrastructure and equipment  1.5 Train CHMCs and CHVs for CHPS implementation including routine immunisation services, Middle Level Managers (MLM) for EPI staff, EPI equipment Technicians, Waste Management focal persons, Cold Chain and logistics Management and quality assurance |  | **Outputs / Intermediate Results:**   * Increased proportion of functioning refrigerator and thermometer * Increased proportion of facilities undertaking at least 75% of planned outreach activities * Reduced vaccine stock-out rate for OPV, PENTA, MR and PCV * Increased proportion of district with managers trained in MLM |  | **Immunisation Outcomes:**   * Increase PENTA 3 Coverage * Increase in the proportion of district with PENTA3 coverage >80% |  |
|  | **Related Key Activities Indicators:**   * Number of sub districts provided with essential logistics and transport * Number of districts and sub districts supported with resources to undertake outreach services * Number of supportive supervision undertaken at all levels * Number of facilities provided with cold chain infrastructure and equipment * Number of people trained by type of training |  | **Related Intermediate Results Indicators:**   * *Proportion of functioning refrigerators at regional, district and sub-district levels* * *Proportion of facilities undertaking at least 75% of planned outreach activities* * *Stockout rate for OPV, PENTA and Measles* * *Proportion of district with managers trained in MLM* |  | **Related Immunisations Outcome Indicators:**   * *National PENTA 3 Coverage* * proportion of district with PENTA3 coverage >80% |  |
| ***Objective 2: To strengthen health worker capacity and distribution so as address equity issues in districts levels*** | | | | | |  |
|  | **Key Activities:**  2.1 Develop HR productivity measuring framework/tools  2.2 Train CHOs and SDHMTs in Management |  | **Outputs / Intermediate Results:**   * *Increased number of children immunised in the low performing districts.* |  | **Immunisation Outcomes:**   * *Increase proportion of districts with PENTA 3 at or above 80%* |  |
|  | **Related Key Activities Indicators:**   * *Availability of HR productivity measuring tool* * *Number of districts and sub districts with managers trained in management.* |  | **Related Intermediate Results Indicators:**   * *Proportion of low performing district ( <80%) with PENTA 3 immunisation above 80%,* * *Proportion districts and sub-districts with managers trained in management* |  | **Related Immunisations Outcome Indicators:**   * *proportion of districts with PENTA 3 at or above 80%* |  |
| ***Objective 3: To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices*** | | | | | |  |
|  | **Key Activities:**  *3.1 Reorganise the national and district stores to improve logistics management*  *3.2 Build capacity, support and monitor procurements at district and sub district levels:*  3.3 Improve the use of the central logistics management information system at regional medical stores and expand to regional and district hospitals to respond to demand:  3.4 Rehabilitation of Regional Medical Stores in Volta and Northern Region |  | **Outputs / Intermediate Results:**   * *Reduced proportion of regional medical stores with stockout of essential tracer commodities (Auto disable syringes, BCG syringes, safety boxes, ORS, key anti malaria drugs)* |  | **Immunisation Outcomes:**   * *Increase PENTA 3 Coverage* |  |
|  | **Related Key Activities Indicators:**   * *Number of district stores reorganised* * *Number of districts with staff trained in procurement management* * *Number of districts with stores with computerized networked with national level* * *Two regional medical stores rehabilitated* |  | **Related Intermediate Results Indicators:**   * *Proportion of regional medical stores without stockout of essential tracer commodities* |  | **Related Immunisations Outcome Indicators:**   * *National PENTA 3 Coverage* |  |
|  | ***Objective 4 To empower civil society for increased demand for health services at the community*** | | | | |  |
|  | **Key Activities:**   * 1. Strengthen the national level (GCNH) to coordinate CSOs activities in health   2. Develop capacity of CSOs to better support community level services, including mainstreaming gender (Male involvement)   3. Establish and build the capacities of five satellite sites for CSOs to support community service delivery   4. Recruit/train retired community Health nurses and Midwives to partner CSOs to operate in the establish satellite sites in hard to reach communities   5. Undertake community outreach activities in partnership with DHMTs and retired Midwives in hard-to- reach communities in the selected 20 districts |  | **Outputs / Intermediate Results:**   * Increased proportion of intervening districts reporting active CSO participation in annual DHMT micro planning meetings and reviews per annum * Increased proportion of volunteers trained to undertake EPI activities * Increased proportion of targeted districts implementing planned community outreach services (e.g. durbars) * Increased knowledge and acceptance of immunisation services within the communities |  | **Immunisation Outcomes**   * Increased PENTA 3 coverage in targeted districts * Improved geographic equity of PENTA 3 coverage - % of targeted districts that have at or above 80% PENTA 3 coverage |  |
|  | **Related Key Activities Indicators:**   * *National secretariat level of GCNH capacity built* * *Number of CSOs with capacity built to support community level activities* * *Five satellite sites identified and provided with support for community level activities* * *Number of retired nurses and midwives recruited and trained* * *Number of outreach activities undertaken* |  | **Related Intermediate Results Indicators**   * *Proportions of intervening districts reporting active CSO participation in annual DHMT micro planning meetings and reviews per annum* * *Proportion of targeted communities with volunteers trained to undertake EPI activities* * *Proportion of targeted communities benefiting from planned community outreach services (e.g. durbars)* * *Proportion of targeted communities sensitized on the benefits of immunisation and the need for service uptake* |  | **Related Immunisations Outcome Indicators:**   * PENTA 3 coverage in targeted districts * PENTA 3 coverage - % of targeted districts that have at or above 80% PENTA 3 coverage |  |
|  | ***Objective 5 To strengthen governance and health information management for improved health service delivery*** | | | | |  |
|  | Key Activities:   * 1. Upgrade management information system (DHIMS 11, FMIS and LMIS)   2. Build the capacity of health information officers and CHOs and undertake quarterly technical and financial data validation at district and sub-district levels   3. Improve capacity of sub-district and CHPS Zones staff in micro-planning and develop micro-plans at these levels   4. Support the development of health accounts and joint annual performance review   5. Strengthen data management and M&E systems |  | **Outputs / Intermediate Results:**   * *Increased percentage of districts reporting data completeness and timely in the DHIMS* * *Increased proportion of districts with technical and financial data quarterly validated* * *Increased proportion of districts and sub-districts with integrated annual operational plans* |  | **Immunisation Outcomes:**   * Increased Geographic equity of PENTA 3 coverage - % of districts that have at or above 80% PENTA 3 coverage |  |
|  | **Related Key Activities Indicators:**   * DHIMS II upgraded and integrated with DVD-MT and LMIS * Number of BMCs with staff trained to undertake technical andfinancial data validation * Number of districts, sub districts and CHPS zones with capacity build in micro planning * Performance management systems strengthened |  | **Related Intermediate Results Indicators:**   * *percentage of districts reporting data completeness and timely in the DHIMS* * Proportion of BMCs at the district level with technical and financial data quarterly validated * Proportion of districts and sub-districts with integrated annual operational plans |  | **Immunisation Outcomes:**  Geographic equity of PENTA 3 coverage - % of districts that have at or above 80% PENTA 3 coverage |  |
| ***IMPACT: Please provide an impact statement and indicator(s)***  ***Under five mortality rate (per 1000)***  ***Infant Mortality Rate (IMR) per 1,000*** | | | | | | |
| ***ASSUMPTIONS:***   * *Political stability (stable environment)* * *Absence of national disasters* * *Availability of funds from Government and other sources* * *Low staff attrition* * *Low fiduciary risks* * *Stable institutional arrangements* | | | | | | |

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| 14. MONITORING & EVALUATION FRAMEWORK |
| **Mechanism for monitoring the HSS grant**  The MoH has developed an M&E framework to guide the implementation of HSMTDP (2014 -2017). The management of this support will include a comprehensive M&E system, which is part of the regular M&E process for the entire health sector. The emphasis is on monitoring action-relevant information, including data validation and feedback mechanisms. This proposal has a set of outputs related to activities that will be used to monitor progress towards the achievement of the outcomes. There is a set of intermediate results to measure the extent of progress on the outcomes. The levels for performance monitoring is described as follows:  District level – (i) Quarterly review with sub-districts (ii) supportive supervisory and monitoring visits (iii) monthly data validation and feedback.  Regional level – (i) Monitor results primarily through the DHIMS and send feedback to the district level. (ii) Quarterly monitoring visits to all districts to provide technical guidance. (iii) quarterly and annual performance reviews  National level – (i) Quarterly MoH/health partners’ joint monitoring, (ii) half year and annual reviews, (iii) quarterly managerial and technical visits to regions and districts, (iv) health summit to assess the performance of the sector (including performance of health partners), (v) quarterly business meeting to report progress made in implementing health sector annual programme of work as well as other development partner intervention support. The health summit ends with a signed aide memoire between MOH and DPs, which is monitored quarterly.  **Data source for M&E**  The main data source for routine monitoring and evaluation of performance is from the DHIMS platform. Both manual and electronic systems are employed as the primary data source. At the community and sub district levels, the eRegister database system is used to capture and transmit data into DHIMS at the district level on pilot. However, most sub districts are using the manual system which has implication for data quality. Client specific immunisation data is obtained from child health record and child welfare clinic register.  Progress on the implementation of the GAVI/HSS grant will be reported through the existing reporting systems (which is from sub districts through districts, regions to national level using the DHIMS). In addition to the routine system, the outcome and impact indicators will be reported through surveys (MICS and DHS) and the other process monitoring systems including operational research.  In relation to EPI, specific surveys are undertaken to inform management decisions. These include coverage surveys, EVMA, cold chain inventory, dropout surveys, KAP, safety monitoring (AEFI). There is also quarterly and annual EPI reviews at all levels to identify challenges and re-strategise.  **M&E systems strengthening activities**  MoH has a technical unit responsible for coordinating M&E activities within the sector. In a bid to strengthen M&E MoH has developed and implemented M&E framework which is currently under review. It is noted that M&E activities in the sector are not harmonised and as such, MOH developed its first integrated M&E system which sought to coordinate all programmatic and routine activities. The integrated system needs to be strengthened to ensure effective and efficient outcomes. In complementing efforts aimed at strengthening the M&E system this proposal will support the following activities   * Build capacity for M&E at all levels:   + Strengthen the integrated M&E systems, Develop and implement integrated M&E checklist in monitoring district., Monthly performance monitoring based on the newly developed indicators   + Strengthen data management systems at the facility level including Data Quality training on DHIMS 2 and the use of information for evidence based decision making.   **PBF performance indicator**  To facilitate M&E for PBF, the number of children (male and female) immunised for PENTA 1, 2, and 3 has been chosen as the prime indicator.  PENTA 3 (DPT 3) has been the proxy indicator for immunisation. The PBF will support efforts to immunisation coverage in all the three vaccinations. This will help address the gaps in drop outs rate for this indicator. |

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| PART E – BUDGET, ANALYSIS AND WORKPLAN |
| 15. DETAILED BUDGET AND WORKPLAN NARRATIVE |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **HSS Proposal Objectives** | **Activity Total per Year** | | | | | **Total per Objectives** |  | | **2014** | **2015** | **2016** | **2017** | **2018** | | Objective "1". To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services | 3,155,700 | 1,895,766 | 2,093,900 | 2,153,750 | 1,970,400 | 11,269,516 | 62% | | Objective "2" To strengthen health worker capacity and distribution so as to address equity issues at district level | 10,000 | 23,500 | 23,500 | 23,500 | 28,000 | 108,500 | 1% | | Objective "3" To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices | 100,000 | 50,000 | 250,000 | - | 55,000 | 455,000 | 3% | | Objective "4" To empower civil society for increased demand for health services at the community | 214,700 | 425,850 | 386,750 | 475,750 | 502,750 | 2,005,800 | 11% | | Objective "5" To strengthen governance and health information management for improved health service delivery | 819,000 | 1,044,980 | 685,500 | 787,000 | 884,000 | 4,220,480 | 23% | | **Total** | **4,299,400** | **3,440,096** | **3,439,650** | **3,440,000** | **3,440,150** | **18,059,296** | **100.0%** | | Percentage of Annual Allocation | 24% | 19.0% | 19.0% | 19.0% | 19.0% | 100.0% |  |   The total proposed budget for the funding support from GAVI is US$18,059,296 for a period of five years from 2014 -2018. A total amount of US$11,269,516 (62%) has been allocated for implementation of activities related to objective 1 (service delivery), objective 2 (workforce and human resource), US$108,500 (1%), objective 3 (logistic and supply chain management) US$455,000 (3%), Objective 4 (community support and civil society organisation) US$2,005,800 (11%), and objective 5 (governance and health information management for improved health service delivery) US$4,220,480 (23%).  A total amount of US$4,299,400(24 %) is expected to be spent in the first implementation year spanning from July 2014 to June 2015. This is followed by about US$3.44 million (19.0%) in each of the four subsequent (See Excel -based Monitoring and Evaluation Framework). implementation periods. .  Twenty one key activities are planned to be undertaken during the five years. Five activities (24%) each are planned for objective 1 (service delivery), objective 4 (community support and civil society organisation), and objective 5 (governance and health information management for improved health service delivery) respectively. Two activities (10%) are planned under objective 2 (health workforce) and four activities (9%) under objective 3 (logistic and supply chain management).  Using GAVI Grant categories, Service Delivery was allocated the largest amount of US$11,126,900 (62%) followed by Community and other Local Actors with budget of US$3,517,180 (20%) and Health Information Systems with US$1,412,616 (8%). The other allocations were as follows: Programme management (US$730,000 – 4.0%); Workforce and Human Resources (US$71,250 – 4%) Procurement & Supply Chain Management (US$447,350 – 3%) and Health financing, US$12,000 (0.1%).  Based on GAVI grant sub categories, the highest budget of US$ 3,143,000 (17%) was allocated to cold chain equipment followed by strengthening community groups US$2,494,180 (14%) and transportation 1,827,500 (10%). Improving quality of care was allocated US$1,712,500 (10%) and demand generation US$1,695,600 (9%). The least amount of US$12,000 (0.07%) was allocated to Improving equity.  The public sector which has three lead implementers was allocated US$ 16,053,496 (88.9%) of the total budget as against US$2,005,800 (11.1%) for the CSOs as implementers. |

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| 16. Gap Analysis & Complementarity |
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Even though it might be stated that the Health Sector Medium Term Plan is still under development and no costing has been done, therefore a need-based approach was adopted to for the development of the GAVI-HSS proposal. The approach focused on the amount of resources and related activities that must be implemented to achieve and sustain high immunization coverage from a system perceptive.  The total need-based budget to address the prioritised bottlenecks in this proposal was estimated at US$64,416,490. The current budget is justified given the fact that there would be continuous increase in population, changing fiscal space of the economy and relatively decreasing DP support. Moreover, the number of districts has also increased from 170 in 2010 to 216 currently necessitating their resourcing for health service delivery.  In relation to objective 1 which focuses on service delivery interventions, the total amount for the need-based was US$36,197,490.Out of this amount it is expected that the Government of Ghana and other partners who support the country’s budget would provide an amount of US$16,128,812 over the five-year period. This would still leave a gap of US$20,068,678 to be filled. It is anticipated that this proposal would provide US11,269,516 of the identified gap leaving unmet budget of US$8,799,162.  Objective 2 is aimed at strengthening health worker capacity and distribution to address equity issues. The total need-based budget is US$2,405,000. However, so far US$200,000 has been secured under the MAF to address the MDG4&5 to support this activity. This leaves a gap of US$2,205,000 on this objective out of which US$ 108,500 is to be funded under this proposal. This leaves unmet budget of US$2,096,500.  Objective 3 is targeted at strengthening procurement management systems to improve on health service delivery for which an amount of US$4,615,000 has been estimated as needed. It is anticipated that the GoG and DPs would provide US$3,875,000 leaving a gap of US$740,000. It is also anticipated that US$455,000 will be funded by GAVI leaving unmet budget of US$285,000.  Collaborating with civil society organizations to increase demand in targeted communities under objective 4 is estimated at US$2,300,000. However, so far an amount of US$135,770 is available from the Global Fund under the National Malaria Control Program to support NGOs in related community level interventions, leaving a funding gap of US$2,164,230 out of which US$2,005,800 is to be funded under this proposal, with an unmet gap of US$158,430.  Objective 5 aims to strengthen governance systems required to provide adequate support to the health systems without which effective health service delivery would be difficult to achieve. The budget for this objective is estimated at US$18,899,000, out of which GoG and DPs are expected to provide US$5,000,000 leaving a gap of US$13,899,000. This proposal is also expected to fund US$4,220,480 to address identified bottlenecks leaving unmet budget of US$9,678,520.  Overall, a total funding gap of US$39,076,908 still exists. The GAVI/HSS proposal is expected to provide US$18,059,296 towards complementing efforts to address the prioritised bottlenecks leaving a budgeted variance of US$21,017,612. In order to fill this gap the strategy is to engage the private sector more to increase their participation in supporting the health sector. Government recently, developed national Public Private Partnership Policy and urged all MDAs to make use of it in engendering national development. The health sector has also developed its PPP policy. These policies would be used as one of the main tools in bringing on board the private sector for immunisation services. Advocacy would also be done to increase GoG and existing DPs’ support as well as bring on board other DPs to support in filling this gap. Strategies have also been put in place to ensure the timely disbursement of funds to the implementing levels to facilitate the achievement of the stated objectives of this proposal. |

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| 17. Sustainability |
| Government of Ghana is becoming the major funder of health care in Ghana (National Health Accounts (2005 -2010). As part of Government sustainability measures, a clear budget line has been established in successive POWs make specific GOG budgetary allocations to support vaccines and essential logistics procurement for immunizations and other child health interventions. Major investment expenditure and procurement items such as vaccines, cold chain equipment are procured centrally at the national levels. In addition, there is an earmarked fund from the NHIF for public health interventions services with specific allocations for immunizations. Both commitments from government are progressive towards ensuring sustainability.  Almost all public health sector workers are government employees and are remunerated from public funds allocated to the health sector. GoG budget for Goods and Services are allocated to decentralized cost centres to be implemented according to their approved plans. Outreach, supervision, training and monitoring constitutes some of the major activities of the district plans.  All public health facilities in Ghana generate revenue from service provision of which hundred per cent is retained service delivery improvement. The use of Internally Generated Funds by facilities is guided by guidelines developed by the MOH. Currently, health facilities accredited by the NHIA are reimbursed for services rendered to their clients whilst non-insurance clients purchase service from out of pocket.  Development Partners’ funds include sector budget support and earmarked funds which are fully planned for under the MTEF, and support all expenditure areas except personnel emolument.  Earmarked funds on the other hand may support annual budget but are ring-fenced for specific activities or may not be aligned to the annual budget. Non- aligned earmarked funds are mostly disbursed outside the planned annual budget.  MOH will continue to explore the many opportunities within the international community to mobilize resources to support health system strengthening. There will be strong advocacy with evidence of the successes of the National Immunization Plan to the Government of Ghana through the Ministry of Finance to increase funding to the health sector. The sector will also work with the Local Government structures through the District Health Administrations for support from the Metropolitan, Municipal and District Assemblies (MMDAs). Specific efforts will be made to support MMDA in advocacy. Government is commited to continue providing immunisation service.  A number of business entities through their corporate social responsibility programmes are investing in various aspects of health. The MoH will exploit the emerging opportunities within the expanding private business sector in Ghana for resource mobilisation through initiatives including public private partnership for immunisation services to ensure sustainable health service delivery. |

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| PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION |
| 18. Implementation Arrangements |
| HSS grant implementation is under the auspices of the Policy Planning Monitoring & Evaluation Division (PPMED) of the Ministry of Health which oversees the Common Management Arrangement. This arrangement regulates relationships and partnerships between MOH and its agencies, key stakeholders like Development Partners and NGOs. The PPME Ghana Health Service (GHS) will coordinate implementation of the HSS grant at the operational level using the existing sector management and implementation systems (See figure 2 below).  The health sector has a robust coordination mechanism (Health Sector Working Group) which includes representatives of MOH and its agencies, DP, NGOs and private sector providers. The HSCC meet monthly and has quarterly Business Meetings and Annual Summits. The existing mechanisms under the HSCC and other arrangements as stated in the CMA will be used in monitoring the implementation of this grant. GHS, the main executing agency submits quarterly, bi-annual and annual reports to the HSCC as part of the agreed monitoring and reporting mechanisms within the sector. The HSCC endorsed annual report will be shared with the GAVI Secretariat. The ICC meets quarterly to discuss issues related to child health, especially immunisation. The output from the ICC is fed into the monthly Sector Working Group meetings. Currently the Global Fund Country Coordinating Mechanism works closely with the ICC on three diseases-HIV/AIDS, TB and Malaria.  Provision of oversight and stewardship for the GAVI/HSS will be provided by MoH with policy guidance from the Chief Director. The PPMED will organise various progress meetings at the national level. HSCC and ICC will provide platform for discussing progress and implementation outcomes and endorse annual progress report to GAVI  **Ministry of Health**  (National Level)  HSCC, ICC,  PPMED, Finance and Audit  GHS will coordinate implementation of the GAVI/HSS and be responsible for providing technical and operational guidance to regions and districts. PPMED-GHS will monitor overall indicators and report to the MoHthrough the Director General on issues concerning implementation.  GCNH as an umbrella organisation will coordinator, monitor and report on progress of CSOs implementation at the various levels to GHS and MOH  **Ghana Health Service**  (Operational level)  PPMED, EPI, SSDM, HRDD, Finance  **CSOs**  Ghana Coalition of NGOs in Health  (National Level)  EPI is integrated into the public health system under the Deputy Director Public Health (DDPH) and managed within the RHMT.The RHD will receive and transfer resources and funds to districts, assess district performance and monitor district activities under the GAVI/HSS  Regional Health Directorates  District Health Directorates/Sub Districts  Districts/Communities  (Satellite Communities) At the District level, the Disease Control Technical Officers and District Public Health Nurses are primary responsible for EPI activities in the districts. The DHMT plan, implement and monitor immunization activities. They also collect activity reports from the sub-districts and summarize them for transmission to the regional level through DHIMS. **Key**  Implementation coordination  Reporting  Administrative function  Figure 2: implementation arrangements  An Inter-Agency Coordinating Committee exists to monitor, provide advice, mobilize funds and provide some advocacy for joint activities in the area of Immunization. The ICC membership include MoH/GHS, WHO, UNICEF, USAID, Red Cross, Rotary International, Noguchi Memorial Institute for Medical Research, Coalition of NGOs for Health, Rotary, Paediatric Society and other partners and government offices. Technical working groups are set up to prepare the topics for each meeting and oversee the implementation of prioritised interventions. These structures ensure effective coordination, monitoring and evaluation of programmatic and donor funding supports. Most of the entities within the health sector (PPMEDs of MOH and GHS, Finance Divisions of MOH and GHS, Family Health Division and Public Health Divisions of GHS, and CHAG) are part of the technical working groups which participate in the development of grant proposals for most health initiatives like GAVI/HSS and GFATM for malaria, and other programmes, and MDG Acceleration Framework (MAF) for maternal health. Concerted efforts have been made to ensure that activities under these grants are synchronised as much as possible to minimise duplication of efforts. Development Partners, Coalition of NGOs in Health and Private Health Service Association of Ghana are also represented on the grant writing technical working groups. As part of agreed sector process, grant executing agencies report on progress during annual health summits. Prior to the holding of Business Meetings, joint MOH-DPs monitoring visits are organised as part of the review process to peripheral areas in regions and districts to monitor progress in agreed implementation areas. The findings of these monitoring visits are factored into discussions with appropriate actions and recommendations made. The composition of the membership for the monitoring visits covers NGOs and members of parliamentary select committee on health.  As employed in the previous GAVI support, the GHS PPMED will continue to provide secretariat support for the implementation and will have a focal person to be responsible for overall GAVI/HSS activities at the agency level. The PPMED will also perform the monitoring and evaluation role during implementation. The proposed activities will form part of overall medium term and annual work plan of the agency and shall be subjected to the agency’s rules and guidance on updates and reporting of activities. At the regional level, the Regional Director of Health Service (RDHS) shall be responsible for the implementation and monitoring of activities. The GAVI/HSS activities at the regional level will be part of the MTEF plan at that level. Progress of implementation will be discussed during periodic Regional Health Management Team Meetings (quarterly, half year and annual).The District Health Management Teams will coordinate the preparation and implementation of activities at that level. This will include the provision of technical guidance and leadership for implementation and monitoring at the CHPS level through the sub-district. The community-based interventions will be supervised by the sub-district health teams.  The GCNH will coordinate and monitor activities of NGOs that will be involved in the implementation of community level interventions in targeted deprived and hard to reach areas. GCNH will engage collaboratively with the district health management teams and report progress of implementation in periodic meeting that will be organised at that level. The GCNH will therefore report progress to the GHS through to the MoH. Their report will be an integral part of the annual progress report that will be submitted to GAVI secretariat. |

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| 19. Involvement of CSOs |
| The Ghana Coalition of NGOs in Health (GCNH) is an umbrella and coordinating body of activities of all registered member NGOs/CBOs in the health sector in Ghana. GCNH is guided by core values including transparency, empowerment, accountability, non discrimination, non-partisan social justice, respect for human rights and gender equity. GCNH was set up in the year 2000 with a membership of over 500 registered NGO/CSOs/CBOs throughout the regions and districts in Ghana. Our members are into the various health thematic areas in service delivery and right based advocacy to ensure quality, equity and universal health care for all especially the poor in Ghana.  Over the past 4 years GCNH through its members at the grass root level have supported marginalised communities including men and women in understanding the importance and accepting immunisation services. Member organisations who have acquired both technical and indigenous knowledge and experience as a result of community engagement in the delivery of immunisation services through the implementation of the GAVI CSO Type B funding will play a key role. As lead implementers they will work with other NGOS and CBOs in the delivery of immunisation services. Such organisations will include but not limited to Hope for Future Generations, Seek to Save and Future Generation International just to mention a few. The Coalition and it members are represented on the HSCC and has been very active in Inter-Coordinating Committee (ICC) which is responsible for immunization in Ghana and has used this platform to advocate for the involvement of its members in the regions and districts in immunization activities especially in community mobilization and education.  GCNH and its members are committed to the principles of equality and diversity and aims to promote more equitable development processes in its project. It has adopted the Gender Equality and Social Inclusion (GESI) strategy to integrate gender and inclusion perspectives at both the organisational and project implementation level. It acknowledges the diversity among women, and other marginalised groups, and that specific focus and intervention is sometimes necessary to target their interests and needs. The commitment is evident in GCNH areas of focus which is service delivery at the district/community level and advocating strongly for the voiceless and holding government accountable on its promise to deliver quality health for all since there has been a growing realization that not all women and men benefit equally from health care in the country.  GCNH has been involved in the implementation of GAVI cash grant for the CSO type I and II. The CSOs participated actively in the preparation of this grant proposal and as implementers are allocated over 11% of the total budget. There are distinct activities in the GAVI/HSS proposal for CSOs. Funds will be transferred to the CSO just like other implementers for the implementation of their activities. The GHS as the implementing agency for the MoHcollaborates with the CSOs where necessary in the delivery of their activities especially in the districts and the sub districts. It is expected that during various sector engagements like HSCC and ICC meetings and health summits, CSOs will be making submissions on progress on the implementation of their activities. |

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| 20. Technical Assistance |
| Technical assistance will be needed for the implementation of the HSS activities. The main areas of technical assistance include surveys, evaluations and data quality audit. These areas are detailed in the workplan and categorised by inputs and input units as consultancies. External assistance will be needed for the service availability readiness assessment and the EPI cluster surveys. Internal technical assistance will include mid and end evaluation of the support and the documentation of best practices, development of policy briefs and strengthening of CSOs capacity. |

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| 21. Risks and Mitigation Measures | | | | | | |
| *This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by GAVI. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented.*  *→ If the country has existing health sector risk analysis please attach these assessments and provide here a brief reference to the relevant sections.*  *→ If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Guidelines for Completing the HSS Application for a description of the various types of risk. If the risk is categorised as ‘high’, please provide an explanation as to why it is ‘high’.* | | | | | | |
| ***Preamble:*** | | | | | | |
| **Description of risk** | ***PROBABILITY***  ***(high, medium, low)*** | | ***IMPACT***  ***(high, medium, low)*** | | ***Mitigation Measures*** | |
| ***Objective 1: To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services*** | | | | | | |
| *Fiduciary Risks:* | *Low* | | *Low* | | *The financial management system in place is able to track funding. In addition this proposal includes support for the institutionalisation of health accounts which will enable the reporting of all funds by sources and beneficiaries. The MoH will use the same system as in previous grants assuring timely availability of funds at sub national level. The procurement of goods and services as well as the management of financial resources will be in accordance to the Government of Ghana Procurement rules and Accounting Treasury and Regulatory laws. There will also be independent financial auditing of implementation.* | |
| *Institutional Risks:*  *Proposed Decentralisation of the health sector* | *Low* | | *Low* | | *According to government’s decentralisation plan, DHMT will be a department under the district assembly. It is not expected to take place within the medium since it requires change of a number of laws e.g. (Act 525) The institutional risk is low since GAVI fund are managed centrally though disbursed to districts.* | |
| *Operational Risks:*  *Midwives and CHOs are core cadres for the attainment of objective 1.* | *Low* | | *Low* | | *The expansion of functional CHPS zone and the increase in the number s of midwives and CHOs is expected to increase services at the community level..* | |
| ***Overall Risk Rating for Objective 1*** | *Low* | | *Low* | |  | |
| ***Objective 2. To strengthen health worker capacity and distribution to address equity issues in districts levels. (Workforce and Human Resources)*** | | | | | | |
| *Fiduciary Risks:* | | *N/A* | | *N/A* | |  |
| *The extent to which MOH can implement its policies and strategies on HRH* | | *Middle* | | *Low* | | *There is an ongoing institutional reform in the MOH focussing on performance. The Ministry is currently implementing a policy that ensures regionally localised production and retention of staff. Steps are also in place to finalise the staffing norms which when implemented will address distributional challenges.* |
| *Operational Risks:* | | *Low* | | *Low* | |  |
| ***Overall Risk Rating for Objective 2*** | | ***Low*** | | ***Medium*** | |  |
| ***Objective 3. To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices*** | | | | | | |
| *Fiduciary Risks: challenges in the management of logistics at central medical stores* | | *Low* | | *Low* | | *MOH has set up an interim management committee to review and make recommendations for implementation* |
| *Institutional Risks: challenges in the management of logistics at central medical stores* | | *Low* | | *Low* | | *MOH has set up an interim management committee to review and make recommendations for implementation* |
| *Operational Risks:* | | *Low* | | *Low* | |  |
| ***Overall Risk Rating for Objective 3*** | | ***Low*** | | ***Low*** | |  |
| ***Objective 4: To empower civil society for increased demand for health services at the community*** | | | | | | |
| *Fiduciary Risks:* | |  | |  | |  |
| *Institutional Risks:*  *Challenged capacity of CSO in their expanding roles in this proposal* | | *Medium* | | *Low* | | *Capacities of CSOs being strengthened in project/ programme management and provision of vehicles.* |
| *Operational Risks:* | | *Low* | | *Low* | |  |
| ***Overall Risk Rating for Objective 4*** | | ***Medium*** | | ***Low*** | |  |
| ***Objective 5: To strengthen governance and health information management for improved health service delivery*** | | | | | | |
| *Fiduciary Risks:* | | *Low* | | *Low* | | *-* |
| *Institutional Risks: Proposed Government decentralisation programme* | | *Low* | | *Low* | | *MOHHQ will still be in charge of the health sector within government’s decentralised programme.* |
| *Operational Risks:* | | *Low* | | *Low* | |  |

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| 22. Financial Management and Procurement Arrangements | | |
| *Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.* | | The existing accounting system will be used in managing GAVI funds. With this new proposal funds will be channelled to the MoH from GAVI. This is a change from the previous arrangements where funds are sent directly to GHS. MoH will then disburse to GHS and CSOs. This arrangement has been necessary since the MoH plays a key oversight role in this proposal. |
| **Question (b):Financial Management Arrangements Data Sheet** | | |
| **Any recipient organization/country proposed to receive direct funding from GAVI must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).** | | |
| 1. Name and contact information of Focal Point at the Finance Department of the recipient organization | Mrs. Ramatu Ude Umanta  Director of Finance  Ghana Health Service | |
| 1. Does the recipient organization have experience with GAVI, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)? | YES | |
| 1. **If YES**  * Please state the name of the grant, years and grant amount. * **For completed or closed Grants of GAVI and other Development Partners:** Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. * **For on-going Grants of GAVI and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion). | The MoH under the Swap has experience in managing all the funds coming to the health sector. Currently all budget support funding are channelled through the MoH before disbursing to implementing agencies.  Overall, the legal and institutional framework for a performing PFM system for the Health Sector has been put in place. There has been some improvement in the PFM accountability of the MoH with the completion of the revised ATF and DPs’ interest in the internal audit function, external audits and reporting have resulted to these elements performing very well. However, planning and budget execution is weak especially at sub-national levels partly as a result of lack of automation and partly because of the erratic nature of cash releases to BMCs.  3.3There was no mis-procurement or misuses of funds. Two accounts are used to manage the GAVI HSS funds- a cedi and a dollar account at UNIBANK Ghana LTD. The dollar account is a receiving account in which the funds are lodged. The Cedi account is the operational account. Funds are transferred from the dollar account to the cedi account for transactions. | |
| **Oversight, Planning and Budgeting** | | |
| 1. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process. | The MoH will be responsible for the overall oversight of the programme. The MoH coordinates the HSCC and will discuss the GAVI HSS progress during the quarterly HSCC meetings. | |
| 1. Who will be responsible for the annual planning and budgeting in relation to GAVI HSS? | The Director Policy Planning Monitoring and Evaluation of the MoH | |
| 1. What is the planning & budgeting process and who has the responsibility to approve GAVI HSS annual work plan and budget? | Beyond the proposal approval, annual plans and budget for the GAVI HSS will be incorporated in the annual MTEF process. All GAVI HSS annual work programme will be approved by the Chief Director of MoH. | |
| 1. Will the GAVI HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval? | YES | |
| **Budget Execution (incl. treasury management and funds flow)** | | |
| 1. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request. | Funds will be transferred to the earmarked dollar account of the MoH. The Chief Director and the Financial Controller sign the account and the financial controller will be responsible for the replenishment of request | |
| 1. Will GAVI HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity? | The GAVI HSS will be transferred to an existing commercial bank account in the name of the Ghana Health Service (implementing Entity) | |
| 1. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors- “pooled account”)? | This account is an earmarked pool account used for only projects and programmes funded from external sources. This is different from the account for budget support. | |
| 1. Within the HSS programme, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled. | YES  Funds will be transferred to decentralised levels and will be managed by the same existing financial management and accounting arrangements. | |
| **Procurement** | | |
| 1. What procurement system will be used for the GAVI HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners’ procurement procedures) | The Public Procurement Act (Act 663) will guide all procurement funded by the GAVI HSS. | |
| 1. Are all or certain items planned to be procured through the systems of GAVI’s in-country partners (UNICEF, WHO)? | All procurement in this proposal will be procured using the MoH procurement unit | |
| 1. What is the staffing arrangement of the organization in procurement? | The MoH procurement unit is well staffed and have the capacity for undertaking high level procurement activities. | |
| 1. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered? | YES | |
| 1. Is there a functioning complaint mechanism? Please provide a brief description. | YES  The PPA (Act 663) allows for dissatisfied contractors to lodge their complaint with the national Procurement Agency. | |
| 1. Are efficient contractual dispute resolution procedures in place? Please provide a brief description. | YES  (If YES, please describe) | |
| **Accounting and financial reporting (incl. fixed asset management)** | | |
| 1. What is the staffing arrangement of the organization in accounting, and reporting? | The office of the financial controller at the MoH and the GHS has qualified personnel handling financial issues of the MoH and GHS | |
| 1. What accounting system is used or will be used for the GAVI HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?) | The Government is deploying the Government Integrated Financial Management Information System (GIFMIS) in MDAs and this will be in place by the middle of the proposal period. However GHS is using the AccPac software at national and regional level. | |
| 1. How often does the implementing entity produce interim financial reports and to whom are those submitted? | Interim financial reports are produced quarterly and submitted to the Financial Controller of MOH | |
| **Internal control and internal audit** | | |
| 1. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures? | YES | |
| 1. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to GAVI HSS. | YES- For all payments the internal audit pre audits before payments are made. The unit also carries out post audit of financial document and activities. The unit also makes recommendation in respect of the findings to management for the necessary corrective actions to be taken. | |
| 1. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations? | YES | |
| **External audit** | | |
| 1. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[[4]](#footnote-5) | YES | |
| 1. Who is responsible for the implementation of audit recommendations? | The Audit Review Implementation Committee | |
| ***THREE PAGES MAXIMUM*** | | |
| *Question (c): Please indicate the main constraints in the (health sector’s) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions* | | |
| ***HALF PAGE MAXIMUM*** | | |

Annex 1: Roles and responsibilities of key partners (HSCC members and others**)**

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| **Title / Post** | **Organisation** | **HSCC member yes/no** | **Roles and responsibilities of this partner in the GAVI HSS application development** |
| Minister of Health | Ministry of Health | No | Read and discussed the document and endorsed the proposal |
| Minister of Finance | Ministry of Finance | No | Read, discussed and endorsed the document |
| Chief Director | Ministry of Health | Yes | Chairperson of the GAVI HSS Proposal Development TWG |
| Director PPMED | Ministry of Health | Yes | Chairman of the Health Partner Coordinating Group. Critically reviewed the proposal |
| Principal Planner, PPME | Ministry of Health | Yes | Coordinates the development of HSS proposal |
| GHS Directors or their representatives in charge of Public health, Clinical Care, Family health, Finance | Ghana Health Service | No | Core team member in the preparatory to completion stage |
| Deputy Director for Budget | Ministry of Health | Yes | Core team member in the preparatory to completion stage |
| Director PPMED, | Ghana Health Service | Yes | Led the GHS Team to develop the HSS Proposal |
| Deputy Director PPMED (IME) | Ghana Health Service | Yes | Core team member in the preparatory to completion stage |
| Deputy Director PPMED Planning | Ghana Health Service | Yes | Core team member in the preparatory to completion stage |
| Deputy Director PPMED (Policy) | Ghana Health Service | yes | Core team member in the preparatory to completion stage |
| Programme Director – EPI | Ghana Health Service | yes | Core team member in the preparatory to completion stage |
| Director – RHD | Ghana Health Service | yes | Participated in the preparatory to prioritization stage |
| NPO Health Economist | WHO | Yes | Core team member in the preparatory to completion stage. |
| NPO – EPI | WHO | Yes | Provided technical support from EPI programme |
| Focal Person on Health | UNICEF | Yes | Made significant contribution especially reviewing the draft documents |
| Vice National Chairperson | Coalition of NGOs in Health | YES | Core team member in the preparatory to completion stage |
| National Chairperson | Coalition of NGOs in Health | Yes | Core team member in the preparatory to completion stage |
| Executive Members | Coalition of NGOs in Health | Yes | Core team member in the preparatory to completion stage |
| Executive Secretary | CHAG | Yes | Team Member in developing and review of proposal |

# References for Prioritised Bottlenecks

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| **Objective 1.**     To strengthen and scale-up community health interventions aimed at improving the quality of primary health care services (Service Delivery) | | |
| **PRIORITY BOTTLENECKS** | **REFERENCE DOCUMENTS/ANALYTICAL WORKS** | **KEY ACTIVITY/PRIORITISED INTERVENTION** |
| Inadequate cold chain capacity at district level and below: | Effective Vaccine Management (EVM) Assessment Report September 2010 (pages, 18, 19) | 1.1 Procure needed logistics and improve transport capacity to support service delivery |
|  | Ghana Immunization Services Review– 2012, “From Better to Best” PART I: National Report |
|  | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 17, 28) |
| Inadequate access of immunization service in riverine and island communities: | Ghana Immunization Services Review– 2012, “From Better to Best” PART I: National Report (Page 37) | 1.2 Strengthen capacity and provide resources needed to undertake outreach services at the district and sub district levels |
|  | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 16, 23) | 1.3 Support National, Regional, Districts and Sub District team Supervision and monitoring |
|  | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 17, 31-36) |
| Inadequate infrastructure: | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page 19) | 1.4 Construct and renovate cold chain infrastructure and equipment: |
|  | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 29-31-36) |
| Poor waste management practices | Ghana Immunization Services Review– 2012, “From Better to Best” PART I: National Report (Page 59) | 1.5 Train CHMCs and CHVs for CHPS implementation including routine immunization services, Middle Level Managers (MLM) for EPI staff, EPI equipment Technicians, Waste Management focal persons, Cold Chain and logistics Management and quality assurance |
| Inadequate resource to support the undertaking of planned outreach service at facility level | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page 59) |  |
| Inadequate Supportive Supervision | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page 27) |  |
| Low capacity and resources for supportive supervision at the regional, district and lower levels | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page27, 62) |  |
| Inadequate demand creation: | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page 54) |  |
| Inadequate availability of service delivery data collection tools | Effective Vaccine Management (EVM) Assessment Report September 2010 (pages, 14) |  |
|  | Post-Introduction Evaluation of the Measles second dose (MSD), the Pneumococcal Conjugate Vaccine (PCV0 and the Rotavirus Vaccine (ROTA) in Ghana (Page 9) |  |
|  | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 17, 23) |  |

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| **Objective 2. To strengthen health worker capacity and distribution so as address equity issues in districts levels. (Workforce and Human Resources)** | | |
| **PRIORITY BOTTLENECKS** | **REFERENCE DOCUMENTS/ANALYTICAL WORKS** | **KEY ACTIVITY/PRIORITISED INTERVENTION** |
| Weaknesses in Deployment of CHOs and their embedding/embeddings in communities | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 13 - 14) | 2.1 Develop and implement performance based financing to improve health service delivery in remote and deprived areas: |
| Need for clear policies to ensure equitable distribution and retention of key human resources (especially at hard to reach areas) | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 27-28, 30) | 2.3 Institutionalise an efficient HR information system in the sector: |
|  | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 13 - 14) |  |
|  | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 17) |  |
| Weak performance management | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 29) | 2.4 Scale-up managerial and leadership capacity building at district and sub district levels |
| Need to scale-up leadership and management capacity building at the district and sub-districts levels and the | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 28) |  |
|  | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 31) |  |
| Establishment of clearly defined system for measuring health worker force productivity | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 59) |  |

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| **Objective 3. To improve storage, distribution and management of logistics and ensure the availability of potent, quality and safe vaccines, medicines and devices(Procurement, Logistics and Health Technologies)** | | |
| **PRIORITY BOTTLENECKS** | **REFERENCE DOCUMENTS/ANALYTICAL WORKS** | **KEY ACTIVITY/PRIORITISED INTERVENTION** |
| Inadequate *capacity* and support to monitor procurements at district and sub-district levels | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 42-43) | 3.1 Reorganise the national and district stores to improve logistics management: |
|  | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 24, 29) |  |
| Weak interconnectivity of logistics management information system at central, regional medical stores and district hospitals |  | 3.2 Build capacity, support and monitor procurements at district and sub district levels: |
| Weakness in integration of district vaccine data management tool (DVD-MT) into LMIS |  | 3.3 Improve the use of the central logistics management information system at regional medical stores and expand to regional and district hospitals to respond to demand: |
| Weak infrastructure of regional and district medical stores coupled with low availability of transport and other logistics for timely distribution | Draft Report: Review of Ghanaian Health Sector Medium Term Development Plan (HSMTDP 2010-2013) (Page 42) | 3.4 Integrate district vaccine data management tool (DVD-MT) into LMIS and DHIMS |
|  |  | 3.5 Rehabilitation of Regional Medical Stores in Volta and Northern Region |

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| **Objective 4: To empower Civil Society for increased demand for health services at the community level in targeted districts** | | |
| **PRIORITY BOTTLENECKS** | **REFERENCE DOCUMENTS/ANALYTICAL WORKS** | **KEY ACTIVITY/PRIORITISED INTERVENTION** |
| Inadequate funding to undertake impact-oriented community level interventions by CSOs and | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 17) | 4.1  Strengthen the national level (GCNH) to coordinate CSOs activities in health |
| Poor incentive support for working in hard to reach areas | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 31-36) | 4.2  Develop capacity of CSOs to better support community level services, including mainstreaming gender |
| **Low coverage of key essential health interventions (including immunization) in some population:** | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 31-36) | 4.3 Establish and build the capacities of five satellite sites for CSOs to support community service delivery |
|  |  | 4.4  Recruit/train community Health nurses and Midwives to partner CSOs to operate in the establish satellite sites in hard to reach communities |
|  |  | 4.5 Undertake monthly community outreach activities in partnership with train community Health nurses and Midwives retired community health personnel in hard-to- reach communities in the selected 20 districts |

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| **5. To strengthen governance and health information management for improved health service delivery** | | |
| **PRIORITY BOTTLENECKS** | **REFERENCE DOCUMENTS/ANALYTICAL WORKS** | **KEY ACTIVITY/PRIORITISED INTERVENTION** |
| Poor documentation and data management for effective planning and decision making at the operational level: | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 19, 33) | 5.1 Upgrade DHIMSII, build the capacity of health information officers and CHOs and undertake quarterly technical and financial data validation at district and sub-district levels |
| Inadequate operational research to inform policy and decision making: | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 17, 19) | 5.2 Review and revise existing records management information system (manual and electronic) and expand the use of the hospital electronic information software |
|  |  | 5.3 Improve capacity of subdistrict and CHPS Zones staff in micro-planning and develop micro-plans at these levels |
| Weak capacity for micro planning and management at the sub district and CHPS Zone Level: |  | 5.4 Support joint annual performance reviews, budgetary planning and implementation and financial reporting system |
| Inadequate funds at the operational level for training, outreach services, social mobilization activities, supervision, maintenance of equipment | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page, 31) | 5.5 Build capacity of national level staff in integrated planning, management including monitoring and evaluation |
| Weak micro planning at the operational level: | Ghana Immunization Services REVIEW– 2012, “From Better to Best” PART I: National Report (Page 26, 27), | 5.6 Strengthen existing efforts at institutionalisation of health accounts and build capacity of regional and district staff (through training) to assist in the production of health accounts on an annual basis |
|  | Immunization Programme Comprehensive Multi-Year Plan (2010-2014), Ministry Of Health/Ghana Health Service, 2011 (Page 17) |  |
| Weak management practices at sub district and CHPS level: | Health Sector Medium Term Strategy (Draft) 2014 - 2017(Page 20,24, 30) |  |

# Annex 2: Trend of sector wide indicators)

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|  | |  |  | | |  | | |  |  | | | | | | **2012 POW** | | | | | |
|  | | **2007** | | | **2008** | | | **2009** | | | | **2010** | | **2011** | | **Target** | **Performance (4%)** | | | **Performance (3%)** | **Source** |
| **Health Objective 1: Bridge equity gaps in health care and nutrition services and ensure sustainable financing arrangements that protect the poor** | | | | | | | | | | | | | | | | | | | | | |
| 1 | % children 0-6 months exclusive breastfed | - | | 62.8% | | | - | | | | - | | - | | 70% | | | 45.7% | 45.7% | | MICS |
| 2 | Equity: Poverty (U5MR) | - | | 1.72 | | | - | | | | - | | - | | 1:1.5 | | | 2.04 | 2.04 | | MICS |
| 3 | Equity: Geography - Services (supervised deliveries) | 2.47 | | 2.17 | | | 1.49 | | | | 1.89\* | | 1.66\* | | 1:1.70 | | | 1.48 | 1.48 | | GHS |
| 4 | Equity: Geography - Resources (nurse: population) | 2.26 | | 2.03 | | | 1.81 | | | | 1.99\* | | 1.73\* | | 1:1.95 | | | 1.75 | 1.75 | | MOH |
| 5 | Equity: NHIS – Gender | - | | 1.22 | | | - | | | | - | | 1.38 | | - | | | 1.23 | 1.23 | | MICS |
| 6 | Equity: NHIS – Poverty | - | | 0.82 (F) | | | - | | | | - | | - | | - | | | 0.69 (F) | 0.69 (F) | | MICS |
| 7 | Outpatients attendance per capita (OPD) | 0.69 | | 0.77 | | | 0.81 | | | | 0.91\* | | 1.04\* | | 0.88 | | | 1.17 | 1.17 | | GHS /TH |
| 8 | % population living within 8 km of health infrastructure | - | | - | | | - | | | | - | | - | | N/A | | |  |  | | - |
| 9 | Doctor: population ratio | 1:13,683 | | 1:13,499 | | | 1:11,698 | | | | 1:11,833\* | | 1:10,217\* | | 1:9,700 | | | 1:10,452 | 1:10,452 | | MOH |
| 10 | Nurse: population ratio | 1:1,537 | | 1:1,353 | | | 1:1,494\* | | | | 1:1,516\* | | 1:1,262\* | | 1:900 | | | 1:1,251 | 1:1,251 | | MOH |
| **Health Objective 2: Strengthen governance and improve efficiency and effectiveness in the health system** | | | | | | | | | | | | | | | | | | | | | |
| 1 | % total MTEF allocation on health | 14.6% | | 14.9% | | | 14.6% | | | | 15.1% | | 15.8% | | ≥15.0% | | | 15.4% | 15.4% | | MOH |
| 2 | % non-wage GOG recurrent budget to district level and below | 49.0% | | 49.0% | | | 62.0% | | | | 46.8% | | 55.3% | | 50.0% | | | 38.5% | 38.5% | | MOH |
| 3 | Per capita expenditure on health | 23.0 | | 23.2 | | | 25.6 | | | | 28.6 | | 35.0 | | 30.0 | | | 50.7 | 50.7 | | MOH |
| 4 | Budget execution rate (Item 3 as proxy) | 110.0% | | 115.0% | | | 80.4% | | | | 94.0% | | 82.1% | | ≥95.0% | | | 86.8% | 86.8% | | MOH |
| 5 | % of annual budget allocations disbursed to BMC by end of year | - | | 23.0% | | | 39.0% | | | | 31.0% | | 89.8% | | 50.0% | | | - | - | | - |
| 6 | % of population with valid NHIS membership card | - | | - | | | - | | | | 33.7% | | 33.4% | | 70.3.0% | | | 34.0% | 34.0% | | NHIA |
| 7 | Proportion of claims settled within 12 weeks | - | | - | | | - | | | | - | | - | | 70.0% | | | - | - | | - |
| 8 | % IGF from NHIS | N/A | | 66.5% | | | 83.5% | | | | 79.4% | | 85.0% | | 75.0% | | | - | - | | - |
| **Health Objective 3: Improve access to quality maternal, neonatal, child and adolescent health services** | | | | | | | | | | | | | | | | | | | | | |
| 1 | Maternal Mortality Ratio (MMR) per 100,000 live births | - | | 451 | | | - | | | | - | | - | | - | | |  |  | | - |
| 2 | Total Fertility Rate | - | | 4.0 | | | - | | | | - | | - | | 3.8 | | | 4.3 | 4.3 | | MICS |
| 3 | Contraceptive Prevalence Rate |  | | 16.6% | | |  | | | |  | |  | | - | | | 23.4% | 23.4% | | MICS |
| 4 | % of pregnant women attending at least 4 antenatal visits | 62.8% | | 63.8% | | | 81.6% | | | | 71.1% | | 71.3% | | 80.1% | | | 72.3% | 96.4% | | GHS |
| 5 | Infant Mortality Rate (IMR) per 1,000 live births | - | | 50 | | | - | | | | - | | - | | <30 | | | 53 | 53 | | MICS |
| 6 | Under 5 Mortality Rate (U5MR) per 1,000 live births | - | | 80 | | | - | | | | - | | - | | <50 | | | 82 | 82 | | MICS |
| 7 | % deliveries attended by a trained health worker | 35.1% | | 42.2% | | | 45.6% | | | | 48.2% | | 55.8% | | 60.0% | | | 58.5% | 77.9% | | GHS/TH |
| 8 | Under 5 prevalence of low weight for age | - | | 13.9% | | | - | | | | - | | - | | 8.0% | | | 13.4% | 13.4% | | MICS |
| **Health Objective 4: Intensify and control of communicable and non-communicable diseases and promote a healthy lifestyle** | | | | | | | | | | | | | | | | | | | | | |
| 1 | HIV prevalence among pregnant women 15-24 years | 2.6 | | 1.9 | | | 2.1 | | | | 1.5 | | 1.7 | | <1.7% | | | - | - | | GHS |
| 2 | % of U5s sleeping under ITN | 55.3% | | 40.5% | | | - | | | | - | | - | | 70.0% | | | 41.5% | 41.5% | | MICS |
| 3 | % of children fully immunized by age one - Penta 3 | 87.8% | | 86.6% | | | 89.3% | | | | 87.4% | | 88.1% | | 91.4% | | | 87.8% | 117.1% | | GHS |
| 4 | HIV+ clients ARV treatment | 13,429 | | 23,614 | | | 33,745 | | | | 40,575 | | 59,007 | | 80,014 | | | 73.339 | 73.339 | | NACP |
| 5 | Incidence of Guinea Worm | 3,358 | | 501 | | | 242 | | | | 8 | | 0 | | <50 | | | 0 | 0 | | GHS |
| 6 | % households with improved sanitary facilities | - | | 12.4% | | | - | | | | - | | - | | 21.3% | | | 15.0% | 15.0% | | MICS |
| 7 | % households with access to improved source of drinking water | - | | 83.8% | | | - | | | | - | | - | | 80% | | | 79.3% | 79.3% | | MICS |
| 8 | Obesity in population (women aged 15-49 years) | - | | 9.3% | | | - | | | | - | | - | | - | | | - | - | | - |
| 9 | TB treatment success rate | 74.5% | | 84.6% | | | 85.4% | | | | 87.0% | | 85.3% | | 89.0% | | | 86.2% | 86.2% | | NTP |
| **Health Objective 5: Strengthen institutional care, including health service delivery** | | | | | | | | | | | | | | | | | | | | | |
| 1 | Psychiatric patient treatment and rehabilitation rate | - | | - | | | - | | | | - | | - | | 25% >bl. | | | 84.8% | 84.8% | | Chief Psy. |
| 2 | Equity index: Ratio of mental health nurses to patient population | - | | - | | | - | | | | - | | - | | 25% >bl. | | | 1:63 | 1:63 | | Chief Psy. |
| 3 | Number of community psychiatric nurses trained and deployed | - | | - | | | - | | | | - | | - | | 25% >bl. | | | 400 | 400 | | Chief Psy. |
| 4 | % tracer psychotropic drug availability in hospitals | - | | - | | | - | | | | - | | - | | 75.0% | | | 85.0% | 85.0% | | Chief Ph. |
| 5 | Institutional infant mortality rate | - | | 7.0 | | | 7.4 | | | | 6.8 | | 6.4 | | - | | | 2.2 | 2.2 | | GHS |
| 6 | Basket equipment functioning in hospitals | - | | - | | | - | | | | - | | - | | 80.0% | | | - | - | | - |
| 7 | % tracer drugs availability in hospitals | - | | - | | | - | | | | - | | 94.1% | | 90.0% | | | 85.7% | 85.7% | | Chief Ph. |
| 8 | % of hospitals assessed for quality assurance and control | - | | - | | | - | | | | - | | - | | 90.0% | | | - | - | | - |
| 9 | Institutional under-five mortality rate | - | | 9.0 | | | 10.2 | | | | 9.7 | | 9.7 | | - | | | 4.0 | 4.0 | | GHS |
| 10 | Institutional MMR | - | | - | | | - | | | | 190 | | 211 | | - | | | 193 | 193 | | GHS /TH |

below presents sector wide indicator trends recalculated for the previous years on basis of the 2010 census projections for expected pregnancies (3%), expected children under one year (3%) and WIFE (25.8%).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | **POW 2012** | |
|  |  | **2008** | **2009** | **2010** | **2011** | **Performance** | **Source** |
| **Health Objective 1: Bridge equity gaps in health care and nutrition services and ensure sustainable financing arrangements that protect the poor** | | | | | | | |
| 1 | % children 0-6 months exclusive breastfed | 62.8% | - | - | - | 45.7% | MICS |
| 2 | Equity: Poverty (U5MR) | 1.72 | - | - | - | 2.04 | MICS |
| 3 | Equity: Geography - Services (supervised deliveries) | 2.17 | 1.49 | 1.89\* | 1.66\* | 1.48 | GHS |
| 4 | Equity: Geography - Resources (nurse: population) | 2.03 | 1.81 | 1.99\* | 1.73\* | 1.75 | MOH |
| 5 | Equity: NHIS – Gender | 1.27 | - | - | 1.38 | 1.23 | MICS |
| 6 | Equity: NHIS – Poverty | 0.82 (F) | - | - | - | 0.69 (F) | MICS |
| 7 | Outpatients attendance per capita (OPD) | 0.77 | 0.81 | 0.91\* | 1.04\* | 1.17 | GHS /TH |
| 8 | % population living within 8 km of health infrastructure | - | - | - | - | - | - |
| 9 | Doctor: population ratio | 1:13,499 | 1:11,698 | 1:11,833\* | 1:10,217\* | 1:10,452 | MOH |
| 10 | Nurse: population ratio | 1:1,353 | 1:1,494\* | 1:1,516\* | 1:1,262\* | 1:1,251 | MOH |
| **Health Objective 2: Strengthen governance and improve efficiency and effectiveness in the health system** | | | | | | | |
| 1 | % total MTEF allocation on health | 14.9% | 14.6% | 15.1% | 15.8% | 15.4% | MOH |
| 2 | % non-wage GOG recurrent budget to district level and below | 49.0% | 62.0% | 46.8% | 55.3% | 38.5% | MOH |
| 3 | Per capita expenditure on health | 23.2 | 25.6 | 28.6 | 35.0 | 50.7 | MOH |
| 4 | Budget execution rate (Item 3 as proxy) | 115.0% | 80.4% | 94.0% | 82.1% | 86.8% | MOH |
| 5 | % of annual budget allocations disbursed to BMC by end of year | 23.0% | 39.0% | 31.0% | 89.8% | - | - |
| 6 | % of population with valid NHIS membership card | - | - | 33.7% | 33.4% | 34.0% | NHIA |
| 7 | Proportion of claims settled within 12 weeks | - | - | - | - | - | - |
| 8 | % IGF from NHIS | 66.5% | 83.5% | 79.4% | 85.0% | - | - |
| **Health Objective 3: Improve access to quality maternal, neonatal, child and adolescent health services** | | | | | | | |
| 1 | Maternal Mortality Ratio (MMR) per 100,000 live births | 451 | - | - | - |  | - |
| 2 | Total Fertility Rate | 4.0 | - | - | - | 4.3 | MICS |
| 3 | Contraceptive Prevalence Rate | 16.6% | - | - | - | 23.4% | MICS |
| 4 | % of pregnant women attending at least 4 antenatal visits | 81.1% | 81.6% | 71.1% | 71.3% | 96.4% | GHS |
| 5 | Infant Mortality Rate (IMR) per 1,000 live births | 50 | - | - | - | 53 | MICS |
| 6 | Under 5 Mortality Rate (U5MR) per 1,000 live births | 80 | - | - | - | 82 | MICS |
| 7 | % deliveries attended by a trained health worker | 56.3% | 60.8% | 65.0% | 73.0% | 77.9% | GHS/TH |
| 8 | Under 5 prevalence of low weight for age | 13.9% | - | - | - | 13.4% | MICS |
| **Health Objective 4: Intensify and control of communicable and non-communicable diseases and promote a healthy lifestyle** | | | | | | | |
| 1 | HIV prevalence among pregnant women 15-24 years | 1.9 | 2.1 | 1.5 | 1.7 | - | GHS |
| 2 | % of U5s sleeping under ITN | 40.5% | - | - | - | 41.5% | MICS |
| 3 | % of children fully immunized by age one - Penta 3 | 115.5% | 119.1% | 114.5% | 115.3% | 117.1% | GHS |
| 4 | HIV+ clients ARV treatment | 23,614 | 33,745 | 40,575 | 59,007 | 73.339 | NACP |
| 5 | Incidence of Guinea Worm | 501 | 242 | 8 | 0 | 0 | GHS |
| 6 | % households with improved sanitary facilities | 12.4% | - | - | - | 15.0% | MICS |
| 7 | % households with access to improved source of drinking water | 83.8% | - | - | - | 79.3% | MICS |
| 8 | Obesity in population (women aged 15-49 years) | 9.3% | - | - | - | - | - |
| 9 | TB treatment success rate | 84.6% | 85.4% | 87.0% | 85.3% | 86.2% | NTP |
| **Health Objective 5: Strengthen institutional care, including health service delivery** | | | | | | | |
| 1 | Psychiatric patient treatment and rehabilitation rate | - | - | - | - | 84.8% | Chief Psy. |
| 2 | Equity index: Ratio of mental health nurses to patient population | - | - | - | - | 1:63 | Chief Psy. |
| 3 | Number of community psychiatric nurses trained and deployed | - | - | - | - | 400 | Chief Psy. |
| 4 | % tracer psychotropic drug availability in hospitals | - | - | - | - | 85.0% | Chief Ph. |
| 5 | Institutional infant mortality rate | 7.0 | 7.4 | 6.8 | 6.4 | 2.2 | GHS |
| 6 | Basket equipment functioning in hospitals | - | - | - | - | - | - |
| 7 | % tracer drugs availability in hospitals | - | - | - | 94.1% | 85.7% | Chief Ph. |
| 8 | % of hospitals assessed for quality assurance and control | - | - | - | - | - | - |
| 9 | Institutional under-five mortality rate | 9.0 | 10.2 | 9.7 | 9.7 | 4.0 | GHS |
| 10 | Institutional MMR | - | - | 190 | 211 | 193 | GHS /TH |

**Sector wide indicators 2007-2012 based on both 3% of children under 1-year/expected pregnancies, greyed out indicators are not measured on annual basis.**

# SUMMARY OF A COMPLETE APPLICATION

|  |  |  |
| --- | --- | --- |
| **HSS Proposal Forms and Mandatory GAVI attachments**  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | HSS Proposal Form | *X* |
|  | Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members | *x* |
|  | Minutes of HSCC meeting endorsing Proposal | *x* |
|  | Minutes of the last three meetings of the HSCC or equivalent | *X* |
|  | HSS Monitoring & Evaluation Framework | *X* |
|  | Detailed work plan and detailed budget | *X* |

|  |  |  |
| --- | --- | --- |
| **Existing National Documents - Mandatory Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions | *X* |
|  | National M&E Plan (for the health sector/strategy) | *X* |
|  | National Immunisation Plan |  |
|  | Country cMYP | *X* |
|  | Vaccine assessments (EVM, PIE, EPI reviews), if available | *X* |
|  | Terms of Reference of Health Sector Coordinating Committee (HSCC) | *X* |

|  |  |  |
| --- | --- | --- |
| **Existing National Documents - Additional Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | Joint Assessment of National Health Strategy (if available) | *N/A* |
|  | Response to Joint Assessment of National Health Strategy (if available) | *N/A* |
|  | If funds transfers are to go directly to a CSO or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor | *N/A* |
| … |  |  |

**Applicants are strongly encouraged to carefully read the instructions provided within the relevant sections of the guidelines before completing the application form.**

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* The Ghana Health Sector 2013 Programme of Work Theme: Countdown to 2015; Working Together to Achieve MDGS 4 & 5
* The Health Sector Medium Term Development Plan 2010 – 2013, Ministry Of Health Ghana
* Work Plan Monitoring and Evaluation of the Health Sector Ministry of Health, 2011

1. Health Sector Working Group is Ghana’s equivalence of HSCC. [↑](#footnote-ref-2)
2. Table showing disaggregated data by regions and districts presented in Annex…… [↑](#footnote-ref-3)
3. The proposed DHS for Ghana has been deferred from 2013 to 2014 [↑](#footnote-ref-4)
4. If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget. [↑](#footnote-ref-5)