

AFRICAN DEVELOPMENT BANK GROUP



GHANA

**EVALUATION OF BANK ASSISTANCE TO
HEALTH SECTOR**

**OPERATIONS EVALUATION DEPARTMENT
(OPEV)**

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TABLE OF CONTENTS

ABBREVIATIONS	i
EXECUTIVE SUMMARY	ii
1.1 Evaluation Objectives	1
1.2 Scope and Methodology	1
1.3 Socio-economic Context	2
1.4 The Country's Historical Relations with the Bank	3
2. REVIEW OF THE BANK'S ASSISTANCE STRATEGY	5
2.1 The Bank's Health Sector Policy	5
2.2 The Bank's Strategy for the Country	6
2.3 The Government's Policies and Strategies	7
2.4 Relevance of Bank Assistance Strategy	8
3. EVALUATION OF RESULTS: LENDING OPERATIONS	8
3.1 Lending Operations to the Health Sector	8
3.2 Relevance	9
3.3 Achievement of Objectives	10
3.4 Efficiency	11
3.5 Institutional Development Impact	12
3.6 Sustainability	12
4. EVALUATION OF RESULTS: NON-LENDING OPERATIONS	13
4.1 Economic and Sector Work/Policy Dialogue	13
4.2 Resource Mobilization/Co-financing	14
4.3 Aid Coordination, Harmonization and Results Orientation	15
5. CONTRIBUTORS' PERFORMANCE	16
5.1 Borrower and Executing Agencies	16

5.2	Bank	17
5.3	Other Donors and Co-financiers	17
5.4	Other Stakeholders (Civil Society, Private Sector)	18
6.	OVERALL ASSESSMENT	18
6.1	Cross-cutting Aspects	18
6.2	Counterfactual	19
6.3	Overall Assessment of Bank Assistance to the Sector	20
7.	LESSONS LEARNED AND RECOMMENDATIONS	21
7.1	Lessons Learned	21
7.2	Recommendations	22
	ANNEXES	24
	Annex 1. List of documents consulted	24
	Annex 2. Bank assistance to the social sector & bank social policies	27
	Annex 3. Aid commitments for health, 1990-2004 in million us\$	28
	Annex 4. Detailed ratings of the bank's health project portfolio	29

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ABBREVIATIONS

ADB	African Development Bank
ADF	African Development Fund
AIDS	Acquired Immune-Deficiency Syndrome
DANIDA	Danish International Development Assistance
DFID	Department for International Development (UK)
ERP	Economic Recovery Programme
EU	European Union
HIV	Human Immune-deficiency Virus
JICA	Japan International Cooperation Agency
NGO	Non-governmental Organisation
OECD	Organisation for Economic Co-operation and Development
POW	Programme of Work
SWAp	Sector Wide Approach
TAF	Technical Assistance Fund
TB	Tuberculosis
UA	Units of Account
UNDP	United Nations Development Programme
UNICEF	The United Nations Children's Fund
UNFPA	The United Nations Fund for Population Activities
USAID	United States International Aid Agency
WHO	World Health Organisation

EXECUTIVE SUMMARY

1. *Objective, Scope and Methodology of the Review:* The objective of the review is to evaluate the Bank's health policy, strategy and interventions for the period 1985 to 2004, in order to identify good practices and shortcomings to draw up useful lessons for the Bank's future health strategy. The evaluation is based on documentary sources and interviews with the Bank's staff, country officials and stakeholders during the country visit. Three lending and one non-lending interventions were examined.

2. *Country Economic Context & Sector Policies:* The macroeconomic environment in Ghana has fluctuated since Independence with periods of high inflation, public financial constraints and little private sector investment. Economic performance since the early 1980s has been reasonably strong and stable but currency fluctuations have affected some of the Bank interventions. Since 2001, there have been efforts to adopt prudential fiscal and monetary measures resulting in economic stability with lowered inflation, although private sector investments remain stagnant. In terms of general living conditions, the situation has gradually improved over the last 15 years. The Government has vigorously pursued extensive health sector development plans and for several years mobilised most of the health sector development partners through a proven working SWAp arrangement, thereby improving the health indicators. Among the challenges still persisting is limited access to health services. Malaria remains the major cause of morbidity and mortality. The prevalence of HIV is low compared to the African epidemiological situation but has the potential to increase and drain resources from health financing. More than ever, trained medical staff leaving the health sector and the serious brain drain hampers the health service delivery.

3. *Bank Sector Strategy and Relevance:* The Bank and Government policies are largely congruent. They aim at improving human capital in order to increase economic growth and reduce poverty. However, on the implementation level, the Government desires that the Bank's interventions become an integral part of the SWAp whereas the Bank maintains a project-based approach. The Bank's health policy is in line with other lead donors such as World Bank but the policy is hampered on operational level. It is challenged by the country-specific problems, such as the substantial brain drain and general lack of human resources in the health sector. The health sector is well coordinated and the Government leads the sector dialogue and policy work with the assistance of several development partners. World Bank and DFID are most actively involved. In terms of overall policy dialogue, the Bank has not played its potential role in the process of developing Ghana's health sector policies and strategies.

4. *Evaluation of the Sector Interventions:* The interventions were evaluated according to the Bank's standard evaluation benchmarks. The projects are highly relevant and scored satisfactory in efficacy, institutional development impact and sustainability, but with room for improvements in some of these areas. The main problem is efficiency of interventions, which is rated unsatisfactory. However, it should be added that some of the project interventions were implemented in periods with high inflation as well as currency fluctuations in Ghana, and this affected the plans and budgets. The problems were compounded by lack of Task Manager for a three-year period. The problems concerning efficiency involved considerable delays and insufficient quality at entry, leading to cost over-runs and incompleteness of some construction and medical equipment installations. A number of training activities and sub-components had to be changed to meet the budget reallocations. In addition, the health sector interventions were hampered by ineffective communication with the Bank and unsatisfactory utilisation of participatory approaches in the project cycle. The evaluation of the Bank's health sector interventions is supplemented by an overall evaluation and rating of other key

areas. In this evaluation, Assistance Strategy is rated satisfactory whilst the performances of the Borrower and the Bank are rated less than satisfactory. The overall average rating, when combining the ratings of interventions and other key areas, is satisfactory but with room for improvements to make future support more efficient.

5. *Main Lessons Learned:* a) The lack of national representation constitutes a missed opportunity for the Bank to take advantage of policy dialogue; b) participation in all cycles of project interventions improves effectiveness, yet the realisation of projects pays lip service to participation; c) dedication of the staff managers and task managers, political support, beneficiaries, and effective participation are likely to attain planned outcomes.

6. *Recommendations to the Government:* a) In view of the fact that the brain drain is one of the major challenges in the health sector, the Government should step up measures to provide staff accommodation and other incentives and train more hospital managers; b) initiate a study to better document and analyse the brain drain while the designing and planning of interventions should be based on a realistic assessment of local resources and include capacity development; c) the Government should ensure that the project managers effectively manage and implement projects in order to attain the desired objectives and utilise the private sector where relevant; d) the Government should ensure the implementation of the New Audit Service Act to present to Development Partners a solid framework for using the SWAp.

7. *Recommendations to the Bank:* a) the Bank should enter the Health Basket Fund in a manner suitable to the Bank's procedures; b) the Bank should systematically rely on pertinent social studies of the areas of its interventions; c) the Bank should not keep task managers on the same project and/or in the same country for more than five years; d) the Bank should improve efficiency by upgrading the use of participatory processes in all aspects of the project cycle, increasing the quality of its appraisal process, increasing the training of the personnel of the implementing agencies and reducing the work-load of the task managers.

1. BACKGROUND

1.1 Evaluation Objectives

1.1.1 The objectives of the Health Sector evaluation are to: a) assess the relevance of funded activities through projects over the years 1985-2004; b) assess the effectiveness of Bank support to the Ghanaian health sector in improving health system delivery and access to health services; c) promote changes in health sector policies and institutional reforms; and d) identify lessons from experience over the period in order to strengthen Bank's future policies and procedures and improve quality of Bank operations.

1.1.2 The review critically: a) analyses the extent to which the strategies of lending and non-lending activities of the Bank match the health priorities of the country, and b) assesses the impact of the interventions of the Bank in the health sector showing linkages between the goals/objectives with the outcome indicators targeted by the Bank during the Country Assistance Strategy period. . Thus, the findings of this review, lessons and recommendations would serve as inputs for the Evaluation of the Bank Country Assistance Strategy in Ghana, input into future Sector Wide Evaluations by OPEV and sharing lessons with Operations Department.

1.2 Scope and Methodology

1.2.1 The review primarily documents from past and recent lending and non-lending activities of the Bank in the health sector in Ghana and evaluates the strategies employed over the years in order to draw the lessons from experience and recommend the way forward. The evaluation is based on a review of the available documents such as Appraisal Reports, Project Completion Reports, Country Portfolio Review Reports, Supervision Mission Reports and Annual Portfolio Reviews, of on-going and completed interventions in the health sector. The review takes into account the evolution of the Bank with respect to the changing emphasis on the development agenda such as crosscutting issues - governance, gender, poverty, environment, HIV/Aids, community participation and regional integration. It also takes into account the impact of policy documents introduced at different periods, and the evolving operational guidelines and procedures adopted over the years in managing the portfolio of the Bank¹.

1.2.2 The methodology includes interviews with staff of the Bank, the Government, implementing agencies, development cooperation partners and other stakeholders who have first or second hand knowledge of the Bank's projects. The methodology relies on field missions in Ghana from 27th February to 16th March 2005 to share the views of the various stakeholders in the sector and to assess results. Interviews and focus group discussions were carried out with end-users, notably the health staff and members of the public, who have been the main targets of the health sector investments. The evaluation has benefited from adequate data and publications by Government and Development Partners, except for the *Pre-Investment Design and Engineering Studies in the Health Sector*² for which documents were not available in Tunis and Accra.

¹ The Evaluation Team would like to thank all individuals and organisations that collaborated and cooperated in the Evaluation.

² ADF Ghana: *Loan Proposal for the Financing of a Pre-Investment Design and Engineering Studies in the Health Sector*, 16 August 1985.

1.3 Socio-economic Context

1.3.1 Ghana is a country of 239,000 km and the population has grown from approximately 11 million in 1980 to the present estimate of 21 million³. Since its independence in 1957, Ghana has experienced different political regimes with different economic results and social outcomes. During that period, the government's tax base diminished by falling income and production. The resulting large deficit led to rising inflation and a large external debt burden. It also resulted in lower expenditure and a general neglect of the country's infrastructure and its educational and health services. It is estimated that about 2 million Ghanaians left the country, including 14,000 teachers. Health personnel were very de-motivated and many chose to emigrate. It is also estimated that 60% of medical doctors who graduated in the eighties were employed outside of Ghana.

1.3.2 In 1983, the new Rawling's Government took steps to reduce corruption and restore the basis of economic growth through the first Economic Recovery Programme (ERP I) developed in close collaboration with World Bank and IMF to stabilize the economy. In 1992, there was an introduction of a new multiparty constitution, followed by elections. Ghana experienced a brief period of economic uncertainty, compounded by difficulties in fiscal management and the fall in earnings from cocoa and gold. The Government increased its expenditure, which exceeded the agreed levels, and a number of donors suspended their assistance. Government holdings in a number of companies were sold. The government, however, continued to acknowledge the need to alleviate poverty and opted to maintain expenditure on education and basic health.

1.3.3. When the Government of President Kufuor took over in January 2001, the economy of Ghana was again facing crisis. Inflation was running at 41% while the budget deficit as well as external and domestic debts stood at unsustainable levels. This macro-economic context had a negative impact on expenditure in social sectors and poverty reduction activities as the Government found it increasingly difficult to meet its counterpart funding obligations to donor supported projects, including the social sectors.

1.3.4 With strong donor support, the present Government of President Kufuor adopted and implemented prudential fiscal and monetary measures that resulted in macroeconomic stability and economic growth and investor confidence. The inflation rate decreased from 40.5% by the end of 2000 to 10.5% at the end of first quarter, 2004. In terms of economic progress, the increase in fuel prices puts Ghanaian economy under pressure. The level of fuel prices and Government subsidy is discussed in Ghana as the country strives to adjust to increased prices⁴.

1.3.5 Although there is a huge task ahead, there has been a general improvement of living conditions in Ghana for more than 15 years. The average annual real economic growth rate per capita was -1.1% and 1.9% respectively for the periods 1980-1990 and 1991-2003. Household final consumption expenditure per capita decreased annually by -0.8 and increased by 1.6 during the period 1980-90 to 1990-2001. The Human Development Index was 0.439, 0.511, and 0.568 respectively in 1975, 1990 and 2002. The population with sustainable access to improved sanitation has increased from 61% in 1990 to 72% in 2000. The undernourished proportion has decreased from 35% to 25% between 1990/92 and 1999/2001. The prevalence of HIV/Aids in Ghana is low compared to the African epidemiological situation. In 2003, the prevalence rate was 3.1% (standard error 1.9-5.0). Life expectancy increased from 49.9 years to 57.9 between 1970-75 and 2000-2005. Under-five mortality also decreased considerably from 190 to 100 for the period 1970-2000.

³ ADB: *African Development Report 2004 and Selected Statistics on African Countries 2004*.

⁴ Professor Mike Ocquaye, 'Govt can't reduce fuel prices', *Daily Graphic*, 02.03.05.

1.3.6 One of Ghana's big challenges is the heavy dependency on donor support. For example, in the agricultural sector where most of the poor are working, donor support represented 67% of the budget for agricultural programmes in 2003. Such high dependency on aid creates uncertainty and limits the possibilities of growth in agriculture, given the decrease in donor inflow per capita since 1990⁵. The problems of becoming more dependent on donor support are aggravated by the stagnation in private investments, which represents a major challenge for sustainable growth in Ghana⁶. The stagnation in private sector capital formation in 2003 for the third successive year causes concern because the Government has the private sector as the engine of growth.

1.3.7 In the health sector a number of challenges still persisting are: a) A worrying stagnation in progress on important sector wide indicators, despite the increases in health spending; b) In particular the high infant and under-5 mortality rates require in depth analysis; c) Malaria continues to be the major cause of high morbidity as well as mortality; d) Maternal mortality is high but the exact figures and causes are yet to be established; e) In addition to serious consequences for individuals and families, the HIV/Aids epidemic has the potentials to drain resources in the health sector as well as important human resources needed to further develop the country; f) A major cause of serious illness and mortality in particular among the poor is lack of access to health services due to financial constraints; g) Lack of physical access remains a reason for under-utilization of health services; h) High out migration to developed countries of trained health workers, particularly doctors and nurses, continues to hamper the effective provision of health services, especially at regional and district levels; and i) The health sector continues to be under-financed.⁷

1.3.8 Ghana is known as one of the African countries with the highest rate of brain drain in the medical sector. It is estimated that about a third of Ghana's trained health personnel left the country in the period 1993-2002⁸. The health sector is facing another challenge, namely the difficulty in attracting and retaining qualified health personnel in rural and deprived areas. The Government is continuing its efforts to reverse the brain drain in the health sector⁹ and has among others set up a vehicle revolving fund for health workers in 2002. To limit the brain drain of students sent abroad for post-graduate studies the Government opened a Medical College in 2004. To further retain and attract qualified people in the Country, Ghana will have to review its civil services conditions in order to increase economic efficiency and the social sector service delivery.

1.4 The Country's Historical Relations with the Bank

1.4.1 For more than three decades, the Bank has been engaged in operations in Ghana, beginning in 1973 with the Nasia Rice Project. Up to the end of 2003, the total cumulative approvals stood at close to UA 855 million, representing 2.6% of total cumulative Bank loans and grant approvals for Africa up to 2003. Over a five-year period, 1999-2003, the Bank's total loan and grant approvals to Ghana increased from approximately 16 million UA in 1999 to approximately 81 million UA in 2003. The comparative cumulative distribution of approvals by sector in Ghana and in the whole of Africa for the period 1967-2003 is given in table 1.

⁵ DAC-OECD database.

⁶ ADB: OECD, 2003/2004: *African Economic Outlook*

⁷ *Health Partners Memorandum. Joint Response to the MoH Draft POW 2005*, Health Summit December 2004 *Op. cit.*, p. 2.

⁸ Development Bank / OECD, *African Economic Outlook, 2003-2004*. Paris, 2004, p. 175.

⁹ The strategy and measures are set out in Government of Ghana / Ministry of Health: *Human Resource Policies and Strategies for the Health Sector, 2002-2006*, September 2002.

Table 1. Loan and Grand Approvals by sector, 1967-2003

Sectors	Ghana	Africa	Ghana	Africa	Difference
	(000,000 UA)		%	%	%
Agriculture and Rural Development	188	6,132	22.0	18.5	3.5
Social Sectors:	148	3,901	17.3	11.7	5.5
<i>Education</i>	51	2,195	6.0	6.6	-0.7
<i>Health</i>	49	1,217	5.7	3.7	2.1
Transport	127	5,325	14.8	16.0	-1.2
Industry and Mining	120	1,928	14.0	5.8	8.2
Multi-sectors	104	4,881	12.1	14.7	-2.5
Financial Sectors	92	4,503	10.7	13.6	-2.8
Power/Energy	41	3,134	4.8	9.4	-4.6
Water Supply and Sanitation	31	2,500	3.6	7.5	-3.9
Telecommunications	5	911	0.6	2.7	-2.2
Total	856	33,215	100.0	100.0	0.0

Source: African Development Bank, *Compendium of Statistics on Bank Operations, 2004*.

1.4.2 In Ghana, the agriculture and rural development sectors received the largest share followed by the social sectors. Within the social sectors, education and health received almost the same share of about 6%. With regards to the approvals to all Regional Members Countries, the social sectors are the fifth largest compared to the second rank in Ghana. Table 1 shows that Ghana has an advantage above other African countries in health investments whereas education received equal attention as other African countries. Available data covering the last five years show that the total amount disbursed to the social sectors in Ghana has been increased significantly from 1999 and 2003, which is an indication of an increased commitment to the social sectors. This trend is in line with the Bank's vision and its declared priorities to support African countries to reach Millennium Development Goals, all of which consist in improving human capital.

Table 2. Bank Assistance to the Social Sector (end of 2004 in UA)¹⁰

Sector	Instrument				Status	
	Loan	Grant	Net Signed	%	Completed	To start
Health	4	2	45 338 659	42	4	2
Education	3	1	49 776 665	46	2	2
Gender Equity	1	1	1 834 780	2	2	0
Poverty Alleviation-Micro Finance	1	0	11 000 000	10	1	0
Total Social Sector	9	4	107 950 103	100	9	4

Source: African Development Data

1.4.3 The Bank's approved cumulative assistance to the social sectors up to end of 2004 has been as indicated. Within the social sectors, the Bank has supported the Health and Education

¹⁰ The support to the health sector excludes approved but not utilised funds of UA 3 million, as detailed in 3.1.

Sectors at almost the same level and in total with 88% of all approvals to the sector. The detailed history of the Bank's interventions in the social sector is found in Annex 2.

2. REVIEW OF THE BANK'S ASSISTANCE STRATEGY

2.1 The Bank's Health Sector Policy

2.1.1 Since inception, the Bank has paid attention to development of human resources in its Regional Member Countries. Bank lending to the health sector began in 1975 and a *Health Sector Policy Paper* providing a technical foundation based on which projects and studies have been financed was adopted in 1987¹¹. The policy paper analyses the major problems affecting health in Africa, highlights the relationships between health and socio-economic development and establishes guidelines for health sector financing. For African health administrations, lacking capabilities to effectively plan and manage health programmes, the health policy was intended to finance, on a priority basis, those projects aiming at improving skills of government officials involved in the planning and management of health programmes by training and short-term technical assistance.

2.1.2 In 1996, the health policy was revised to better respond to new challenges such as the HIV/Aids pandemic, rapid population growth, and increase in female-headed households¹² and it recognised the need for participation of all stakeholders. The Bank's health policy acknowledges the fact that public health programmes were often organised and managed vertically and that a large share of public funds went to urban-based hospital curative care at the expense of the mass of the rural populations. It is therefore considered that adoption of primary health care would offer the best opportunity for African countries to improve access to health in a more cost-effective and sustainable way. It recognises the need for participation of end-users, beneficiaries, private sector and NGOs in the preparation of projects. Furthermore, it states the need for joint efforts of RMCs and development partners through effective collaboration in health development.

2.1.3 The *Annual Portfolio Review* of 1998, which focused on the health sector, noted an increased commitment to social sector development, as articulated under the African Development Fund V and VI, and an improvement of the relevance and quality of lending in the health sector. The *Review of Bank's Experience in Rural Health*, carried out in 1999, found that health care services absorbed 71.5% of the Bank financing in the health sector and that Primary Health Care and Preventive Services received only 2.3% and 2.6% respectively. It also found that 80% of the funds supported investments in infrastructure. It underscored several shortcomings that hinder development of better health in rural areas notably: a) inadequate budget support for recurrent costs in rural health centres and district hospitals; b) staff shortages due to unsatisfactory working conditions; c) imbalances favouring the urban curative sector; d) ineffective human resources development policies; e) lack of communication with referral hospitals.

2.1.4. To sum up, within the health strategy outlined above, the Bank has identified the following priorities in the health sector; a) promotion of reproductive health, family planning, maternal health and safe motherhood, nutritional measures to fight HIV/Aids, and behavioural change; and; b) support to institutional reforms including decentralisation, investment in research, training, and infrastructure, development of managerial capacity, appropriate infrastructure and equipment for better health services delivery; and c) development of its

¹¹ African Development Bank, *Health Sector Policy Paper*, Abidjan, October 1987.

¹² African Development Bank, *Health Sector Policy Paper*, Abidjan, September 1996.

partnership with international organisations, and facilitation of dialogue on health development with Regional Member Countries.

2.1.5 The Bank's health policy is similar to other lead donors and development banks such as World bank, still the Bank appears to be hesitant in bringing itself to the forefront concerning policy improvements and in this way, the Bank is not in full meeting its development obligations. This is exemplified by HIV/Aids, where Africa is the worst hit continent. This could lead the Bank to focus more thematic attention and resources to establish a knowledge-based reference centre on best practices and to define the future strategies needed.

2.2 The Bank's Strategy for the Country

2.2.1 The Bank's health sector interventions are based on the strategies defined in its policy documents towards the Regional Member Countries. Up to 1996, the interventions were based on the Economic Prospects and Country Programming documents. The Paper for 1991-1993 notes that the poor performance of projects in Ghana is linked to the difficult economic conditions and mismanagement. The report also notes how the brain drain and high staff turnover was set-off as a result of the poor economic conditions in Ghana. The Paper for 1994-1996 is concerned with the time taken by implementing agencies in preparing documents for loan effectiveness and the lack of understanding of the Bank's disbursement and procurement procedures. These findings are confirmed in the present evaluation.

2.2.2 Since 1996, the Bank's Strategy for Ghana has been set out in a series of *Country Assistance Strategy Papers*. In the Bank's *Country Strategy Paper of Ghana 1996-1998*, the Bank prioritised poverty reduction as its main focus. Therefore, emphasis was on the social sectors; where access to basic education in disadvantaged areas and HIV/Aids were mentioned. The social sector obtained 35% of the proposed allocations in the CSP.

2.2.3 Following the Government Poverty Reduction Strategies, the *Country Strategy Paper 1999-2001* underscored, like its predecessor, the importance of supporting the Social Sectors. In terms of actual disbursement, however, the funding in this CSP period was rather on Multi-sector support. The paper noted that in July 1999 the Bank joined the Comprehensive Development Framework, which is a process to enhance the Government's ownership and leadership in its development programmes. The Comprehensive Development Framework brought together Development Partners to support the implementation of their interventions. The programmes were developed and articulated by 15 sector co-ordinating groups established and headed by the Government. The Country Strategy Paper notes, however, that the Bank Group did not participate in any of the sector co-ordinating groups because of lack of physical presence in Ghana. The 1999 Update is concerned with the efficiency and efficacy of the social sector portfolio, including the health projects.

2.2.4 The *2002-2004 Country Strategy Paper*¹³; a) notes the looming HIV/AIDS pandemic as a major constraint to sustainable growth and poverty reduction in Ghana, mentions how HIV/AIDS has led to the *Health Services Rehabilitation III* Project, which includes significant support to improving blood transfusion and blood screening services; b) indicates the need for improved dialogue between the Bank and the Government on the issues of Multi Donor Budget Support, Good Governance, and Portfolio Management, in order to improve the performance of some projects in Ghana in terms of implementation and efficiency. The Social sectors received 48% of actual disbursement in this period.

¹³ ADB /ADF, *Ghana, Country Strategy Paper 2002-2004*, 16 April 2003.

2.3 The Government's Policies and Strategies

2.3.1 The Ghana Poverty Reduction Strategy is the framework for coordination of social and economic development¹⁴. The Strategy includes all government programmes in all sectors, and sets out a number of priorities to improve quality and equity of access to basic health services. The Strategy recognizes that health issues, especially HIV/Aids, are affected by the actions of a range of other sectors. It also identifies a number of priority vulnerable and excluded groups: women and children, the disabled and the elderly, and people living with HIV/Aids. These groups are specifically targeted for basic services. The three Northern Regions and the Central Region are identified as priority areas. For several years the Government has organised the financing of the health sector strategy through a proven SWAp arrangement involving almost all key development partners, fully or partially.

2.3.2 The *First Programme of Work*, which corresponded to the Medium Term Health Strategy 1997-2001, showed that despite significant health gains in a number of areas such as immunization coverage and under five mortality (which declined by 27% between 1988 and 1998), childhood deaths still account for 50% of total mortality¹⁵. Current health policy is set out in the *Second Health Sector 5 Year Programme of Work 2002-2006*, the overall goal of which is to reduce health inequalities in Ghana – between the North and the South, between urban and rural areas, as well as inequalities linked to gender, education, and disability. The key components of government policy are related to international development targets towards health: a) Reduce by two-thirds the rate of infant and child mortality by 2015; b) Cut the rate of maternal mortality by three-quarters by 2015; c) Attain universal access to reproductive health services by 2015; d) Reduce HIV infection rates by 25% among 15-24 year-olds globally by 2015; and e) Decrease TB and malaria mortality by 50% by 2010. These targets have been translated into national targets and will be further translated into regional and district level targets to guide and inform local priority setting in a decentralized system.

2.3.3 Despite the fact that the number of health facilities increased significantly over the first and second five-year programmes of work at the Sub-district and District Levels, the expected improvement of the quality of health service has been hampered by brain drain. The investment in sub-district structures has not yet removed all obstacles to health care. From independence to the early 80's there was a rapid expansion of government-owned and staffed facilities with the assumption that these would benefit the poor by increasing geographic access to relatively low priced services. Today it is considered more important to develop the community-based level to focus on the client and community orientation of the services and to tailor services to individual and community needs and wishes¹⁶.

2.3.4 The Government strategy for health is anchored on the *Community-Based Health Planning and Services* approach, which provides an opportunity for achieving both the critical intermediate performance measures of the health sector programme and the three Ghana Poverty Reduction Strategy key action areas. The focus of the *Community-Based Health Planning and Services* approach is to achieve three important objectives; a) improve access to services; b) improve efficiency and responsiveness to client needs and; c) develop effective Inter-sectoral collaboration. The role of decentralisation and the degree of financial and human resource capacity of the District Assemblies and community health resources are crucial 'make or break' factors in the Government strategy to improve equity of access for the poor who suffer disproportionately from ill health and other risks.

¹⁴ Ghana Poverty Reduction Strategy 2003-2005 - An Agenda for Growth and Prosperity, Volume 1.

¹⁵ Ministry of Health, *The Second Health Sector 5-Year Programme of Work 2002-2006*, November 2003, p. 5.

¹⁶ Community-Based Health Planning and Services, *Ghana Health Service Policy Document No 20*, January 2005.

2.3.5 In order to tackle the human resources crisis in the health services, the Government has developed a *Human Resource Policies and Strategies* document to address problems of misdistribution of health staff and of brain drain¹⁷. The strategy projects the need for human resources and supply in the next five years (2002-2007) and describes how to obtain the optimum numbers of staff to achieve desired ratios. End of 2001 Ghana had a population of 18,468,000, served by 1,600 doctors, 11,876 nurses, and 1,136 pharmacists. The number of doctors per 1000 inhabitants was 0.09, 0.4 for nurses, and 0.07 for pharmacists. In 1967 the corresponding ratios were 0.08, 0.4, and 0.04 respectively, showing a lack of any appreciable increases in 35 years. Ghana's desired ratio for the year 2006 is respectively 0.2 for doctors, 0.1 for pharmacists, and 1.01 for professional nurses. This policy implies that undergraduate enrolments will need to be adjusted substantially and more staff will be retained¹⁸. In recognition of the need to address the brain drain, the Government policies set out several activities to try to retain staff at different levels in the health service. This constitutes a daunting challenge as Ghanaian medical staff is in great demand from several developed countries.

2.4 Relevance of Bank Assistance Strategy

2.4.1 The Bank Assistance Strategy and policies have been highly relevant to the health priorities of Ghana. It is in line with the Bank's and Government's goal of promoting sustainable economic growth and reducing poverty in Africa notably by investing in human capital development. The Bank's members, including Regional and Non-Regional countries, share this goal, which also has been assumed by the international community through the Millennium Development Goals to be attained by 2015¹⁹.

2.4.2 The Government and the Bank have poverty reduction as the overriding goal; this means that the objectives of health support and policies are corresponding. They both share the aim of improving the human resource base and reduce poverty as specified in Ghana Poverty Reduction Strategy. However, as for the education sector, in terms of implementing health sector investments, the Bank's approach differs from the Government's. The Bank seems reluctant to conform fully to the Government's institutional arrangements for the health sector and this appears to be one of the reasons for the long delay in starting up the new health interventions approved by the Bank in October 2002.

3. EVALUATION OF RESULTS: LENDING OPERATIONS

3.1 Lending Operations to the Health Sector

3.1.1 The Bank has financed three lending interventions, which are all completed, as detailed in Annex 2. A fourth lending intervention is planned to follow, but is yet to take off. The *Hospital Rehabilitation Studies Project* were approved in September 1985, signed the following month, commenced in February 1987 and finally completed in June 1994, in total a period of nine years²⁰. The project was approved at UA 1.73 million and the approved amount

¹⁷ As an example, the number of doctors fell from 1,154 to 964 between 1996 and 2002.

¹⁸ Government of Ghana / Ministry of Health: *Human Resource Policies and Strategies for the Health Sector, 2002-2006*. September 2002, p. 12.

¹⁹ The Millennium Development Goals formulated by the United Nations in 2000 aim at; a) eradicating extreme poverty and hunger; b) achieving universal primary education; c) promoting gender equity and empower women; d) reducing child mortality; e) improve maternal health; f) combating HIV/Aids, malaria, and other diseases; g) ensuring environmental sustainability and h) developing a global partnership for development. According to a recent report by DFID, Ghana is judged to be on track to achieve universal primary education by 2015 and even earlier. Ghana will come close to achieving gender parity by the end of 2005 in Primary Education in the seven southern regions.

²⁰ The Health Study Report was not available for the evaluation.

was disbursed. The aim of the project was to undertake pre-investment design and engineering studies of the future Health Services Rehabilitation Project I.

3.1.2. The *Health Services Rehabilitation Project I* was approved in January 1990, signed in November 1990, commenced in January 1991 and was completed by the end of 1999. The project was approved at UA 13.88 million and approximately UA 12.53 was disbursed, leaving UA 1.35 million under-utilised. The main activities in the Health Services Rehabilitation Project I were to; (a) rehabilitate Korle Bu Teaching Hospital, Accra, Komfu Anokye Teaching Hospital, Kumasi, and Effia-Nkwanta Hospital, Sekondi /Takoradi; (b) strengthen hospital maintenance capacity; (c) strengthen hospital management; (d) support primary health care by supporting Expanded Programme of Immunisation; and (e) create and support to a Project Implementation Unit.

3.1.3. The *Health Services Rehabilitation Project II* was approved in December 1991, signed in April 1993, commenced in December 1993 and was completed in December 1999. The project was approved at UA 13.82 million and approximately UA 12.53 million was disbursed, leaving UA 1.67 million under-utilised. The main activities carried out, or planned to be carried out, in Health Services Rehabilitation Project II were to; (a) rehabilitate the District Hospitals in Yendi, Keta, and Kibi; (b) strengthen Hospital Maintenance Capacity; (c) strengthen Hospital Management; (d) support Primary Health Care by supporting the Expanded Programme of Immunisation; and (e) reinforce the Project Implementation Unit.

3.1.4 For both projects, I and II, Project Completion reports have been written although all activities were not carried out as planned. The Project Completion Reports show over-runs of between US\$ 400,000 and 1,000,000 on major components, resulting in the cancellation of several activities, despite the fact that the funds were not fully utilised in the end.

Table 3. Bank Lending to the Health Sector (in UA end December 2004)

Projects	Approval	Net Signed	Disbursement %
Hospital Rehabilitation Studies	27-Sep-85	1,723,323	100
Health Services Rehabilitation I	16-Jan-90	12,527,818	100
Health Services Rehabilitation II	30-Oct-91	12,146,927	100
Total Health Completed, Lending		26,398,068	100
Health Services Rehabilitation III, planned	30-Oct-02	17,640,000	0
Total Health Projects, Lending		44,038,068	60

Source: African Development Bank.

3.1.5. The *Health Services Rehabilitation III* project is yet to commence²¹. The process of developing the project provides a good illustration of the process and indicates the challenges of the Quality at Entry for the previous health interventions. Efficiency in the start-up process for the health projects has been generally low. A recent example is the negotiations concerning the *Health Services Rehabilitation Project III*, which have taken two years so far. One of the reasons for the ongoing delay stems from the non-compliance of the Ministry of Health in recruiting the managerial staff of the project in appraising the new project.

3.2 Relevance

3.2.1 The Bank lending interventions in the health sector are highly relevant. The project aims to improve access to health by increasing health infrastructure and health staff capacity

²¹ [All conditions have been fulfilled after the evaluation and the implementation started.](#)

in rural and urban areas, which are in line with the Government health sector priorities. The interventions have been based on the results of an investment study, which illustrates the constraints and needs of the health sector in terms of health challenges and financing problems.

3.2.2 Taken as a whole, the Bank-supported interventions are relevant to the Poverty Reduction Strategy Paper and the national health policies of Ghana. The relevance of the Bank interventions is illustrated by the activities carried out by the projects such as financing health infrastructure, personnel training, equipment and furniture.

3.3 Achievement of Objectives

3.3.1 The mission received adequate documentation for the evaluation but data for quantitative outcome assessments were in the main not available. According to the staff of the hospitals visited, the Bank interventions have improved the access to health services in terms of quality and the number of patients. Yet it was not possible to obtain statistics indicating the increase in patients' access to health services.

3.3.2 The Bank supported projects have in general achieved many of their objectives concerning infrastructure, training and improvement of access to health services. Some objectives, such as training for health managers, maintenance staff, and strengthening the Project Implementation Unit, have been partially achieved; while in others, especially those regarding delivery and installation of equipment, renovation and construction of new infrastructure, the projects have performed less than satisfactory. For the Health Services Rehabilitation I, and Health Services Rehabilitation II projects, objectives concerning infrastructure work have been completed although behind schedule and with problems of quality. Yendi Hospital rehabilitation has not been completed by the project but has since been completed with government funds. In general delivery of equipment has been completed. However, some equipment was not installed or broke down within a short time after commissioning. An example is Kibi Hospital pharmacy block, where the workbench has not been delivered, and part of the kitchen equipment was installed in the pharmacy and has never been in use. On the other hand, some of the equipment installation has been successful (Keta and Kibi X-ray equipment, and their theatre equipment), but experience maintenance problems.

3.3.3 Efficacy could have been higher with a better quality at entry of projects. Among the examples illustrating low quality at entry is Keta Hospital where the project has rehabilitated the maternity ward, but overlooked the importance of providing an antenatal ward, which is required to provide basic quality of maternity service. Several of the design problems stem from the rigidity of the rehabilitation plans; they did not allow for modifications based on expressed needs and local constraints. All the projects have complaints of little user involvement and the lack of participatory process in project design has impacted negatively on the achievement of objectives.

3.3.4. For the *Health Services Rehabilitation I* and *Health Services Rehabilitation II* projects, objectives concerning infrastructure work have in the main been completed although behind schedule and with problems of quality. An example of the problems associated with efficacy is found in Keta District Hospital, several of the modern kitchen equipment supplied under Health II has never been in use.

3.3.5 As regards the components, Strengthened Hospital Maintenance capacity, some training has not been completed due to the premature closure of the loan, as there was pressure to start the Health Services Rehabilitation III. By supporting the Expanded Programme of Immunisation, the 'Support to Primary Health Care' component was not

achieved, but abandoned²². Some degree of institutional strengthening has been achieved via training of the district health personnel.

3.3.6 In overall, the Bank interventions appear to have contributed to improvements in Ghana health service delivery but the results are mixed. Efficacy would have been better with more user involvement, better project appraisal and implementation.

3.4 Efficiency

3.4.1 Efficiency in the Health Services Rehabilitation Projects I and II was unsatisfactory and has in general suffered from several problems, including; a) poor quality of the dialogue between the Bank and the Government; b) insufficient degree and quality of beneficiary participation in the project cycle; and c) quality and specification of the construction and other inputs. It should be added that part of the implementation has taken place in a period when Ghana was facing financial constraints with a high inflation and currency fluctuations. Both projects had no Task Manager for a three-year period and this is likely to have added considerably to the problems. This influenced part of the interventions, plans and budgets as well as the efficiency of implementation.

3.4.2 According to the Ministry of Finance, some times good intentions included in project appraisals are challenged by unpredicted constraints during the implementation process. For example, the assessments of the process of decentralisation can overestimate the organisational, managerial, and financial capacity at the district level and below, to take ownership of project activities. Although the District Assembly Common Fund should include some funds for district hospitals, it is also now to be expected that District Assemblies help sustain the hospitals in their districts (via internally generated funds). However, it appears that funds from District Assemblies are limited and in practice the expectation that some basic maintenance will be carried out by the districts appears to be unrealistic to many rural based districts. This was the case in Health Services Rehabilitation II project in Keta and Kibi Hospitals visited by the evaluation team.

3.4.3 Efficiency in the Bank interventions was hampered by inadequate appraisal. For example, due to mistakes made in the Appraisal Report in 1988, the scope of the project changed in the Health Services Rehabilitation Project I. The work for construction and for procuring equipment was tendered simultaneously, meaning that the equipment arrived before the buildings were ready for the equipment installation. As a result of the delay, infrastructure deteriorated, and equipment stored in containers for some three years, suffered theft of parts and the service contracts expired. These delays have implied higher costs.

3.4.4 The fact that both Health Project I and II closed without utilising the approved funds and yet without achieving all outputs, indicates inefficiency over the project cycle. Adding to these problems is the inefficient communication between the Borrower and the Bank. Finally, the efficiency of implementation has also been affected by delays in counterpart funding from Government. Such delays associated with delivery of financial services to contractors can create disaffection and uncertainty about government commitment to providing financial assistance to entrepreneurs²³, thus hampering effective project implementation.

²² The Health Services Rehabilitation Project I Project Completion Report, p. 17 (6.3, Component IV, C) states that: “No procurement of equipment for Support to Primary Health Care Component} effected because of overspending in procurement of vaccines”.

²³ Doctor Samuel Nii Ashong, Former Minister of State in charge of Finance and Economic Planning, “SIF launches Micro Finance Project”, *The Ghanaian Times*, Monday June 16, 2003.

3.5 Institutional Development Impact

3.5.1 The Bank supported interventions have contributed to institutional development. However, the practice of using a Project Implementation Unit in executing projects with specially hired staff creates institutional problems by creating a parallel structure. The parallel structure is time bound and after closing the project, the Government staff can no longer capitalise on the skills vested in the Project Implementation Unit. Both the Ministry of Health and the Ministry of Finance have raised such concerns and prefer that the Bank joins the SWAp.

3.5.2 Under the Health Services Rehabilitation Projects I and II, institutional development impact was achieved in two ways: a) via training of health staff, such as technicians, maintenance staff, hospital administrators and pharmacists; and b) by the input made by the health consultants seconded to the Project Implementation Unit, although inputs are only provided for a limited time. As regards the impact on health staff in the hospitals, the participating staff appreciate the training, which has helped them improve their skills and arguably to provide better service to the public. However, subsequent transfers of staff have in some cases diminished the potential impact of training maintenance and management staff.

3.5.3 The major problem hampering the potential institutional development impact expected from the support is the general staffing problems in Ghana's health sector. It seems that the magnitude of possible institutional strengthening from the Bank supported interventions cannot possibly cope with the inadequate staffing in the health sector, including the brain drain challenge. The human resource problems in the sector have to be met by a concerted effort involving the Government and all development partners.

3.5.4 In conclusion, institutional development has been satisfactory but with room for improvement. In view of the huge human resource challenges of the health sector, there is a need for studying more innovative ways to support institutional capacity development in the health sector at large.

3.6 Sustainability

3.6.1 The Bank supported interventions have contributed towards sustainability through staff training. The fact that the rehabilitated hospitals to a large extent are utilised indicates the relevance and thus the users' inclination to sustain the project contributions. As for relevance and quality at entry, the sustainability could have been better with much more user involvement and implied ownership. The ownership and sustainability are at risk by the lack of a participatory process in designing the projects; to a large extent the staff appears to be mainly passive spectators in finding out solutions to the major maintenance problems. The Government is working on several initiatives to develop and support the financing of maintenance and investments. These include the SWAp, health insurance and user fees.

3.6.2 In order to enhance sustainability of health investments, the Ministry of Health has institutionalised planned preventive maintenance by setting up an Estate Management Unit funded from the National Budget. The visits to Keta or Kibi District Hospitals showed that these policy measures have not yet been translated fully into action leading to improved maintenance of equipment. As a positive measure to ensure sustainability of facilities is the use of private sector to provide maintenance, as demonstrated in Kibi District Hospital. The technical sustainability will depend on the Government's ability to fund the required maintenance.

3.6.3 The sustainability of equipment supplied from the projects would have been better if some of the equipment was more durable. Another area where sustainability could have been improved is the planned construction of maintenance workshops. In some cases such as Effia

Nkwanta Regional Hospital in Sekondi-Takoradi, sustainability is severely threatened by the fact that the proposed maintenance workshop was not built²⁴. Other critical issues affecting the sustainability of equipment supplied include lack of appropriate training of health staff in the use of and basic maintenance of medical equipment and poor funding of equipment maintenance.

3.6.4 Brain drain is a major threat to the sustainability of training and human resources development components of the Bank health portfolio. It has not been within the power of either the Bank or the Government to stop professionals from leaving Ghana or to prevent foreign recruitment agencies contracting large numbers of skilled and highly prized Ghanaian health cadres. But, as described earlier in this report, the Government is taking concerted action to reverse the brain drain, which is a major threat to sustainability of institutional capacity.

4. EVALUATION OF RESULTS: NON-LENDING OPERATIONS

4.1 Economic and Sector Work/Policy Dialogue

4.1.1. The Bank financed one non-lending project in the health sector under Technical Assistance Fund grants: the *Health Services Rehabilitation I* project, further details in Annex 2. Further to this, the Bank approved a non-lending intervention linked to the Health Services Rehabilitation III Project, which is yet to start.

Table 4. Bank non-lending in the Health Sector, (in UA as of December 2004)

Project title	Approval	Net Signed	Disbursement (%)
Health Service Rehabilitation, Completed	16-Jan-90	300,590	100
Health Services Rehabilitation III, Planned	30-Oct-02	1,000,000	0
Total Projects; Non-lending		1,300,590	23

Source: African Development Bank.

4.1.2 The *Health Services Rehabilitation* project conformed to the Bank's Country Assistance Strategy for Ghana, to Government health policy priorities and to the Bank's health sector policy. The project was combined with the lending project: Health Services Rehabilitation I and was approved in January 1990, signed in December 1990, commenced in January 1991, and completed in December 1999, a total of almost 10 years. Despite the long time from approval to completion, the approved project funds of UA 1.3 million was under-utilised as only UA 0.3 million was disbursed. The low utilisation of Bank approvals is considered a missed opportunity, which indicates severe problems in preparatory work and in management of the intervention. The fact that this project was the only non-lending in 14 years consists a poor track record.

4.1.3 The non-lending *Health Services Rehabilitation I* project has been relevant to the development and improvement of government health planning, and the quality of the teaching hospitals. It could ultimately contribute in some measure to reduce diseases in Ghana. However, the delays in starting and implementing the project have diminished its significance in government health planning, which represents a lost opportunity. While some delays are

²⁴Government of Ghana/ Ministry of Health: *Health Services Rehabilitation Project I, Project Completion Report*, Project Implementation Unit, August 2001, p. 16 (6.3, B). The report does not explain why the maintenance workshop was not constructed.

attributable to the Bank's procedures, which are found difficult by the users, it is also apparent that the Ministry of Health's capacity to implement and properly manage the project through the Project Implementation Unit has been problematic.

4.1.4 In terms of policy dialogue in the Health Sector, the Bank has up to now not been very active in the health sector and has been hampered by not having a permanent Country Office representation in Ghana. However, the Bank joined the Comprehensive Development Framework in July 1999, as noted in the Country Strategy Paper 1999-2001. The Government and the development partners are inviting the Bank to participate more actively. Among development partners, World Bank and DFID are the most involved in the economic and sector work as well as in the policy dialogue.

4.2 Resource Mobilization/Co-financing

4.2.1 The Bank supported health projects have been co-financed by the Government counterpart funds, the Bank loans financing the largest share. Resources mobilization and co-financing is linked to the modalities of funding and of implementation. The Government has requested the Bank to enter the SWAp in order to avoid duplication of resources and works. In health, most of the development partners have joined SWAp under various versions of budget support and earmarked funding.

4.2.2 The Bank has assisted in resources mobilization and co-financing at implementation level by supporting a joint African Development Fund, Nordic Development Fund and UNDP financed intervention. This was done to support the implementation of priority areas as identified by the Government and development partners in the Ministry of Health's Second Five year Programme of Work (2002-2006). Another example is in the new *Health Services Rehabilitation III project*, two Bank missions (supported by the Japanese Trust Fund) have taken place, in November 2001 (Preparation Mission) and April 2002 (Appraisal Mission).

4.2.3. Table 3 shows the average annual distribution of total assistance to Ghana and to the Health Sector over the latest 3-year period, 2001-2003. Among the largest donors to the Health Sector, the Bank is the second biggest donor in terms of total amount, the fifth regarding assistance to health and the last in terms of relative share to health.

Table 5. Assistance to Health Sector in Ghana by some Donors, in million US\$

Development Partner	Whether in the SWAp	Total Annual Amount Average 2001-03	Health Annual Amount Average 2001-03	Health %
World bank	Yes	177.9	35.3	20%
USAID	Yes	57.6	20.1	35%
DFID	Yes	83.9	13.4	16%
JICA	Yes	32.8	8.9	27%
ADB	No	104.2	8.4	8%
Danida	Yes	39.3	7.9	20%

Source: ADB, 2004, UNDP, 2004.

4.2.4 Looking over a longer period, the total aid commitments, loans and grants, to the health sector for the period 1990-2004 is found in Annex 3, including types of external commitments to Health Sector; the aid group representing 76% of the total Health Sector external commitments and the non-aid group contributing 24%. Within the aid group, the Bank is ranked the sixth - contributing 7% of the group – after DFID, World Bank, USAID, UNICEF, and DANIDA.

4.3 Aid Coordination, Harmonization and Results Orientation

4.3.1 Aid coordination of the policy appears not to have been optimal between the Bank, government and other development partners. This is mainly due to the absence of a Country Office and the Bank has therefore not been physically present at the donor coordination meetings in Ghana.

4.3.2. All Co-operating Partners, including external partners and technical agencies of the Ministry of Health, support a sector policy, a common sector program and an agreed expenditure under the leadership of the Government of Ghana. To reinforce Government ownership, and to strengthen institutional development, the Co-operating Partners have undertaken a SWAp approach. The Government has adopted a second 5-Year Program of Work 2002-2006 and Common Management Arrangements for the implementation. In this context, the Government coordinates and harmonises aid orientation and as part of the work plans and monitoring, strives towards results orientation. The development partners continue working towards strengthening and utilizing Government systems including planning and budgeting arrangements, mechanisms, rules and procedures for procurement, disbursement, accounting, auditing, reporting, monitoring and evaluation. A Memorandum of Understanding, signed by the partners contributing to the donor pooled Health Account, sets out the application of the Co-operating Partners' and Governments' respective financial management, procurement and disbursement policies to the Program. Policy dialogue and joint planning with Co-operating Partners follow the annual planning cycle with regular meetings.

4.3.3 According to the Sector and Thematic Coordination Groups' report²⁵ the health sector has followed a SWAp since 1994 and consequently has a good track record of an active sector group that includes most major stakeholders. However, integrating new initiatives that relate to the health sector has been a challenge. The long-term vision is that these would all be included in the Plan of Work, using the same monitoring indicators and following the same schedule. A Collective Evaluation System has been developed to assess basket funds, although the Bank is not part of this process.

4.3.4 The following development partners are members of the Development Partner Coordination Group for health; United Kingdom, Denmark, European Union, France (which funnels its money through United Kingdom), Germany, Japan, Netherlands, UNAIDS, UNFPA, UNICEF, USAID, World Bank, and WHO. Among the challenges discussed amongst the development partners are; a) improving access to services: physical access and financial access despite poverty; b) over-stretched human resources at national and implementation levels; c) lack of a comprehensive policy on Information, Monitoring and Evaluation for the sector; and d) slow engagement of private sector and civil society.

4.3.5 Despite the fact that the number of health facilities increased significantly over the first and second five-year programmes of work at the Sub-district and District Levels, the expected improvement of the quality of health service has been lowered by brain drain. The investment in sub-district structures has not yet removed all the barriers to health care. However, the consensus is that it is important to develop the community-based organisations to customise health services to individual and community needs and priorities²⁶.

²⁵ Sector and Thematic Coordination Groups' Report in Ghana, November 2004.

²⁶ Ghana Health Service, *Community-Based Health Planning and Services*, Policy Document No. 20, January 2005.

5. CONTRIBUTORS' PERFORMANCE

5.1 Borrower and Executing Agencies

5.1.1 The Government and its health sector agencies are faced with a range of challenges in implementing the Bank interventions. The projects designed and agreed upon are in reality much too optimistic, especially in view of the limited resources and institutional capacity to implement the investments in the health sector. This unfortunate trend creates frustration on both sides. When projects are constantly delayed, there is a shared responsibility on the side of the Borrower and the Bank approving the funding.

5.1.2. The overall health sector performance in Ghana depends ultimately on the amount of fiscal revenue and other Government revenue that are set aside to pay for health services. The quality of the health services also depend on the ability of the Ministry of Health to plan and manage health services, in particular human resources, medical equipment, and drugs, in a coherent, cost effective and well managed way. In 2001 the percentage of Gross Domestic Product spent on public health was 2.8%, up from 1.3% and 1.8% in 1990 and 1995-1999 respectively²⁷. This increase illustrates the Government's commitment to the health sector and the commitment is demonstrated further by the Government's good leadership in mobilising extensive resources from development partners into the health SWAp. However, as the need for improvements in health service delivery is paramount, the resources to implement the investments are still inadequate.

5.1.3 The available documentation, site visits, and interviews carried out with the Bank health specialists as well as senior staff from Ministry of Finance and Ministry of Health point to a performance that is less than satisfactory on the side of the Government. Management and staffing of the Project Implementation Unit, whose role is essential for implementing the health projects, and for supervising the contractors and consultants carrying out the various activities, have not met the required standards especially as regards supervision of project activities

5.1.4 The less than satisfactory performance of the Project Implementation Unit appears also to stem from the fact that contractors sometimes renege on agreements or delay their activities. The delays in construction have also been partly due to delays in disbursing Bank funds, which slowed down progress. At the same time it is recognised that the Bank has contributed to implementation problems by not joining other donors in basket funding arrangements, joint procedures and joint efforts towards institutional strengthening. Ghana has limited resources available to attract and retain sufficient human resources in the public sector. As the Bank implements through its member countries, the problems affecting the country's own implementation capacity are likely to be replicated in the project implementation of Bank support.

5.1.5 The Government has performed well in identifying relevant health needs and priorities and the Ministry of Finance is striving to harmonise the assistance from development partners, including the Bank. Good harmonisation and an open policy dialogue could ease the burden on the public sector of implementing Bank-supported projects. However, the human resources problems in the health sector are crucial for good health service delivery and the Government needs to address the problem more vigorously and possibly seek assistance from the development partners.

²⁷ Bank, Selected Statistics on African Countries, Tunis 2004.

5.2 Bank

5.2.1 With regards to the health sector interventions, the Bank has performed well in identifying priority areas of interventions allied with Government priorities. However, the Bank support has been hampered by slow communication, disbursement and weaknesses in project monitoring, supervision and irregular payments. This is mainly linked to the fact that the task managers are often overburdened with several projects to address in different countries and by inefficiencies in internal institutional procedures, including lack of delegation. Thus implying that the task managers' ability to respond in time is further reduced. This leads to a lack of capacity in the Bank, which further adds to reducing attempts for the required participatory process in all cycles of the interventions.

5.2.3 The Bank could probably assist government by joining the common approaches with other development partners. This would reduce the stress on the Borrower's administrative capacity and give the Bank a chance for a larger impact via a more direct participation in the sector dialogue.

5.2.4 Despite having financed important health interventions in Ghana, the Bank has effectively been a spectator rather than a catalyst in the Health Sector Reform process starting in the mid 1980s. The Borrower clearly supports the Bank's assistance and sees the Bank as "his own" Bank, despite the frustrations listed above. This should in fact provide the Bank with a unique opportunity to play a much larger role in capacity building, sector dialogue and institutional development.

5.3 Other Donors and Co-financiers

5.3.1 As shown in Annex 3, the Health Sector is favoured by receiving a lot of support and attention from several donors and co-financiers. Most of them are participating in the SWAp and budget support arrangements. The health sector is the most advanced of the social sectors in Ghana towards these financing instruments. For the last 15 years, the key donors have remained the same, which could explain the well-coordinated assistance to the sector. The Government deserves tribute for the strong leadership and coordination demonstrated in the health sector.

5.3.2. World Bank is the leading donor in the health sector and its Country Assistance Strategy guides the support. World Bank's health sector support is under the Service Provision for Human Development part. In the Health Sector, World Bank will; a) continue its support through the SWAp; b) undertake economic and sector work; c) support the Ghana activities against HIV/Aids.

5.3.3. DFID is closely involved in the health sector work and is among the leading donors in the sector. It aims to support the Health Sector by strengthening Government health system and has additional focus on malaria treatment and HIV/Aids. DFID's support to the health sector has been through basket funding via the SWAp. Its support is increasingly moving towards budget support. DFID sees the continuation from some development partners to maintain a project focus as a threat to overall aid-efficiency according to DFID's Country Assistance Strategy Plan 2003-2006,

5.3.4. Many other donors, such as the Netherlands, UNICEF, USAID, DANIDA, Jica, provide health sector assistance in line with Poverty Reduction Strategy, the Health Programme of Work and the SWAp. All Development Partners met expressed serious concern on the Bank's lack of implication in sector work. The Bank being one of the key donors in health to Ghana, is expected to have a very significant contribution to the sectors. Yet, up till now, the Bank is seen as shying away from its obligation towards the sectors and rather focusing on the project related issues only relevant to the Bank own conservative practices.

All donors and the Government are urging the Bank to be more pro-active in policy dialogue, sector work, and the new financing instruments.

5.3.5. Among the development partners there is a serious concern about the quality and efficiency of public service delivery, including the Ghana Health Service. The need for a civil service reform linked with a more effective decentralisation is increasingly voiced. The impression is that although Government is in principle in favour of efforts to increase efficiency in the public sector, the political implications of major changes delay the needed improvements. This explains why the process has been on going for several years without being effective. The reform is expected to increase the remuneration of civil servants and to take into account the decentralisation process. For the Health Sector a civil service reform could increase incentives having a positive effect on the brain drain and the serious staffing problems, especially outside the urban areas. Such reforms would improve the efficiency of the development partners' health sector assistance, including assistance from the Bank.

5.4 Other Stakeholders (Civil Society, Private Sector)

5.4.1 The private sector, including NGOs, are increasingly becoming important players in the health sector. Among the major NGOs working in Ghana's health sector are Oxfam and Action Aid to illustrate the contribution of the other stakeholders towards health sector. Oxfam's sustainable livelihoods programme is the fulcrum of the Ghana Programme with emphasis on food and income security for poor women and men in the three northern regions of Ghana where poverty is beginning to be endemic. In the health sector, Oxfam supports the Ghanaian Ministry of Health in its immunisation programme, health education, and other work²⁸.

5.4.2 Action Aid supports the health sector mainly in the prevention and management of HIV and Aids. The Support to the International Partnership against Aids in Africa project includes Ghana. The project is funded by DFID and implemented by Action AID, mainly by offering capacity building to the Ghana AIDS Commission, and to non-governmental organisations and community base organisations working to prevent HIV/Aids and providing home based care and counselling services in the communities. The major activities include giving: a) education on prevention (youth to youth and peer education, action clubs in schools); b) training (stepping-stones community methodology); and c) support to people living with HIV/Aids²⁹.

6. OVERALL ASSESSMENT

6.1 Cross-cutting Aspects

6.1.1 Health activities are intrinsically gender oriented. In the design of the health sector interventions reviewed, the gender dimension is generally directed towards improving the condition of women in the context of improving district health services and the rural referral system. By increasing capacity of health care delivery, women benefit most as they use health facilities more than men. For instance, in 2001 health attendance for females was 58%. In the Pre-Investment Design and Engineering Studies project, there is emphasis on gender, by studying the problems of improving district health service delivery (including ante-natal and post-natal maternal health services) and improving the quality of the teaching hospitals, which, promise to be of benefit to women. The more recent Bank Health Sector policy papers show increasing awareness of a gender dimension in health. The challenge to the Bank is to operationalise and mainstream gender into health projects.

²⁸ www.oxfam.org.uk

²⁹ www.actionaid.uk

6.1.2 Environmental aspects are taken into consideration when the Ministry of Health prepares the location assessment for the construction of health facilities. However, there is room for improvement. For example, in Keta District Hospital, the Bank support was to have included construction of adequate drainage, but this has not been done, and the original drainage system now contains stagnant wastewater and chemicals from the mortuary and wards.

6.1.3 With respect to poverty, the Bank interventions are fully in line with the Ghana Poverty Reduction Strategy. The health interventions target areas at district level and support the rural population where most of the population lives and where poverty mainly exists. The aim of the Government is to decentralise the health care delivery and if the Bank's future interventions go in line with this trend, they may even have a higher impact on poverty.

6.1.4 The Bank interventions are to be maintained by the private sector and in the hospitals where this is the case, facilities are in general kept operational. Despite financial constraints in some of the hospitals, in the long run, the local private sector will be utilised in maintenance and part of the gradual renewing of facilities.

6.1.5 Towards regional integration, Ghana has an accredited regional centre in blood transfusion, which, if properly implemented, could be a regional reference centre and benefit West Africa. The Bank interventions have considerably strengthened regional integration, by helping to improve the facilities at Komfo Anokye Regional Hospital under *Health Services Rehabilitation I* project. This important hospital is a cancer centre and takes patients from many African countries. Under *Health Services Rehabilitation II* project, the rehabilitation of Keta District Hospital has led to an increase in the number of patients from Togo seeking health care services³⁰.

6.2 Counterfactual

6.2.1 Although it is difficult to assess the net effect of Bank health interventions, they are high even if they proved to be not cost-effective. In fact, the Bank assistance could only have been replaced with extra financial hardship to the nation. The health sector is under-financed compared to the needs, the health sector plans seek improved funding, and it is thus unlikely that other aid donors would increase their contribution, should the Bank have refrained from funding. More so because Ghana does not receive all the external assistance pledged, it is most likely that Government would not have been able to substitute Bank financing. It would thus have had to postpone the Bank supported interventions.

6.2.2 It seems likely that without the Bank interventions and despite the problems in implementing the projects, as mentioned earlier, the health sector output would have been reduced in Ghana, as facilities are being utilised to the extent practically possible. Especially at decentralised level, the health care would be much worse without the Bank support³¹. It is too early to judge long-term sustainability as the districts are being capacitated to take over a larger role in operation and maintenance. With proper maintenance, there is a positive contribution from the Bank interventions.

6.2.3. Better planning and implementation would have increased the value of Bank support. Some of the key factors under the Government's own efforts, mainly improvements in health sector staffing, would also have increased the impact.

³⁰ According to hospital health staff interviewed.

³¹ For example, there is now a centre able to deal with prevailing diseases in the region of Keta District. Prior to the Bank support, traumas and other cases had to be sent nearly 190 km to Accra. Even more importantly, the Bank's interventions have enabled the hospital to deal with emergency situations such as road accidents, maternal emergencies, and trauma.

6.3 Overall Assessment of Bank Assistance to the Sector

6.3.1 The Bank's health project portfolio in Ghana is evaluated based on criteria of relevance, efficacy, efficiency, institutional development impact and sustainability. The Bank standard for rating ranging from 1 (highly unsatisfactory) to 4 (highly satisfactory) is used. The overall score for the health interventions is 3, which is satisfactory. When examining the detailed ratings, the major shortcomings, which have lowered the ratings, include the low efficiency of implementation and loan disbursement as well as the lack of a participatory process in designing and implementing the projects. This has negatively affected the completion of construction, poor sustainability of equipment, and institutional development, where there is room for improvement. It is, however, noteworthy that the objectives are found highly relevant to Ghana's health development needs.

6.3.2 The comments leading to the ratings are detailed in the relevant sections of chapters 3 and 4 above, and in Annex 4 of this report. The rating from evaluating the lending and non-lending interventions is provided below in table 6.

Table 6. Overall Rating of Health Sector Interventions

Project	Relevance	Efficacy	Efficiency	Institutional Development	Sustain-ability	Average	Comments
<i>Lending</i>							
Pre-investment Design and Engineering	4	2	2	2	3	3	Satisfactory
Health Services Rehabilitation I	4	3	2	2	3	3	Satisfactory
Health Services Rehabilitation II	4	3	2	3	2	3	Satisfactory
<i>Non-lending</i>							
Health Service Rehabilitation	4	2	2	3	3	3	Satisfactory
<i>Average Rating</i>	4	3	2	3	3	3	Satisfactory
Comment	Highly Relevant	Satisfactory	Inefficient	Satisfactory	Likely	Satisfactory	

6.3.3. The other key evaluation aspects are also evaluated based on the rating 1 to 4 and comments are found below in table 7. Here the Assistance Strategy is rated satisfactory while the Bank's performance and the Borrower's performance are both rated less than satisfactory. The Bank and the Government are too optimistic in designing and planning the interventions, leading to frustrations on both sides. The detailed rating comments provide information on the areas for improvements.

Table 7, Rating of Other Health Sector Aspects.

Rating of other key areas:	Score	Comments
Assistance Strategy	3	Relevant, poverty reduction based and largely congruent with Gov. Policy, but in reality too project focused, insufficient participation in sector dialogue and coordination and not enough attention to the brain drain challenge.
Bank Performance	2	Positive in identifying health needs, positive image but performance is hampered by project concept and too optimistic project design, slow disbursements, overburdened task-managers, bureaucracy, in-effective communication and lack of a systematic participatory approach.
Government Performance	2	Good in developing and promoting the SWAp, in mobilizing donors, but too optimistic and not proactive in relation to Bank interventions, insufficient resources for effective implementation and supervision of contractors and consultants and with a civil service reform being overdue.

6.3.4 The fact that the Bank maintains its project concept, when the Government and key development partners are increasingly emphasizing a sector approach, is limiting the Bank's contribution. However, when combining the rating of lending, non-lending with the rating of Assistance Strategy, Bank performance and Government performance, the overall rating is satisfactory, as shown below.

Table 8, Overall Rating of Health Sector Support.

Overall	Score	Comments
Assistance Strategy	3	Satisfactory
Lending	3	Satisfactory
Non-lending	3	Satisfactory
Bank Performance	2	Un-satisfactory
Government Performance	2	Un-satisfactory
Overall rating	3	Satisfactory

6.3.5 By implementing the improvements needed, especially in efficiency, the Bank's health portfolio could potentially continue to offer a significant contribution to improving the Quality of Care for the poor and underprivileged populations, especially women, children, and infants, in urban, peri-urban and rural areas.

7. LESSONS LEARNED AND RECOMMENDATIONS

7.1 Lessons Learned

7.1.1 The lack of national representation constitutes a missed opportunity for the Bank to take advantage of policy dialogue, and to learn from ongoing institutional arrangements in order to improve development assistance (4.1.4; 4.3.1).

7.1.2 Lack of incentives in terms of accommodation and transportation makes it difficult to attract and retain qualified personnel in rural areas and to find a solution to human resources deficit and regional imbalances. In addition, installing medical equipment and constructing new or renovating hospital buildings may not necessarily lead to significant improved quality of services; if staff is not in place, the equipment does not work, power supply is erratic or unaffordable and the hospital cannot maintain equipment (1.3.8; 2.3.5).

7.1.3 It is not necessarily a best practice to retain the same task manager in a particular sector and/or in a particular country for a period of more than five years. Staying for a long time in the same sector and/or in the same country could negatively affect efficiency, efficacy, and innovation in business practice (3.4.2; 3.4.3; 3.4.4).

7.1.4 The fact that some medical doctors are administrative managers of a hospital, constitute a considerable opportunity cost for the health technical aspects in that they have better comparative advantages due to the long time required to acquire medical competence (5.1.4; 5.1.5).

7.1.5 Participation in all cycles of project interventions improves effectiveness, yet despite the fact that the Bank's development policies insist on dialogue and the beneficiaries' participation in its interventions in Regional Member Countries, the realisation of projects pays lip service to participation. Thus, participation is not effective. This situation is

supported by the behaviour of the beneficiaries towards maintenance problems, as they seem to be spectators in a process over which they have no control (2.1.2; 6.3.1).

7.2 Recommendations

To the Government of Ghana

7.2.1 With the brain drain being one of the major challenges in the health sector, the Government of Ghana should step-up measures to provide staff accommodation and other incentives particularly for health personnel in rural areas, especially in under-privileged areas. It is also recommended that more hospital managers be trained in order to relieve doctors and other medical staff from administrative and managerial responsibilities (1.3.8; 2.3.5; 5.3.5).

7.2.2 The Government should address the serious Human Resources problems in the health sector. The number of trained health staff leaving the country for positions abroad constitutes a big challenge for the Health Sector, and innovative solutions to the situation should be examined. A study to better document the problem and analyse the best approaches to solve it should be initiated, and should integrate ideas from the Health Sector personnel. The designing and planning of interventions should be based on a realistic assessment of local resources and include capacity development (3.6.4; 4.3.4; 5.1.4).

7.2.3 The Government should ensure that the project managers effectively manage and implement projects in order to attain the desired objectives. It should ensure that Governmental investments in the Health Sector are accompanied by measures to ensure benefits and sustainability. In addition, regular maintenance of equipment and facilities should be organized to ensure optimal use within their normal life span, and the private sector should be utilised to improve maintenance (3.4.2; 5.1.3).

7.2.4 The Government of Ghana should ensure the implementation of the New Audit Service Act to present to Development Partners a solid framework for utilization of funding within the new international assistance instruments settings: Sector Wide Approach and budget support (4.3.2).

7.2.5 The Government should enhance the country wide administrative capacity to collect information useful for monitoring and evaluating its development actions (3.3.1).

To the Bank

7.2.6 In Ghana, the process of implementing new intervention instruments, which provide predictable funding via the Government's budget and reduces Government's administrative burden, is well established with effective donor coordination under the Government's leadership. The Bank should enter the Health Basket Fund in a manner suitable to the Bank's procedures; this could be totally or partially by earmarked funds, which allows the tracing of fund utilization (5.2.3; 5.3.1).

7.2.7 There is a need for the Bank to effectively pursue more innovative ways to support institutional capacity development in the health sector at large. To this end, the Bank could systematically rely on pertinent social studies of the areas of its interventions (3.5.5).

7.2.8 It is recommended that the Bank should not keep task managers on the same project and/or in the same country for more than five years. In order to increase efficiency, efficacy and innovation in business practice, systematic rotation of task managers should be considered (3.4.2; 3.4.3; 3.4.4).

7.2.9 The participatory process in designing, appraising, implementing and assessing project activities should be effective and involve all relevant stakeholders in every stage of the project

cycle. The Bank should increase the quality of its appraisal process, as well as training of the personnel of the implementing agencies. It should also reduce the workload of the task managers. These recommendations could cut down the time lag in responding to beneficiaries' requests (3.4.1; 3.6.1; 5.1.1; 5.2.1).

ANNEXES

ANNEX 1. LIST OF DOCUMENTS CONSULTED

Documents Referring to Health Study Projects

1. ADB, *Ghana: Loan Proposal for the Financing of a Pre-Investment Design and Engineering Studies in the Health Sector*, 16 August 1985. Unbound report, 10 pp with annexes.

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22. ADB, *Ghana: Country Strategy Paper 2002-2004*, Update. 04 August 2004.
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General Health Policy Studies, Poverty Studies, Economic Studies, and Government Documents

28. Ghana, Ministry of Health, *Common Management Arrangements for the Implementation of the Second Health Sector 5-Year Programme of Work 2002-6*, January 2002.
29. Ghana, Ministry of Health, *The Second Health Sector 5-Year Programme of Work 2002-2006*, 2003.
30. Ghana, Ministry of Health, *The Ghana Health Sector Annual Programme of Work, 2003*, January 2003.
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ANNEX 2. BANK ASSISTANCE TO THE SOCIAL SECTOR & BANK SOCIAL POLICIES

Table 9. Bank Group Assistance to the Social Sectors (in UA end 2004)

Project title	Sub Sector Name	Source	Instrument	Approval Date	Net Signed	Cumulative Disbursements	Disbursement ratio (%)
Hospital Rehabilitation Studies	Health	ADF	Loan	27-sept-85	1 723 323	1 723 323	100
Health Services Rehabilitation I	Health	ADF	Loan	16-janv-90	12 527 818	12 527 818	100
Health Service Rehabilitation (Grant)	Health	ADF	Grant	16-janv-90	300 590	300 590	100
Tertiary Education Rehabilitation	Education	ADF	Loan	18-juin-91	12 776 665	12 776 665	100
Women's Community Development	Gender Equity	ADF	Grant	18-juin-91	1 388 151	1 388 151	100
Women's Community Development	Gender Equity	ADF	Grant	18-juin-91	446 629	446 629	100
Health Services Rehabilitation II	Health	ADF	Loan	16-déc-91	12 146 927	12 146 927	100
Primary Education Rehabilitation Project	Education	ADF	Loan	09-janv-97	12 000 000	11 913 115	99
Poverty Reduction Project	Pov.AL/Mic.Fi.	ADF	Loan	10-déc-97	11 000 000	10 818 385	98
Health Services Rehabilitation III	Health	ADF	Loan	30-oct-02	17 640 000	0	0
Health Services Rehabilitation III	Health	ADF	Grant	30-oct-02	1 000 000	0	0
Senior Secondary School Support Project - III	Education	ADF	Loan	24-sept-03	20 000 000	62 915	0
Senior Secondary School Support Project - III	Education	ADF	Grant	24-sept-03	5 000 000	0	0

Policy Document	Year	Reference
Education Sector Policy	1986	
Health Sector Policy	1987	
Environment Policy	1990	
Women in Development Policy	1990	
Health Sector Policy	1996	ADB/BD/WP/96/52
Strategy and Assistance in Microfinance to RMCs	1997	ADF/BD/WP/97/48
Education Sector Policy	1999	ADB/BD/WP/99/92
Agricultural and Rural Development Policy	1998	ADF/BD/WP/99/105
Integrated Water Resources Management	2000	ADB/BD/WP/99/146
Policy for Cooperation with Civil Society Organizations (CSOs)	2000	ADB/BD/WP/2000/05 Rev.1
Population Policy and Strategies for Implementation	2001	ADB/BD/WP/2000/142
Gender Policy	2001	ADB/BD/IF/2001/62
Policy on Poverty Reduction	2001	ADB/BD/IF/2000/83
Environment Policy	2003	ADB/BD/WP/2003/116
Policy on Poverty Reduction	2004	ADF/BD/WP/2003/151/Rev.2
HIV/AIDS Strategy for Bank Group Operations	2001	ADB/BD/WP/2001/11/Rev.3
ADF Strategy and Assistance in Microfinance to RMCs	2001	ADF/BD/WP/2001/97/Add.5
Malaria Control Strategy	2001	ADB/BD/WP/2002/25/Add.2
Malaria Control Operational Guidelines	2001	ADB/BD/WP/2002/45
Policy on Involuntary Resettlement	2002	ADB/BD/WP/2002/98
Policy on Poverty Reduction	2002	ADB/BD/IF/2002/248
Guidelines for Bank Operations Using Sector Wide Approaches (SWAp)	2003	ADB/BD/WP/2003/88
Guidelines on Development Budget Support lending (DSL)	2003	ADB/BD/WP/2003/182
Bank Group Post-Conflict Assistance Policy Guidelines	2003	ADB/BD/WP/2003/184
Gender Plan of Action	2004	ADB/BD/IF/2004/88
Guidelines on Communicable Disease	2004	ADF/BD/WP/2004/19/Rev.1/
Guidelines for the Implementation of Bank Group's Policy on Population	2004	ADB/BD/IF/2004/10
Operational Guidelines on User Fees in Health and Education	2004	ADB/BD/WP/2004/144

ANNEX 3. AID COMMITMENTS FOR HEALTH, 1990-2004 IN MILLION US\$**Table 10. Aid commitments**

AID GROUP	Amount	%	NON-AID GROUP	Amount	%
Arab Bank for Economic Dev't (BADEA)	4,1	0,46	Bank Austria N.V.	14,5	5,31
African Development Fund	61,7	7,00	Banco Santander, S.A.	30,7	11,23
Government of Belgium	3,4	0,39	Banco Brussels Lambert S.A.	2,1	0,77
Government of Canada	1,5	0,17	Banco Bilbao Vizcaya Argentaria	5,9	2,16
Government of Denmark	75,9	8,61	Deutsche Bank Soci. Anonima Espanol	5,6	2,05
European Economic Community	11,6	1,32	Fintech Holding GMBH	28,9	10,57
Government of the Fed, Rep, Of Germany	2,9	0,33	GerTech GmbH	12,3	4,50
International Development Association	191,8	21,75	Hospital Engineering GMBH	45,9	16,79
Government of Japan	16,3	1,85	International Hospital Group	22,0	8,05
Nordic Development Fund	16,2	1,84	Internationale Netherlanden Bank	16,6	6,07
Government of the Netherlands	25,6	2,90	Midland Bank PLC	8,7	3,18
OPEC	5,2	0,59	National Westminster Bank PLC	21,7	7,94
Government of Saudi Arabia	4,5	0,51	Standard Chartered Bank	29,3	10,72
Government of Spain	33,3	3,78	Stericon GMBH	8,1	2,96
Government of Swiss Confederation	0,4	0,05	Taylor & Taylor/Elena Diagnostic	10,5	3,84
The Government of the United Kingdom	192,2	21,80	Union Bank of Switzerland	10,5	3,84
United Nations Children's Fund (UNICEF)	77,6	8,80			
United Nations Development Programme	0,7	0,08			
United Nations Fund For Pop Activities	17,8	2,02			
Government of United States of America	139,3	15,80			
World Food Programme	3,9	0,44			
Total-AID Group (76,3%)	881,8	100	Total Non-Aid Group (23,7%)	273,3	100
Total Commitments (Aid and Non-Aid Group) : 1155,10					

Source: Ministry of Finance

ANNEX 4. DETAILED RATINGS OF THE BANK'S HEALTH PROJECT PORTFOLIO

Table 11. Detailed Ratings

Health II Keta Hospital: Staff	Score	Comments (Staff assessment on 04.03.05)
Relevance	4	Hospital needed rehabilitation & equipment. Staff needed training. Project respected government policy.
Quality of Entry	2	Poor; lack of consultation about equip.& infrastructure preferences; antenatal unit not provided. Consultant did not communicate w. staff
Efficacy (Achievement of objectives)	2	Rehabilitation completed; most equip. installed; some equip. never worked; some second hand instead of news beds of poor quality supplied; training done, EPI component not done
Efficiency	2	Very delayed civil & equipment installation, leading to damaged equipment.
Institutional Development	3	Good training, although regional authorities did not ensure trained management / maintenance staff stayed in their posts (or replaced)
Sustainability	2	Some equip. does not work / improperly installed; anaesthetics machine not repaired, removed from hospital, theatre table does not work. kitchen equip. non functional, electric oven not repaired, walk in fridge non functional, trained maintenance personnel not replaced
Cross Cutting Issues	3	Gender good, females trained: environmental considerations not accounted for in disposal of mortuary / xray waste. Regional integration average, patients come from Togo
Average	3	
Health II Keta Hospital: Team	Score	Comments (Visit on 04.03.05)
Relevance	4	Hospital needed rehabilitation & equipment. Staff needed training. Project respected government policy.
Quality of Entry	2	Poor design, staff wishes not listened to. Consultant did not communicate w. staff. Appraisal process top down and paternalistic.
Efficacy (Achievement of objectives)	3	Fair. Some training done, although EPI component abandoned. Equipment handover & installation process, and its quality, poor, renovation reasonable standard.
Efficiency	2	Poorly performing consultant who was not accountable to MOH or hospital staff. Delays led to damage and wastage of resources.
Institutional Development	3	Initially fair, but staff that were trained were transferred and no replacements were made.
Sustainability	2	Some equip. does not work / improperly installed, never installed; anaesthetics machine not repaired, removed from hospital, theatre table does not work. kitchen equip. non functional, electric oven not repaired, walk in fridge non functional, trained maintenance staff no longer in place.
Cross Cutting Issues	3	Good on gender because target women's health, and train females, but weak on environmental, ok on regional integration.
Average	3	
Health II Kibi Hospital: Visit	Score	Comments (Staff assessment, 10.03.05)
Relevance	4	Hospital needed rehabilitation & equipment. Staff needed training. Project respected government policy.
Quality of Entry	3	Good, the project fitted our hospital management, infrastructure expansion, and training needs.
Efficacy (Achievement of objectives)	3	Good, all objectives achieved, ambulance, except EPI, and except pharmacy installations and equipment which were not completed.
Efficiency	1	Very delayed civil & equipment installation, leading to opportunity costs while surgery and other areas temporarily closed.
Institutional Development	4	Staff were trained in hospital management and maintenance, a valuable contribution to health services.
Sustainability	3	Service contract with private sector to maintain kitchen equip., but pharmacy equip. broken down & not replaced.
Cross Cutting Issues	3	Good on gender, poor on environmental aspects.
Average	3	
Health II Kibi Hospital: Visit	Score	Comments (Visit in 10.03.05)
Relevance	4	Hospital needed rehabilitation & equipment. Staff needed training. Project respected government policy.
Quality of Entry	2	Poor, although the project did fill health needs, but the appraisal and negotiation procedures and loan disbursement did not enjoy a two-way dialogue.
Efficacy (Achievement of objectives)	3	Acceptable, but EPI not done, pharmacy not done, and some equip. never worked (the washing machine for soiled linen, pharmacy equip. not delivered and installations not completed
Efficiency	2	Very delayed civil & equipment installation, leading to theft and decay of equip. kept in storage and frustration of staff in hospital.
Institutional Development	3	Staff were trained in hospital management and maintenance, a valuable contribution to health services.
Sustainability	3	Positive that there is a service contract with private sector to maintain kitchen equip., but pharmacy equip.(distilling plant) is broken down & not repaired, and the parts for the diesel motor for electricity generation too expensive for hospital (inappropriate technology).
Cross Cutting Issues	2	Good on gender, poor on environmental aspects, regional integration not an issue here.
Average	3	

Health I Overall (MOH staff)	Score	Comments (Assessment by MOH staff, 11.03.05)
Relevance	4	Relevant to strengthen hospital management by training courses. At that time, a lot of infrastructure was run down, so the two referral hospitals (Korle BU and Komfo Anokye) urgently required upgrading. Project respected government policies.
Quality of Entry	2	Poor, little or no two way dialogue or respect of MOH's wishes and preferences. All infrastructure work was given to one consultant, this was inefficient as he had insufficient capacity.
Efficacy (Achievement of objectives)	3	"Everything was delivered". "User application was not completed, esp. kitchen equip., and no stock of spare parts was provided". "Training was carried out".
Efficiency	2	"ADB was too costly in terms of inputs. Surgical Block at Korle Bu took several years instead of 18 months to do. And we lost in terms of opportunity costs to the overall hospital. Contractor declared himself bankrupt. Planned budgets for civil works were overrun". "ADB instructed that the non-civil (training) money be repaid". "Closure of the training meant spare parts were not delivered."
Institutional Development	3	Poor PIU performance was addressed by ADB loan.
Sustainability	3	Sustainability is likely because Operation and Maintenance have been taken over by the Government in the Annual Budgets (Common Funds) for health.
Cross Cutting Issues	4	Beneficiaries are women; Improved incineration cuts pollution; regional integration good, because Effia-Nkwanta has taken a lot of AIDS patients from Senegal, and Korle Bu hospital and Komfo Anokye hospital take cancer patients from all over Africa for cancer treatment.
Average	3	
Health II Overall (MOH staff)	Score	Comments (Assessment by MOH staff, 11.03.05)
Relevance	4	Relevant. At that time, a lot of infrastructure was run down, so the district hospitals required upgrading urgently.
Quality of Entry	3	Acceptable.
Efficacy (Achievement of objectives)	3	"Not fully complete" (infrastructure and equipment, especially at Yendi district hospital was never finished.
Efficiency	2	"Yendi Hospital suffered massive theft"
Institutional Development	4	Poor PIU performance was addressed by ADB loan.
Sustainability	4	Government (MOH) has taken over all maintenance so sustainability is good. Government has introduced National Health Insurance to increase cash flow into health system.
Cross Cutting Issues	4	
Average	3	
Health I Evaluation Score	Score	Comments (Based on Evaluation findings and assessment)
Relevance	4	Relevant to expressed needs and policies, especially as regards training for improving hospital management and upgrading infrastructure.
Quality of Entry	2	Poor, appraisal process excluded MOH, and hospital staff on the ground, and was top-down.
Efficacy (Achievement of objectives)	3	Infrastructure achieved, but equipment installation, quality and technology choice not always appropriate, and ignored MOH new procedures (Biomedical Unit). Some, not all training achieved. EPI component not achieved.
Efficiency	2	Delayed and therefore cost inefficient civil works, delays led to equipment damage / deterioration. Training was efficient.
Institutional Development	2	Fair. Some training was done for hospital management and this strengthened hospital management capacity; PIU was also trained; and some hospital maintenance staff were trained.
Sustainability	3	Equipment in district hospitals (Keta and Kibi) has some sustainability problems, more severe in Keta. Benefits of training diminished by transfers.
Cross Cutting Issues	3	Gender good, environment not good, regional integration reasonable.
Average	3	
Health II Evaluation Score	Score	Comments (Based on Evaluation findings and assessment)
Relevance	4	Relevant to expressed needs and policies, especially as regards training for improving hospital management and upgrading infrastructure.
Quality of Entry	2	Poor, appraisal process excluded MOH, and hospital staff on the ground, and was top down.
Efficacy (Achievement of objectives)	3	Infrastructure achieved, but not in Yendi, equipment installation, quality and technology choice not always appropriate, and ignored MOH new procedures (Biomedical Unit); equipment not installed, some was stolen and never installed, some installed equipment never worked or broke down after a short while.
Efficiency	2	Civil works delayed, or incomplete. Not all equipment delivered / installed (Keta, Kibi). Training was efficient, although efficiency returns were diminished by transfers without replacement of staff in Keta hospital.
Institutional Development	3	Fair, Keta not satisfactory, more satisfactory in Kibi. PIU is strengthened while the project lasts to pay staff, but it has diminished strength in the run-up to ADB Health III.
Sustainability	2	Poor in Keta, satisfactory in Kibi.
Cross Cutting Issues	3	Gender good, environment not good, regional integration reasonable.
Health II Evaluation Score	3	