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The Health Sector in Ghana and the Role of UK Development Assistance:

A 30-year perspective

June 2024

UK Foreign, Commonwealth & Development Office

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Executive Summary

This paper describes events in the health sector in Ghana from 1993 to 2023 and the role of UK development assistance. Six phases are identified, delineated by the UK's main bilateral health support programmes. For each phase, the paper looks at key developments in Ghana's health sector, the nature of UK support, and what was happening at the time in wider UK policy in international development. Development assistance, by its nature, is political, based in domestic political realities and philosophies. The politics of one country affects what happens in another.

The six phases involved a number of different approaches to the bilateral development assistance programme, starting with an innovative Health Sector Aid Programme, then contributing to a 'Health Fund' managed by the Ministry of Health, moving into a combination of Sector Budget Support and General Budget Support before swinging back to earmarking and projects, with DFID heavily involved in the details of design and implementation. Since 2020 UK support has declined considerably in financial terms, with a growing focus on directly awarded contracts to implement projects, and social sector rather than health-specific programmes. In the period around 2020-22 support was extremely fragmented and unpredictable, which had a negative effect on Ghana/UK relations in the health sector.

An important feature of the period 2000-2015 was the existence of a SWAp (Sector Wide Approach). A SWAp is a way of development partners working together to support an agreed national plan in a coherent, non-duplicative way, strengthening national ownership, and supporting government priorities and resource allocation systems. To reduce fragmentation and transaction costs, it is governed by agreed Common Management Arrangements, covering planning, funding channels and monitoring. There are usually annual sector reviews and a forum for dialogue about challenges and policies. The Ghanaian health SWAp was influential nationally and internationally.

The paper reflects on how the past can inform future decisions. Specific attention is paid to development assistance effectiveness and modalities; decisions about what to fund; and how to measure progress. The paper shows how changes in UK politics affected the development assistance programme in Ghana and notes the cyclical nature of history, with discussions about development assistance effectiveness in 2024 having distinct echoes of the debates of the late 1990s.

The paper identifies lessons about aid modalities and ways of organising effective development assistance, including:

- SWAps have many advantages in terms of co-ordination and alignment with national priorities and systems. They require political and managerial commitment and can be difficult to maintain in the long term.
- Providing substantial funds, or joining a large pooled arrangement, is one way of gaining a seat at the policy-influencing table. Another way is to show leadership in promoting co-ordination amongst development partners.
- Aid modalities can co-exist, and each has its advantages. Financial Aid can be appropriate to support service delivery, and also to gradually tackle long-term knotty challenges, such as developing an efficient national health insurance scheme.
- Technical assistance (TA) is an important element of development assistance. To influence reforms, the TA planning and management arrangements must be well embedded in government systems.
- Whatever modality is used, it helps to 'keep it real' by including activities at the sub-district or district level and indicators about on-the-ground delivery.

In terms of what to fund, the paper describes the evolution from Ghana as a low-income country (when large-scale health systems strengthening projects and support for service delivery were appropriate) to

lower-middle income status, the decline in development assistance budgets and the shift to thinking about aid at the margin.¹

The paper describes the changing role of target-setting over time, including a period when there was an extreme focus on measurable improvements that could be attributed directly to UK spending. The Ministry of Health's Holistic Assessment Tool, a legacy of the SWAp era, looks at management performance and service delivery, as well as outcomes, and uses both qualitative and quantitative information. It remains a useful tool to inform government/development partner dialogue.

Over the 30 years documented here, political changes in the UK have at times led to mid-programme changes in direction in Ghana. When this happens, it is a failure in predictability and in being accountable to Ghana. Whilst domestic politics will always have times of upheaval and the desire for speedy change, international development brings with it a responsibility to another nation and its people.

SWAps and the aid effectiveness agenda were about mutual accountability and building national systems – they worked reasonably well in Ghana for about 15 years. There is an opportunity now to re-visit the principles of effective development co-operation and to foster genuine mutual accountability. Discussions about Financial Aid and SWAp-type arrangements are back on the agenda in Ghana, making this a fitting time to reflect on the lessons of recent history.

¹ Aid-at-the-margin is the idea that priority services should be fully funded by national government and that development partners should direct support at the next level of priorities that may not be funded otherwise.

Acronyms

Abbreviation	Description
ANC4+	At least four Antenatal Care Visits
BMC	Budget Management Centre
CHPS	Community Health Planning and Services Strategy
CMA	Common Management Arrangements
DFID	Department For International Development
DP	Development Partner
DPT3	Combination Vaccines against Diphtheria, Pertussis, and Tetanus
FCDO	Foreign, Commonwealth and Development Office
FCO	Foreign and Commonwealth Office
GBA	Ghana Beyond Aid
GBS	General Budget Support
GDHS	Ghana Demographic Health Survey
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GPRS	Ghana Poverty Reduction Strategy
HSIP	Health Sector Improvement Plan
HSMTDP	Health Sector Medium Term Development Plan
HSSP	Health Sector Support Programme
HWF	Health Workforce
ICAI	Independent Commission for Aid Impact
LMIC	Lower Middle-Income Country
LNOB	Leave No One Behind
MDBS	Multi-Donor Budget Support
MDG	Millennium Development Goals
MoH	Ministry of Health
NHIA	National Health Insurance Authority (Agency until 2005)
NHIS	National Health Insurance Scheme
NCD	Non-Communicable Disease
ODA	Overseas Development Assistance
OOP	Out of Pocket Spending
PBA	Partnerships Beyond Aid
PFM	Public Financial Management
POW	Programme of Work
SBS	Sectoral Budget Support
SDG	Sustainable Development Goals
SWAp	Sector Wide Approach
THE	Total Health Expenditure
UHC	Universal Health Care

1 Introduction:

The Health Sector in Ghana and the Role of UK Development Assistance

Key Points

- Between 1993 and 2023 Ghana evolved from a low-income country returning to constitutional rule and in receipt of considerable sums of development assistance, to a lower-middle income country pursuing the 'Ghana Beyond Aid' agenda.
- Six phases are identified. For each phase, there is a discussion of developments in the Ghana health sector and the nature of UK support. UK international development policy is also reviewed, in recognition of the political nature of development assistance.
- The paper is based on a literature review and interviews.

This paper describes events in the health sector in Ghana from 1993 to 2023 and the role of UK development assistance. It then reflects on this history and discusses how the past can inform future decisions. Specific attention is paid to development assistance effectiveness and modalities; decisions about what to fund; and how to measure progress. The paper shows how changes in UK politics affected the development assistance programme in Ghana and notes the cyclical nature of history, with discussions about development assistance effectiveness in 2024 having distinct echoes of the debates of the late 1990s.

The 30-year period began when Ghana was a low-income country returning to constitutional rule and in receipt of considerable sums of development assistance; by the end of the period Ghana was a lower-middle income country pursuing the 'Ghana Beyond Aid' agenda.² Less than a decade after Independence in 1957 a period of political instability began, with a succession of military and civil governments and economic turmoil. Since the return of Constitutional Rule in 1993 the country has had national elections every four years, with peaceful transfers of government between different political parties in 2001, 2009 and 2017. In 1993 the first UK residential health adviser came into post in Ghana, managing a sizeable support package; by 2023 the UK's development assistance for health was considerably smaller in real terms and integrated with education and social protection as social sector support.

The paper identifies six phases, delineated by the UK's main bilateral health support programmes (see Figure 2). For each phase, we look at key developments in Ghana's health sector, the nature of UK support, and what was happening at the time in wider UK policy in international development. The reason for including the policy perspective is that development assistance is political, based in domestic political realities and philosophies.³ The politics of one country (in this case, the UK) affects what happens in another (Ghana, in the context of this paper). Sometimes a change in one country fits well with what is happening in the other, sometimes not. We recognise that the politics discussed here are the specific politics of development assistance, not the bigger political issues of global inequalities and power imbalances.

The six phases involve a number of different approaches to the bilateral development assistance programme, starting with an innovative Health Sector Aid Programme, then contributing to a 'Health Fund' managed by the Ministry of Health, moving into a combination of Sector Budget Support and

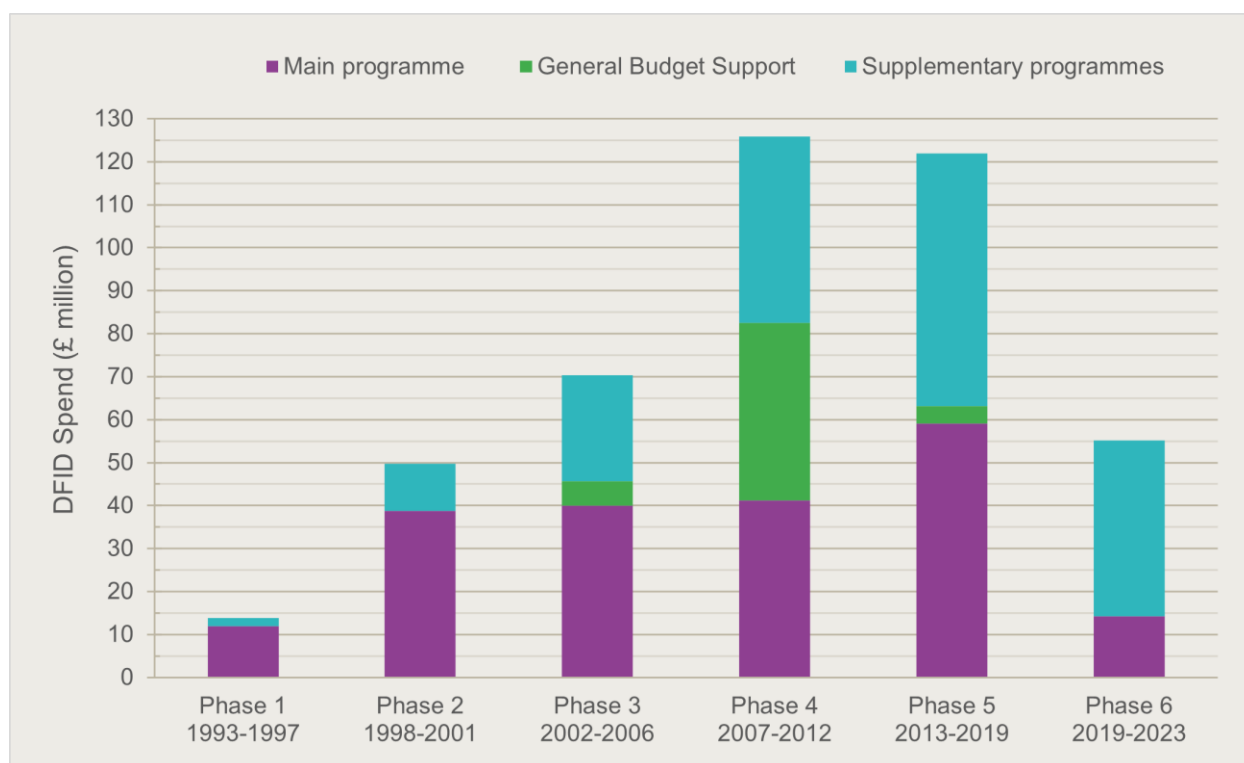
² Republic of Ghana (2019). Ghana Beyond Aid Charter and Strategy Document

³ Valters C and Whitty B (2017) The politics of the results agenda in DFID 1997-2017

General Budget Support before swinging back to earmarking and projects, with DFID heavily involved in the details of design and implementation. Since 2020 UK support has declined considerably in financial terms, with a growing focus on directly awarded contracts to implement projects, and social sector rather than health-specific programmes.

In terms of the UK’s role, the paper focuses predominantly on the main health sector support package at the time. However, the UK was involved in many other ways. Typically, alongside the main programme, DFID funded research and a number of smaller health projects, as well as centrally managed multi-country programmes which included Ghana. The smaller health projects focussed on a particular issue (such as malaria, family planning, vitamin A and HIV/AIDS) that ran concurrently with the main health systems strengthening programme. They often tackled a risky or new area, which the Government of Ghana was unwilling to fund initially, but would likely fund after the need was demonstrated and implementation had been proved to be possible. Figure 1 shows DFID/FCDO spend by phase, broken down to show the main health sector support programme, the health component of General Budget Support and other, smaller bilateral health programmes. In Phase 1 the vast majority of spending was on the main health systems support programme rather than smaller programmes – the reverse was true in Phase 6. General Budget Support was extremely important in Phase 4 (2007-12), of minor importance in Phases 3 and 5, and non-existent in Phases 1, 5 and 6.

Figure 1: DFID/FCDO Spending in health in Ghana, (1993-2023)



Source: Dev tracker, FCDO official estimates, and project reports

The UK government also contributed financially to many development partners active in the Ghanaian health sector, including the World Bank, UNFPA, WHO, the Global Fund and GAVI. At the start of the 30-year period, most UK spend in Ghana was bilateral. Later on, multilateral channels were dominant, accounting for an estimated 66% of the total UK development assistance in Ghana in 2017, compared with 45% in 2011.⁴ As well as making financial contributions, the UK took an interest in the work of these

⁴ ICAI (2020) The changing nature of UK aid in Ghana Country - portfolio review

organisations in Ghana and other countries, and was involved in global level discussions about the performance of many multilaterals and global health initiatives.

The 30 years described in this paper saw dramatic changes in global health, influencing the rapid development of Ghana's health sector. Ghana in turn shaped global health thinking, notably through its work on SWAps (the sector-wide approach) and the Community-Based Health Planning and Services strategy (CHPS). In 1993 there was still a focus on primary health care based on the 1978 Alma Ata Declaration and 'Health for All by the Year 2000'.⁵ The adoption of the Millennium Development Goals (MDGs) by the UN Assembly in 2000 focused minds on specific health outcomes; international spending on health increased dramatically. Several global health initiatives emerged to address some of the most significant challenges, including UNAIDS in 1996, Roll Back Malaria in 1998, the Global Alliance for Vaccines and Immunisation (Gavi) in 2001 and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria in 2003. At the same time as these often vertically managed initiatives were coming to the fore, a large number of partners - including the Ghanaian and UK Governments - signed the Paris Declaration on Aid Effectiveness in 2005.

Primary health care remained in the spotlight following the 2008 conference which re-affirmed the 1978 Declaration, the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa by African Heads of States, and the 2018 Astana Declaration.⁶ In 2017 the Sustainable Development Goals (SDGs) heralded a wider perspective on health and a deeper approach to addressing equity, notably through Universal Health Coverage (UHC). From the early 2000s the national health insurance scheme in Ghana grew in importance to make a vital contribution to the overall financing of the sector. Then, in the 2020s, although mortality from COVID-19 was low by global standards, the Ghanaian economy and health sector were severely disrupted by the pandemic.

The development of Ghana's health sector over 30 years is of course a very complex story. There are numerous private health facilities, both for-profit and not-for-profit. The share of private health facilities has grown since the 1990s, but as of 2023 the public sector is still larger, with 57% of all health facilities.⁷ The determinants of health are much wider than the activities of the health sector, with investments in education, water supply and many other areas contributing to the improvement in Ghanaians' health. There were numerous other development partners at play over the period, including bilateral and multilateral agencies, NGOs and global health initiatives. However, this paper focuses on the UK's role and the public sector in health in Ghana, whilst acknowledging the major role played by many other factors. It also focuses in particular on the aid modalities being used – in other words the financial, planning and reporting channels – because this was a keenly contested issue over the timespan of this work.

There were a number of name changes for the provider of UK development assistance over the period – from the Overseas Development Administration (ODA) at the start, changing to the Department for International Development (DFID) for most of the period, and becoming the Foreign, Commonwealth and Development Office in 2020.⁸

The next section of this paper describes changes over time in Ghana's economy health status and health systems performance. Some key health systems issues are reviewed, followed by discussion of the six phases of support. The paper then reflects on what can be learnt from this 30-year history to inform future practice, notably in the areas of aid modalities, deciding what areas to fund, and the use of indicators and targets.

⁵ WHO (1978) Alma Ata Declaration on Primary Health Care

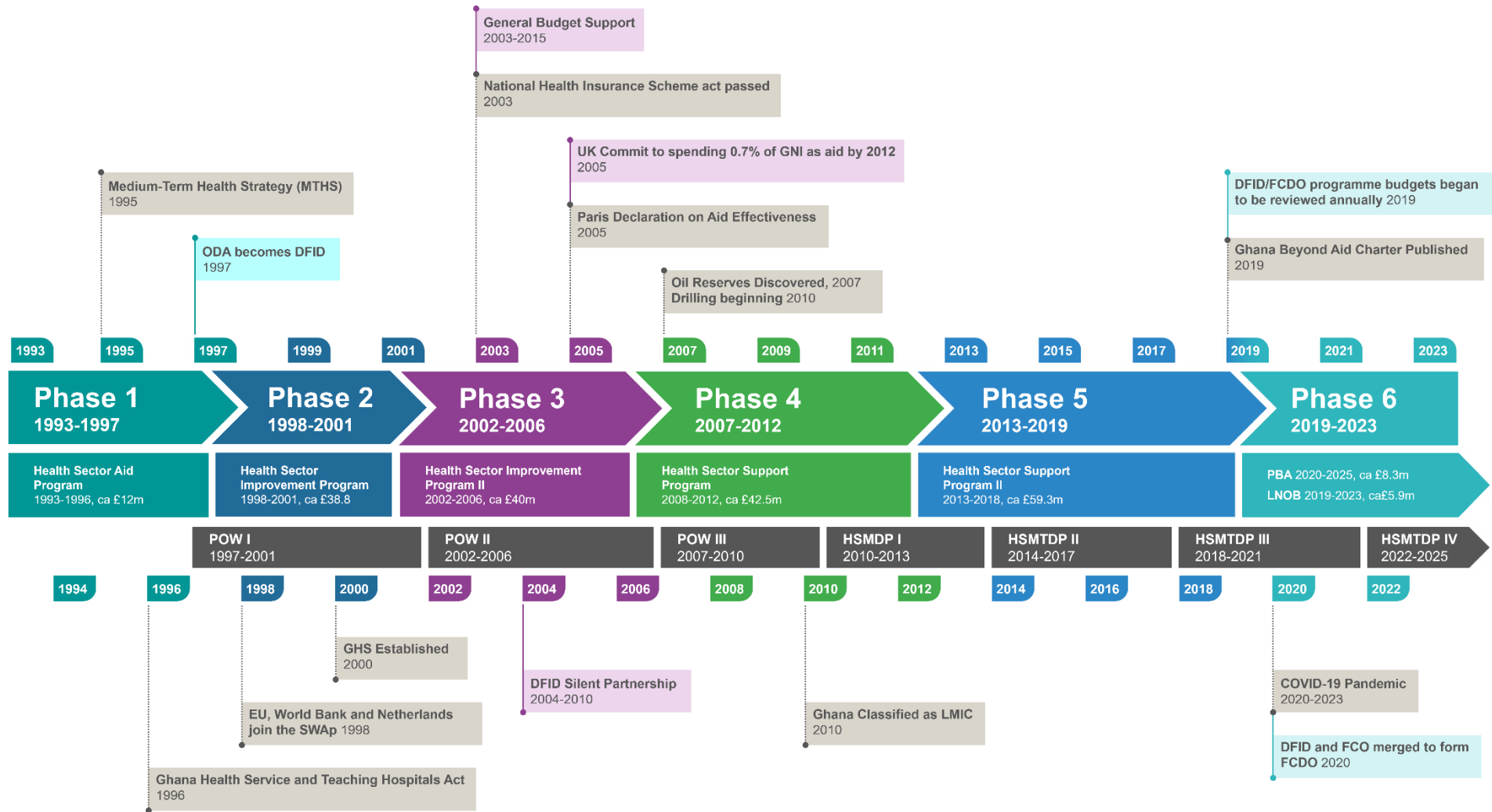
⁶ WHO (2018) Astana Declaration

⁷ Ministry of Health, Ghana (2024) 2023 Holistic Assessment of the Health Sector

⁸ Contemporaneous names are used when possible. DFID is used when referring to multiple time periods as it was the name used for most of the period under discussion.

The paper is based on a literature review and interviews with a cross-section of people involved in the events described here – Ghanaian policymakers, past and present DFID health advisers, implementers, Development Partners (DPs), and other health sector players. In the interest of frankness, it was agreed that the interviewees would remain anonymous.

Figure 2: A 30-year timeline of events in Ghana, (1993-2023)



2 Ghana's Economy and Health

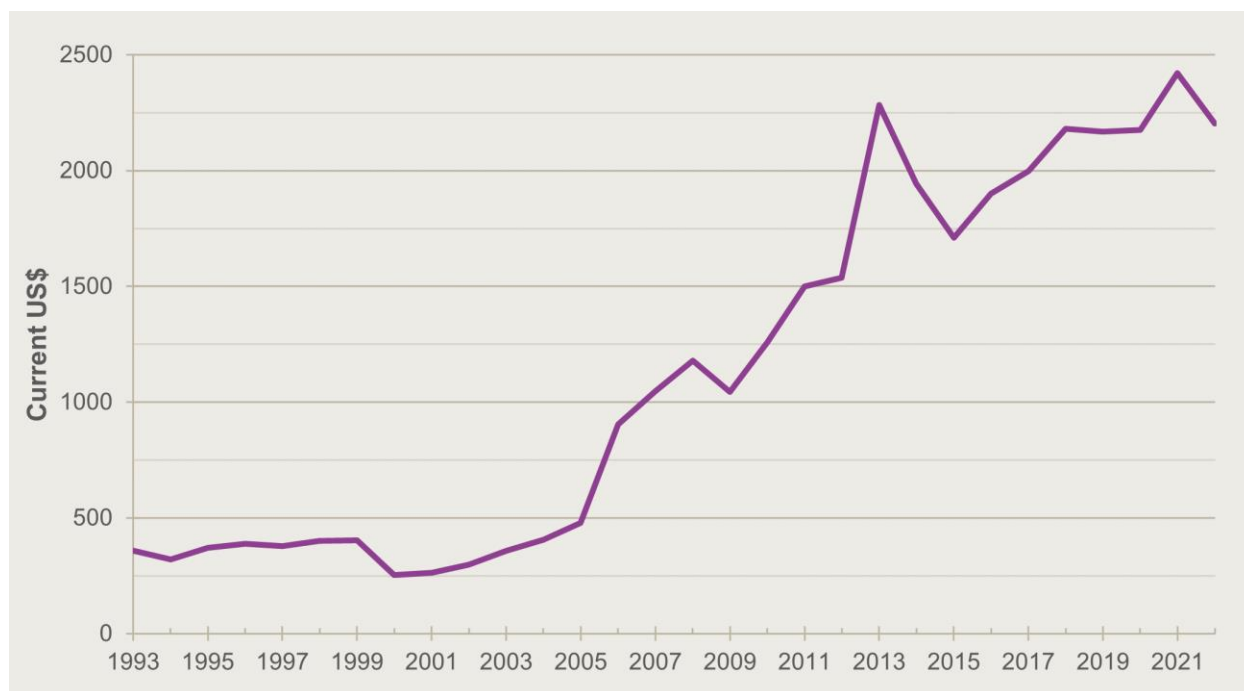
Key points

- Health and economic status generally improved over the 30 years. 1993 to 2010 saw the most progress, with slower improvement – and in some cases reversal – after 2010.
- Performance has been mixed when compared to countries of similar socio-economic levels.
- Geographic and income-based health inequalities have persisted.

2.1 Economics, inequality, and poverty

Figure 3 shows GDP per capita over time, with notable falls in 2009, 2014/5 and 2022. The discovery of oil contributed to economic expansion in the 2000s, a reduction in the poverty rate by over half, and attainment of lower-middle income country status in 2010. However, in the early 2020s the economy faltered, with poverty increasing. The COVID-19 pandemic and rising global instability contributed to a worsening macro-economic environment which culminated in 2023 with the 17th IMF bailout since independence.

Figure 3: GDP per capita in Ghana, (1993-2022)



Source: World Bank Indicators, 2022, <https://data.worldbank.org/indicator>

Ghana has persistent challenges in terms of inequality and poverty. The Gini index measures how far the distribution of income or consumption deviates from perfect equality – 0 represents full equality.⁹ The Gini co-efficient for Ghana was 38.4 in 1991, worsening gradually to 43.5 in 2016, which is the most recent

⁹ World Bank Indicators (2022), <https://data.worldbank.org/indicator>

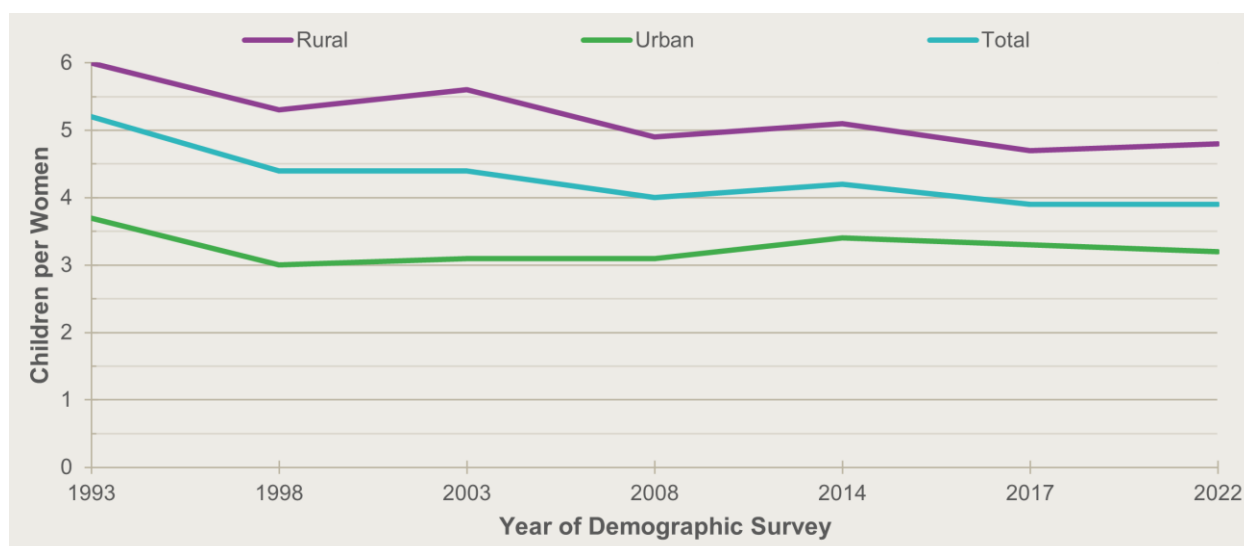
calculation available. This is the highest Gini co-efficient of any West African lower-middle income country.

The poverty ratio at \$2.15 per day fell from 55% in 1998 to 42.5% in 2005 and 25.2% in 2016. Amongst West African lower-middle income countries Ghana has the second highest poverty ratio after Nigeria. Ghana's poverty ratio was also consistently higher than the lower-middle income country (LMIC) average – for LMICs the rate was 15.9% in 2016, compared with 25.2% in Ghana. Extreme poverty actually increased from 10% in 2013 to 13.6% in 2019 (and probably more during the pandemic).¹⁰

2.2 Health status overview

Ghana's population has increased almost five-fold since independence, from 6.9 million in 1960 to 33.5 million in 2022,¹¹ with the proportion of urban residents increasing from 23% to 57%.¹² Annual population growth fell steadily but slowly to 1.9% in 2022, from a recent peak of 2.7 in 2002 (in 1993 it was 2.4%). The total fertility rate fell from 5.2 in 1993 to 3.9 in 2022 (see Figure 4).

Figure 4: Fertility trends by residence in Ghana, (1993-2022)



Source: Ghana Demographic and Health Survey, 2022

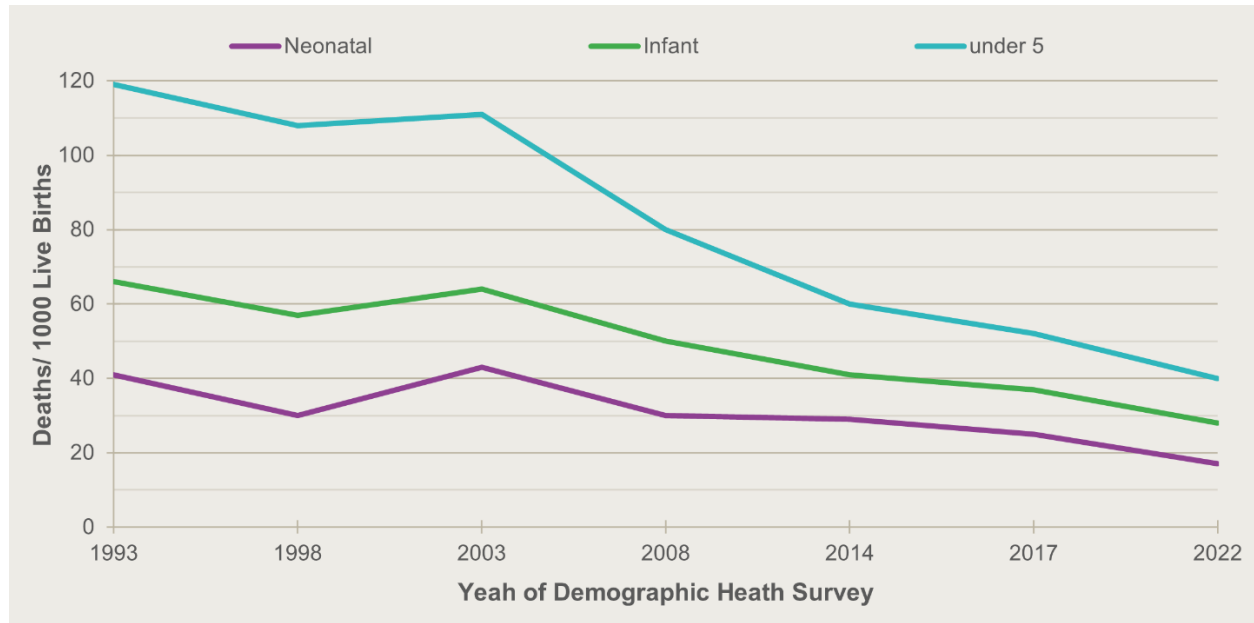
¹⁰ FCDO (2023) UK-Ghana development partnership summary

¹¹ World Bank Indicators (2022), <https://data.worldbank.org/indicator>

¹² Ghana (2021) Population and Housing Census. <http://census2021.statsghana.gov.gh>

Ghana has seen many aspects of improvement in health. Using data from successive Demographic and Health Surveys, Figure 5 illustrates the broad decline of neonatal, infant and under-5 mortality over the 30-year period.

Figure 5: Neonatal, infant and Under-5 mortality in Ghana, (1993-2022)



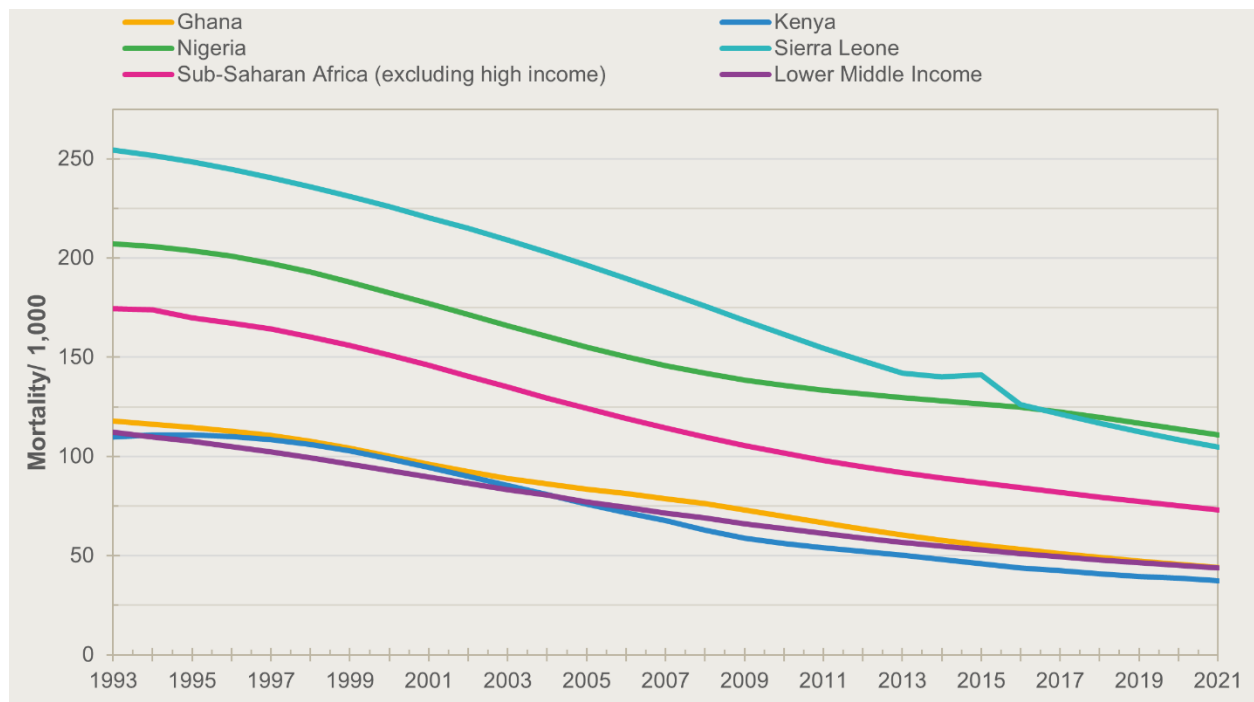
Source: Ghana Demographic Health Survey, 2022 and Ghana Maternal Health Survey, 2017

Figure 6 shows that in terms of the under-five mortality rate over time Ghana has matched the performance of Kenya and of the LMIC average, whilst doing consistently better than the Sub-Saharan African average.^{13,14}

¹³ Salem K (2013) Ghana's Health Sector: A comprehensive assessment. World Bank

¹⁴ Statistics for Ghana are from the Ghana Statistical Service, including the Demographic and Health Surveys, where possible. International data sets are used for international comparisons. There are some minor inconsistencies between these sources. Comparisons over time always use a consistent dataset.

Figure 6: Under-5 mortality per 1,000 comparison, (1993-2022)

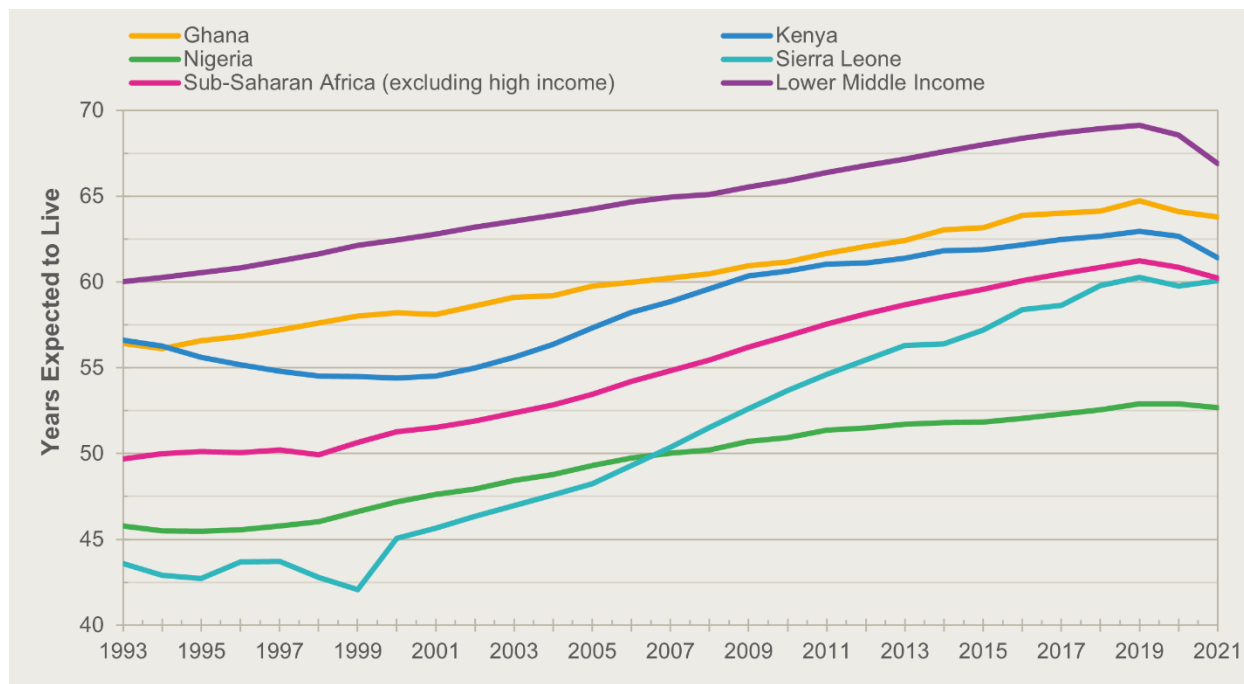


Source: World Bank Indicators, 2022, <https://data.worldbank.org/indicator>

Figure 7 shows life expectancy for Ghana and a number of other African countries, as well as Sub-Saharan Africa and lower-middle income countries (LMIC). Ghana does well by African standards, but has been consistently lower than the LMIC average. In common with a number of other LMICs, life expectancy in Ghana has dropped slightly since 2019.¹⁵

¹⁵ World Bank indicators (2022), <https://data.worldbank.org/indicator>

Figure 7: Life expectancy at birth comparison, (1993-2021)



Source: World Bank Indicators, 2022, <https://data.worldbank.org/indicator>

The incidence of malaria dropped from 431 in 2000 to 164 in 2021, though cases rose considerably between 2007 and 2011. However, as the overall burden of disease changed, non-communicable diseases became more prominent – in 2019 stroke ranked as the 2nd most common cause of death, with ischemic heart disease 5th and diabetes 9th.¹⁶ 22.5% of Ghanaians now die from a major non-communicable disease (CVD, cancer, diabetes or CRD).

Despite these improvements in health indicators, Ghana suffers from persistent health inequalities by geographical area, urban–rural location, and socio-economic status. The poorer regions in the north tend to have the least favourable indicators - Northern region at times had more than double the under-5 child mortality rate of Greater Accra region.

If we compare Ghana’s health statistics to the average for LMICs, a mixed picture emerges. Ghana’s levels are within 10% of the lower-middle income average for life expectancy, maternal mortality, and under-five mortality. Mortality from NCDs in Ghana is very near the LMIC average of 22.0%. The statistics where Ghana is most different from the LMIC average are population growth rate (1.0% average compared with Ghana’s 1.9%) and total fertility rate (2.6 average and 3.9 in Ghana).

Comparing with only LMICs in West Africa – Benin, Cabo Verde, Côte d’Ivoire, Guinea, Mauritania, Nigeria and Senegal - for many of the indicators (life expectancy, population growth, total fertility, under five mortality, NCDs) Ghana lies somewhere in the middle. The two exceptions are maternal mortality and malaria – in both of these Ghana performs relatively well. With the exception of tiny Cabo Verde, Ghana has the lowest maternal mortality of this group. Ghana’s 334 (2017) compares with Senegal’s 440 (2018) and Guinea’s 833 (2016).¹⁷

Of the five countries which had a broadly similar incidence of malaria in 2000 – Benin, Côte d’Ivoire, Ghana, Guinea and Nigeria – Ghana has achieved the most significant sustained decrease. Nigeria saw a huge decline between 2011 and 2015, but incidence has increased since then (latest data 2021).

¹⁶ IHME Ghana Facts (2024), <https://www.healthdata.org/research-analysis/health-by-location/profiles/ghana>

¹⁷ World Bank indicators (2022), <https://data.worldbank.org/indicator>

Ghana is unusual in Africa for the extent to which it has prioritised support for mental health. Historical data on mental health in Ghana is not available. It has been estimated that about 13% of Ghanaians have a mental disorder, with 3% having a severe disorder. The top three diagnoses out of people who seek treatment are schizophrenia, substance abuse and mood disorders.¹⁸ However many patients do not receive a specific diagnosis, and the treatment gap is estimated at 98%.

2.2.1 Key features of the health system and its performance

Key points

- Ghana's health system performance generally improved over the 30 years, with 1993 to 2010 seeing the most progress.
- Government has been responsible for an increasing proportion of total health expenditure over time, but with a dip in 2010 to 2014.
- The National Health Insurance Scheme (NHIS) has expanded significantly since the 2000s, but has faced persistent financial sustainability issues.
- The expansion of health infrastructure since the 1990s was not matched by budget expansion or changes to practices to maintain and supply the institutions.
- Health worker to population ratios doubled between 2005 and 2015, however, inequitable distribution of human resources persisted.
- The routine health information system has evolved into an integrated internet-based District Health Information System.

Ghana has made satisfactory improvements in health status and service coverage over the past 30 years, but the slowing down (and in some cases reversal) of improvements from 2010 is notable. Although some reduction in the pace of health improvements is epidemiologically inevitable, and the determinants of health are multiple, coverage of some basic health services has faltered.

Health Service coverage and utilisation

Out-patient attendance per capita improved significantly from 0.32 in 1995 to a peak of 1.16 in 2013, then hovered around 1.0. (These figures are under-estimates, due to shortcomings in data about the private sector.) The main drivers of increased utilisation include the construction of more facilities, the Community Health Planning and Services strategy (CHPS), and improved financial access due to the National Health Insurance Scheme (NHIS). However as with other aspects of health, outpatient attendance varies greatly by geography. In 2023, 12 out of the 16 regions had an out-patient attendance rate of 0.95 or more. The other four regions had rates between 0.57 and 0.78.¹⁹

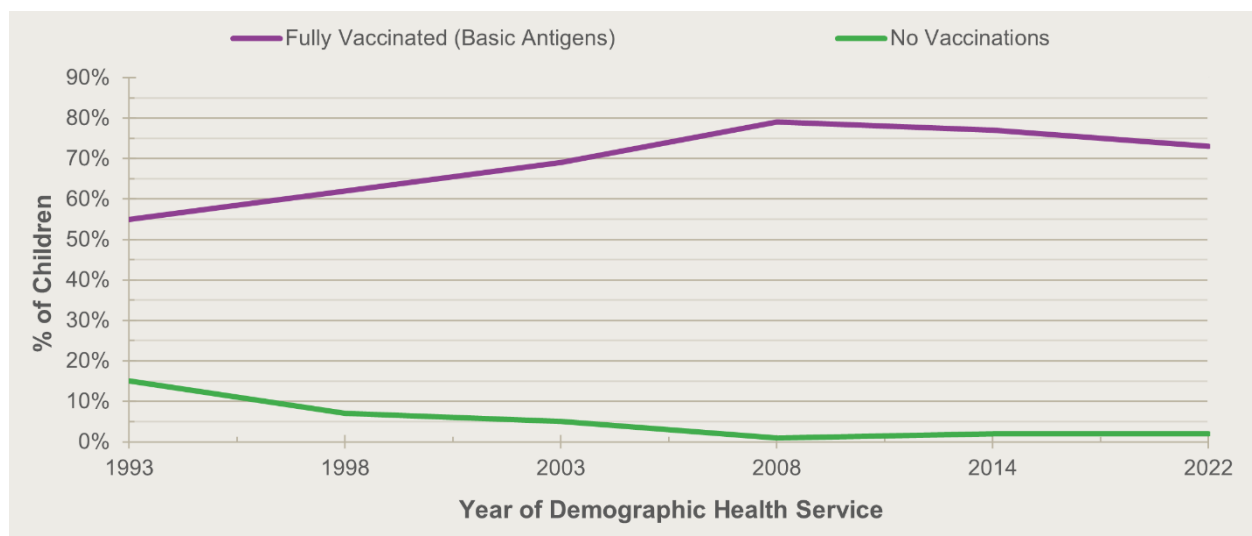
Since it began in 1978 the national immunisation programme has expanded its coverage dramatically, as well as increasing the number of routine antigens delivered from 6 to 13. However full immunisation rates have been falling since 2008 (see Figure 8).²⁰ Ghana piloted Human Papilloma Vaccination from 2013-2015 and discussions are ongoing about its inclusion in the routine system. Ghana participated in malaria vaccine trials and approved one vaccine ahead of WHO approval. In 2023 roll-out started, with a view to nationwide coverage.

¹⁸ Nonvignon, J et al (2020) Benefit-Cost Analysis of Mental Health Interventions in Ghana: Ghana Priorities. National Development Planning Commission and Copenhagen Consensus Center

¹⁹ Ministry of Health (2024) Holistic Assessment 2023

²⁰ Ghana Statistical Service and The DHS Program, USA (2023) Ghana Demographic and Health Survey 2022 Key Indicators Report

Figure 8: Trends in childhood vaccinations in Ghana, (1993-2022)



Source: Ghana Demographic Health Survey, 2022

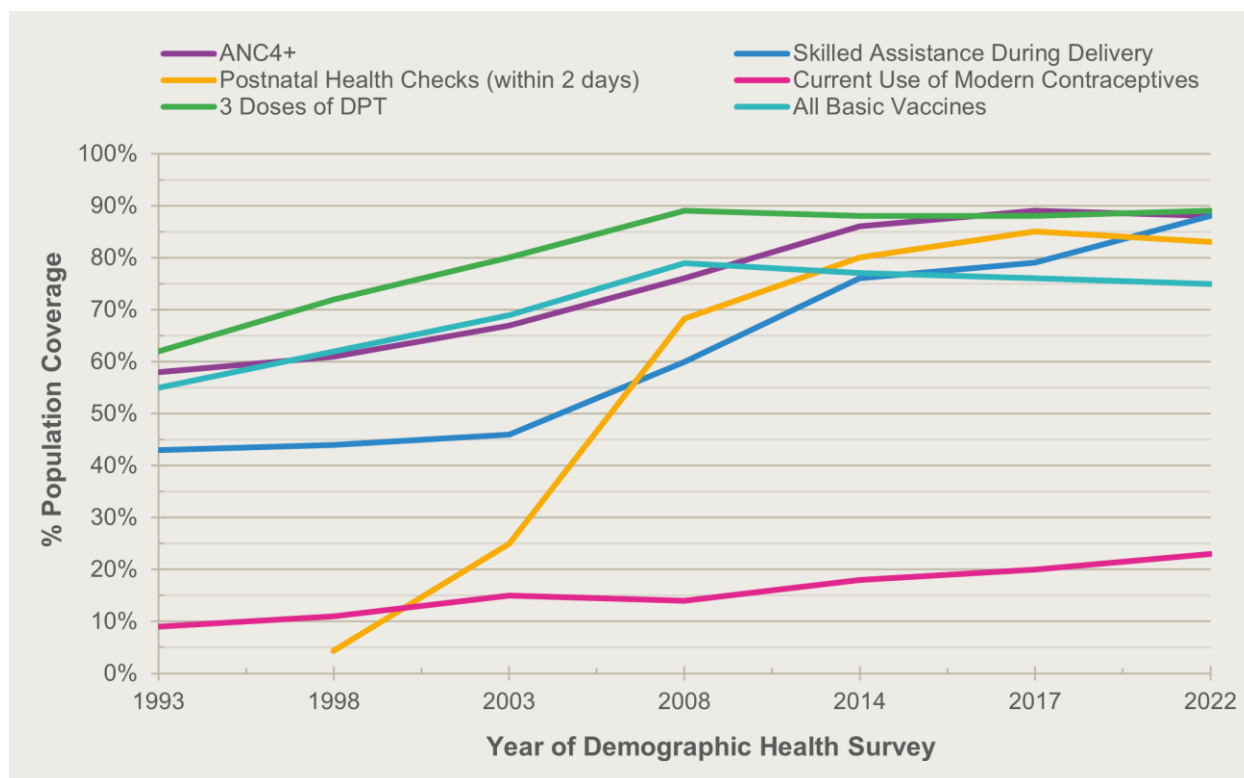
Reproductive health services have seen steady progress over the 30-years: rates of family planning acceptors among married women increased from 10% in 1993 to 28% in 2020; first attendance at antenatal care became almost universal, increasing from 82% in 1988 to 98% in 2022 with no significant differences by region, urban–rural residence, or socioeconomic status; the proportion of pregnant women who made at least four antenatal visits (ANC4+) increased to 89% in 2017, before stagnating around that level. Skilled attendance at delivery increased from 44% in 1993 to 88% in 2022.²¹ Despite seeing significant increases in all of these indicators over the 30-year period, Figure 9^{22,23} shows a clear stagnation in improvements, and some reversal, since 2010. The downward trend in basic vaccines since 2008 is of particular concern.

²¹ Ghana Statistical Service and The DHS Program, USA (2023) Ghana Demographic and Health Survey 2022 Key Indicators Report

²² WHO Indicators (2021), www.who.int/data/gho/data/indicators

²³ Ghana Maternal Health Survey, 2017

Figure 9: Maternal and family health coverage indicators in Ghana, (1993-2022)



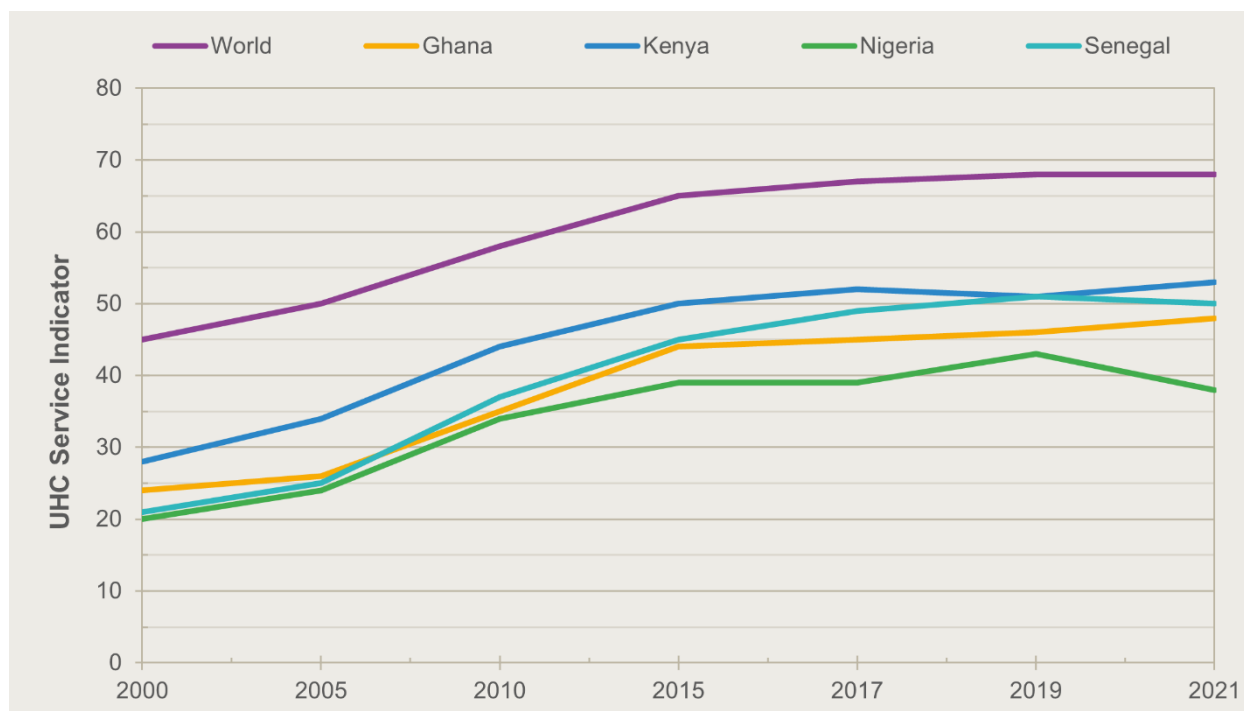
Source: Ghana Demographic Health Survey, 2022 and Ghana Maternal Health Survey, 2017

The Universal Health Coverage Service Indicator, which is an SDG indicator²⁴, is based on access to a basket of representative health services.²⁵ Figure 10 shows the indicator over time for the world as a whole, Ghana and other selected lower-middle income countries in Africa. Ghana's experience is fairly typical – rapid rises between 2000 and 2015, and then expansion slowing down considerably. Ghana's coverage did increase between 2019 and 2021, unlike many other countries (and the global total) - the COVID-19 pandemic and its economic consequences adversely impacted most health systems worldwide.

²⁴ SDG 3.8.1.

²⁵ WHO and World Bank (2023) Tracking universal health coverage: 2023 global monitoring report. Geneva. Licence: CC BY-NC-SA 3.0 IGO

Figure 10: Universal health coverage service indicator (out of 100) comparison, (2000-2021)²⁶



Source: WHO Indicators, 2021, <https://www.who.int/data/gho/data/indicators>

Health financing

Money for health comes from multiple sources: Government, development partners, individuals paying directly through out-of-pocket spending (OOP), or by purchasing health insurance. In the 1990s health financing interventions were largely focused on how to mitigate the adverse effects of out-of-pocket spending on vulnerable users through targeted exemptions and on co-ordination of development assistance. The National Health Insurance Scheme (NHIS) was initiated in 2003 as a decentralised scheme with three objectives: to reduce health inequalities, improve access, and increase utilisation of the health system. In 2012 a revised law consolidated the policies into a centralised Scheme. The NHIS is mostly funded by the National Health Levy (2.5% VAT) and 1% of contributions from the Social Security and National Insurance Trust (SSNIT).²⁷ However in practice there have been many problems with disbursements by the Ministry of Finance from the VAT Levy to the Insurance Authority, with less than 7% of the Levy being transferred in 2021.²⁸ While the NHIS has led to higher levels of healthcare utilisation and financial protection for those enrolled, challenges persist including low enrolment levels, financial deficit and out-of-pocket spending amongst those enrolled.²⁹ Other reasons for the financial instability of the scheme include a low premium value (less than US\$1), a high number of premium exemptions, and increasing costs for procurement, logistics and health service delivery.³⁰

²⁶ SDG indicator 3.8.1

²⁷ Novignon et al (2021). Political economy and the pursuit of universal health coverage in Ghana: a case study of the National Health Insurance Scheme. *Health Policy and Planning*, 36, 14–21

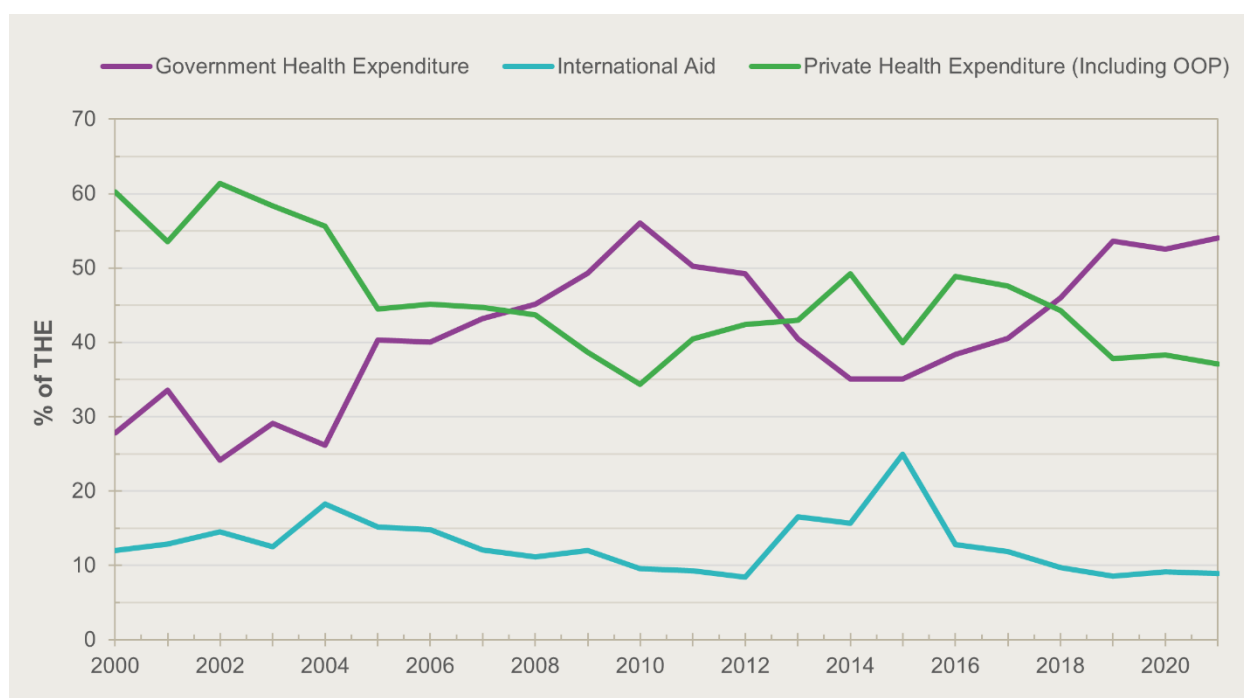
²⁸ Ministry of Health (2023) Ghana Health Financing Strategy 2023-30

²⁹ Vellekoop et al (2022). Supporting a review of the benefits package of the National Health Insurance Scheme in Ghana. *Cost Effectiveness and Resource Allocation*, 20(1), 32

³⁰ Alhassan et al (2016). A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects? *PLOS ONE*, 11(11), e0165151

Figure 11³¹ shows the composition of Total Health Expenditure (THE) in Ghana broken down by Government, development assistance ('international aid'), private expenditure (including OOP). This shows a growing role of Government financing in the health system at the same time as the proportion of private expenditure fell. This is primarily because of the NHIS, with active membership rising quickly until the 2010s when it stagnated at 35-40%. It returned to growth from 2019 and reached 54% in 2021 after the introduction of the electronic renewal system.^{32,33} It then rose to 55.5% in 2023.³⁴ These changes in coverage match changes in Government health expenditure (see Figure 11). An inverse relationship can be seen between OOP and Government health expenditure. The slump in NHIS progress was a result of financial and managerial challenges, for example not adjusting tariffs to reflect market rates, long delays in reimbursing providers that resulted in the introduction of some unofficial co-payments, and providers opting out of the Scheme. The introduction of electronic membership renewal, along with more robust vetting of claims, improved these processes, but delays in payments and adjustments of tariffs in the highly inflationary environment remain major concerns for service providers. It has proved easier to improve practical operational processes than the more politicised challenges linked to finances.

Figure 11: Total health expenditure sources in Ghana, (2000-2022)



Source: WHO Indicators, 2021, <https://www.who.int/data/gho/data/indicators>

³¹ WHO Indicators (2021), www.who.int/data/gho/data/indicators

³² World Bank (2017) Ghana's NHIS: Improving Financial Sustainability based on expenditure review

³³ Ministry of Health Holistic Assessment Reports 2017, 2022

³⁴ Ministry of Health (2024) Holistic Assessment Report 2023

Table 1: Health expenditure as a % of GDP and government expenditure in Ghana, (2000-2021)

Indicator	2000	2005	2010	2015	2021
Total Health expenditure (THE) as % GDP	2.8	3.6	4.2	4.5	4.2
Government health expenditure as % GDP	0.8	1.5	2.4	1.6	2.2
Government health expenditure as % Total Government Expenditure	6.0	10.6	11.9	8.6	8.2
Out-of-pocket Spending (OOP) as % of total health expenditure	52.6	37.1	27.6	35.8	27.3

Source: WHO Indicators, <https://www.who.int/data/gho/data/indicators>, 2021

As seen in Table 1, health spending in Ghana rose between 1993 and 2015 as a percentage of GDP. Health expenditure as a percentage of total Government spending rose from 2000-2010 but then fell as priorities shifted. Nevertheless, as per Table 2, Ghana's Government allocation of spending on health compares favourably to the African average, though it is lower than Kenya and the Global Average (in 2021).

Table 2 also illustrates that Ghana is less reliant on OOP and private health insurance than other countries in the region, and close to the global average. However, it should be noted that – at 27% - OOP is still higher than the WHO recommended upper limit of 20%.

Table 2: Health expenditure comparisons³⁵

Indicator	Ghana	Nigeria	Kenya	Sierra Leone	Africa Average ³⁶	Global average
Government health expenditure as % Total Government Expenditure	8.2%	4.10%	9.30%	6.90%	7.25%	11.20%
Government Health Expenditure as % of Total Health Expenditure (THE)	54%	13.30%	48.70%	22.60%	34.40%	53.70%
Government Health Expenditure/ capita in current US\$	\$54	\$11	\$46.1	\$10	\$65.1	\$980.5
Private Health Expenditure as % THE	37%	78.9%	32.80%	51.70%	41.40%	35.70%
Out-of-pocket Spending (OOP) as % of total health expenditure	27%	76.2%	22.80%	51.40%	33%	28.20%
International Aid as % of THE	8.9%	7.9%	18.4%	25.7%	24.2%	11.6%

Source: WHO indicators, 2021, <https://www.who.int/data/gho/data/indicators>

³⁵ Data from 2021 or the most recent available data

³⁶ WHO Africa Region

Health service inputs

Health services are delivered through a three-tier system: primary (district services), secondary (regional services), and tertiary (specialised and teaching hospitals). There are public and private facilities, plus traditional and alternative medicine service providers. The Ghana Health Service (GHS), established in 1996, is the lead agency for primary and secondary-level service delivery. The Christian Health Association of Ghana (CHAG), an umbrella NGO of Christian health facilities, is the main faith-based non-profit health service provider, providing 18% of out-patient visits in 2023. CHAG is an influential stakeholder in the sector.

The **private sector** in Ghana consists of hospitals, clinics, pharmacies, chemical shops and laboratory facilities. According to the 2023 Holistic Assessment, 18% of out-patient visits were to health facilities in the for-profit private sector in 2023 - this figure does not include pharmacies or chemical sellers, which in practice account for more than half of initial contacts/informal consultations.³⁷ For-profit facilities are heavily concentrated in urban areas in the south of Ghana – 80% of health facilities in the Greater Accra region are privately owned.³⁸ An analysis disaggregated by ecological zone found that 52% of people in Ghana with an illness or injury went to a private health facility. Accra had the highest rate (69%), whilst the areas classified as 'rural savannah' had the lowest (35%). Of all types of health facility (public and private), hospitals were the most frequently attended (35%), followed by chemical stores (29%).³⁹

There has been a massive expansion of **government health infrastructure** since the 1990s with new clinics, health centres and hospitals (district, regional and teaching). However, this has not been matched by appropriate budgets and practices to maintain and supply institutions. The CHPS, a flagship programme to increase access to basic PHC services, has been slow to scale up since its adoption in 2000. A 2016 review supported a revamped implementation, but issues with infrastructure, equipment and operational funds for delivery persisted. An essential health services package was developed for all levels of the health system to support PHC and UHC. Currently, the Network of Practice (NoP) Strategy is being scaled up nationally to strengthen PHC at the sub-district level.^{40, 41}

³⁷ Ghana Statistical Service (2019) Ghana Living Standards Survey Round Seven 2017 (GLSS7) Main Report.

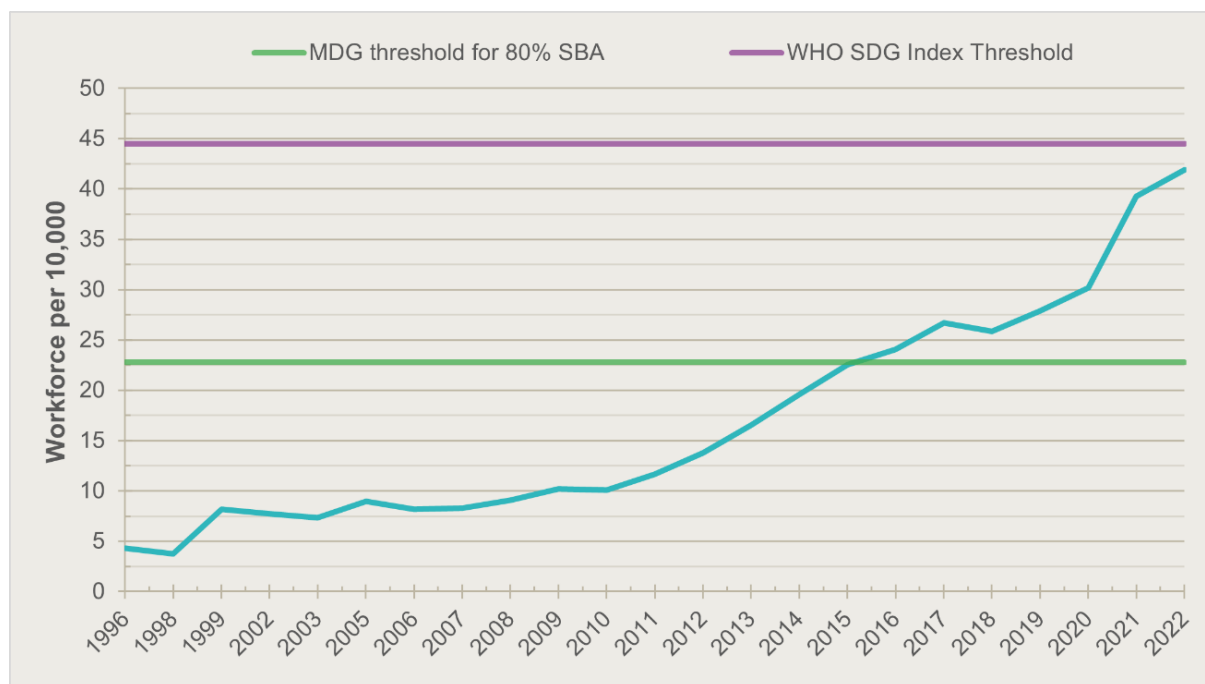
³⁸ Nimako B A et al (2020) Towards effective participation of the private health sector in Ghana's COVID-19 response. Pan Africa Medical Journal.35(2):47. DOI: 10.11604/pamj.supp.2020.35.2.23387

³⁹ Ghana Statistical Service (2019) Ghana Living Standards Survey Round Seven 2017 (GLSS7) Main Report

⁴⁰ The plan is to have a model health centre as a hub at the sub-district level capable of providing the full package of primary care and the basic essential public health functions. It would have referral and support linkages to the CHPS zones and other health facilities within its catchment area.

⁴¹ World Bank Project map, 2024, <https://projects.worldbank.org/en/projects-operations/project-detail/P17316>

Figure 12: Density of health workforce per 10,000 in Ghana, (1996-2024)



Source: Ministry of Health (2024) Labour Market Analysis for The Health Sector of Ghana

In terms of the **health workforce**, Figure 12 shows the density of health workers in the public sector from 1996-2022. By 2022, health worker numbers were almost at the level identified by WHO (44.5 per 10,000) as sufficient to deliver the Sustainable Development Goals, including UHC.⁴² However this aggregate data masks two issues. First, there are in fact about 83 trained health workers (doctors, nurses and midwives) per 10,000 people, but approximately 40% of these are unemployed. Second, there are significant geographical inequalities: Greater Accra and Ashanti regions have a disproportionate share of doctors, pharmacists and Registered General Nurses. The two regions together account for 32% of the population, but around 67% of all doctors, 67% of all pharmacists and 51% of Registered General Nurses are employed there.⁴³

The **health information** system has evolved over the 30 years period from an unco-ordinated passive collection of data with minimal analysis and use, to an integrated internet-based District Health Information System (DHIMS 2) in which live data is accessible to authorised users. DHIMS 2 was scaled nationwide in 2012 and has become a vital source of information for health managers and many development partners, as well as the main source of data for the annual Holistic Assessment of sector performance. Parallel internet-based information systems have been developed for transactional medical records, human resources, logistics and financial management.⁴⁴

Periodic population-based information gathering has also improved since 1987/88 when the first Ghana Demographic and Health (GDHS) and the Ghana Living Standards Surveys (GLSS) were conducted. Since then, there have been seven GDHS, seven GLSS, two Maternal Health Surveys and a Harmonised Health Facility Assessment.

⁴² Scheffler R et al (2016) Health workforce requirements for universal health coverage and the Sustainable Development Goals – Background paper N.1 to the WHO Global Strategy on Human Resources for Health: Workforce 2030. Human Resources for Health Observer Series No 17. WHO.

⁴³ Ministry of Health (2024) Labour Market Analysis for The Health Sector of Ghana

⁴⁴ Lighthouse Integrated Medical Records System (LIMS), Ghana Integrated Logistics Information Management System (GhiLMIS), Human Resource Management Information System, and Ghana Integrated Financial Management Information System (GIFMIS)

3 A Timeline of Ghana's Health Sector and UK Development Assistance

Key points

- This section describes the evolution of the Ghanaian health sector and UK support over the 30-year period (1993-2023). Six phases of shifting priorities and aid modalities are identified.
- The focus is on the main programmes - large value health systems and policy development work that supported the jointly agreed five-year Programmes of Work. Other smaller programmes funded by the UK were implemented concurrently.
- Aid modalities shifted over time from primarily Financial Aid to more UK-managed, earmarked support. Support for Technical Assistance (TA) was a constant.
- From the late 2010s, the UK development assistance budget in Ghana dropped substantially.

This section describes the evolution of the Ghanaian health sector and DFID support from 1993 to 2023 through six phases, which are based on the timeframes of the major UK health support programmes. Figure 2 (page 8) illustrates the six phases and key events. For each phase, we briefly describe key developments in the health sector in Ghana, the nature of UK support, and, in recognition of the political nature of development assistance, the prevailing UK development policies.

The paper focuses on DFID's main programmes: large-value health systems and policy development programmes which supported jointly agreed five-year Programmes of Work (POW). The main modality was Financial Aid (FA) in varying forms (including a pooled fund and sector budget support), plus Technical Assistance (see Box 1). Health also benefitted from General Budget Support from 2003–2015. However, the FA model changed significantly in 2013 with the introduction of earmarked support to specific areas and became relatively less important in the 2020s as more contracts were directly awarded by the FCDO.

The main programmes in this period were complemented by smaller value programmes in HIV/AIDS,^{45,46} malaria^{47,48,49,50}, reproductive health, family planning, mental health, neglected tropical diseases, strategic information generation and the health workforce.

Over the 30-year period DFID consistently focused support on sector governance and equity. Governance included sustained engagement on health financing, public financial management, sector planning and monitoring, and (latterly) regulatory capacity and accountability. An equity focus was adopted in capacity development for national health insurance, the Ghana Health Service, community health and mental health. These areas aimed to contribute to the efficiency and effectiveness of the Ghanaian public health system, but also gave space for DFID to talk about the appropriate use of its funds.

⁴⁵ DFID Support to the Multi- Sectoral HIV & AIDS Programme 2006-2010

⁴⁶ DFID Ghana Aids Partnership Programme 2001-2005

⁴⁷ DFID support a pilot on local production of nets with treatment by local tailors in Accra and Kumasi in 2006

⁴⁸ DFID (2013). Ghana Malaria Prevention, Diagnosis and Data Programme 2013-2016

⁴⁹ DFID (2011). Prevention of Malaria through Procurement and Distribution of Long Lasting Insecticide Treated Nets (LLINs)

⁵⁰ DFID (2016). Private Sector Malaria Project Ghana 2016-2019

Box 1: Aid modalities for UK programmes: financial Aid and technical Assistance

Financial Aid (FA) is development assistance provided to a partner government, which is responsible for spending the funds. However, the development partner may be involved in decisions about how the funds are spent, for example through earmarking.⁵¹ There are a variety of forms of Financial Aid, one important difference being the nature of any earmarking - none, earmarking for a specific sector such as health, or earmarking for particular activities or outcomes.

Starting in 1997, FA was channelled through a pooled donor Health Fund to support the sector's first 5-Year Programme of Work (POW). From 2008 the Health Fund was replaced by performance-based Sector Budget Support (SBS). SBS was channelled through the Ministry of Finance and managed completely by the Government of Ghana (allocation, reporting and auditing). This modality was stopped in 2014 and was replaced with earmarked FA to specific programmes. FA then continued until the end of the period, but at a lower level and as a smaller proportion of UK support.

Technical Assistance (TA) was funded throughout all the main programmes. It was organised in several ways, including in-house health advisers, contracted consultants (long- and short-term) and study tours. TA was sometimes funded by the UK and sometimes alongside other development partners (DPs). Requests for specific pieces of policy work were largely initiated by the MoH, though the funds were also useful for investigating issues of concern to DPs. In 2013 a new model was introduced for a few years: a £5 million TA fund managed by the Ministry of Health. This was essentially FA that enabled the MoH to procure TA for issues of its choice.



3.1 Phase One (1993-1997): Initial conceptualisation of the sector wide approach

Key Points

Core UK Programme: Health Sector Aid Programme (HSAP), 1993-1996
Programme Value: ca £12 million

- There was strong, far-sighted Government leadership in Ghana.
- Ghana was at the forefront of thinking about the Sector Wide Approach (SWAp), which influenced global thinking.
- The UK's Overseas Development Administration (ODA) provided much-needed funding and facilitated Government ownership.
- There was not a strong focus on impact measurement, as improvements in health were *assumed* to occur because of systems development. However, a subsequent Demographic and Health Survey showed improvements in mortality rates and services between 1993 and 1998.

⁵¹ Rabinowitz G (2016) Identifying the main categories of Financial Aid instruments (beyond budget support) and how they have been used. Development Institute

3.1.1 Ghana's health sector

Ghana's prolonged political instability following the 1966 coup⁵² and the accompanying economic turmoil had a deleterious effect on the health sector. The sector was cash-starved: infrastructure deteriorated and there was little recurrent financing beyond salaries; there was a significant exodus of health professionals; user fees were introduced as part of the IMF/World Bank-backed economic reforms in the 1980s^{53,54} which further limited access for the poor, especially in rural areas.

In 1986 Dr Moses Adibo became technical head of the Ministry of Health (MoH). His visionary leadership ensured that by 1993 a national health system that focused on primary health care, with regional and district health management teams, was under development. Furthermore, Dr Adibo, with the support of development partners (including the Overseas Development Administration), strategically developed the skills of young, motivated professionals in health policy, planning and management.⁵⁵

During the 1990s development partners were increasingly interested in the Ghanaian health sector. This generated a demand for stronger health planning, but paradoxically served to undermine central planning. This was a recurrent theme amongst our Ghanaian interviewees. The preponderance of DPs brought new challenges: DPs focused on specific parts of the system which resulted in resource allocation distortion; there was limited capacity building; many relatively small-scale projects were never scaled up; and a fragmented approach led to gaps and duplications that did not necessarily reflect national priorities.

Interview Highlight

“Development Partners both demanded and undermined health planning.”

Sector management was accelerated by the 1996 Act 525 that paved the way for the establishment of the Ghana Health Service (GHS) in 2000. This was a major development in the evolution from one health ministry to a MoH at the centre, with the GHS, teaching hospitals and three regulatory bodies managing the sector.

Financial management in the MoH had traditionally been highly centralised, with the result that district health offices had minimal access to cash and little financial management experience. This limited their ability to respond flexibly to needs. In the mid-1990s it became evident that if joint working was to promote primary care and public health, districts would need to develop capacity in managing money. District Budget Management Centres (BMCs) were created with the purpose of accrediting districts as fit to manage funds: districts were assessed in terms of their staffing and financial systems. This systematic approach gave a focus to extensive support for districts and enabled the disbursement of substantial resources to the local level.

By 1996 there was enough stability and capacity in strategic planning and operational management for the DPs and MoH to reconsider the nature of their relationship. Ghana was a thought leader in the global formation of the Sector Wide Approach (SWAp). The conceptualisation and birth of SWAps was largely a result of experience in Ghana⁵⁶ and Zambia, countries whose leaders wanted ‘to do business differently’. (See Box 2 for an explanation of SWAps.) A Joint Financial Appraisal in 1996 recognised that financial management had improved and identified areas for further strengthening. Collectively, these reflected a

⁵² Following the military/police takeover of the Nkrumah government in 1966 there were four military and three civilian governments

⁵³ Waddington C, Enyimayew KA. (1989), A price to pay, part 1: the impact of user charges in Ashanti-Akim district, Ghana. *International Journal of Health Planning and Management*. 4:17–47. 37

⁵⁴ Waddington C, Enyimayew KA. (1990) A price to pay, part 2: the impact of user charges in the Volta region of Ghana. *International Journal of Health Planning and Management*. 5: 287–312

⁵⁵ International funding for Masters Courses decreased from 2000 onwards; the School of Public Health (established 1994) was producing more graduates.

⁵⁶ Cassels A (1997) A guide to sector-wide approaches for health development: concepts, issues and working arrangements. WHO

significant commitment to strengthening institutions and systems related to sector wide planning, budgeting, financial management, procurement, human resources, and support services management.

At the end of Phase one in 1997 the first SWAp programme was initiated – the Programme of Work I (POW I). Ghana's SWAp was founded on three documents: the Medium-Term Health Strategy, the first Five-Year Programme of Work (POW I) 1997-2001, and the Common Management Arrangements (CMA) which set out how DPs could work together to support the Ministry's POWs.

Box 2: What is a SWAp?

Sector-wide Approach (SWAp) is an approach to development partner working – it does not have globally standardised rules and procedures and it is not a financing modality. It is a way of development partners working together to support an agreed national plan in a coherent, non-duplicative way. A SWAp seeks to strengthen national ownership in a sector, supporting government priorities and resource allocation systems. To reduce fragmentation and transaction costs, it is desirable to have a broad set of common management arrangements, covering planning, funding channels and monitoring. There are usually annual sector reviews and a forum for dialogue about challenges and policies.⁵⁷

3.1.2 ODA's policy support and development assistance instruments

The Overseas Development Administration's main programme was the Health Sector Aid Programme (HSAP), 1993-1996. It had six components: policy and strategy; district strengthening; financial management; human resource development; medical equipment; and transport systems.

HSAP was unusual for its time because it was emphatically a health systems strengthening programme with results in terms of health impact initially assumed, but only roughly described. HSAP's six components dealt with some conventional areas for ODA (human resources and financial management), but also included more unusual systems-focussed programmes such as transport and medical equipment standardisation and maintenance. The philosophy was that well-functioning systems were a necessary part of the MoH's effectiveness. Resources were provided through FA and paid into a Trust Fund, while HSAP also funded TA and the procurement of equipment and vehicles.

The first logical framework for ODA's support in this era was devised in 1996. By 1997 a list of 20 core indicators had been agreed by the MoH and several development partners. Whilst an important breakthrough in terms of streamlined shared monitoring, the list encountered many practical problems. For example, some indicators quickly had 100% achievement, but they were not adapted for some time.

By shifting resources to districts, equity was assumed, rather than explicit during this phase, partly because of a paucity of data, but partly because it was presumed that health systems strengthening would lead to improvements. In practice inequalities amongst districts *increased* because of the resource allocation formula which favoured districts with higher populations and more health workers. This disadvantaged sparsely populated rural districts, which also faced higher costs because of the need to travel between localities.

3.1.3 UK international development policy⁵⁸

In 1997 New Labour came to power, with an international commitment to shared poverty reduction based on the principle of partnership and country ownership. National interest was not an overt consideration.

Events in Ghana were influenced by this ideology, which in turn influenced ODA's global thinking. ODA's relationship with the Government of Ghana shifted. It was at the centre of discussions about SWAps, and

⁵⁷ FAO, Investment Learning Platform, <https://www.fao.org/investment-learning-platform/themes-and-tasks/swaps/en/>

⁵⁸ The policy sections for the period 1997-2017 draw heavily on Valters C and Whitty B (2017) The politics of the results agenda in DFID 1997-2017.

championed thinking that emphasised national ownership, a holistic view of the sector and health systems strengthening.

As well as changes in policy, ODA's management and communication systems were also changing. At the start of the period in 1993 the financial management systems were not well-suited to supporting flexible local decision-making. E-mail was not yet available and requests for funding had to be sent to the UK by fax or through the diplomatic bag. A local imprest account was managed in the health office through basic manual systems. Over time this system was streamlined so that there were electronic transfers to pooled funds and later the Government of Ghana's treasury.

Interview Highlight

The Director of Medical Services at the time was fond of a quote from a visiting ODA team leader in 1988/9 as he interpreted it as heralding an era of openness and partnership:

“We have not come with solutions. We are here to help you solve some of your problems.”



3.2 Phase Two (1998-2001): The birth of the sector wide approach in Ghana

Key points

Core UK Programme: Health Sector Improvement Programme I (HSIP I), 1998-2001
Value of Programme: ca £38.8 million

- The SWAp mobilised resources for the health sector, empowered managers and created a strong partnership between the MoH and development partners. Ghana was at the forefront of translating SWAp principles into practice and country leadership was paramount.
- The SWAp was in line with DFID's⁵⁹ preferred way of doing business. The UK saw itself as contributing to a country's progress through shared goals; specific attribution to DFID was not seen as important.
- The lack of improvement in most service delivery and health outcomes reported during the annual reviews and the 2003 Demographic and Health Survey underlined the challenges that the SWAp needed to address, including slow, unclear reforms and weak monitoring of service delivery.
- Greater focus was given to central level policy issues rather than implementation on the ground, reflecting the belief that central reforms were a necessary investment for future gains.

3.2.1 Ghana's health sector

The first Programme of Work 1997-2001 (POW I) was the framework for the SWAp and reflected Ghana's commitment to improving the nation's health, in consonance with the Millennium Development Goals (MDGs) which were adopted in 2000. It had the following objectives:

⁵⁹ In 1997 the ODA became DFID

- Increasing geographical and financial access to basic services.
- Improving quality of healthcare.
- Improving efficiency.
- Fostering closer collaboration with communities and other sectors.
- Increasing overall resources in the sector and promoting equity.

POW I heralded a new relationship between the MoH and development partners. Some DPs supported it through their own parallel projects and others through the first 'Pooled Trust Fund' that was established in 1997. A Memorandum of Understanding was signed between the MoH and each of the DPs willing to participate. The funds were managed by the Ministry of Health while a DP-approved audit firm conducted annual audits in conjunction with the National Public Audit Body. Initially the Danish International Development Agency (DANIDA) and DFID contributed to the Health Fund, with the EU, the Netherlands, and the World Bank joining in 1998.^{60,61}

The management arrangements were regarded as innovative because the MoH had considerable leeway to plan how resources were utilised within the programme's broad parameters. This was a clear change from the more specific project support of the past and began a long period when DFID and other development partners worked in this way.^{62,63}

The SWAp evolved and strengthened over time. Joint planning and monitoring were core to the new way of working. Initially there were two annual health summits. The April Summit reviewed health sector performance in the previous year, informed by an independent review report and a joint audit report by an external audit firm and the Government Auditor-General. District, regional and national reports contributed to the independent review. The October/November Summit focused on the POW for the following year. Each Summit involved a broad range of stakeholders and ended with business meetings between the MoH and development partners. The meetings concluded with the signing of an Aide Memoire by the Minister of Health and each development partner. There were three business meetings per year that discussed sector performance, emerging policy issues and pledges of support. Partners also held monthly meetings.

The review at the end of POW I - *Health of the Nation*⁶⁴ - noted that it had attracted more resources, and that more of these were reaching districts. However, it also found that this had not translated into increased sector performance. Some of the problems identified were long delays in implementing Government reforms and a lack of clarity about the respective roles of the MoH and the Ghana Health Service. Moreover, the review noted that plans at the local level were not scrutinised, and implementation was not adequately monitored.

3.2.2 DFID's policy support and development assistance instruments

DFID replaced ODA in 1997 and responded to POW I with a year of planning that led to the Health Sector Improvement Programme (HSIP) of 1998-2001, with a value of around £38.8 million.

HSIP was aimed at increasing access to quality health services. To this end, HSIP supported major institutional developments such as increased capacity of the decentralised Budget Management Centres,

⁶⁰ MOH (1996). The Common Management Arrangements

⁶¹ Addai E & Liz Gaere (2001). Capacity-building and systems development for SectorWide Approaches (SWAps): the experience of the Ghana health sector

⁶² Asamoah-Baah & Smithson, (1999). DPs and the MOH: New Partnership in Ghana

⁶³ Addai E & Liz Gaere, (2001). Capacity-building and systems development for Sector Wide Approaches (SWAps): the experience of the Ghana health sector

⁶⁴ Ministry of Health Ghana (2001) The health of the nation: reflections on the First Five Year Health Sector Programme of Work 1997-2001

establishment of an internal audit unit in the MoH, and most critically, launching the Ghana Health Service. Support continued for the efficient management of transport and medical equipment.

HSIP used two aid modalities. It provided Financial Aid through the Health Fund: DFID was deeply involved in the design of the Fund and shaped its evolution. It also engaged TA to support reforms and new policies.

HSIP, the Health Fund, and the alignment of support with the POW I priorities demonstrated confidence in national leadership and Ghana's systems. The targets of the national programme were adopted into DFID's monitoring and accountability tool, the logical framework (logframe).

In addition to HSIP, DFID funded a maternal vitamin A supplementation trial⁶⁵ and a review of private health, which led to the establishment of the Coalition of NGOs in Health and the engagement of the private sector in the evolving health sector partnership.⁶⁶ It had been noted in earlier Health Summits that private sector engagement was missing from the sector support programme.

3.2.3 UK international development policy

The prevailing UK development policy described under Phase One continued, with the focus on results strengthening over time. The UK saw itself as contributing to a country's progress through shared goals; specific attribution to DFID was not seen as important. Ideas were evolving about aid effectiveness and the importance of harmonised systems of support and alignment with national plans.

An example of DFID's commitment to participating in SWAPs was the publication in 1998 of a guide for DFID health advisers - *Developing Sector Wide Approaches in the Health Sector*.⁶⁷

⁶⁵ LSHTM/KHRC (1999). "ObaapaVitA" Vitamin A Supplementation and Maternal Mortality Trial: Randomized double-blind placebo controlled trial to evaluate the impact of vitamin A supplementation on maternal mortality in Ghana

⁶⁶ DFID/MOH (2000). Promoting the Participation and Financing of Civil Society: An Options Appraisal Study of the Ghana Health Sector

⁶⁷ Walford, V (1998) Developing Sector Wide Approaches in the Health Sector – an issues paper for DFID advisers and field managers. Institute for Health Sector Development



3.3 Phase Three (2002-2006): The evolution of the SWAp, the silent partnership and general budget support

Key points

Core UK Programme: Health Sector Improvement Programme II (HSIP-II), 2002-2006
Value of Programme: ca £40 million

- The National Health Insurance Scheme (NHIS) Act was passed with the goal of removing financial barriers to healthcare.
- The SWAp continued. DFID was a major funder but a 'silent partner' from 2004-2010. In effect this meant that DFID waived its right to a seat at the table for oversight of HSIP-II, delegating it to the Netherlands Embassy.
- The silent partnership was not welcomed by the MoH, its agencies, or by other development partners. Consultations about the change were considered minimal and DFID's active contribution to policy dialogues was missed.
- Most health indicators improved and the SWAp attempted to tackle persistent challenges such as inequality of service provision and use.
- Beyond the health sector, some development partners started to provide General Budget Support.

3.3.1 Ghana's health sector

Ghana's Programme of Work from 2002-2006 (POW-II), which guided the detail for HSIP-II, was entitled *Partnerships for Health: Bridging the Inequalities Gap*. It echoed the priorities of the Ghana Poverty Reduction Strategy (GPRS) that was developed as part of work on the so-called 'highly indebted poor countries' in 2002. POW-II had three objectives:

- Bridging equity gaps in access to quality health services.
- Ensuring sustainable financing arrangements that protected the poor.
- Enhancing efficiency in service delivery.

In response to this strategic direction, the National Health Insurance Agency (NHIA) was created in 2005 (elevated to an Authority in 2012) with the aim of improving access to care for poorer people. There was major investment in primary care through a programme called Community Health Planning and Services (CHPS).

HSIP II continued to see good sector outcomes. However, progress on pro-poor initiatives and overall governance and performance was mixed. Little progress was made on the equitable distribution of personnel and the ratio of salary to non-salary expenditure. The roll-out of CHPS was sporadic and hampered by the low level of non-salary spending. Nonetheless, health sector wages rose, the migration of health workers abroad was curbed and user-fees at service delivery points were officially abolished.

POW-II was guided by the Common Management Arrangements II (CMA II), a refreshed 'rules of the SWAp'. POW-II continued to mature the SWAp ways of working: twice yearly health summits, business meetings and annual independent assessments became important events. These activities provided opportunities for health, Ministry of Finance and local government officials and implementers to debate progress and challenges with development partners. The MoH and development partners had productive

policy engagement and the fiduciary governance was considered good. There was strong international interest in the SWAp.

In parallel to the health sector, major relationship changes between the Government and development partners occurred. In 2003 the Government signed agreements with a number of DPs to create the Multi-Donor Budget Support (MDBS) partnership that provided General Budget Support. Box 3 gives more information about MDBS.

Interview Highlight

Although General Budget Support made resources directly available to the Government of Ghana, the interviews revealed that many MoH officials did not support it. They feared that the health sector's traditionally high level of financial support from DFID and other development partners might be eroded.

The main reasons for starting General Budget Support in 2003 were at the macro level, notably Parliamentary endorsement of the Poverty Reduction Strategy and IMF approval for a new growth facility.⁶⁸ Evaluations do not reference the experience of SWAs in health and education as an influence on the decision. One benefit of GBS was said to be that it improved policy dialogue between government and development partners within sectors, but this was less of a change in education and health, where dialogue had been active before GBS. Whilst GBS was judged in evaluations to have brought about improvements in the national aid architecture, and Ghana's legal and policy framework, it encountered the same problems as sector budget support in being unsuccessful in influencing some long-running challenges, notably the very high percentage of the recurrent budget spent on wages.⁶⁹

⁶⁸ Lawson A et al (2007) Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology Final Report Volume One: Evaluation Results and Recommendations on Future Design & Management of Ghana MDBS. Report to the Government of Ghana and to the MDBS Partners, Overseas Development Institute and CDD-GHANA

⁶⁹ Particip GmbH in collaboration with IEG (2017) Joint evaluation of budget support to Ghana (2005-15) High-level summary. Independent evaluation jointly managed by the European Commission (DG DEVCO's Evaluation Unit), the World Bank's Independent Evaluation Group, the Governments of Ghana, Denmark, France and Germany

Box 3: General budget support (2003-2015)

General Budget Support (GBS): This aid modality operates through the Ministry of Finance's allocation processes. Funds are channelled through Government systems with oversight from multi-donor mechanisms. The Multi-donor Budget Support (MDBS) was a Ghanaian version of GBS.

What was MDBS? Several development partners came together to sign agreements with the Government to provide Financial Aid as GBS. The first MDBS agreements were signed with 9 DPs: (African Development Bank, Canada, Denmark, EU, Germany, Netherlands, Switzerland, UK, and World Bank) in 2003, with France following in 2005. A new agreement was signed with 11 DPs (including Japan) in 2008.

What was the objective of MDBS? The primary objective was to create a harmonised mechanism for the disbursement of budget support to assist the implementation of the Poverty Reduction Strategy, later the general government budget. GBS was promoted as a means to encourage pro-poor macro policies and implementation. It was based on a mature Government/ DP relationship which to some extent viewed projects, with their DP-managed inputs, as narrowly focused and imposed from outside.

How did it operate? A twice-yearly dialogue between the Government and MDBS partners was established. They discussed the annual national programme, a common Performance Assessment Framework, a disbursement schedule, and an annual progress assessment.

How did MDBS perform? It contributed an average of 10% of the annual Government budget between 2003 and 2015. 17% of the MDBS was spent on health. It ran into problems after the 2013 annual review when the Government and the DPs could not agree on the Performance Assessment Framework. There were also concerns about poor macro-economic performance, financial management, and the ballooning Government wage bill. Some partners started earmarking their support and others left the arrangement when Ghana was classified as a lower-middle income country in 2011.

DFID's contribution to the MDBS: DFID was at the forefront of the establishment of the MDBS and their country assistance programme (2003-2006⁷⁰) focussed on supporting the Poverty Reduction Strategy through the MDBS. Overall DFID contributed around £304.5 million through GBS. This support peaked in 2008, reduced in 2009-2011 and significantly tailed off in 2011-2015.

3.3.2 DFID's policy support and development assistance instruments

DFID continued its involvement with the SWAp, supporting a national strategic health plan, adopting its results framework, engaging in SWAp processes, and providing significant resources. TA was also funded.

As the SWAp evolved, there were two significant developments in *how* DFID support was provided. Firstly, there was a move away from the pooled Health Fund towards Sector Budget Support (SBS), which was channelled through the Ministry of Finance, but earmarked for health. This was using, and displaying confidence in, more of Ghana's administrative structure. SBS was the leading modality for HSIP-II (2002-2006) and the Health Sector Support Programme 2008-2012 (HSSP-I).

Secondly, a period called the 'silent partnership' started in 2004. DFID provided substantial funds, but delegated oversight to another partner, the Netherlands Embassy. This was the theory at least – in practice DFID was somewhat inconsistent and at times was present in discussions. During the 'silent

⁷⁰ DFID (2003). DFID Country Assistance Programme 2003-2006

partnership' DFID did not have a resident health adviser. This somewhat radical arrangement is described in Box 4.

DFID's technical programme responded to the equity focus by supporting the development of the National Health Insurance Agency (later Authority) and the implementation of exemption policies related to user fees. DFID also supported a number of specific technical areas, including malaria,^{71,72} HIV/AIDS (through both pooled and earmarked FA)^{73,74} and service availability mapping, which provided information about gaps in delivery for the preparation of the Poverty Reduction Strategy and the next 5-year POW.⁷⁵

Box 4: The silent partnership (2004-2010)

During the 'silent partnership' DFID remained a major funder, but programme management was done through pooled arrangements. DFID delegated its 'seat at the policy table' (including representing DFID in sector policy dialogue) to the Netherlands Embassy and did not have a resident adviser. jointly

The partnership with the Netherlands did not include managing DFID funds. Moreover, DFID was not entirely 'silent', as at times it participated in key missions and debates. The MoH felt that it had not been appropriately consulted about DFID's plans for the partnership. Additionally, the silent partnership was devised when the SWAp was regarded as performing well, but faced significant challenges when it experienced a less stable period of declining development partner confidence in results.

The silent partnership ended in 2010 (Phase 4) because DFID started to increase its monitoring requirements and because the Netherlands found the role increasingly onerous. This increased interest in details reflected a DFID-wide shift away from delegated responsibility.

This period of the silent partnership was in stark contrast to other times when DFID was often nominated as the lead DP amongst collaborators. The silent partnership appeared to have been promoted centrally by DFID when there was great enthusiasm for partnership-based working: it supported governments and it gave the possibility for DPs to work more efficiently and save resources. The arrangement was estimated to have saved DFID around £100,000 per year.

The silent partnership arrangement was not always understood by other partners, many of whom (including key MoH staff) were left believing that DFID had 'lost interest' in the Ghanaian health sector. A review of the silent partnership captures the mood:

*"The majority of respondents [health officials and DPs] felt that removal of a DFID health adviser had been a loss to the sector policy dialogue. Whilst they recognised the efficiency gains in having fewer partners to discuss with, they felt that in a context of sector working – where much of the interaction was in a group - that having one person more or less was not the key issue. Several people said they appreciated a diversity of views and that 'two heads are better than one', for example in venues such as the workshop to prepare the sector Programme of Work. In some ways this is a positive finding – showing that people valued the inputs of past DFID health advisers."*⁷⁶

3.3.3 UK international development policy

2003 to 2007 was a significant period for UK international development policy. 2005 saw the UK's political commitment to provide 0.7% of Gross National Income as aid spending by 2013. The UK was a major

⁷¹ In 2004, DFID and USAID funded a mixed public-private sector ITN distribution project using a voucher system in the Volta Region.

⁷² DFID supported a pilot on local production of nets with treatment by local tailors in Accra and Kumasi in 2006

⁷³ DFID Ghana Aids Partnership Programme (GAPP) 2001-2005

⁷⁴ DFID Support to the Multi- Sectoral HIV & AIDS Programme (MSHAP) 2006-2010

⁷⁵ MOH (2007). Ghana Service Availability Mapping (SAM) Report. Conducted in 2005

⁷⁶ Walford V Evaluation of the Netherlands-DFID Partnership in the health sector in Ghana. 2007

proponent of the 2005 Paris Declaration on Aid Effectiveness that sought to institutionalise co-ordination through the principles of harmonisation and alignment. In the health sector, the Paris Declaration was taken forward with the establishment in 2007 of the International Health Partnership (IHP), an agreement between DPs and development assistance recipients on a process of mutual responsibility and accountability for the production and implementation of national health plans.⁷⁷

The UK's international development policy fitted well with Ghana's situation: there was political and economic stability and the UK had confidence in the health sector and the wider development context. The UK appreciated that the Government of Ghana proactively reached out and shaped new relationships with development partners. Ghana was 'ahead of the pack' in adopting these relationships.



3.4 Phase Four (2007-2012): The height of the SWAp, but doubts start to creep in

Key points

Core UK Programme: Health Sector Support Programme I (HSSP-I), 2008 -2012
Programme Value: ca £41.2 million

- Health improvements largely stalled.
- The start of this period saw the closest Government/development partner relationship over the 30 years.
- Overall DFID financial support increased substantially, largely because of the ongoing General Budget Support.
- The phase started with strengthening of the SWAp, including consolidation of the Holistic Assessment Tool (Box 5). However, the latter years signalled the beginning of the end of the SWAp.
- DPs began to move away from Common Management Arrangements. Ghanaian officials found DFID's increasing demands for information arduous.
- DPs expressed doubts about health sector leadership, while visible tensions developed between the MoH and the Ghana Health Service.

3.4.1 Ghana's health sector

The 2007 *National Health Policy: Creating Wealth through Health* guided the development of the Programme of Work 2007-2011 (POW-III). This was truncated in 2010 and replaced with the first 4-year Health Sector Medium Term Development Plan 2010-2013 (HSMTDP-I).⁷⁸ HSMTDP-I adopted Universal Health Coverage, which remained at the centre of successive HSMTDPs.

These broad plans were supported by technical policies that guided the development of annual workplans at all levels. A notable SWAp 'tool' was the Holistic Assessment Tool (see Box 5). The Tool measured a range of health performance indicators – each was scored to give a composite score, thus allowing for

⁷⁷ Lancet (2007) International Health Partnership: a welcome initiative

⁷⁸ This was in response to the National Development Planning Commission's directive to all sectors to develop four-year medium term development plans to align with the national economic development policy agenda

annual comparisons. HSMTDP-I was supported by refreshed Common Management Arrangements 2008-2013 (CMA III) which, as with previous CMAs, determined the 'rules of engagement' and the SWAp working mechanisms.

Several recurring organisational challenges were noted with concern by development partners over this period. One problem was that overly-verticalised programmes went against the reforms strengthening the Regional and District Health Management Teams in the 1990s. The MoH was challenged to provide strategic leadership and tensions emerged between the Ministry and the Ghana Health Service.⁷⁹ A committee set up in 2008 to review the relationship recommended the re-establishment of a unified Health Service. Legislative processes to that end started but stopped after the change of Government in 2009.

Health improvements largely stalled during these years and it became clear that achievement of MDGs 4 and 5 was unlikely.⁸⁰

Box 5: The holistic assessment tool

The Holistic Assessment Tool was an important part of the joint working arrangements. It was a widely respected SWAp tool that influenced SWAp monitoring in other countries. The Holistic Assessment Tool was unusual in that it looked at management performance and service delivery, as well as outcomes, and used both qualitative and quantitative information. It is still used to this day.

The MOH described it as the following:⁸¹

“The Holistic Assessment Tool was designed to offer stakeholders the opportunity to dialogue on sector performance within an agreed framework. It is a departure from assessing a basket of a few indicators and generalizing such performance as representative of the whole sector. The tool provides a broader framework for assessing the health sector in a more comprehensive and holistic manner. The primary objective of the holistic assessment of the health sector is to provide a very brief but well-informed, balanced and transparent assessment of the sector’s performance and factors that are likely to influence this performance. The outcome of the assessment should lead to proposals for remedial measures to be put in place. The rationale is to encourage incremental improvement in service delivery outcomes over a specified period.”

3.4.2 DFID’s policy support and development assistance instruments

DFID continued with its strong support for SWAp principles and sector planning. It did so through its policy engagement and review of performance that was nominally linked to the following year’s tranche of support – as was Ghana’s performance against macro policy areas (financial management, pro-poor policies, and human rights).

HSSP-I had the specific objective of accelerating progress towards achieving the health orientated MDGs. HSSP-I consisted of a large sum of SBS (ca £40 million) and a small component for TA (around £2.5 million). DFID’s overall investment continued to grow, with about £34 million reaching the health sector through General Budget Support.

⁷⁹ MOH (2010). Independent Review of Health Sector Programme of Work 2009, Ghana: Final Report

⁸⁰ MDG 4: Reduce the Under-5 mortality by two thirds. MDG 5: Reduce maternal mortality by three quarters. (1990 and 2015)

⁸¹ MOH, Ghana (2018). Holistic assessment of the 2017 health sector Programme of Work

3.4.3 UK international development policy

The UK economy suffered after the 2007 global financial crash. Public support for aid seemed to wane and HSSP-I was influenced by a changing direction of UK international development policy after 2007.

In 2010, the new Conservative Government retained the 0.7% commitment and swiftly moved to emphasise evidence, value for money and accountability. The Independent Commission for Aid Impact (ICAI) was established in 2011 to hold UK development spending to account. The understanding and use of the term 'results' changed. As Valters and Whitty state: *"Used colloquially, 'results' simply means developmental aims or ends. Yet the results agenda has come to represent a political agenda for foreign aid, associated with fixed target-setting, which has changed the way DFID operates around the world"*.⁸²

The approach to results changed with the replacement of aid effectiveness principles and 'contribution' to projectised support with 'attribution'. The focus moved to management processes organised around (attributable) results. The use of logframes (the main tool for accountability and reporting) meant pre-planned targets, rather than monitoring based around the looser notion of contribution to outcomes.

DFID's central office set targets and country offices bid for funds based on what they said they could contribute to these targets. An example of this approach was the establishment of two global frameworks in 2010: one for Malaria and one for reproductive, maternal, and newborn health (RMNH).^{83,84} Both were based on results and indicators against which DFID would be monitored and held accountable. Country offices were encouraged to explore country needs and priorities in these areas.

DFID Ghana responded in a measured way to the two global frameworks. Malaria and Reproductive, Maternal, Neonatal, and Child Health (RMNCH) were both of concern to policymakers and development partners in Ghana. DFID did not establish a separate programme for RMNCH until 2012 and that was focused on family planning, which contributed to DFID's central targets for averted maternal deaths and new family planning users.

By the time of HSSP-I, the language of DFID programme documents had become much more about health outcomes, with less of an overt emphasis on strengthening health systems. There was a greater focus on project management processes, particularly logframes. In Ghana, the DFID health logframe still used national results frameworks and SWAp management arrangements, whilst also responding to DFID's growing reporting requirements and ever greater fiduciary scrutiny.

⁸² Valters C and Whitty B (2017): The politics of the results agenda in DFID, 1997-2017

⁸³ Choices for women: planned pregnancies, safe births and healthy newborns. The UK's Framework for Results for improving reproductive, maternal and newborn health in the developing world. 2011

⁸⁴ Breaking the cycle, saving lives and protecting the future: the UK's Framework for Results for malaria for the developing world. 2010



3.5 Phase Five (2013-2019): The demise of the SWAp

Key points

Core UK Programme: Health System Support Programme II (HSSP-II), 2014-2017
Programme Value: ca £59.1 million

- MDGs 4 and 5 were not achieved, despite good progress on child mortality.
- The Independent Commission for Aid Impact assessed the HSSP-II work on improving access to primary health care through better community services. It found improvements in the availability and quality of community facilities and staff in the four regions supported by UK funds, as well as higher results on some key indicators such as the family planning acceptor rate.⁸⁵
- The SDG era began, and Ghana was an early adopter of the concept of Universal Health Coverage.
- The National Health Insurance Scheme encountered serious financial difficulties and reimbursements to health facilities were very delayed.
- General and Sector Budget Support ended in 2015, replaced by earmarking and project funding. This was effectively the end of the SWAp.

3.5.1 Ghana's health sector

Ghana's Health Sector Medium Term Development Plan II 2014-2017 (HSMTDP-II) commenced with a strong focus on Universal Health Coverage (UHC). It noted that whilst there had been improvements in many areas, quality and equity remained significant issues. A new National Mental Health Authority (NMHA) was established in 2014 and there was a review and re-prioritisation of the Community Health Strategy (CHPS) in 2015.

Financing challenges continued. A major concern was escalating costs, with 90% of the Government budget for the MoH going to wages. Domestic health spending stalled amidst ongoing national macro-economic pressures. No progress was made with tackling the sustainability of the NHIS, as scale-up of the capitation payment system was abandoned with the change of government in 2017.

In July 2011 Ghana moved from low-income to lower-middle-income country (LMIC) status, according to World Bank country classifications. The new classification was due to a re-basement of national income data, rather than a substantive change in Ghana's economic circumstances. Nevertheless, middle-income status meant higher expectations about domestic resource generation for public spending and about standards of governance and management. However, since Ghana's move to lower middle-income status was unplanned, the nature of the relationship changed in a somewhat chaotic manner. Our Ghanaian interviewees were of one mind that Ghana's LMIC status was a statistical change that did not reflect reality on the ground.

⁸⁵ Independent Commission for Aid Impact (2020). The changing nature of UK aid in Ghana: Country portfolio review

3.5.2 DFID's policy support and development assistance instruments

The Health Sector Support Programme II 2013-2018 (HSSP-II) supported the Medium Term Development Plan with budget support until 2015. The design of HSSP-II reflected the recognition that improvements in health had largely slowed down since 2008. DFID held that the sector's problems required a stronger focus on governance and should include support for regulatory bodies, as well as a sustained focus on equity.

The primary modality, Sector Budget Support, was retained until 2014. However, in a departure from earlier programmes, there was also earmarked Financial Aid to three authorities, with funding released on completion of agreed reform-orientated annual plans. These authorities were:

- the financially troubled National Health Insurance Authority (NHIA). The earmarked support incentivised improved efficiency of its financial management systems.
- the Food and Drugs Authority (FDA), with support to accelerate its work on quality assurance and medicines safety.
- the National Mental Health Authority (NMHA), with financial support to enable it to become established and commence implementation of its activities.

Interview Highlight

The National Mental Health Authority and many service providers recognised DFID's role in the development of the Mental Health Act.

The Chief Executive of the NMHA said:

“DFID support was very significant. Without it, the DFID support the Mental Health Authority would have been stillborn. 99.9% of our activities are supported by DFID.”

Earmarked Financial Aid was broadly successful in accelerating progress in the agreed policy areas for the NHIA and FDA. However, without the anticipated complementary Government engagement, the Mental Health Authority became heavily dependent on DFID.

The support to the FDA to accelerate its work on quality assurance and medicines safety was rather effective, despite this being a difficult area to work in, given the vested interests at play in relation to counterfeit items. HSSP supported a reduction in the percentage of drugs tested as sub-standard from 16% in 2011 to less than 2.5% in 2017, an increase in local manufacturing capacity and increased capacity to assess drug quality and report adverse drug effects.⁸⁶ By 2020 WHO had approved the FDA as having achieved a certified stable, well-functioning and integrated regulatory system for medical products (maturity level 3).⁸⁷ The FDA earned a good reputation in West Africa and played a leadership role in the region.

The HSSP-II logframe reflected DFID's policy on results. It started by adopting national targets and ended with DFID-specific quantifiable deliverables – reflecting DFID's general shift to 'what does our money deliver?' with less concern for 'what does our policy engagement deliver?'. Consequently, HSSP-II employed more consultants to provide additional management and fiduciary oversight. These significantly increased programme management requirements had to be managed by a fixed number of DFID Ghana staff.

⁸⁶ DFID (2019), Ghana Health Sector Support Programme (2013-2019) Project Completion Review

⁸⁷ WHO (2020), Ghana's regulatory system achieves critical milestone, <https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2020/ghana-s-regulatory-system-achieves-a-critical-milestone>

In 2015 DFID moved much of its financial support for SBS into earmarked Financial Aid for CHPS. There were concerns about stagnating health sector performance, sector governance, leadership, and financing, but also a growing view that neither General nor Sector Budget Support could incentivise improvements. This was, in effect, the end of the SWAp.

DFID followed the World Bank by providing earmarked support to CHPS. The World Bank was becoming an increasingly dominant partner in the health sector and its analysis of the sector's performance and how to accelerate improvements were influential within DFID. The Bank started providing earmarked FA for some regions - DFID mirrored this model in the remaining 4 regions. As a lower-middle income country, Ghana arguably ought to have funded primary health care itself. However, the World Bank and DFID agreed to provide time-bound support in response to a Presidential commitment to accelerate primary health care through CHPS and improved governance and accountability. This helped deal with DFID's desire to reduce its exposure to risk, as well as the feeling that the transition to LMIC had happened too quickly.

The Multi-Donor Budget Support partnership, which provided General Budget Support, started to break down when Government and the development partners could not come to consensus on the Performance Assessment Framework during the 2013 review. There were concerns about the macro-economy in terms of the use of the windfall revenue from oil: the over-spending, inflation and currency problems that led to Ghana's request to the IMF for an extended credit facility in 2015.^{88,89} The loss of confidence in the Government affected the social sectors as well. Alleged mismanagement of public procurement in the health sector and a bloated wage bill underscored development partners' waning confidence in the government's commitment to public sector management and poverty reduction. The result was the end of General Budget Support in 2015.

It is difficult to tease out the cause and effect of this change. There is no doubt that the UK's attitudes to risk, value for money and modalities such as budget support were changing significantly in the mid 2010s. There were, however, reasons to have doubts about Ghana's management of resources. A fire at Central Medical Stores in 2015 further stoked feelings amongst development partners that there were problems with the management of development assistance funds. The fire was suspicious: at the time the US ambassador said "*This has dealt a blow to our ability to support public health in Ghana*" and the UK High Commissioner stated "*The UK Parliament is worried about the Central Medical Stores arson*".⁹⁰ Moreover two indices related to corruption also suggest that there were problems in Ghana in the mid-2010s. Transparency International's Corruption Perception Index, which began in 2012, recorded a fairly stable situation in Ghana from 2012-2015, but then a larger-than-usual (but still relatively modest) drop between 2015 and 2016.⁹¹ The World Bank's CPIA transparency, accountability and corruption in public sector rating also showed a worsening situation between 2013 and 2016.⁹²

During this phase DFID also established a new instrument for technical assistance: a TA Fund managed by the MoH. This was to fund policy work and was primarily used for financial management strengthening, health financing reforms and workforce planning. At the time the Fund was criticised for being used too often for activities which were not a priority for DFID – for example activities in the largest hospital in the country. Management arrangements tightened over time, with disagreements about the transparency of the use of funds.

⁸⁸ DFID (2014), General Budget Support Ghana 2012-2015: 2013 Annual review

⁸⁹ Particip GmbH in collaboration with IEG (2017) Joint evaluation of budget support to Ghana (2005-15) High-level summary. Independent evaluation jointly managed by the European Commission (DG DEVCO's Evaluation Unit), the World Bank's Independent Evaluation Group, the Governments of Ghana, Denmark, France and Germany

⁹⁰ Quoted in Offin-Amiampong G (2017) The Anatomy of Ghana Medical Stores Fire: What Did We Learn From It? Modern Ghana

⁹¹ Transparency International (2024) Corruption Perceptions Index 2023: Score timeseries since 2012

⁹² World Bank indicators (2022), <https://data.worldbank.org/indicator>

In retrospect, the list of important policy areas that were addressed through the TA Fund is impressive, including:

- Development of the National Health Policy.
- Burden of Disease Study.
- Antimicrobial Resistance Policy and Action Plan.
- Roadmap for sustainability and transition from external finance.
- Health financing strategy and implementation plan.
- Standard treatment guidelines.
- Legal instruments to regulate professionals.
- Workforce planning model.

Moreover, this was not expensive, costing less than £5m out of a health programme worth about £59 million.

Interview Highlight

The then Director of the Ministry said:

“The TA Fund was crucial in enabling the MOH to move forward on many reforms in the HSMTDP, because it came at a time when the country and for that matter the MOH was facing a severe financial crunch.”

The report of the independent commission for aid impact (ICAI)

ICAI, the Independent Commission for Aid Impact, published a review of UK support to Ghana from 2011 to 2019.⁹³ In general, the health portfolio was reviewed very positively by ICAI – health and education were judged to be the most effective programmes. The health portfolio was considered to have a strong focus on vulnerable people and people in poverty. In the face of stagnating poverty reduction and growing inequalities in Ghana, the health programme was seen to have done well in targeting vulnerable populations.

The review assessed the effectiveness of HSSP-II in improving access to primary health care through better community health services and echoed the findings of the World Bank’s 2020 Implementation Completion and Results Report.^{94,95} The availability and quality of community health facilities and staff in the four regions supported by the UK were found to have improved, with particularly promising results on some key indicators such as the family planning acceptor rate. Figure 13 shows the increase in female family planning acceptors in primary care 2014-19 for the programme as a whole, not just the UK-funded regions. Other outcome indicators did not improve, such as the share of five-year-olds treated for diarrhoea. The review concluded:

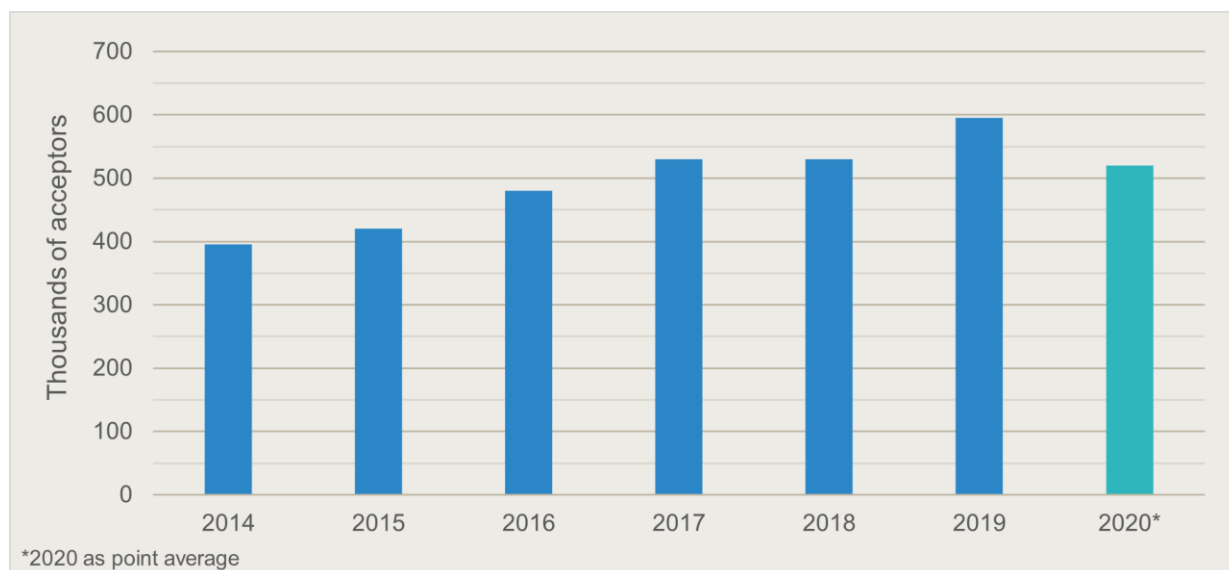
“UK aid’s contribution to improved community health services has been significant in the regions where it is active. Without its support the expansion of facilities and the delivery of the maternal and child health programme at facilities would not have occurred to the same degree. While outcome results are mixed, the general trend is that more services were made available closer to communities in the four DFID regions as a result of UK aid support. We therefore find that UK aid made a strong contribution to medium results.”

⁹³ Independent Commission for Aid Impact (2020). The changing nature of UK aid in Ghana: Country portfolio review

⁹⁴ Independent Commission for Aid Impact (2020). The changing nature of UK aid in Ghana: Country portfolio review

⁹⁵ World Bank (2020) Implementation Completion and Results Report – Multi-donor Health Results Innovation Trust Fund

Figure 13: New female acceptors of modern family planning methods in Ghana, (2014-2020)⁹⁶



Source: World Bank (2020) Implementation Completion and Results Report – Multi-donor Health Results Innovation Trust Fund

This predominantly positive assessment of CHPS was borne out by a systematic review of 58 studies. The review found that CHPS was effective in reducing under-5 mortality, particularly for the poorest and least educated, increasing family planning use and reduced fertility. CHPS worked best in rural areas that were not particularly remote. It concluded that challenges remained in terms of addressing NCDs, adapting the model to work well in urban and very remote areas, and improving ways of financing the programme.⁹⁷

3.5.3 UK International development policy

In 2015 the UK legislated that 0.7% of gross national income should be spent on aid – it became a statutory duty. International development policy kept evolving: the role of the private sector increased and there was a growing emphasis on how development assistance could contribute to furthering the UK's interests. The results agenda moved towards short-term, narrow results of projects, and away from wider processes of change. Predictions of outcomes (despite often operating in volatile environments) and assurances of accountability to the UK taxpayer became increasingly important. The move from 'shared' national results to 'attributable' results accelerated. After years of accepting shared results of a multi-stakeholder partnership, DFID began to demand DFID-specific results. The focus on accountability in terms of evidenced impact is entirely appropriate, but by its very nature the impact of spending in other countries cannot be isolated in terms of just the UK spend. As the results agenda bedded down, it became possible, however, for DFID to work out practical project management arrangements that allowed some flexibility.

This interest in attributable results and low risk tolerance led the UK to question the effectiveness of SWAs and its prevailing instrument, Financial Aid. DFID Ghana gradually changed its portfolio by increasing its focus on the performance of Global Health Initiatives and UK-managed programmes. The move away from SWAs reflected doubt in the international literature (Box 6).

⁹⁶ Within Primary Health Care.

⁹⁷ Elsey H et al (2023) Implementation of the Community-based Health Planning and Services (CHPS) in rural and urban Ghana: a history and systematic review of what works, for whom and why. *Frontiers in Public Health*, Volume 11:1105495, doi.org/10.3389/fpubh.2023.1105495

Box 6: The Ghana health SWAp

A good deal has been written about Ghana's health SWAp. Publications included a World Bank review (Vallaincourt, 2009),⁹⁸ a review of SWAps in Africa (Walford, 2007),⁹⁹ and a lesson-learning paper about health SWAps in Health Policy and Planning (Peters, 2013).¹⁰⁰

The general conclusion of these papers was that SWAps had clear advantages on paper, but that in practice it could be difficult to get common arrangements to work well. In Ghana, a particular strength of the SWAp was said to be its ability to move funds out to Budget Management Centres (districts and hospitals), although moving funds to sub-districts proved more difficult.

Vallaincourt concluded:

“There is strong consensus among countries and DPs that more rational and country-led management of aid is a goal worth pursuing. But...the adoption of a SWAp does not automatically lead to improved development effectiveness.”

She then identified four critical success factors for a SWAp to have a positive effect on health outcomes:

- Programmes of Work with ambitious-but-feasible targets and relevant reforms.
- Strong national capacity and systems to implement common management arrangements.
- Partnerships with appropriate membership, clear roles, and the ability to work together constructively.
- Predictable flow and use of health sector resources, both domestic and external.

For some considerable time the SWAp in Ghana worked reasonably well, with all these critical success factors present. Over time, however, development partners became disillusioned with progress towards targets and there were issues related to the predictability and management of both Ghanaian and international funds. DPs felt that macro-economic mismanagement harmed the health sector and reduced its budget.

⁹⁸ Vallaincourt D (2009) Do health SWAps achieve results? Emerging evidence from six countries. World Bank

⁹⁹ Walford V (2007) *A review of SWAps in Africa*. HLSP Institute

¹⁰⁰ Peters D et al (2013) *Swaps in health: what have we learned?* Health Policy and Planning 2013; 28:884–890



3.6 Phase Six (2019-2023): Ghana beyond aid, COVID and an unstable period in UK development assistance

Key points

Core UK Programmes:	Leave No-one Behind (LNOB), 2019-2024 Partnerships Beyond Aid (PBA), 2020-2025
Programme Value:¹⁰¹	LNOB Budgeted £39m; reduced to £8.3 million PBA Budgeted £25 million; reduced to £5.9 million

- The focus in Ghana remained on UHC and developing the insurance scheme, plus work on adolescent sexual and reproductive health services and health security. There was also a growing emphasis on non-communicable diseases and mental health.
- The COVID-19 pandemic was followed by a serious economic downturn in Ghana, including a fall in government health spending.
- DFID merged with FCO to form the FCDO in 2020. This was a volatile period in terms of UK politics and development assistance budgets.
- FCDO's support in Phase 6 was very different to previous phases. There were two major social sector programmes, rather than health-specific ones. Programme budgets were lower, cut over time, and subject to annual re-negotiation. The percentage of the budget spent as Financial Aid was lower and there was more emphasis on non-governmental partners.
- FCDO support for mental health continued.

3.6.1 Ghana beyond aid, the economy, and the health sector

The macro-economic situation and Ghana beyond aid

In May 2019, the Government of Ghana issued its Ghana Beyond Aid (GBA) strategy, presenting GBA as a national agenda for economic transformation and a shift in mindset, attitudes, and behaviour. GBA described a move away from aid towards self-reliance based on the private sector. However, it made clear that it was not a rejection of aid, but rather a realignment of engagement with development partners to ensure that future aid supported Ghana's economic transformation. It set a target to increase Ghana's own contribution to basic public services with a reducing reliance on external grants. Aid should be *"re-directed to areas where they are likely to have more catalytic effects on economic and social transformation"*.¹⁰²

The economic growth described in GBA was, as it acknowledged, ambitious. Per capita GDP would more than double between 2018 and 2028 to US\$4,500, requiring annual GDP growth of 9.5%. However, in reality the economy during and after the COVID-19 pandemic was extremely weak. Ghana experienced low growth (0.5% in 2020, 3.1% in 2022 and 1.5% in 2023) and high inflation (peaking at 54% in

¹⁰¹ In practice it is impossible to say what the final budget will be for current programmes because budgets are re-assessed annually. The "reduced to" figure is sourced from the official UK Government Development Tracker website.

¹⁰² Republic of Ghana (2019). Ghana Beyond Aid Charter and Strategy Document

December 2022), with significant repercussions in terms of social hardship. The international poverty rate (\$2.15 in 2017 USD PPP) increased to 32.6% in 2023, up from 25.2% in 2017. Inflation was estimated to have pushed over 800,000 Ghanaians into poverty in 2022. Unemployment and food insecurity worsened.¹⁰³ The economic circumstances threatened previous progress with Universal Health Coverage. Persistent geographical, income and social inequities worsened during COVID-19, with the impacts of the pandemic falling disproportionately on women and in the north of the country.¹⁰⁴

The Sustainable Development Report 2023¹⁰⁵ described a globally bleak picture in terms of the SDGs. At the mid-point of the 2030 Agenda, all SDGs were seriously off track; after the pandemic SDG progress had stalled globally. Many low- and lower-middle-income countries were experiencing problems with fiscal space and levels of public expenditure, leading to a reversal in progress on several goals and indicators. Ghana fits this description well. Like many countries, Ghana's SDG health indicators were judged to still face many challenges. Maternal mortality and life expectancy had stalled since 2019, though neo-natal and under-5 mortality had improved slightly, as had the age-standardised death rate due to the major non-communicable diseases.¹⁰⁶

The health sector

Health spending as a proportion of Government of Ghana expenditure peaked at 8.1% in 2019, but fell to 6.7% in 2023. (The Abuja Declaration recommends 15%). The Government was clear that it wanted increased Financial Aid from FCDO and others, to help protect the social sectors from the economic crisis, even though this went against the intention of Ghana Beyond Aid. Ghana was not alone in this situation: a 2023 WHO Report *Global Spending on Health: Coping with the Pandemic* – found that international development assistance provided crucial support for government spending in 2021 in low and lower-middle income countries, and that the sharpest rises in external development assistance were in LMICs.¹⁰⁷

The revised National Health Policy of 2020 reflected the changing patterns of burden of disease in Ghana, notably a rise in non-communicable diseases (NCDs). The Policy acknowledged the importance of mental health, and the wider determinants of health including lifestyle, living environment and socio-economic status. The central importance of UHC was affirmed. The 2020 UHC Roadmap¹⁰⁸ described the package of services envisaged for UHC. The largest component was maternal, child health and nutrition services, with significant inclusion of NCDs, mental health services and emergencies.

The Health Sector Medium Term Development Plan IV 2022-25 (HSMTDP-IV) focused on UHC, with specific mention of reducing avoidable maternal, adolescent and child deaths and disabilities, and increasing access to responsive clinical and public health emergency services. The overall approach was very much of health systems strengthening.

The Plan documented performance from 2018-2022. The overall sector score (based on the Holistic Assessment Tool) declined from 3.6 (out of 5) for 2019, 3.1 for 2020 and 2.6 for 2021. There were some improvements in health delivery, notably ANC4+ (60.5 in 2017 to 65.7 in 2021) and post-natal care coverage for newborn babies (49.8% to 62.1%). The ratios of nurses, midwives and doctors to population all improved. There was, however, a steep decline in the Couple Year Protection (CYP).

The population with active NHIS Membership rose from 35.3% to 54.4% and the average time of claims settlements dropped from 6 to 4 months. However, the Sector Plan flagged up a clear problem that the proportion of funds released to NHIA by the Ministry of Finance had dropped from 100% to 6.7% of the

¹⁰³ World Bank (2023) First Resilient Recovery Development Policy Financing Ghana, Project Information Document

¹⁰⁴ World Bank (2023) Ghana Tree Crop Diversification Project, Project Information Document

¹⁰⁵ Sachs, JD et al. (2023). Implementing the SDG Stimulus. Sustainable Development Report 2023

¹⁰⁶ Specifically cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30-70

¹⁰⁷ WHO (2023) Global spending on health: coping with the pandemic. Geneva

¹⁰⁸ Ministry of Health (2020) Ghana's Roadmap for Attaining Universal Health Coverage 2020-30

actual expenditure by the insurance scheme in 2021 (i.e., 6.7% of reimbursements due to health providers and other NHIA costs that were intended to be covered by the Ministry of Finance).¹⁰⁹

HSMTDP-IV planned to increase the integration of mental health services into the wider health system, with close collaboration between the Ghana Health Service and the Mental Health Authority. One of the activities specified in the plan was to scale up the integration of mental health services and their financing into the general health care system. The two prioritised specific tasks related to mental health were improving workforce capacity to deliver mental health services and establishing a system for the generation of nationally representative data on mental health.

Phase 6 included the period of the COVID-19 pandemic. A WHO study of Primary Health Care and COVID-19¹¹⁰ concluded that Ghana's response to COVID-19 was reasonably successful, with a Case Fatality Rate of 0.9%, lower than the rates in Nigeria, Kenya and Burkina Faso, the same rate as Côte d'Ivoire, and marginally higher than in Togo and Benin.¹¹¹ The study noted the significance of vaccine hesitancy during the pandemic. There were general education efforts, as well as the televised vaccination of prominent individuals. Some of the skills and practices developed in mental health services with UK support were positively adapted to the COVID pandemic. In particular, work on stigma, discrimination, and access for vulnerable people could be adapted to improve vaccination rates in various vulnerable population groups.

The WHO study emphasised that the response to COVID-19 was, by necessity, a multisectoral one and that the health sector response was multifaceted, involving many parts and levels of the health system. Their final conclusion shows the importance of the health system:

“COVID-19 has brought to the fore the importance, interdependencies and limitations of the different levels of the health system in responding to health emergencies. The pandemic has demonstrated that multisectoral preparedness and response planning that involves all stakeholders at all levels, with periodic testing and updating of plans through simulations, is essential to build capacity, achieve buy-in and co-ordinate responses. The District Health System, with regional support, implements critical policy action, whereas the national level of the health system provides policy and technical direction, mobilizes and allocates resources equitably, and provides overall stewardship. Deficiencies in any of these functional roles will have an adverse effect on the management of public health emergencies, hence the need for the health system to be strengthened at all levels.”

3.6.2 FCDO's policy support and development assistance instruments

FCDO's support in Phase 6 was very different to previous phases. There were two major social sector programmes, rather than health-specific ones. Programme budgets were lower, cut over time, and subject to annual re-negotiation. (However, budgets did start to rise again from about 2023 onwards.) Spending on the social sector accounted for about 70% of UK bilateral spend in Ghana in the early 2010s, falling to about 45% by 2019.¹¹² The percentage of the budget spent as Financial Aid was lower, without the large health systems-focussed programme of support to the government which was typical of previous phases. There was more of an emphasis on non-governmental partners, in addition to the joint programmes with government.

¹⁰⁹ See also Ministry of Health (2023) Ghana Health Financing Strategy 2023-30

¹¹⁰ Agongo E et al (2023) Ghana: A primary health care case study in the context of the COVID-19 pandemic. WHO

¹¹¹ John Hopkins Coronavirus Resource Centre, data as of October 2023

¹¹² Independent Commission for Aid Impact (2020). The changing nature of UK aid in Ghana: Country portfolio review., page 18

Whilst the widened social sector scope brought challenges (it was more complicated than just an arrangement with the Ministry of Health), it also brought advantages by making cross-sector connections, such as links between mental health and poverty, discrimination, human rights, and social protection schemes. Links between health and social care were particularly important because joined-up services are crucial as populations age and long-term chronic illness increases. Cross-sector working also proved useful during the time of COVID, for example when collaboration between education and health facilitated school re-openings before the end of the pandemic.

The two main social sector programmes were Leave No-one Behind (2019-24) and Partnerships Beyond Aid (2020-25). The first years of Phase 6 (2019-22) were rather chaotic in terms of planning and implementation for two main reasons – COVID and the radically changing political and budgetary situation in DFID/FCDO.

Leave no one behind (2019-2024)

The Leave No-one Behind programme coincided with a period of uncertainty and upheaval that was unprecedented in the previous 25 years of Ghana/UK collaboration. Political and economic crises in the UK and globally led to periods of budget uncertainty, cuts, changing priorities, re-programming, pauses in activity, and the abandonment of some plans. LNOB had to adapt its plans when COVID-19 hit, and again with the publication of the 2022 International Development Strategy, with its strong focus on women and girls. Moreover, LNOB coincided with a period when the Ghanaian economy was faring badly.

FCDO's 2023 Annual Review of the LNOB programme describes the challenges resulting from the budget cuts:

“The biggest threat to the programme’s impact is around sustainability. With reduced funding we would need to consider how to maintain our relationships, credibility, and social capital with reduced spend. We would need to consider using all our levers e.g., our convening power, influencing skills to keep our seat at the table. We also need to consider the funding gap that may be created and ways we can ensure a ‘responsible exit’.”¹¹³

In terms of aid modalities, LNOB had four main routes to implementation – a World Bank Trust Fund; a commercial contract to support the government’s scaling up of quality, integrated mental health services, plus some work on disability; support for WHO and UNICEF, notably for WHO to work on maternal mental health; and an FCDO-managed Synergy Fund, which included up to £2 million of results-based Financial Aid to the Ministry of Health for milestones related to strengthening and integrating mental health services. The consortium contract for work in mental health and disability started at £12.0 million but was reduced over time to £8.5 million because of overall budget cuts.

Up to 2023, 39% of LNOB expenditure was on health with a focus on mental health. In Phase 5, the Health Sector Support Programme (2013-2018) also included work on mental health. This was an unusual area for a development partner to support,¹¹⁴ but appropriate given the major contribution of mental health conditions to the overall burden of disease in Ghana and the fact that 85%+ of people in need of mental health support were not accessing appropriate treatment.¹¹⁵ Support for mental health was difficult and risky, given the stigma associated with mental illness and the safeguarding issues involved. The UK was the only development partner to provide substantial funding in this field, complemented by technical support from WHO. The Government of Ghana displayed its commitment to mental health in a number of ways, for example by facilitating the inclusion of reimbursable treatments for four priority mental health conditions in the National Health Insurance package.

¹¹³ FCDO (2023) Annual Review 2022-3 - Leave no-one behind as Ghana moves beyond aid

¹¹⁴ At least in terms of development; international funding for mental health is more common in humanitarian crises.

¹¹⁵ Mental Health Authority/Ghana Somubi Dwumadie Programme/UK AID (undated, 2021?) Why Ghana needs to invest more in mental health

There was a focus on integrating mental health activities into the wider health system, including district level plans and the work of primary health care facilities. Progress was made in a variety of areas – setting up Mental Health Review Tribunals; procurement of psychotropic drugs; inclusion in the National Health Insurance Scheme; health facilities implementing quality rights improvements; inauguration of a mental health information system; expansion of research on mental health; and production of a Maternal Mental Health Situational Analysis. These changes were effectively supported through the results-based financing element of LNOB, coupled with TA.

Interview Highlight

A Senior Official at the National Mental Health Authority said:

“DFID/FCDO support has been the life wire of mental health services in Ghana, being the only donor for mental health since the passage of the Mental Health Act. Without the DFID funding, the Act would not have been operationalised because there was no other major source of funding beyond government.”

However, there was a feeling both in the MoH and the NMHA, that too much of the mental health work had been contracted out, rather than channelled through the government. There was general agreement that civil society organisations had a comparative advantage in community-based activities, but that some other activities were better done by government.

The Independent Commission for Aid Impact was very positive about the support for mental health, concluding *“Without the DFID programme, little would have been done on mental health care...As a result of the UK aid intervention, more than 100,000 patients accessed mental health services in 2018”*.¹¹⁶

Partnerships beyond aid (2020-2025)

The Investing in Human Capital through Partnerships Beyond Aid in the Social Sectors Programme began in January 2020, shortly before the COVID-19 pandemic took hold. (Known as Partnerships Beyond Aid, or PBA.) As was the case for LNOB, PBA endured significant upheaval. The original budget in the Business Plan was £25 million, but this reduced significantly. Health accounted for over 90% of PBA expenditure up to 2023, higher than planned because of COVID. The 2023 Annual Review stated that FCDO budget uncertainty delayed implementation and *“undermined FCDO’s credibility”*.¹¹⁷

The health elements of PBA focused on COVID-19 in 2020 and 2021. Ghana’s COVID response, and the UK’s role in that, were generally seen as reasonably positive and effective. The UK supported vaccinations, awareness, surveillance, and more general work on the quality of primary care. The Annual Review cited the impressive statistic that *“Approximately 19% of Ghana’s national vaccine uptake during the AR period (as of December 2019) is directly attributed to support through the PBA programme”*.

The Independent Commission for Aid Impact judged that the UK’s bilateral efforts in respect of COVID-19 were *“rapid and effective, drawing on the knowledge of staff with experience of past epidemics, including Ebola”*. One such member of staff was the FCDO Health Adviser in Ghana, who took up the role in 2019. Her considerable experience in responding to disease outbreaks was a boon for the DPs’ response to COVID-19.

Radical re-structuring of PBA was required in 2022, as UK priorities and budgets changed. PBA’s goal was self-reliance by the Government of Ghana in managing and financing the social sectors to deliver quality services to all. The idea was that technical assistance, research, technical analysis, and

¹¹⁶ Independent Commission for Aid Impact (2020). The changing nature of UK aid in Ghana: Country portfolio review

¹¹⁷ FCDO (2023) Annual Review 2022-3. Partnerships Beyond Aid

partnerships with UK institutions, coupled with greater GoG accountability for spend in the social sectors, would lead to efficient, evidence-driven social sector institutions. Key assumptions were increases in funding to the social sectors, and that commitment to reforms was sustained. The assumption about Ghana government budgets was not met in the first three years of the programme.

The management of PBA was relatively complicated compared with much bigger programmes in previous years, with a number of agreements between FCDO and a variety of implementers. The fragmentation and lack of co-ordination was tackled through a 2023 Aide Memoire between the Government of Ghana and development partners to improve alignment with national priorities. This helped with the orientation of the multiple PBA workstreams.

During 2023, in addition to two COVID/health security surveillance workstreams that were finishing, the health part of the programme involved the following significant partners:¹¹⁸

- STAR Ghana Foundation: working on gender rights and empowerment to increase access to quality services for women and girls. This included influencing work related to the manifestos of key political parties.
- The World Health Organization Ghana (WHO):
 - Work on the Ghana Demographic and Health Survey and other surveys; strengthening data generation, analysis and use.
 - Capacity building support to the Ghana Health Service to support the roll out of free family planning services to all women of reproductive age through the National Health Insurance Scheme.
 - Strengthening health workforce leadership and management.
 - Strengthening health security.
- Other UK government departments: The PBA programme facilitated partnerships between Ghana and other branches of UK government, notably with the Department of Health and Social Care (health workforce issues) and the Department for Environment, Food and Rural Affairs (animal health and its links to health security). In practice the facilitation role involved activities such as providing TA for project design, technical oversight, problem-solving and co-ordination with other programmes.
- The World Bank: funds to a World Bank Trust Fund.

In 2023 FCDO provided funds through Partnerships Beyond Aid to the World Bank's £150m multi-donor trust fund delivering the Ghana Primary Health Care Investment programme. The programme sought to support Ghana's 'Network of Practice' strategy, which was about re-configuring services at the sub-district level, especially in rural and peri-urban settings, to better deliver services (curative and preventive) that would be paid for through the NHIS.¹¹⁹ FCDO's funds in the multi-donor trust fund were to contribute to increasing the number of adolescents using health services at the sub-district and community levels, with projections of an additional 882,000 adolescents (13% of adolescents), accessing health services including sexual and reproductive health services. There were targets linked to disbursements to achieve this.¹²⁰

The Trust Fund also supported key policy reforms, notably health financing policy development and supporting measures to improve financing of primary health care through both the national budget and the NHIS. These were issues which over the years had been central to the UK's support to Ghana – the support continued, but through a multilateral agency and (for the UK) at a very much reduced level.

The partnership with the World Bank went beyond UK funding to the Trust Fund. From the mid 2010s onwards, DFID/FCDO worked increasingly closely with the Bank, both programmatically and in policy discourses. There were mutual benefits – the Bank was a high-profile player in the sector with large

¹¹⁸ FCDO (2023) Annual Review 2022-3. Partnerships Beyond Aid

¹¹⁹ World Bank (2022) Ghana: Primary Health Care Investment Program: Technical Assessment

¹²⁰ World Bank (2024) Primary Health Care Investment Program: Implementation Status & Results Report

programmes and high-level engagement. The UK had considerable experience in the health sector and a dedicated adviser, which was valuable to the Bank. PBA's participation in the Trust Fund provided the platform for FCDO to engage in policy and implementation discussions across the sector, to a greater extent than would have been possible without the partnership with the World Bank.

The achievements of PBA in 2023 illustrate the different approach to working from previous phases. Support for sexual reproductive health and rights focused largely on training, empowerment and advocacy from community to national level. Work was done to influence and support the National Health Insurance Scheme's roll-out to re-imburse family planning across the country, and with the World Bank about the strengthening of reproductive health in its programme.

There was ongoing support for the National Health Insurance Scheme – enrolment increased gradually, and an important link was made with poverty reduction by enrolling beneficiaries of an anti-poverty programme. Release of money from the National Health Insurance Levy to the Insurance Authority remained a challenge.

PBA supported data analysis to inform policies and practice, notably through support for the Demographic and Health Survey, a STEPS survey of risk factors for non-communicable diseases and work on the links between health and climate change.

These achievements illustrate the focus on partnerships, strategic advocacy and increasing effectiveness by making linkages between workstreams, such as connecting work on family planning and on poverty to support for the National Health Insurance Scheme. The shift away from directly supporting service delivery was apparent (with an exception for mental health).

The Independent Commission for Aid Impact reflected on the significant drops in UK development spending in Ghana, particularly in education and health. Political and economic change in the UK, combined with the seemingly complementary Ghana Beyond Aid agenda, were often cited as the rationale for cutbacks, even when it was clear that they would harm sustainability and that it was happening at a time when real government spending in Ghana was declining. In some cases, other DPs filled gaps left by the UK, in others not – sexual and reproductive health (SRH) and family planning supplies were areas often cited by Ghanaian interviewees as having been 'abandoned' by the UK. USAID picked up some, but by no means all, of the SRH areas previously funded by the UK.

ICAI criticised decisions about where to cut expenditure that were not based on robust enough analysis of the consequences for service delivery and outcomes. The social sectors accounted for 84% of DFID Ghana's reduction in bilateral spending during 2011-19, when both poverty and geographic inequalities were worsening. As a result, development gains achieved through these programmes were at risk of being reversed. ICAI recommended that transitions towards ending bilateral funding should include consideration of whether the gap left would be filled, and to work at an appropriate pace to reflect that. As we have seen, what happened in practice was that some support for service delivery did occur after 2020. ICAI stressed that this recommendation was not against the reduction of bilateral budgets in transition countries – it was about the way and pace in which this was done. It was *"a warning against winding down support so fast that past development gains would be lost"*.¹²¹

3.6.3 UK international development policy

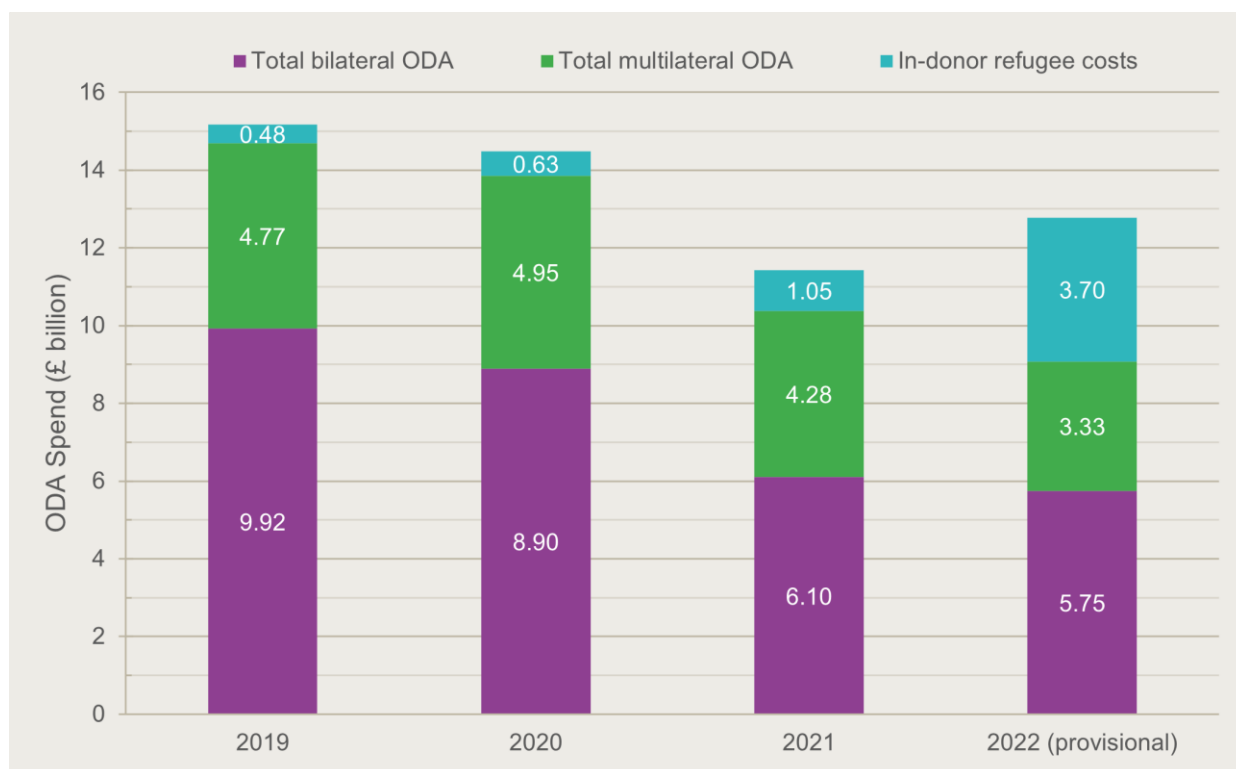
The Independent Commission for Aid Impact, ICAI, described 2019-2023 as *"an exceptionally challenging period for UK aid"*. A number of global crises required emergency responses, including COVID-19, Afghanistan, and Ukraine. Ministers and government priorities changed frequently – there were four Prime Ministers and five Foreign Secretaries between 2019 and 2023. In 2020 the Foreign and Commonwealth Office (FCO) and DFID merged, having been separate ministries for 26 years. In 2021 the government announced that, due to the economic impact of COVID, it would temporarily spend 0.5%

¹²¹ ICAI (2020) The changing nature of UK aid in Ghana Country - portfolio review

of GNI on aid, thus putting on hold its statutory duty to spend 0.7%.^{122,123} The development programme’s budget endured periods of uncertainty and significant cuts, changes which ICAI called “*drastic and highly disruptive*”.

Figure 14 shows the decline in total UK bilateral funding (global, all sectors) between 2019 to 2022 from £9.92 billion to £5.75 billion. In the same period spending on refugees from the aid budget increased almost eight-fold.

Figure 14: Overseas aid spend, including refugee costs, (2019-2022)



Source: ICAI (2023) UK aid under pressure: A synthesis of ICAI findings from 2019 to 2023, page 12

In 2023, two UK government publications articulated the changes in international development thinking and spend that had become apparent since the recent budget cuts. The White Paper, *International Development in a Contested World: Ending Extreme Poverty and Tackling Climate Change*¹²⁴, included a focus on three themes that heavily influenced bilateral programmes:

- The centrality of long-term, equitable partnerships “*beyond an outdated ‘donor-recipient’ model*”.
- The continued importance of poverty reduction.
- A key role for UK expertise, including in universities and the NHS.

The White Paper used the phrases “*patient diplomacy*” and “*patient development*” which were about long-term relationships, mutual respect, and a strong offer of UK skills. In a testimonial for the White Paper, the President of Ghana, Nana Akufo-Addo, recognised the shared agenda of moving beyond aid:

¹²² Loft P and Brien P (2023) The 0.7% aid target. House of Commons Library

¹²³ Overseas aid as a % GNI in the UK rose from 0.3% in 1993 to 0.7% in 2013. Apart from between 2007-2016 (when the UK was higher), this has been broadly comparable to the percentage in Germany. Sweden has been consistently higher, and the US has oscillated between 0.1% and 0.2%, is considerably lower.

¹²⁴ FCDO (2023) *International development in a contested world: ending extreme poverty and tackling climate change*. A White Paper on International Development

“Building beyond aid is crucial for equal partnerships, where voices of developing countries are heard and respected”.

In practice, this approach led to much more fragmented UK support – there was less money being spent on more separate partnerships and projects. Moreover, the focus on UK partners meant that an increasing proportion of the budget, even discounting refugee costs, went to UK institutions. The Independent Commission for Aid Impact criticised the substantial share of aid-funded research allocated to UK universities, noting that this *“appeared contrary to the UK’s commitment to untying all its development aid”*.¹²⁵

The FCDO’s May 2023 Global Health Framework¹²⁶ (which pre-dated the White Paper by six months) reflected the same themes of poverty, partnerships, and expertise. Three objectives were of direct relevance to bilateral programmes – strengthened global health security, strengthened country health systems, and advancing UK leadership in science and technology. Common to these objectives was a focus on working through partnerships (with governments, civil society, academia, and the private sector); poverty, including the role of UHC; and promoting sustainability by strengthening a country’s capacity to manage its health sector efficiently and effectively. Convening other UK government departments to work on health topics was also emphasised as a way of working – for example the Department for Environment, Food and Rural Affairs (DEFRA) in relation to One Health and global health security.

FCDO focused much more on science, technology, and innovation (ST&I) during this period. The joint UK-Ghana Science, Technology, and Innovation Strategy 2023-2027 promoted public and private sector collaborations, based on *“mutual respect, transparency, and shared knowledge”*.¹²⁷ This was a highly proactive Strategy, looking at stages of collaboration from systematically mapping what was happening to eventual commercialisation and scaling up.

One of the five technical priority areas was health/pharmaceuticals. An example of good practice given in the Strategy summary was the collaboration between the Wellcome Centre for Anti-Infectives Research and the Drug Discovery Unit from the University of Dundee and five Ghanaian universities/research institutes to establish a Drug Discovery Hub in Ghana. One workstream, funded by the Bill and Melinda Gates Foundation, was about developing new anti-malarials.

The Ghana programme reflected the White Paper and the Global Health Framework well. There was a focus on evidence and advocacy, many partnerships that included a UK partner, and support for the efficiency of the health sector, for example through the expansion and strengthening of the National Health Insurance Scheme.

¹²⁵ ICAI (2023) UK aid under pressure: A synthesis of ICAI findings from 2019 to 2023

¹²⁶ UK Government (2023) Global Health Framework: Working together towards a healthier world

¹²⁷ FCDO and Government of Ghana (undated, 2022?) UK-Ghana Science, technology and innovation strategy 2023-7

4 Looking Backwards to Look Forwards: Lessons from History

This section identifies three fundamental questions that have been relevant throughout the 30 years – what to fund? how to fund it (what modality)? and how to measure activities and achievements? It considers what lessons can be drawn from past experience and how these might inform future practice.

4.1 What modalities to use?

Key points

- Over time, DFID worked through a continuum of bilateral aid instruments from projects at one extreme, through earmarking, the Health Fund and Sector Budget Support, to General Budget Support at the other extreme. At one end of the continuum was close control of planning and implementation by development partners and at the other was very considerable Ghana Government control, with reporting to, and dialogue with, the funders.
- During 1997–2010, there was a focus on working through Common Management Arrangements, brought together in a SWAp.
- DFID developed more separate arrangements in the 2010s, a period when there were concerns about the quality of Ghanaian systems, particularly the management of finances and goods.
- UK development assistance in the early 2020s was marred by frequent changes in direction, re-budgeting and re-planning. Ghanaian stakeholders were disappointed by the confusion and unpredictability of this period.
- As was the case in the 1990s, there is debate in the mid-2020s about aid modalities and how benefits can be reaped by working collaboratively.
- Box 7 offers 10 key lessons about aid modalities.

4.1.1 Looking backwards - a recap of modalities over time

The term aid modalities (or aid instruments) refers to the ways in which international development support is organised in terms of relationships with national plans and budgets, financing channels and reporting arrangements.

Over the 30 years discussed here, DFID worked through a continuum of bilateral aid instruments from projects at one extreme, through earmarking, the Health Fund and Sector Budget Support, to General Budget Support at the other extreme. At one end of the continuum was close control of planning and implementation by development partners and at the other was very considerable Ghana Government control, with reporting to, and dialogue with, the funders. Aid instruments often co-existed, for example general and sector budget support, or sector budget support and projects. Alongside these changes was a fairly consistent thread of technical assistance (TA).

For more than 15 years starting in 1993 the very fact of partnership working was seen as a virtue. With its strong health sector leadership and relative political stability, Ghana was well placed to develop country-owned joint working arrangements that were admired by many national governments, DPs, and other parts of DFID. The silent partnership marked the apotheosis of the partnership approach, with a belief so strong that DFID felt able to be financially generous but managerially 'silent'.

Apart from the years of the silent partnership, DFID played a key role in nurturing the MOH-DP partnership, building bridges, and bringing dissatisfied partners back to the negotiation table. DFID's active engagement in supporting key health sector events such as the development of plans and programmes of work, health sector review meetings, Health Sector Working Groups and joint monitoring

earned the trust of Government and DPs, making it possible to challenge the government about sensitive issues such as health impact, equity, financial mismanagement, sustainable financing and the role of civil society.¹²⁸ A key Ghanaian informant illustrated the effect such partnership working could have:

“Sometimes one particular issue would dominate government/donor discourse as they sought to agree on shared plans. One such example was the inclusion of four new regional hospitals in government plans in the mid-1990s. These planned hospitals were going to be expensive to build and run. DPs saw them as taking up an unreasonable portion of the total budget at a time when there were pressing needs in the more cost-effective areas of public health and primary care. The issue was eventually discussed by the President of Ghana and at least one donor’s international development Minister. As a result, the cost of the regional hospitals was very significantly reduced in the final plans.”

The situation in terms of aid modalities began to shift in the first half of the 2010s (Phases 4-5), as DFID placed more emphasis on attributable results and accountability to UK taxpayers. The involvement in Sector Budget Support ended because of waning confidence and support from DFID as a whole, with increased aversion to the risks of SBS (particularly financial risks). There was a feeling that improvements in the health sector had stalled, and that budget support had been going on for so long that it was taken for granted and was no longer an incentive for improved governance. The relationship was also harmed by problems with leadership and management in Ghana, notably financial management and problems with pharmaceutical supplies: this at a time of high levels of Financial Aid which gave the Government of Ghana considerable autonomy over spending. DFID was not alone in this shift: DANIDA and the EU also withdrew from SBS in 2014/5, and the Multi-Donor Budget Support partnership broke up in 2013.

Sector Budget Support was largely replaced by more hands-on DFID management of earmarked financing that was able to demonstrate faster, more tangible and attributable results (i.e., results that could be directly linked to DFID funding). This results agenda was not compatible with the previous joint working arrangements and resulted in project-type financing that had complex logframes, with partial retention of national indicators and targets. The well-regarded Holistic Assessment Tool was at times bypassed in favour of separate logframes and different indicators.

Since 2020 (Phase 6), FCDO has operated largely through directly contracted project funding. The main exception is Financial Aid for mental health services, where it is accepted that it is still appropriate to support service delivery in this fast-expanding, historically neglected part of the sector. It is intended that the Financial Aid will drive reforms. With indicators set jointly with the Ministry of Health and the Mental Health Authority.

In the period around 2020, two things were happening simultaneously. The UK budget for development assistance was declining, particularly the bilateral spend, and the significance of Ghana’s status as a lower-middle income country was taking hold, both in Ghana (notably with the publication of *Ghana Beyond Aid*) and in the UK, in terms of its allocation of bilateral resources to favour the least developed countries and humanitarian crises. The shift of funding towards least developed countries was something that the Government of Ghana could understand, even if it rued the reduced grants it received. However, the drastic cuts and flip-flopping policies of the early 2020s had a very negative effect on the Ministry of Health, not least because of the periods of uncertainty and frequent needs for re-planning. The piecemeal decision-making of this period undoubtedly had a negative effect on DFID/FCDO’s reputation in Ghana. Many of our senior interviewees from the health sector lamented the drastic drop in funding and the period of chaos, making it more difficult to sustain a relationship that could tackle difficult issues together.

¹²⁸ DFID’s strength in partnerships is also reflected in the numerous joint projects with different partners, some of which were multi-country. Collaborative programmes included Ghana Multi-sectoral HIV/AIDS Response (with DANIDA & World Bank), STAR Ghana for advocacy and Watch-Dog (with EU & DANIDA), ITNs in malaria control (UNICEF), FP2020 for family planning, AHME in health financing & management, with Bill & Melinda Gates Foundation and many international NGOs involving Ghana, Nigeria & Kenya.

A 2020 study of transitioning from donor aid for health in Ghana explored opinions in Ghana about declining donor budgets. They found that there were more concerns than optimism, but that stakeholders could also see opportunities, notably that it might be more straightforward to make an urgent case about the need to leverage domestic resources for health and improve revenue mobilisation through the health insurance levy.¹²⁹

Over the years, Technical Assistance was generally managed separately. The modality for TA also changed over time, ranging from management by an agency contracted by DFID to management by the Government of Ghana. TA support appears to be an important element of collaborative arrangements: it facilitates the follow-up of issues of concern and gives the MOH a useful vehicle to help move policy priorities forward. Responsive policy support seemed to enhance DFID's reputation as a supportive partner with a long-term perspective. Sometimes TA was the game changer, even though its monetary value was much lower than the Financial Aid.

Not all the areas of technical support and government/DFID dialogue had unequivocally positive outcomes. The establishment of the Ghana Health Service, which was intended to enhance efficiency by segregating policy and oversight roles from implementation, resulted in political patronage filling the vacuum created by the diffusion of technical leadership. It also undermined the very district and regional health management teams which had been strengthened in the 1990s because it gave more control to central agencies and issue-based vertical programmes that had their own management systems. Efforts to improve the retention and distribution of health professionals had the negative consequences of increasing health sector wage bills and reducing resources for service delivery.

Interview Highlight

A Ministry of Finance official (External Resources) said in 2024:

“Let me put it on the record that most expenses [i.e. FCDO expenditure] did not go through the country systems so it’s difficult to give the breakdown in allocation to the sectors. We don’t have the records of how much each sector benefited unless you find out from the sectors...UK aid is not in synch with Aid Effectiveness principles which are mutual accountability, transparency, harmonization, alignment, ownership, management for results etc. Some Development Partners such as the World Bank, Canada and recently the USA pass through the Country Systems, but UK Aid does not, which affects accountability.”

The description of modalities above is in relation to the main programme of support, which tended to focus on health systems strengthening. The modality for the smaller bilateral programmes supporting specific sub-sector areas (such as malaria, HIV/AIDS or family planning) was generally earmarked funding and contracted suppliers, usually of TA. These programmes were worth a total of £138 million between 1997 and 2019. Ghana was also involved in a number of centrally managed multi-country DFID/FCDO programmes, addressing issues such as neglected tropical diseases and unsafe abortion.

¹²⁹ Mao W et al (2020) Transitioning from donor aid for health: perspectives of national stakeholders in Ghana. *BMJ Global Health* 2021;6:e003896. doi:10.1136/bmjgh-2020-003896

The Ghanaian perspective

Ghanaian interviewees were largely positive about DFID support over the years, making the following points:

- Financial assistance was helpful, as the sector always needed more money and this was more predictable and stable than both government revenue and project financing.
- The DFID health adviser generally played a positive role, often supporting the MOH to engage effectively with other DPs, the Ministry of Finance, and sometimes even the presidency. This was particularly important during the SWAp. Many (former) officials expressed their dissatisfaction with the silent partnership, when DFID was largely absent from the policy table.
- TA was largely appreciated, but regrets were expressed that the government did not always make optimal use of the opportunities offered by TA. Reasons included a lack of strategic vision, rapid turnover of officers, little succession planning, unresolved conflicts resulting from institutional reforms, and the fact that good TA should be about the transfer of knowledge and skills to local players, which requires a significant time commitment from busy officials.

However, there were varied views amongst the Ghanaian key informants about aid modalities:

- The Ministry of Finance liked General Budget Support, understandably so. They felt less connected to Sector Budget support, which they saw as the purview of the Ministry of Health. Finance officials particularly disliked health sector projects and the Health Fund, which were seen as by-passing the core government function of resource allocation.
- Health officials liked the Health Fund, as it gave them latitude to address their priorities and was a more regular and reliable source of funds than Government. Most felt that General Budget Support had no impact on the health sector, or even if it did it was only through wages, as government's contribution to the goods and services budget was very small, particularly at the district level and below. Sector Budget Support also received some criticism: there were delays in releases from the Ministry of Finance to the Ministry of Health.
- Many agencies, especially the Ghana Health Service, felt they did not receive their due share. Agencies, regions, and districts preferred earmarking and projects, where they felt in the driving seat; they least liked projects directly managed by third parties and support to civil society organisations without information copied to the relevant government agency.

In short, stakeholders' preferences for the different aid modalities largely depended on the level of control they had in the management of the resources, rather than on the health impact of that particular modality.

Interview Highlight

We interviewed a number of senior Ministry of Health and GHS officials in 2024. This is a distillation of very similar things said by several interviewees:

The UK used to be an important partner, financially and technically. Now its development assistance is much smaller, and at the same time it has stopped being channelled through government systems. This means that we don't necessarily know what is happening, and our priorities are not necessarily supported. There was a feeling that the Ministry was expected to co-ordinate everything, but without being sufficiently involved in setting up and implementing projects. To compound this problem, UK aid is now fragmented, coming from multiple ministries, so it is hard to get an overview of what is happening.

Development partners can, of course, legitimately reduce their spend in a country, and this will always cause some difficulties. The lesson learnt here is perhaps an obvious one – that a gradual, well-

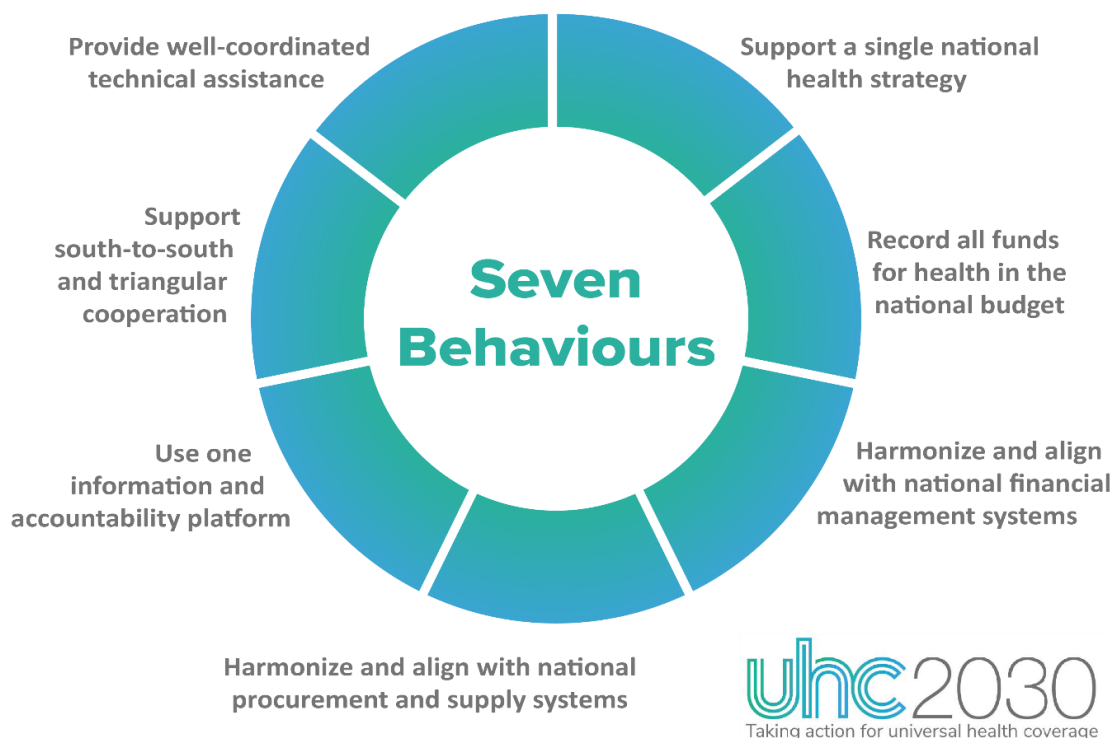
considered, well-communicated, timely reduction is better than significant reductions that disrupt existing plans. Sometimes, clearly, political, or economic changes in the development partner's country will lead to urgent budget reductions, but this has costs in terms of reputation and trust.

4.1.2 Considering the lessons- aid effectiveness

'Aid effectiveness' came to the fore in the early 2000s, as it was increasingly recognised that development assistance should be producing better impacts. The 2005 Paris Declaration, which was endorsed by more than 100 countries and agencies including Ghana and the UK, identified five central pillars of effective aid - ownership, alignment, harmonisation, managing for results and mutual accountability. There were follow-ups to the Declaration in Accra in 2008 and in Busan in 2011. The crux of the Declaration was the importance of respecting a country's priorities and systems, and for development partners to avoid creating parallel plans and systems for financial flows and reporting. The aid effectiveness agenda became less prominent as the 2010s evolved. In contrast to the 2000s (broadly Phases 2-4), when modalities were energetically discussed, ICAI's review of the period 2011 to 2019 did not refer to bilateral aid modalities at all.

However, in the 2020s there appears to be renewed interest in how to improve the effectiveness of development assistance. UHC2030 aims to accelerate progress towards universal health coverage (UHC) through building equitable and resilient health systems – both Ghana and the UK are signatories to its international compact.¹³⁰ UHC2030 talks about the 'seven behaviours' of effective co-operation. These strongly reflect the principles of the Paris Declaration of alignment with country plans and management systems (see Figure 15).

Figure 15: Seven behaviours of effective cooperation



Source: <https://www.uhc2030.org/what-we-do/improving-collaboration/health-systems-strengthening/>

¹³⁰ UHC 2030 Partners (2024), <https://www.uhc2030.org/who-we-are/uhc2030-partners>

Many of the principles of aid effectiveness were realised in Ghana during the relatively long period from about 1998 to 2012 (broadly Phases 2-4). There was a systematic process for planning, implementing, and monitoring activities, which some but not all development partners adhered to. Maintaining this arrangement was hard work for all concerned, in terms of both mutual trust and practical logistics. There were definite advantages in terms of coherence and strengthening Government of Ghana's systems - although precise attribution is impossible, it seems likely that the current format of Ghana's Health Sector Medium Term Development Plans, with their review of previous performance and clear priorities, is a legacy of the systematic, relatively unified, and evidence-oriented approach of the years of Financial Aid and SWAps. There was the opportunity to discuss some important policy challenges, but there were also areas where the SWAp DPs had less leverage, for example government's contracting out work to private or third sector providers and developing accountability to the people of the country. The Government of Ghana was certainly historically reluctant to pay other providers with 'its' money. Accountability programmes generally have to be funded separately. There were also no magic bullets to long-standing problems such as health inequalities.

Most of all, maintaining the relationships was about political will, committed leadership and robust management. It is probably inevitable that SWAps are time-limited, as the mutual satisfaction with arrangements is very difficult to maintain over a long period.

It is notable that Technical Assistance is singled out as one of the Seven Behaviours, reflecting many countries' experience of intensive and unco-ordinated TA which is disruptive and time-consuming for government officials and health staff. TA is often managed separately from Financial Aid, but the same principles of harmonisation and alignment apply.

4.1.3 Looking forwards

The UK thinking about its work in Ghana is set out in the FCDO's 2023 *UK-Ghana development partnership summary*. The paper makes a number of points which are relevant to future support in the health sector:

- A central role for *"patient, long-term partnerships tailored to the needs of the countries we work with, built on mutual accountability and transparency"*.
- An increased role for other UK government departments, beyond the FCDO.
- As per the 2022 International Development Strategy, a focus on women and girls and other vulnerable groups.
- Poverty reduction, climate change and global health security are all priority areas.
- Health work that focuses on using UK expertise *"to strengthening systems, rather than to deliver services, except where there are strong cases for pilot testing new approaches"*.
- The importance of drawing on centrally managed programmes, and on adviser relationships with Government of Ghana counterparts and other donor partners.
- A narrative of partnership, rather than donor/recipient.

The *Partnership Summary* also highlights UK leadership in supporting mental health and in developing a UK-Ghana Science, Technology and Innovation strategy.

In discussing the FCDO budget for Ghana, the document reveals the complex organisation of UK support:

"It should be noted that these figures do not reflect the full range of UK ODA spending in these individual countries as they do not include spend delivered via core contributions to multilateral organisations, or regional programmes delivered by the FCDO's central departments. Other UK government departments also spend a large amount of ODA overseas. Details of ODA spent by other UK government departments can be found in their annual report and accounts and the Statistics for International Development."

In other words, it is difficult to summarise UK spending in Ghana because it flows through so many channels.

The FCDO Global Health Research Programme has mapped the research and product development work it funds in the areas of global health security and ending preventable deaths. An analysis of activities in Ghana shows the complexity of UK funding. There were 9 programmes (research, public-private product development partnerships or clinical trials) active in Ghana.¹³¹

It is clear that all was not well in terms of the Government of Ghana believing that current UK support was transparent, accountable and tailored to national needs. UK support in Ghana had fragmented rapidly, involving more UK ministries and many more different channels, with many relatively small partnerships and the increased importance of multilateral bodies and centrally managed programmes. This diversification did bring some advantages, but in Ghana it was hard to understand what the UK as a whole is supporting in the health sector. There is a role for better messaging and communications here.

Interview Highlight

A typical remark from an MoH Official:

“UK aid in the past was the torch blazer in the health sector but the scaling down of its support to lower levels has made its contribution not much felt now.”

Since 2015, DFID’s strong focus on Financial Aid has been largely, but not entirely, replaced by project funding, contracted directly by DFID. Even though the situation is now very different (smaller budgets and service delivery no longer directly funded, except in mental health), there are still Financial Aid principles which are worth preserving, especially government ownership of workstreams.

After a period of relative silence about aid modalities, there is once again lively discussion about the pros and cons of various options in Ghana. There are valuable insights from past experience which are still relevant today – indeed it is extraordinary how the debates of the 1990s are being re-visited in the 2020s. The Government of Ghana is keen to receive support through Financial Aid and has received cautiously positive responses from USAID and KOICA (South Korean Aid). However development partners have long-standing doubts about aspects of public financial management (PFM). In addition to World Bank support for PFM in general, there may be a need for work specific to the health sector.

Whereas the UK was once a clear leader in espousing the principles of aid effectiveness, which include mutual accountability, transparency and alignment with national plans and priorities¹³², this is not how many Ghanaian government officials now view the UK. There are two things which could be done to address this:

- Use a wider range of aid modalities. The current situation of most of the money being transacted through directly awarded contracts is historically unusual, with less of a direct role for the Government of Ghana than has historically been the case. An arrangement such as the Ministry of Health-managed TA Fund from Phase 5 could once more be appropriate, with its good record in terms of government ownership and work on (mostly) strategically important issues.
- Be explicit about the relationship between UK thinking and the Ministry of Health’s plans and priorities.

¹³¹ FCDO (2024) Summary of the RED Global Health Research Programme Footprint in Ghana

¹³² OECD (2005) Paris Declaration on Aid Effectiveness

The 2023 Aide Memoire between the Government of Ghana and development partners about prioritisation and co-ordination in health was a positive step, echoing previous Aide Memoires in 2007¹³³ and 2010¹³⁴. However, experience has shown that in this context actions speak louder than words – Aide Memoires need to be backed up by actions to streamline aid modalities and funding channels. Box 7 summarises ten key lessons about aid modalities and the ways of working.

Box 7: Ten key lessons, aid modalities and ways of working¹³⁵

1. SWAp-type arrangements (pooled DP funds; common management systems) can be made to work.
2. There are many advantages to the 'one plan, one budget, one report' way of working, including a clear focus on agreed priorities. There can be long-term positive effects in terms of strengthened national systems for planning and reporting.
3. It is difficult to maintain a SWAp over a long period of time, not least because what constitutes 'good enough' government systems is a subjective judgement that can change over time.
4. Managing SWAPs is hard work and requires a commitment to joint working and problem-solving. However, managing multiple relatively small projects is also time-consuming.
5. Providing substantial funds, or joining a large pooled arrangement, is one way of gaining a seat at the policy-influencing table. Another way is to show leadership in promoting co-ordination amongst development partners.
6. Domestic DP politics affects what happens in the development assistance programme. However, there is a two-way accountability at work here, and responsibilities to governments about existing arrangements when budgets and policies change. The Independent Commission for Aid Effectiveness judged it critical *"to reduce the volatility of the UK aid budget and facilitate a return to multi-annual planning to restore the UK's reputation as a reliable development partner"*.¹³⁶
7. Technical assistance is an important element of development assistance. To influence important reforms, the TA planning and management arrangements must be well embedded in government systems.
8. Aid modalities can co-exist, and each has its advantages. Financial Aid can be appropriate to support service delivery, and also to gradually tackle long-term knotty challenges, such as developing an efficient national health insurance scheme.
9. Whatever modality is used, it helps to 'keep it real' by including activities at the sub-district or district level and indicators about on-the-ground delivery.
10. There will not be agreement in Ghana about the best way to manage development assistance – this depends on where a particular stakeholder sits, and the extent to which they can directly influence spending.

¹³³ ModernGhana.com (2007), Health Ministry partners sign Aide Memoire to show commitment

¹³⁴ Business Ghana (2010), MOH signs Aide Memoire with development partners
<https://www.businessghana.com/site/news/general/112787/MOH-signs-Aide-Memoire-with-development-partners>

¹³⁵ Original list assembled by the authors

¹³⁶ ICAI (2023) UK aid under pressure: A synthesis of ICAI findings from 2019 to 2023, page 24

4.2 What types of activities should be funded?

Key Points

- Throughout the 30 years DFID fairly consistently supported some core health system areas, including financial management, human resources, health financing and institutional strengthening.
- Systems support works better when it includes activities and indicators at the district or sub-district level – this helps to ‘keep it real’.
- Support in the 2000s decade placed more emphasis on health outcomes through support for health service delivery.
- COVID illustrated the importance of robust country-wide systems.
- Good programme design makes it possible to weave support for a particular technical area together with appropriate systems strengthening.
- It is now timely to think in terms of aid at the margin, the idea that the core package of the highest priority services should be fully funded by the national government. Development partners should direct their support to the next level of priorities, those that would otherwise not have been funded.
- Support for mental health fits in with the aid-at-the-margin concept. Other possible areas are discussed – the breadth of the social determinants of health means that sometimes investments out with the health sector can bring the biggest returns in terms of health improvement.

4.2.1 Looking backwards – What has been funded?

Throughout the 30 years DFID fairly consistently supported some core health system areas, including financial management, human resources, health financing and institutional strengthening. The systems support included a strong focus on district and sub-district strengthening (including community-based health services, CHPS), sometimes not. Change tended to be more noticeable – and outputs more tangible – when a localised element was included. It can be valuable to complement systems change (which often has a central focus) with activities that work directly with health facilities and local levels of health pressure.

This focus on health systems strengthening was largely about long-term effectiveness and sustainability. Many of the health systems activities were investments for the future, rather than measures to produce short-term improvements in health. For example, even if everything had proceeded smoothly, it would have taken a number of years for the National Health Insurance Authority to have a major impact on health status.

Over time, the core planning and information systems improved: planning grew to include private health facilities and National Health Accounts became a regular feature. A mature, holistic annual performance system became institutionalised. Information about cost structures improved and unit costs were used to construct more realistic budgets. Burden of disease data was collected, analysed and used to inform planning. TA was used to support evidence-based decision-making.

In later years health systems strengthening included other parts of the system, notably the Food and Drug Authority, with its crucial role in relation to the quality of medicines.

Over the 30-year period, attention gradually turned more to the relationship between health services and health outcomes and equity, and to systemic weaknesses which hampered achievements in these areas. A number of different factors influenced this shift. In Ghana, a period of relative political stability allowed for continuity of health planning. Consecutive plans were able to deal with issues that had not been well captured in the Medium Term Health Strategy and the first POW in the 1990s, such as equity; the roles of civil society and the private sector; gender; adolescent reproductive health; and mental health.

Globally, around the year 2000, the MDGs and the rise of global health partnerships – notably Gavi and the Global Fund – turned attention to specific health programmes and their outcomes.¹³⁷ Over the years, DFID supported a number of programmes focused on a specific health area, including malaria, sexual and reproductive health, maternal, child and newborn health, AIDS, and, latterly, mental health.

A lesson from COVID was that country-wide *systems* need to be robust – the COVID response required national reach, and work in areas as varied as primary health care, hospitals, procurement, laboratories and public health communication. Even when supporting a particular technical area of the sector, it remains important to understand the impact this has on the effectiveness of the health system as a whole.

How countries deal with a strong focus on one particular health issue depends on the robustness of the core health system. In a country with weak, under-resourced systems (Ghana in 1993), a focus on some narrow technical priority can bring results, but also tends to have costs in terms of broader systems strengthening. In a country with more mature systems (Ghana in the 21st century), more robust systems can manage, and be improved by, a focus on particular technical targets.

Over the years, global health has seen passionate arguments about the relative benefits of health systems strengthening versus the so-called ‘vertical programme’ approach. A more rounded view is the idea that health systems are the framework of the system and changes in technical programmes need to be woven into this framework. Over time, a rather sophisticated way of weaving together support in a particular field with systems strengthening has evolved. Thus we see, for example, funding for mental health medicines complemented by work on improving co-ordination between the Ghana Health Service and the Mental Health Authority, and leveraging work with the National Health Insurance Scheme to broaden its scope to include mental health conditions. Another example is funding for family planning placed in the wider context of strengthening wider sub-district services.

Interview Highlight

British High Commission, Ghana:

“We have commissioned work on maternal mental health. The long-term aim is to have this included in maternal health modules in the health service. This is an example of how we work – focusing on the health system and weaving in new areas.”

4.2.2 Looking forwards – Applying the concept of aid at the margin

Now that the UK’s health sector development budget in Ghana is much smaller and does not support service delivery (except for mental health) this question of ‘what to support?’ looks rather different. Gone are the days of UK lead involvement in huge sector-wide programmes.

For much of the period discussed here, development partners supported health issues which accounted for large proportions of the burdens of disease and had cost-effective ways of tackling them. Concern that this displaces the government’s responsibility to provide priority services has grown. In their 2023 policy paper ‘*How Refocusing Health Aid at the Margin Could Strengthen Health Systems and Futureproof Aid Financial Flows*’ – Drake et al discuss how it could be possible to foster government ownership and respect government priorities without actually co-financing the highest priority activities.

Aid-at-the-margin is the idea that the core package of the highest priority services (which in theory should be the most cost-effective interventions) should be fully funded by the national government. Development partners should direct their support to the next level of priorities, those that would otherwise not have

¹³⁷ Irene Agyepong (2018). Universal health coverage: breakthrough or great white elephant? *The Lancet* 2018; 392: 2229–36

been funded.¹³⁸ These might not be funded because they are not as cost-effective as what is being paid for, or because they are particularly difficult or risky, perhaps because it is a health issue linked to some form of stigma. Although the aid at the margin concept was primarily designed for supporting service delivery, the idea can also be applied to technical assistance partnerships and research.

A number of potential benefits have been claimed for aid at the margin. It avoids the problems of volatile levels of donor funding because the highest priorities are domestically financed. It should avoid the crowding out of domestic funding for priorities and may in time attract domestic financing for the next tier of priorities. It is evidence-based and is appropriate for countries in transition, where external aid is being phased out. Prioritisation and responsibility for the highest priorities lie with the national government.

Aid-at-the-margin is not compatible with all aid modalities. Unearmarked budget support by definition contributes to the funding of core services and would find it hard to promote neglected services. However, a judicious blend of earmarking and well-chosen targets could contribute to a successful co-existence of Financial Aid and aid-at-the-margin.

Interestingly, the area of mental health fits well with the aid-at-the-margin concept, and UK support for mental health in Ghana in many ways appears to be a successful example. Even though support for mental health started before the at-the-margin concept was developed, it corresponds to that thinking in terms of being an under-funded area relative to need, not supported by multiple donors. Because the UK has been so instrumental in supporting the development of mental health services in Ghana, and because this remains a relatively unusual area for bilateral development programmes, it is appropriate that mental health continues to be supported. This could be in terms of systems (e.g. issues related to governance, as services are developed within existing health facilities but still with a separate Mental Health Authority); specific areas such as maternal mental health; research¹³⁹; or areas where technical programmes and systems are inter-woven, such as in the extension of National Health Insurance into more areas of mental health.

Because this is an unusual area of partnership, the work has the potential for international influence. For example, Ghanaian authors and their collaborators are already making their mark in the global literature on mental health^{140,141} – this is something that can be developed, and could have far-reaching benefits for other countries.

4.2.3 What to support?

The aid-at-the-margin concept - that domestic finances should support essential health services and health aid should primarily be used to expand the package of affordable services at the margin – can be applied, at least in theory, to the existing system of health planning in Ghana and is consistent with the philosophy of Ghana Beyond Aid. The Medium-Term Health Sector Development Plan outlines its priorities and states “*there will be continuous review and monitoring of the HSMTDP to generate evidence to support reprioritization of the HSMTDP interventions*”. There are plans, scenarios and monitoring matrixes for the development of Universal Health Coverage. The UHC Roadmap specifies what are deemed essential services and the related system requirements. This is a framework of thought to which ‘aid at the margin’ could be applied. Although in practice the analysis will not be as neat as it is described here, and there will doubtless be crises when core services are seriously under-funded - this would be a systematic way of working with Ghanaian decision makers and national policy processes. Moreover aid-at-the-margin resonates well with the Ghana Beyond Aid desire that development assistance be catalytic.

¹³⁸ Drake T et al (2023) Re-imagining Global Health Financing: How Refocusing Health Aid at the Margin Could Strengthen Health Systems and Futureproof Aid Financial Flows. Center for Global Development Policy Paper 285

¹³⁹ Mwangi G (2023) Mental health and disability research in Ghana: a rapid review. Pan African Medical Journal. 45:166

¹⁴⁰ Daliri D B et al (2024) Exploring the barriers to mental health service utilization in the Bolgatanga Municipality: the perspectives of family caregivers, service providers, and mental health administrators *BMC Health Services Research* 24:278

¹⁴¹ Gureje O et al (2020) Effect of collaborative care between traditional and faith healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana: a cluster randomised controlled trial. *Lancet*. 396(10251):612–622

Practical co-ordination amongst development partners still exists, but has weakened since the decline of large, multi-donor health sector support programmes. Without over-stating the point, and realising the many other factors at play, aid-at-the-margin could perhaps be used as a way for donors to think together about priorities and about who funds what.

The history and progress with development indicators described earlier in this paper can be put alongside thinking along the lines of aid-at-the-margin to suggest some potential topics which could be addressed in some way through Ghana/UK partnership. Moreover, the margin concept encourages thinking about health outcomes, not the outputs of health services, so can point towards activities in other sectors. The aim here is not to make specific recommendations, as these depend on many local contextual details. Rather it is to illustrate how the at-the-margin concept can be used to identify issues which are emerging, have been neglected, or have been persistently challenging.

Non-communicable diseases (NCDs). NCDs are becoming an increasing part of Ghana's burden of disease. The planned STEPS survey will identify risk factors. Is enough being done to address the most important risk factors, including weight, exercise, diet, alcohol intake and air quality? In 2020 the World Bank highlighted the importance of incorporating prevention and control activities related to NCDs (as well as mental health interventions) into service delivery and demand creation in primary health care.¹⁴²

Private health. Given the size of the private sector, it is important to understand exactly how it can contribute to (or thwart) national goals.¹⁴³ Government recognises this issue - the Health Sector Medium Term Development Plan (2022-25) identifies "*weak co-ordination and sub-optimal harmonization between public and private health services providers*" as one of the six main development challenges in the sector. In practice, however, it can be difficult to implement activities, and there can be mutual suspicion between public and for-profit providers.

Quality assurance and registration. The notion of aid-at-the-margin can also be applied to health systems. The national government should fund the core, with external financing supporting the next most important part of the system to develop. These may well be systems of quality assurance or registration. In Phase 5, support to the Food and Drug Authority to accelerate its work on quality assurance and medicines safety proved highly effective. Is this a form of partnership which could be replicated with other bodies with a quality assurance function?

Poverty and inequality have been persistent concerns throughout the 30 years discussed here. Ghana's poverty rate remains high by LMIC standards and extreme poverty increased from 10% in 2013 to 13.6% in 2019 (and probably more during the pandemic).¹⁴⁴ The Gini co-efficient, reflecting inequality, is high by West African standards.

The relationships between health, poverty and inequalities are clearly highly complex. The distribution of resources such as income, food, housing, education, and health care are strong determinants of length of life and health status. Along with social relationships, these are the social determinants of health, a multi-disciplinary concept which fits in well with the cross-sector focus of future programmes. What are the most important determinants of health in Ghana and is enough being done to tackle them, whatever the sector?

In the health sector, we know that out of pocket expenditure, at 27% of total health spending, is higher than the WHO recommended upper limit of 20%. High out of pocket payments mean that some households remain in, or are actively forced into, poverty. This relationship between insurance, out of pocket spending and poverty is an appropriate area of focus for Ghana/UK collaboration. One focus could be on psychotropic drugs. The UK has supported development of a drug revolving fund for psychotropic drugs, and incorporation of some mental health conditions into the national health insurance package.

¹⁴² World Bank (2020) Implementation Completion and Results Report – Multi-donor Health Results Innovation Trust Fund

¹⁴³ Montagu D et al (2020) Equity lessons from a large scale private-sector healthcare intervention in Ghana and Kenya: Results for a multi-year qualitative study. Gates Open Res. 4:129

¹⁴⁴ FCDO (2023) UK-Ghana development partnership summary

What difference has this made in terms of poor households having extremely high medical costs, and in terms of mental illness impoverishing families?

Climate change will continue to throw up issues related to health and these are already being explored by the Government of Ghana and FCDO. It is important to continue to investigate new vulnerabilities in a timely way. For example are there ways in which climate change is changing the picture in terms of, for example, air pollution or the incidence of malaria?

Demography. In the review of health and related statistics from Ghana over the last 30 years, and comparisons with other countries, two areas where Ghana was very different from other LMICs were population growth rate (1.0% LMIC average compared with Ghana's 1.9%) and total fertility rate (2.6 LMIC average and 3.6 in Ghana). However, when we compare Ghana with only the LMICs in West Africa, we find that Ghana lies somewhere in the middle of the range for population growth and total fertility - it is doing about average for this group of countries. The official Ghanaian view, as expressed in the Long-term National Development Plan¹⁴⁵ is that this young population is an opportunity, not a problem, as long as infrastructure and services keep pace with the rising population. (The challenge of the electricity network was particularly highlighted, as well as housing.) A key piece of economic policy is explained in this way:

"Maintaining a stable exchange rate is a necessary though not sufficient condition for moving Ghana from lower middle-income to a high-income country under the long-term plan. (High and employment-intensive growth as well as moderate¹⁴⁶ growth in population are other critical factors)."

Recognising that there can be different interpretations of what constitutes 'favourable' demographic indicators, the questions of interest include why West Africa is atypical in its demographic statistics, and what the implications of this are for poverty and health?

Whilst UK development assistance to Ghana is likely to reduce over time, appropriately so, relatively small sums can continue to be deployed to effect change in relation to important determinants of health which are neglected or emerging as a priority. Aid-at-the-margin and the social determinants of health are useful concepts to inform the identification of areas for funding.

4.3 How to measure progress?

Key points

- A focus on outcomes, with appropriate indicators and targets, is a key part of a well-designed programme.
- In the 2010s a period of extreme focus on results, targets and attribution to UK spending led to stresses about overly detailed data collection and more contracting directly with non-state providers for quicker results.
- Ghana's Holistic Assessment Tool measures a range of health performance indicators and remains a useful resource.

It is, of course, important to monitor expenditure, for reasons of both financial audit and to know the outcomes of spending.

From a situation in the 1990s where systems and processes were given as much attention as outcomes, the focus on measurable outcomes gradually sharpened. Around 2000 (Phase 2) it had become clear that improvements in service delivery and health outcomes were painfully slow, and not reliably measured. During Phase 3, 2002-2006, information was used systematically to try to address persistent challenges,

¹⁴⁵ National Development Planning Commission (2017) Long-term National Development Plan of Ghana (2018-2057)

¹⁴⁶ "Moderate" seems to be around 2.2%

including inequalities. By Phase 4 the Common Management Arrangements had broken down, meaning that Government of Ghana officials were being asked for more and more information (both technical and managerial) by development partners behaving increasingly unilaterally. This was the era of projects and attributable targets. DFID in particular wanted more information and wanted outputs linked directly to DFID spending and targets.

As we saw in Phase 5, the Independent Commission for Aid Impact identified an unintended consequence of an extreme focus on results, targets and attribution – it led to more contracting directly with non-state providers for quicker results. This was not necessarily because the non-state provider was the most appropriate (which of course it sometimes is), but sometimes because this was a quicker, easier, and neater way of operating.

The lessons are clear – a focus on outcomes is obviously appropriate, and can lead to well-targeted, incentivised work. By their very nature, however, development partners' outcomes will always be shared with in-country partners. Good outcome identification, monitoring and reporting take time and skills, and the more partners which share the same targets the better. The more streamlined the monitoring requirements, the more possible it is to have streamlined, co-ordinated plans.

As the UK moves forward with its focus on cross-government support (emanating from a number of UK ministries), and as it focuses on the value of multiple partnerships, it is important to retain an overview of data for the sector as a whole. The Holistic Assessment Tool remains a useful product of the SWAp era. The Tool was still in use in 2023, though there were gaps in its use and issues about quality. Moreover, the Ministry felt that at times the Tool was used without time to consider the wider complex, meaning that its usefulness in informing future plans was limited. However, it remains a valued tool which development partners are keen to revive.

4.4 Final thoughts – Politics and history

Over the 30 years documented here, political changes in the UK have at times led to mid-programme changes in direction in Ghana. When this happens, it is a failure in predictability and in being accountable to Ghana. Whilst domestic politics will always have times of upheaval and the desire for speedy change, international development brings with it a responsibility to another nation and its people.

SWAps and the aid effectiveness agenda were about mutual accountability and building national systems – they worked reasonably well in Ghana for about 15 years. There is an opportunity now to re-visit the principles of effective development co-operation and to foster genuine mutual accountability. Discussions about Financial Aid and SWAp-type arrangements are back on the agenda in Ghana, making this a fitting time to reflect on the lessons of recent history.

Interview Highlight

DFID Official in the 2010s:

“I really disliked my working life then. It was buying results. It wasn't development.”

5 Annexes

5.1 DFID/FCDO Main programme expenditure, (1993-2023)

Phase	Programmes	Expenditure (£)	Source
Phase 1 1993-1997	1993-1996 Health Sector Assistance Programme (HSAP)	ca 12 million	<ul style="list-style-type: none"> ODA/DFID official from the period
Phase 2 1998-2001	1998-2001 Health Sector Improvement Programme (HSIP)	38.8 million	<ul style="list-style-type: none"> Ghana Health Sector Programme II Project Concept Note
Phase 3 2002-2006	2002-2006 Health Sector Improvement Programme II (HSIPII)	40.0 million	<ul style="list-style-type: none"> DFID Annual Review. (Budgetary Support / SWAPS only)
Phase 4 2007-2012	2008-2012 Health Sector Support (HSSP)	41.2 million	<ul style="list-style-type: none"> HSSP Business Case HSSP Completion report
Phase 5 2013-2019	2013-2018 Health Sector Support II (HSSPII)	59.1 million	<ul style="list-style-type: none"> Programme Business Case HSSP2 Completion report
Phase 6 2019-2023	2019-2024 Leave No One Behind (LNOB)	8.3 million	<ul style="list-style-type: none"> FCDO Official
	2020-2025 Partnerships Beyond Aid (PBA)	5.9 million	

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