Joint Annual Health Sector Reviews: A review of experience

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List of abbreviations

AHSR	Annual Health Sector Review
AM	Aide Memoire
AOP	Annual Operational Plan
APR	Annual Performance Report
BTS	Blood Transfusion Services
CMA	Common Management Arrangement
CoC	Code of Conduct
CoIA	Commission on Information and Accountability
CS	Civil Society
D	District (health district)
DAAR	Disbursement of Accelerated Achievement of Results
DP	Development Partner
DRC	Democratic Republic of Congo
ER	End Review (Final Review)
GAAP	Governance and Accountability Action Plan
GF	Global Fund
Go	Government
HH	Household
HIF	Health Insurance Fund
HIS	Health Information System
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HZ	Health Zone
IASR	Independent Annual Sector Review
IR	Independent Review
JAHR	Joint Annual Health Review
JANS	Joint Assessment of National Strategies
JAPR	Joint Annual Performance Review
JAR	Joint Annual Review
JFA	Joint Financing Arrangement
JR	Joint Review
JRM	Joint Review Mission
M	Million
M&E	Monitoring and Evaluation
MoF	Ministry of Finance
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NA	Not Applicable
NHA	National Health Accounts
NHC	National Health Conference
NHIF	National Health Insurance Fund
NGO	Non-Government Organisation
NMS	National Medical Stores
PAF	Performance Assessment Framework
PNFP	Private not for Profit
PNG	Papua New Guinea
PoW	Programme of Work

SBS	Sector Budget Support
SMART	Specific Measurable Achievable Relevant Timely
SPAR	Sector Performance Assessment Report
SWAp	Sector Wide Approach
ToR	Terms of Reference

1 INTRODUCTION

Joint annual health sector reviews (JARs) are long-established traditions in many countries. They are generally designed to jointly review the implementation of national health sector plans or to assess sector performance and to agree on actions to address constraints in implementation or to improve performance. JARs were established in the early 1990s as part of implementing sector-wide approaches (SWAp) or one of their predecessors. In some countries JARs started when Government and sector partners found sufficient common ground to jointly support the sector without a formal SWAp in place, or in response to a national drive for more transparency and open dialogue.

There is a resurgence of interest in JARs for similar reasons that led to their initial creation: to improve policy dialogue; to increase accountability for results; to increase mutual accountability; to complete the cycle of data collection, analysis, and policy formulation; to have a comprehensive rather than partial review of progress, and avoid setting up parallel processes; to foster agreement on the way forward; to set future benchmarks and targets; and to agree on priorities for further information collection and analysis. At the same time, there is anecdotal evidence of fatigue, and that some JARs have become rather formulaic. There are questions about for whose benefit these events are actually organised.

A key objective of IHP+ is to advance the alignment of international support to national health strategies and plans. One question is if and how well JARs help Development Partners (DPs) and other stakeholders to align their strategies, plans and activities with national sector priorities and plans[1]. The Commission on Information and Accountability (COIA) has also agreed to use JARs as a way to increase accountability for results.

The objective of the study is to review experience and lessons about what has made joint annual health sector review processes effective or not. This review will serve as the basis for a guidance note on options for conducting JARs, and as background for a structured discussion at the 4th IHP+ Country Health Teams Meeting in December 2012.

2 METHODOLOGY

The study team, familiar with the JARs in a number of countries, reviewed documents covering the country-specific JAR process from its start and conducted telephone interviews with selected key actors at country level who could provide a historic perspective of the JAR[2]. The country selection was based on geographical balance, having a JAR in place, with or without an independent review element as part of the JAR and with the decentralised actors directly involved or not. The sample of nine countries (see table 1) include four continents, three lower middle-income countries and six low income countries; three countries have an independent review as part of the JAR; in six countries the decentralised level (province or district) participates to some extent in the review; five countries have a SWAp for more than 10 years (Bangladesh, Cambodia, Ghana, Mozambique, Uganda), three countries with a SWAp for 5 to 9 years (Kyrgyzstan, PNG, Vietnam) and one country has no formal SWAp in place (DRC).

[1] Other modalities promoted by IHP+ to foster alignment are Compacts and Joint Assessment of National Strategies and Plans (JANS).

[2] Key informants include mainly MoH, DPs, NGOs and consultants. Document review was extensive for all 9 countries.

Table 1. Profile of countries reviewed

	DRC	Ghana	Mozam-bique	Uganda	Bangla-desh	Cambodia	Vietnam	PNG	Kyrgyz-stan
Name of the JAR	Revue Annuelle du Secteur de la Santé (RASS)	Annual Health Sector Review (AHSR)	Avaliação Conjunta Anual (ACA) (Joint Annual Review)	Joint Review Mission (JRM)	Annual Program-me Review (APR)	Joint Annual Perfor-mance Review (JAPR)	Joint Annual Health Review (JAHR)	Indepen-dent Annual Sector Review (IASR)	Joint Review (JR)
Low / middle-income	Low income	Lower Middle income	Low income	Low income	Low income	Low income	Lower Middle-income	Lower Middle-income	Low income
Population	68 M	24 M	23 M	35 M	140M	15 M	87 M	6M	6M
Number of districts	515 HZ	134 D	129 D	121 D	64D ; 505 upazillas	69 D	684 D	86D	45D
Greatest Distance from capital	1,800 km, difficult terrain	800km	2700 km	550km	400 km	400 km	600 km	1000 km, difficult terrain	750km
SWAp start date	NA	1997	2000	2000	1998	1999	2007	2003	2006
Compact / MoU	MoU / Compact being prepared	CMA (3rd edition)	CoC 2000, CoC 2003, CoC NGO 2006, MoU 2008, Compact 2008	MoU 2000, MoU 2005, Compact 2011	Partner ship arrange ment 2006, JFA 2012	Aid Effective-ness Declara tion 2006, Compact 2007	2005 Hanoi Core Statement on AE, 2009 MoH-DPs statement of intent	SWAp Partner ship agree ment 2004, 2006.	MoU 2006, Joint Statement 2012
Donor support as part of total health expenditure*	Go: 15% **DP: 23%;** NGO**: 11% HH: 43%	DP 2010 **15.8%** DP 2012 **9.6%** DP 2013 **5.4%**	Go: 55% **DP: 17%** HH: 28%	Go: 15%; **DP: 35%;** NGO <1% HH: 49%	Go: 19% **DP: 6%** NGO:10% HH: 65%	Go: 28% **DP: 9%** HH: 63%	Go: 36% **DP: 1-2%** HH: 62%	Go: 55% **DP: 17%** HH: 28%	Go: 38% HIF: 5%*** **DP: 14%** HH:43%

(*) Sources used: National Health Accounts, MTEF or WHO Global Health Expenditure Database (latest info available)
(**) In DRC NGO includes NGOs and International Foundations
(***) HH means contributions from households; HIF: Health Insurance Fund

For the purpose of this review, the term JAR includes all the elements of the process: preparation, inputs, process, output and follow-up actions. It includes both the review and the health summit / health assembly if considered part of the review process.
The word 'joint' is interpreted in its large sense, including all potential or participating partners active in the health sector (public, private not for profit and for profit, professional associations, NGOs, consumers) as well as outside of the sector (e.g. other ministries, national financing agencies, academia, civil society, Parliament) and development partners (DPs). The minimum scope of 'joint-ness' in the context of this study is understood as MoH together with DPs.
The word 'annual' is interpreted in a larger sense. In some countries review events take place twice a year or every two years.
The short time and limited number of people interviewed obviously limits the degree of detail of the study. However, the familiarity of the study team with JAR processes, the input provided from a variety of actors and the effort made by the study team to balance different views and a wide variety of experiences, as well as to 'distil' the essential information, provides sufficient trust that the main findings and lessons largely reflect the current and historic reality. By summarising the findings in a short note, some of the nuances may however be lost.

3 KEY CONCLUSIONS OF THE REVIEW

- All representatives of government and of partners interviewed for this study were in favour of maintaining JARs. All were positive about the JAR's added value and potential. Several partners also expressed views on how to make the country-specific process more efficient. If fatigue with the JAR is mentioned by some respondents, the main reason is the efficiency of the current modality in place.
- JARs are tailor-made and country-specific. Modalities, processes and inclusiveness evolve over time in order to adapt to changing context, increase efficiency and mitigate possible 'fatigue'. This 'local appropriation' is an absolute strength and developing a "one-size-fit-all" model should be avoided. At the same time, countries can learn from each other and South-South learning should be supported.
- JARs share some common aspects: all are part of the annual M&E cycle; in general they review implementation of last year Programme of Work (PoW) and aim at contributing to or improving the next year PoW; they tend to have an annual rather than a multi-annual strategic focus; they tend to become more inclusive over time; DPs are much involved in several aspects of the JAR and co-finance the JAR together with government.
- JAR modalities vary in terms of name, definition, duration and number of meetings, components, focus, content and information used, inclusiveness and participation, degree of involving decentralised actors, outputs and sharing of information, and follow-up of recommendations.
- JARs tend to strengthen policy dialogue, alignment, accountability, implementation of the sector plan and internal resource allocation. But the JAR is only one out of many contributing factors.
- JARs have a potential to improve plans, mobilise additional resources and promote mutual accountability. These outputs were confirmed in only part of the countries reviewed and effectively strengthening mutual accountability remains a challenge.
- JARs are less recognised for improving harmonisation, setting new targets or indicators and reducing transaction costs. Reviewing targets or indicators is more the output of a Mid-Term Review (MTR) or End Review (ER).
- Factors that determine a successful JAR include strong government leadership, high degree of local ownership of the JAR, meaningful and wide participation of all stakeholders, a constructive climate and an open policy dialogue. Not all JARs provide sufficient space for policy dialogue or are inclusive. More alignment, greater harmonisation between DPs and less fragmentation help reaching consensus. Reliable and timely data, evidence-based information and well-designed performance assessment frameworks are essential for effective monitoring and proper decision making. Timely availability of good quality data, properly validated, as well as capacity to perform strategic analysis of data, is a weakness in several countries. Good preparation and organisation of the joint reviews is essential for ensuring efficient work during the JAR and there is scope for improvement in several JARs reviewed. **Integrating the JAR in the national planning cycle** is essential to ensure improved implementation of future plans.
- Keeping inputs, processes and outputs at a manageable level avoids wasting resources and frustration. This regards the frequency and timing of independent reviews as well as the size and composition of the review team, the country experience of team members and the lack of continuity between subsequent reviews. It also regards the number and profile of participants in joint events and in technical working groups; the number, feasibility, prioritisation and timeline of recommendations; and the size of review reports. JARS should take into account the limited time for implementation between JARs and avoid defining a scope of work that is too ambitious, similar to a MTR or ER. Too many recommendations or

recommendations that are hardly feasible to achieve leads to frustration and the perception that the sector does not perform.

- There is a call (MoH and/or DPs) for more policy / strategic dialogue and less technical / operational focus in joint reviews in several of the countries studied. In larger countries technical/operational JARs could be considered at provincial level while maintaining a more policy-focused JAR at national level.
- Ensuring that JAR reports, and more specifically recommendations and proposed actions, are shared with all stakeholders is essential, both from a point of transparency and accountability and in order to ensure that actions are taken up by the relevant actors.
- Consistently tracking JAR recommendations and proposed actions is considered essential by all partners, but not all countries do this. There is scope for improving SMART[3] action-oriented recommendations, prioritisation, and ensuring regular monitoring by a high level sector body.
- Main challenges are the timely availability of good quality data, properly validated, as well as national capacity to perform strategic analysis of data; how to ensure that relevant JAR recommendations are integrated in decentralised plans; how to balance between a drive for more participation and good technical / policy discussions; how to ensure meaningful participation and further develop mutual accountability in the context of a growing tendency among DPs to ask for a direct attribution of results; and how best to integrate meaningful aid / development effectiveness criteria in monitoring sector and/or national performance.

4 Findings

4.1 There is no “one-size-fits-all”

No guidelines exist on how to organise and carry out a JAR. Regular assessment of sector performance is a ‘standard’ procedure in many low, middle-income and high income countries. The frequency, content, process, inclusiveness, ‘joint-ness’ and type of outcome vary, mainly because these ‘standard’ national or sector procedures are the result of local history, culture, context, local dynamics and experience. Obviously, these processes evolve over time in each country.

JARs do not exist in a vacuum. They are linked to and part of national monitoring and evaluation (M&E) and planning processes and are organised in sequence with other important sector events in the context of local dynamics of high level policy and technical dialogue, working together in technical working groups (TWGs), bilateral meetings, etc. The extent to which outputs such as better alignment, improved policy dialogue, or greater mutual accountability can be attributed to a JAR is difficult to measure. However, as discussed in this paper, JARs may to a lesser or greater extent contribute to those outputs.

Some factors are particularly important to take into account in the review: the country’s wealth, the government’s level of control and influence, the evolution of the SWAp and funding modalities, as well as the degree of donor dependency[4]. A history of strong central planning or of state fragility will colour the policy dialogue, as will the leverage exerted by specific DPs and the local interpretation of concepts such as accountability[5]. This should be taken into account when comparing country specific JARs.

[3] SMART: Specific, Measurable, Achievable, Relevant and Timely.

[4] See table 1. Donor dependency is low in Vietnam and is likely to reduce over the next couple of years in Ghana.

[5] Accountability to civil society is understood differently in Vietnam as government is perceived as part of civil society.

Another factor is the **size of the country** (population in countries reviewed vary between 6 and 140 million; distance from the capital to the furthest town between 400 and 2700 km; number of districts from 45 to 684[6]). Direct or effective participation of districts in the JAR is more challenging in larger countries.

The level and type of **decentralisation** (deconcentration or devolution within the line ministry or through other ministries such as Local Government), the importance of the private sector[7] as well as which line ministries are responsible for service delivery also influence how JARs are being held and who participates.

Finally, in countries with strong **government leadership**, DPs tend to have less influence on how JARs are organised and used. DPs in general have more influence in the early days of a SWAp, as they often have contributed to the start of JARs. When processes become country-owned or are country-owned from the start, DPs are less influential in the organisation of the JAR but remain influential on JAR results through the funding modality and level of financial support.

4.2 JARs have some aspects in common and in essence aim at the same output

In each country reviewed, the JAR is a **well-known regular review activity** that is being referenced in many different official documents, reports, reviews, etc. Specific annual Terms of Reference (ToR) exist in almost all countries[8,9].

All JARs are **part of the annual M&E cycle**. They are most commonly the apex of the annual sector review or Programme of Work (PoW) review. All JARs review the implementation of last year's PoW / Annual Operational Plan (AOP) to some extent and aim at contributing to the next year's PoW/AOP. Most often only central or sector PoWs are being addressed. Influencing provincial or district plans through the JAR is less obvious. Either these are disjointed processes or modalities to influence decentralised plans do not really exist or are not effective. Exceptions are Ghana with a well-developed system of performance hearings and peer reviews up to district level and Uganda using different modalities such as joint district visits, district league tables[10] and participation of all districts in the health summit preceding the joint review. In the DRC, the national JAR is at the apex of 11 six-monthly provincial sector reviews (to varying degrees "joint") and 515 quarterly district (health zone) reviews. This review cascade is, however, only implemented in a few health zones and provinces. In Mozambique, the Provincial Health Directorates are directly involved in the district visits.

Most JARs have **no 'multi-year strategic focus'** (but the holistic assessment[11] in Ghana for example takes a multi-year perspective). A multi-year perspective is more the business of the MTR or ER. In most countries the MTR is done in conjunction with or feeds into the JAR. In some countries it is a

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[6] In both countries mentioned (Kyrgyzstan and Vietnam) the average population of a district is around 130.000 people.
[7] For example, the role of the PNFP provider in the health sector in Mozambique is negligible.
[8] This is not the case in Kyrgyzstan where the general ToR apply.
[9] Most often, the MoH Department of Planning or M&E Unit is responsible for making the ToR. In some countries this is the role of a Higher level Sector Steering Committee (e.g. Health Policy Advisory Committee [HPAC] in Uganda or the Comité National de Pilotage [CNP] in the DRC) or a specific JAR Steering Committee (e.g. Bangladesh). In all countries DPs are involved or consulted in drafting the ToR. In 3 countries, CS is also member of the responsible structure (DRC, Ghana and Uganda).
[10] See annex 6.8 for an example of a district league table, completed every year in Uganda.
[11] See annex 6.7 for an example of a holistic assessment, completed annually in Ghana.

separate exercise (e.g. Cambodia). In other countries the MTR replaces the annual IR (e.g. Bangladesh).

DPs are closely involved in several aspects of the JAR, from developing the ToR and preparing the JAR together with MoH, to participating in joint field visits and/or in technical working groups as well as in the joint review meeting and national health assembly, summit or conference. In some countries, holding a JAR is a DP conditionality. This is mostly the case where sector budget support (SBS) or pooled funding is provided.

In all countries JARs are **financed by MoH together with DPs**. In many countries the financial contribution by DPs is most important, and especially so when an Independent Review (IR) is included (fully funded by DPs). In countries where a basket / pooled fund-like mechanism exist (e.g. Trust Fund in Bangladesh, Pooled Financiers in Kyrgyzstan, Partnership Fund in Uganda) this fund covers the largest part of the JAR. In countries where an intensive or decentralised review process applies (e.g. Ghana, Uganda, Mozambique), MoH co-funding is significant.

4.3 But JAR modalities vary in many ways …

4.3.1 In name and definition

The name of the JAR varies between countries (see table 1)[12]. **'Joint Annual Review'** is the most frequently used designation. The JAR modality is defined in most countries, but the written definition varies, both in content and in specificity. The JAR modality is most often **defined** in a Joint Agreement-like document[13]. Exceptionally it is defined in a national policy document (Uganda, Ghana), more commonly in the Health Sector Strategic Plan / M& E framework (Bangladesh, DRC, Kyrgyzstan, Mozambique, PNG, Uganda), in the M&E plan (Uganda) or in the TOR or report of the JAR (Cambodia, Vietnam). In Ghana and Uganda, sector reviews are requested to happen in all sectors as per National Development Plan[14].

4.3.2 Components making up the JAR

Key components of the JAR vary between countries. In some countries the JAR is part of an intensive, annual, MoH lead M&E process with (Ghana) or without (Uganda, Mozambique) an independent review component. In Uganda, Mozambique, Bangladesh and PNG, the MoH prepares an **annual health sector report**, to be critically assessed and validated by the JAR[15]. In Ghana self-assessment and **performance hearings** are organised at all levels, with all agencies and partners, in addition to conducting an **independent review**, all feeding into the JAR. In Cambodia, the DRC, Mozambique, Uganda, Vietnam, and Kyrgyzstan the main review modalities are centrally organised **workshops** or conferences. **Districts visits** are done in the DRC, Uganda, Ghana and Mozambique[16] and as part of the independent review (IR) in Bangladesh, PNG and Ghana. In the DRC, Provincial performance reports dominate the JAR agenda.

[12] Six names include 'annual review'; five include 'joint'; three mention 'sector review', two 'performance review, one 'independent'

[13] All countries reviewed have a Joint Agreement, MoU, Code of Conduct, Joint Statement or Compact in place.

[14] Only in Uganda, Ghana and Cambodia all sectors are in principle requested to have a JAR. In Uganda and Ghana this is clearly defined in the National Development Plan. In Uganda 1 out of 3 sectors has a JAR in place (7 sectors); in Ghana 4 sectors. In other countries reviewed it is more the exception. The second sector most frequently quoted to have a JAR is education (6 out of 9 countries).

[15] This is an internal exercise in Uganda and Mozambique while being an external, independent exercise in Bangladesh and PNG

[16] In Uganda, Mozambique and Ghana these are joint visits (MoH & partners). Duration is up to one week in Uganda and one day in the DRC.

In Bangladesh, Ghana and PNG **an independent review** (IR) is part of the JAR[17]. In Mozambique IRs were conducted up to 2005 when the process was 'internalised'. In Kyrgyzstan, the introduction of an IR is being considered. Many countries allow DPs to contract individual consultants to participate in the JAR (but this is not part of a formal independent review). In some countries, the MoH contracts a consultant to support the review process (e.g. Mozambique).

4.3.3 Duration and meetings

Duration of joint meetings vary from 1-2 days per year (Bangladesh, Vietnam) to twice 5 days per year (Kyrgyzstan). But the total process, including the preparation of the annual sector report by the MoH, can take up to 3-4 months (Mozambique, Uganda). On average the duration is 10-12 weeks[18]. Most countries have a **one-off** annual JAR event (both reviewing the previous year annual plan implementation and advising on the next year priorities). Ghana, Mozambique and Uganda have in principle **two sessions** at about six months interval[19]. Kyrgyzstan holds two one-week events at six months interval, together being the JAR.

4.3.4 Main focus

Although all JARs, in a way, look at sector performance with a view to set the priorities for the next year plan / future, the main focus differs. Most countries specifically look at the implementation of last year's sector plan[20]. Many countries do a **broad or comprehensive** sector performance analysis (in more or less detail), looking into aspects of all/most health system building blocks (e.g. Ghana, Mozambique, Uganda, Bangladesh, Cambodia, Vietnam, Kyrgyzstan). Others combine this with or focus more on a thematic review. In four countries the **thematic** focus is more important (Ghana, Uganda, PNG and Vietnam).

4.3.5 Inclusiveness and participation

The **degree of inclusiveness varies**, both between countries and over time in the same country. In countries where a health summit is organised, participation in the health summit tends to be more inclusive than in the review strictu sensu. For example, Mozambique has a well-defined review process involving MoH, DPs and NGOs (umbrella organisation) but with a much wider participation at the summits. Ghana and Uganda include a very wide scope of participants in the JAR. Many other countries have a broad spectrum of participants without being fully inclusive. Either the decentralised level of health service providers (district, provinces) are not directly involved or certain stakeholders are not invited (other health-related ministries, local authorities, NGOs, Civil Society [CS], private sector, Parliament, academia or consumers) or are invited but do not participate. In all countries the **degree of inclusiveness progresses over time**. This is specifically the case for NGOs, CS and Parliament. The main ‘missing partners’ in several countries are the for-profit private sector, other health-related ministries, academia, professional associations or the consumer.

The **role of other ministries is generally not defined** in the country specific JAR definition[21]. Participation of other ministries in the health sector JAR varies between countries, from only MoF (or

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[17] Independent Review Teams are always a mix of international and national experts. The size of the team varies with smaller teams in Ghana and PNG (4/4) and a large team in Bangladesh (up to 17).

[18] In Kyrgyzstan the duration is 4 weeks per year.

[19] In Ghana and Uganda the first session is labelled 'JAR' and the second one focuses on approving next year's plan. In Mozambique both sessions are formally part of the JAR and done jointly. The second session is not consistently held as a joint exercise (e.g. Uganda).

[20] This is the case in the DRC, Ghana, Mozambique, Bangladesh, Cambodia, Vietnam and Kyrgyzstan. In the DRC this is mainly based on provincial performance reports; Ghana includes all levels and all agencies. Most countries focus on the central / sector plan, not on decentralised plans.

[21] During the JAR, MoF representatives tend to participate in discussions regarding the sector budget. In a few countries only, MoF makes a statement or presents an analysis regarding the sector budget ceiling, financial gap or MTEF. This is the exception rather than the rule. In Kyrgyzstan the budget rules are consistently part of

with MoPlanning) to those Ministries with a clear responsibility in terms of service delivery (MoSocial Affairs, National Health Insurance or MoLG) to a wider representation (e.g. Cambodia invites Ministries of Education, Women Affairs, Planning, Interior, Economy & Finance, Social Affairs, Labour and Defence). MoF attends the JAR systematically in most countries reviewed (8/9). Participation of health-related ministries is considered weak. Exceptionally, Ministries that have a direct responsibility for service delivery are not present at the JAR.

In order to promote inclusiveness while ensuring sufficient scope and time for technical dialogue, some countries have developed **back-to-back health assembly / joint review meetings** allowing for a wider and decentralised representation in the health assembly (e.g. Uganda: 3-day NHA and 2-day Joint Review). PNG holds a 2 day national health conference every two years to allow for wider participation as compared to the annual health summit (MoH-DPs). Bangladesh closes the JAR with a half-day policy dialogue session, inviting a wide range of stakeholders[22].

Inclusiveness does not mean meaningful participation. Some actors are invited but do not participate. Some are present but their voices are not heard. In some countries the JAR modality does not allow for a meaningful participation (as too little time is allowed, information not timely/sufficiently shared or participation is limited to passive listening to presentations). In several countries ‘the real business is done between government and DPs’ in a side meeting or ‘only the MoH and DP voices are heard’. New participants often still have to learn how to participate in a meaningful way. This applies for example to consumer organisations, CS or members of Parliament.

4.3.6 Involving the decentralised actors

Direct involvement of provincial or district health providers is limited. In 5 countries the provincial health authorities participate in the JAR either by being present or by providing specific provincial performance reports. District health providers and Private not for Profit (PNFP) are directly and meaningfully involved in Ghana (through self-assessment and performance hearings / peer reviews) and in Uganda (through District League Tables / performance assessment; participation of all districts, both local government and health representatives, at the health summit preceding the joint review meeting; and joint district visits). Indirectly, districts and some other stakeholders are involved by providing HMIS data, welcoming district visits or participating in stakeholder consultation (e.g. Bangladesh).

4.3.7 Content / information used in the JAR

Five of the countries reviewed have a more or less developed M&E plan in place[23]. It is currently being developed in Kyrgyzstan and discussed in Bangladesh and Vietnam.

Across countries a **wide variety of data sources and modalities are being used as input data for the JAR** to use, review and/or validate. Each country has developed its own system. Most common data sources used are HMIS, surveys and specific studies. HMIS routine data are directly or indirectly used in all countries either via the annual sector reports or specific provincial or district reports. Several countries (5/9) mention explicitly the use of national surveys[24]. Three countries use specific studies or research reports. For example, Kyrgyzstan uses explicitly and consistently health system studies (e.g. looking into system bottlenecks), coverage studies and patient surveys. In four countries the MOH prepares a sector report for the JAR (or the IR Team) to validate. Four countries make use of specific provincial annual reports. Two JARs explicitly use specific district data (Uganda uses District

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the JAR policy dialogue and the JAR is used as a modality to discuss the budget ceiling more formally with MoF. In Uganda, the AG's report is (since a couple of years) presented at the JAR as well as the MoH response.

[22] Several interviewees confirm that the ‘policy dialogue session’ does not allow sufficient time and space for effective policy dialogue.

[23] The M&E plan recently developed in Uganda is an example of a well-developed, comprehensive M&E Plan.

[24] Via the sector specific PAF most countries use demographic health survey data for some indicators.

League Tables and Ghana organises district performance hearings). Two countries use explicitly DP performance data (Ghana organises DP performance hearings; Mozambique has aid effectiveness criteria in the sector PAF). Other sources of information include agency performance reports/hearings[25], and holistic sector assessment in Ghana; the Auditor General report in Uganda; the stakeholder consultation in Bangladesh.

All countries have a sector Performance Assessment Framework (PAF)[26] in place[27]. While some indicators are more or less standard across PAFs (e.g. MDG related indicators), many indicators are either measuring different type of inputs, processes or outputs or are defined differently. Focus on equity, access, affordability, gender, rights varies a lot between PAFs. **The variety of sector performance measurements** selected in the country-specific PAFs is striking[28].
Mozambique is the only country with **aid effectiveness criteria** integrated in the PAF[29]. Ghana is the only country with a self-assessment and **performance hearing** in place for all sector partners. The sector **Holistic Assessment** in Ghana is an interesting multi-year performance assessment, analysing how the sector evolves and how well it reaches its goals (see annex 6.7).

Sector PAFs in general **do not contain indicators to monitor commitments made in the sector MoU or Compact**. However a few JARs do address specifically the commitments made in the joint agreement (e.g. Mozambique, Ghana and Kyrgyzstan).

Seven countries **use the JAR explicitly or de facto for data validation**[30]. In general JARs do not include additional data collection apart from information gathered or verified during field visits or in thematic reviews done by the IR Teams.

JARs commission **research or specific studies** in 6 of the 9 countries reviewed. In Uganda it is an explicit responsibility of the JAR to plan studies to be reported on in the next JAR.

4.3.8 Report outputs & sharing

Report outputs from the JAR differ in format, size and content. In Kyrgyzstan and the DRC these are mainly summary notes (not very technical); Cambodia, Vietnam and PNG produce technical reports; other countries have technical reports as well as an Aide-Memoire (AM) (e.g. Ghana, Mozambique and Bangladesh). Uganda produces a Joint Aide Memoire. Three countries have the habit of signing the AM of the JAR. This is done only by MoH and DPs (often the representative of the DPs or of the

[25] Performance hearings are held at district, provincial and central level, include all health agencies (such as National Medical Stores, Blood Transfusion Services, National Health Insurance Fund, etc.), professional boards, private not for profit sector) and development partners.
[26] Also called Results Based Framework. In general PAFs use a set of priority sector indicators, many of which are selected from the much larger set of programme indicators.
[27] In the DRC the PAF has been recently introduced and is still to be tested.
[28] Numbers of PAF indicators vary from 26 in Uganda to 126 in Cambodia. The average is 30-50 indicators. Bangladesh has a more elaborate PAF with 41 indicators and 19 “policy responses” or benchmarks to be achieved. In addition the Disbursement of Accelerated Achievement of Results (DAAR) includes 7 thematic areas and 30 indicators / targets to be achieved (faster) over a 3 year period; while the Governance and Accountability Action Plan (GAAP) contains 21 key objectives. All these sector indicators and targets are monitored on annual basis.
[29] These are 3 IHP+ Results criteria for measuring aid effectiveness. Reportedly, these criteria may be removed from the PAF or reviewed as there are different views on reliability of data and/or indicators.
[30] This is explicitly so in PNG (reviewing the Sector Performance Annual Report - SPAR), in Bangladesh (reviewing the Annual Performance Report - APR), in Ghana (the holistic assessment), in Vietnam (the Joint Annual Health Review – JAHR- verifies HIS data), in Mozambique (district visits validate a selection of HMIS data).

wider Partners Group which may include for example NGOs). The added value of reports of several hundreds of pages every year again is being questioned by several partners interviewed[31].

Generally, the lead author of the JAR report is the MoH (7/9) often with the support of a dedicated drafting team, in two countries with support from the IR Teams. In Bangladesh, the IR Team leads the preparation of the report, supported by DPs. In Kyrgyzstan the Summary Note is reportedly a joint effort, but with substantial input from different DPs, each responsible for specific sections of the report[32].

The document is most often **widely share**d, at least with the participants at the JAR or health summit / National Health Conference. In several countries it is publicly available and published on the MoH website (6/9). Late finalisation of the report reduces its potential value and limits sharing with all relevant stakeholders.

4.3.9 Follow-up of recommendations or actions

Many countries (7/9) specifically or systematically assess previous JAR recommendations / resolutions. Each JAR comes up with a list of recommendations, action points, undertakings or the-like, but the review of last year's recommendations or action points is not always recorded in the JAR report. The feasibility and numbers of those recommendations tend to be a problem in some countries. IR teams tend to make too many recommendations, especially when conducting a comprehensive sector review[33]. The feasibility and the volume of recommendations are more under control when the MoH takes a strong lead and owns the process, and when IRs are well-focused thematic reviews. Recommendations tend to be less feasible when there is a high turn-over of senior MOH staff or DP representatives. Too many and/or unfeasible recommendations may lead to the wrong perception that sector performance is unsatisfactory or no action is being taken.

Feasibility of recommendations is also related to the time available for implementation. When the time between two JARs is too short for implementation, the same recommendation may be repeated in subsequent JARs. Other reasons for repeating recommendations or lack of implementation include annual changes of the composition of the IR Team, the omission of appointing a dedicated structure to follow-up the recommendations[34] or an AM or JAR report that does not contain a well-developed action matrix (defining SMART recommendations; specifying the who, what, how and when; providing a multi-year timeframe if applicable).

Follow-up of last year's JAR recommendations is generally (but not consistently) done in the following JAR. This does not suffice if no specific structure is held accountable for implementation. Some recommendations fall of the radar if repeated more than once, as JARs tend to take an annual rather than a strategic multi-annual perspective.

The **main challenge** faced in several countries is how to ensure that relevant JAR recommendations and proposed actions are integrated in decentralised plans.

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[31] The size of the report is less than 50 pages (in 3/9 countries); 50-100 pages (2/9); 100-250 pages (3/9); over 500 pages (1/9).

[32] The report is written in English, explaining why the MoH is less directly involved in the drafting. The report is however reviewed by the MoH before finalising it.

[33] The IR in Bangladesh on average lists 120 to 150 recommendations. The 2008 review came up with 50 immediate, 57 short-term, 35 medium-term and 14 long-term recommendations.

[34] For example, the HPAC in Uganda is formally responsible for following-up implementation of the JAR recommendations every quarter.

4.4 JARs strengthen policy dialogue, alignment, accountability, implementation of the sector plan and internal resource allocation

4.4.1 JARs contribute to open policy dialogue

JARS have definitely contributed to improved policy dialogue in all countries reviewed. Reportedly, this is considered **a major output of the JAR in many countries**, but still with potential to improve in several countries. One country has introduced a specific 'policy dialogue' session at the end of the JAR that could potentially lead to an enhanced policy dialogue with a wider group of stakeholders; today, space for policy dialogue is however still limited.

4.4.2 JARs help partners to better align with government priorities and plans

All country studies confirm that the **JARs contribute (often substantially) to improving alignment of partners**[35] with the sector policy, strategic plan and budget. They are important fora for sharing information, discussing strategies, policy dialogue with a wider audience and with a comprehensive view on the sector as a whole. This is of course not only the effect of the JAR but also of participation in the continuous sector structures for policy dialogue and strategic / technical discussions. But the latter, generally, have a narrower group of partners involved (often only DPs). However, other initiatives such as the preparation of a new strategic plan (or a MTR), can also be very much conducive (or even more conducive) to enhanced alignment.

4.4.3 JARs promote accountability

Accountability of MoH towards its partners, but most specifically DPs, is **one of the main dynamics of the JAR** in most countries reviewed (8/9)[36]. In several countries this goes beyond accountability to only the DPs and involves for example explicitly NGOs, CS and/or Parliament (4/9). Wider accountability is still a learning process in many countries. In some countries the main dialogue is between MoH and DPs while some other partners have more of a token presence in the JAR.

There is a **risk of blame gaming** when accountability is limited to holding MoH solely accountable. Accountability of DPs towards government/MOH is weak or token in most countries. Promoting mutual accountability and mutual responsibility may mitigate this (see below).

4.4.4 JARs contribute to the implementation of the strategic plan

In most countries the respondents confirm that JAR contributes to **improved implementation of the strategic plan** (5/9) or has the potential to do so (4/9). In Ghana this happens mainly through the performance hearings (affecting directly the annual plans at district, provincial and institutional levels), the holistic assessment and the independent review (focusing more on the sector strategic plan). In Uganda the District League Tables and the NHA are said to be important contributing factors to ensuring that district plans take into account NHA/JAR resolutions and district performance is being improved. In Mozambique, Cambodia and Kyrgyzstan the JAR focuses on the implementation of the annual sector plan and decisions to adapt the next year annual plan are made during the JAR. In Bangladesh the JAR also addresses mainly key aspects of the sector strategic plan, but agreed changes to the strategic plan are not always reflected in the 32 operational plans. In several countries (e.g. Bangladesh, Vietnam, Ghana), the JARs have not only reviewed past-year's performance, but also included assessments of thematic areas (e.g. health financing, HRD); these provided recommendations on policy and strategy development in these areas. The degree to which proposed policy / strategic changes are effectively implemented however varies. For example, in Vietnam there is no mechanism to enforce policy implementation. And the poor link between the

[35] Interestingly, the GF is most often mentioned as an example of a less-aligned partner, not participating in the JAR. But In Kyrgyzstan, the GF has signed the Joint Statement in 2012.
[36] The context is different in Vietnam, a middle income country, where DP support to total health expenditures is only 1-2%.

sector strategic plan and the operational plans in Bangladesh does not facilitate policy implementation. In PNG, the potential exists as the IR Team tables the sector weaknesses, but limited evidence exists of effectively implementing policy / strategy changes. In the DRC, today, this may be limited to selected provinces and / or health zones supported by DPs.

Changing or adapting national strategies is more considered the domain of the MTR, ER or when preparing the next strategic plan. Nevertheless, in five countries the JAR has contributed to changing health sector strategies, either by providing evidence on new strategies (e.g. Uganda e-health), indicating gaps of existing strategies (e.g. Ghana on flow of funds and NHIF; Bangladesh on nutrition). The later happens particularly when IR Teams are part of JAR (Ghana, Bangladesh and PNG). And in Kyrgyzstan this is considered the main focus of the JAR. In the DRC and in Vietnam the JAR also has that potential, but it is yet too early to assess. In Mozambique this is considered the role of the MTR. In Cambodia the JAR focuses more on incremental planning, less on strategic review.

4.4.5 JARs help to reallocate resources within the sector

Many examples exist of how a JAR has contributed to **improved internal resource allocation** either by maintaining a strong focus on the government's contribution to health (e.g. Kyrgyzstan), by reallocating resources within the budget (e.g. Bangladesh), by improving resource flows to districts (e.g. Ghana), by addressing NHIF effectiveness (e.g. Ghana), by increasing the health sector budget (e.g. Kyrgyzstan, Uganda), or by providing specific analyses prepared on request by the IR Team (PNG).

4.5 While having a strong potential to improve plans, mobilise additional resources and promote mutual accountability

4.5.1 JARs can contribute to improved planning

As indicated, JARs have more influence on sector / central plans and in some countries on provincial plans. **Improving decentralised plans remains an issue in many countries**. Ghana, through the performance hearings of all districts, seems to have an 'effective' mechanism in place. Uganda, with the district league tables reviewing district performance and both local government and health representatives of all districts participating in the NHA, also has a promising modality in place. Nevertheless the MoH confirms that improved district planning remains a challenge. Disjointed central planning processes in Bangladesh are being addressed as a result of the JAR/ IR.

Ensuring that JAR information trickles down to the operational level also remains an issue in several countries. There is some (limited) evidence of information being shared with the district level in five countries. In the DRC and Mozambique, Provincial Health Divisions use the information as they are directly involved in the JAR. The assumption is that the information is shared with the Health Zones. In Ghana, Uganda and Cambodia districts use information from JARs as they are directly involved in the JAR/NHA process. This is less likely to happen in other countries because there are no specific mechanisms for sharing JAR information to the operational level or provinces/districts do not participate in the JAR.

All country studies found that at least **some DPs make use of the information** provided at the JAR to some extent, including when planning new support.

4.5.2 JARs can help mobilising additional financial resources

Although direct attribution to the JAR is difficult to ascertain, the **JAR reportedly has contributed to better alignment** (e.g. DRC), **increased confidence of DPs and subsequent resource allocation** in some countries (e.g. Ghana, Uganda, Bangladesh, Kyrgyzstan). This is more likely to happen when the MTEF is presented / discussed, the financial gap assessed and commitments of DPs presented during the JAR. This is explicitly part of the ToR of the JAR in some countries. Also, DPs take home the

information discussed in the JAR and share it with their headquarters, which may result in increased resources for the sector. In lower middle-income countries mobilising additional resources may be less a priority (e.g. Vietnam). When low income countries become middle income countries financial support tend to diminish (e.g. Ghana).

4.5.3 JARs can promote mutual accountability

Mutual accountability is promoted in almost all JARS (8/9), but the scope of 'mutual' depends of course on which partners are invited to join and who is being held accountable. Both aspects of JAR could be improved. For example, mutual accountability is different in Ghana and Uganda where participation is broad, as compared to Vietnam where participation is more restricted or to Bangladesh where it is mainly limited to MoH and DPs. In countries with a history of central governance/ planning or in middle income countries with limited external financial support, the concept of accountability may be understood differently (e.g. Vietnam).

Only few countries hold DPs accountable at the JAR. Ghana does so via the DP self-assessment and performance hearings (individual DPs[37]) and Mozambique by having the aid effectiveness criteria reviewed as part of the PAF. In several countries, accountability is limited to discussing timely release of funds and/or addressing the financial gap.

Most **JARS also do not hold accountable other stakeholders** (7/9). It happens to some extent in Ghana with the district assemblies, PNFP, professional associations and agency performance hearings; and in Uganda with the NHA inviting all district assemblies. There is scope to reinforce mutual accountability through JARs in most countries reviewed.

4.6 And less evidence on improving harmonisation, setting new targets and reducing transaction costs

4.6.1 JAR's effect on improving harmonisation is less evident

Harmonisation between DPs **seems more the result of continuous, regular contacts** through consortium / DP meetings, high level policy meetings (e.g. HPAC in Uganda, Steering Committee in Cambodia), joint work in technical working groups and informal dialogue. Four countries confirm that JARs have contributed to harmonisation but examples were hard to provide. In five countries, this was considered less evident. Harmonisation between some DPs is more likely when funders decide to pool resources or move to sector support and is therefore more obvious in the countries where these modalities are being applied.

4.6.2 JARs seldom set new targets or redefine indicators

Redefining indicators, (re)setting targets or benchmarks is **more the job of the MTR and ER** or during the preparation of the new strategic plan. Exceptionally it happens during the JAR (few examples exist). In Mozambique however this is also considered part of the task of the JAR.

4.6.3 JARs do only marginally reduce transaction costs for government, if at all

The JAR by itself reduces transaction costs in the sense that it is a common forum for sharing information and joint policy / strategy discussions. However it generally does not reduce transaction costs in the sense that DPs continue doing parallel reviews, have bilateral negotiations, request parallel programme reports, etc. Only Mozambique and Uganda confirm that parallel reviews may have become less frequent. For those DPs having decided to pool resources or provide sector budget support transaction costs may have diminished (to the extent that they use the JAR outputs in terms of M&E and reporting). On the contrary, the cost of the annual JAR has become an issue in some

[37] In Ghana DPs confirm that this modality carries some moral power but that there are no 'sticks' to be applied when not respecting their commitments.

countries such as Uganda where numbers of participants have 'sky-rocketed' (the JAR victim of its own success?).

5 SO WHAT MAKES A JAR MORE OR LESS SUCCESSFUL?

All people interviewed, without exception, are in favour of having and maintaining JARs. In Kyrgyzstan and Vietnam the experience is relatively recent and modalities are likely to evolve. In Cambodia DPs see potential for improving the JAR modality. In Bangladesh and Uganda there is a discussion going on to review aspects of the current modality, albeit for different reasons: in Uganda the discussion concerns the number of participants and the frequency of the JAR; in Bangladesh the frequency of the IR, the type of IR, the organisation of the policy dialogue are being debated. Ghana recently decided to have the IR every two years. In other words, country-specific modalities change over time, based on local experience, changing environment and expectations. **This 'local appropriation' is an absolute strength and one should avoid developing a "one-fit-all" model.** However, from this review some lessons can be learnt on what determines more or less successful JARs, which may help countries to strengthen or adapt local models when needed.

5.1 Factors determining success

Strong government **leadership**, high degree of **local ownership** of the JAR, meaningful and wide **participation of all stakeholders**, **constructive climate** and **open policy dialogue** ensure more successful JARs. More **alignment, greater harmonisation** between DPs and less fragmentation help reaching consensus. **Reliable, relevant and timely data**, evidence-based information and well-designed performance assessment frameworks are essential for effective monitoring of sector performance and making relevant decisions. This includes developing a **comprehensive M&E plan** (including but not limited to a robust HMIS) with specific procedures for improving **data quality**. Good **preparation and organisation** of the joint reviews is essential for ensuring effective work during the JAR, making best use of the available know-how and avoid wasting time. **Integrating the JAR in the national planning cycle** is essential to ensure improved implementation of future plans.

Keeping inputs, processes and outputs at a manageable level avoids wasting resources and frustration. This regards the frequency, size, composition and continuity of independent review teams; as well as the number and profile of participants at joint events and in technical working groups. As well as the number, feasibility and timeline of recommendations and the size of reports that result from the joint review. Too bulky technical reports and too many recommendations risk leading to 'inaction'. JARS should take into account the limited time for implementation between JARs and avoid too ambitious scope of work. There is a **call for more policy / strategic dialogue** and less technical / operational focus in joint reviews in several of the countries reviewed. **JAR's have a different purpose compared to a MTR and ER**. A MTR and ER of a multi-year strategic plan is likely a more appropriate modality to go more in depth, have a wider scope, benefit more from a 'strong' independent assessment and formulate a wider set of recommendations than a JAR. Both MTR and ER could benefit from a JANS type of assessment.

Ensuring that JAR reports and more specifically recommendations and **proposed actions are shared with all stakeholders** is essential, both from a point of transparency, accountability and in order to ensure that actions are taken up by the relevant actors. Ensuring effective mechanisms to share with decentralised actors (province and district) is a challenge that should be addressed. Ghana and Uganda provide interesting tools and modalities to share.

The size of the country and high numbers of districts may be a constraint to effectively involve districts and hold a meaningful JAR at central level. **In larger countries more elaborate / technical**

provincial JARs could be considered while the national JAR could be limited to / more focused on policy dialogue.

Consistently tracking JAR recommendations and proposed actions is considered essential by all partners. There is scope for improving action-oriented matrices defining SMART recommendations. **Ensuring regular monitoring by a high level sector body** of the implementation of recommendations in-between JARs is to be standard practice.

5.2 Challenges

The main challenge of the JAR is to ensure that decisions made at the JAR, relevant for decentralised actors, are **being integrated timely in decentralised plans and are based on good quality data, that are timely available, properly validated and strategically analysed.** In several countries, this requires further strengthening of national data collection and review mechanisms as well as strengthening/maintaining national capacity in strategic analysis of information and ensuring effective linking central strategic planning to decentralised operational planning.

Meaningful participation requires both openness allowing for participation as well as guidance for how to participate. For example Members of Parliament and CS may require guidance for how to effectively participate in JARs. This may also apply to other stakeholders such as ministries, private sector, NGOs.

In most countries the MoH is being held accountable for the performance of the sector. Other partners participate in the JAR but are not held accountable or only marginally / partially. **How to further develop mutual accountability**, which indicators to use / develop, **how to best integrate meaningful aid effectiveness criteria** and monitoring of Compacts in national or sector reviews or PAF remains a challenge. Both Ghana and Mozambique have some experience to share.

Desire for attribution by some DPs or agencies could be mitigated or balanced by promoting joint accountability. This may become an increasing challenge given the reality of reducing resources for development aid and increased focus on impact or results related to support provided.

Countries can learn from each other and **South-South learning should be supported**. As indicated, local processes mature and evolve over time. Local ownership, leadership and inclusiveness of the JAR tend to increase, based on learning experience and recognition of the added value of the process. Increasing quality of government's routine monitoring and review mechanisms as well as improved local analytical capacity and more effective domestic accountability mechanisms may reduce the need for annual independent reviews. Not all countries have reached that stage yet. Sharing of experiences, modalities and tools may be worth the effort for making JARs even greater value for money.

January 30th 2013

6 ANNEXES

6.1 List of country JARS reviewed and persons interviewed / resource persons

Bangladesh

- ERKEN Arthur, UNFPA Representative, Ex-HNPSP Consortium Chair
- BADIUZZAMAN, WHO Country Office, TNP PLN (previous MoH / Planning)
- BORG Jan, Health Advisor AusAid
- HASSAN Khaled, WHO Country Office, technical officer
- LAMBERT Pierre-Yves, Programme Manager, Delegation of the European Union
- VREEKE Ed, consultant, member JAR 2010, 2012
- GERHARDT Charles, consultant, member JAR 2012
- MARTINEZ Javier, consultant, Team Leader JAR, 2007

Cambodia

- Dr Somuny SIN Director MEDICAM (NGO Umbrella)
- MARTINEZ Javier, Consultant
- LANE Ben, WHO WPRO
- LO Veasnakiry, MOH Cambodia
- JOHNSTON Tim, Pathfinder
- van MAAREN Pieter, WHO representative
- TAKEUCHI Momoe, WHO Senior Programme Management Officer

Democratic Republic of Congo

- BAABO Dominique, DPS Nord Kivu, Provincial Medical Inspector
- BOKOKO Marie-Jeanne, ACDI, Health Advisor
- BULAKALI Joseph, CCM, Coordinator
- COSTA Celestino, UNICEF Kinshasa, Chief, Child Survival
- DAVIS Cornelia, USAID, Senior Health Advisor
- KALAMBAY Hyppolite, MSP/DEP, Director
- KATAMBAYI Léon, MSH, Senior Technical Advisor, IHP DRC
- LADRIERE Fabienne, CTB, Technical Assistant to the DEP
- LOKONGA Jean Pierre, WHO Kinshasa, Health Policy Programme Manager
- MULHOWE Michel, EC, Health Programme Manager
- PORIGNON Denis, WHO Geneva, Health Policy Expert
- RAJAN Dheepa, WHO Geneva, Technical Officer
- TOKO Alphonse, UNICEF Kinshasa, Health Systems Specialist

Ghana

- ZAKARIAH Afisah, Ministry of Health Director, Policy Planning Monitoring & Evaluation;
- ANKU Godwin, Ministry of Finance, Principal Economist
- OMMEN van Lander, Royal Netherlands Embassy, Health Adviser
- DRAEGERT Mia, Royal Danish Embassy, First Secretary
- D'ALMEIDA Selassie, WHO, Health Economist
- DEVILLÉ Leo, consultant, Team Leader JAR 2010, JAR 2011

Kyrgyzstan

- CHINARA, Abdrahmanova – MoH, Head of the coordination unit
- MOLDOKULOV Oskon, WHO, HCO

- DUIVEN Remy, Swiss Cooperation, Deputy Head
- MURATALIEVA Elvira, Swiss Cooperation, Senior Programme Officer
- NJAGANJAC Nedim, World Bank, Team Leader on SWAP
- MAKENBAEVA Burul, Mental Health NGO, Director

Mozambique

- GERRITSEN Marco, Netherlands Embassy Maputo, First Secretary, and ex-donor lead.
- MARTINEZ Javier, Consultant, Team Leader JAR 2005
- de GRAEVE Hilde, WHO Country Office, technical officer
- VILANCULOS Flatiel, WHO Country Office; documentation officer
- FREIBURGHAUS Franzeska, Swiss Development Cooperation (SDC); First Secretary - focal point for M&E Technical Working Group

Papua New Guinea

- SIKOSANA Paulinus, WHO CO, Health System Expert
- LINEHAM Rebecca, New Zealand Aid Programme, Manager (e-mail contact)
- ROEDDE Gretchen, Independent Monitoring & Review Group, Member (2006-2009)
- SINGLETON Garth, Independent Monitoring & Review Group, Lead consultant (2009)
- DEVILLÉ Leo, Consultant, MTR JANS, 2008

Uganda

- BATARINGAYA Juliet, WHO CO, Country Advisor - Organization of Services Delivery
- BYAKIKA Sarah, MoH, Deputy Commissioner
- MUSOBA Nelson, Monitoring and Evaluation of Emergency Plan Progress (MEEPP), Chief of Party, Social and Scientific Systems (previously with MoH Planning)
- GIAMBELLI Paolo, Italian Cooperation, Chair HDP
- DEVILLÉ Leo, Team Leader JANS 2011

Vietnam

- WEELEN Paul, WHO – CO, Senior Health Advisor Policy Dialogue and Coordination
- van der VELDEN Ton, Pathfinder, Vietnam
- Dr N.H. LONG, Vice Director, Planning and Finance, MOH (email contact)
- de THEULEGOET Robert Hynderick, EC Delegation in Vietnam, Coordinator Social Sectors
- BAXTER Charles, US Embassy, Health Affairs Attaché, Member of HPG Core Group

6.2 List of documents consulted

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6.3 Country examples of PAF indicators

6.3.1 Uganda

Table 1: HSSIP 2010/11 – 2014/15 Core Indicators by Domain

INPUT & PROCESS (4)		OUTPUT (5)		OUTCOME (12)		IMPACT (5)	
Health financing Information, Governance		*Service access and readiness*		*Coverage of interventions*		*Health status*	
1	General Government allocated on health as % of total government budget	5	% of new TB smear + cases notified compared to expected (TB case detection rate)	10	% pregnant women attending 4 ANC sessions	22	Maternal Mortality Ratio (per 100,000 live birth)
Workforce		6	Per capita OPD utilization rate (m/f)	11	% of deliveries in public and PNFP (n° of deliveries/expected deliveries)	23	Neonatal mortality rate (per 1000)
2	Annual reduction in absenteeism rate (m/f)	7	% of health facilities without any stock outs of six tracer medicines	12	% children under one year immunized with 3rd dose pentavalent vaccine	24	Infant Mortality Rate (per 1000)
3	% of approved posts filled by trained health workers	8	% HCs IV with a functioning theatre (providing EMOC)	13	% one year old children immunized against measles	25	Under 5 mortality rate (per 1000)
Infrastructure		*Service quality and safety*		14	% pregnant women who have completed IPT2	*Financial risk protection*	
4	% of villages/ wards with a functional VHT, by district	9	% clients expressing satisfaction with health services	15	% of children exposed to HIV from their mothers accessing HIV testing within 12 months	26	% of households experiencing catastrophic payments
				16	% UFs with fever receiving malaria treatment within 24 hours		
				17	% eligible persons receiving ARV therapy		
				Risk factors and behaviours			
				18	% of households with a pit latrine		
				19	% U5's new visits with height /age above lower line (PR)		
				20	% children under 5 with weight /age above lower line (PR)		
				21	Contraceptive Prevalence Rate		

6.3.2 Mozambique (PAF 2012)

MATRIZ DE DESEMPENHO DO SECTOR SAÚDE: METAS REFERENTES AO PERÍODO 2007 - 2014;

nº ordem	Objectivo	Indicador de Resultados [Fonte de Verificação]	Base (ano)	Meta 2009	Meta 2012*	Realizações(Acções)	Responsável
1	*Reduzir a mortalidade infanto-juvenil*	**INDICADOR A**:Taxa de mortalidade infanto juvenil [IDS]	178 por mil (DHS 2003); 154 por mil (MICS 2008)	140 por mil	125 por mil	Reforço das actividades do PAV, e principalmente a componente das brigadas móveis, para pelo menos manter a % de crianças de um ano de idade imunizadas DPT HepB3	MISAU - DNSP
2						Reforço das actividades do PAV, e principalmente a componente das brigadas móveis, para aumentar a % de crianças completamente vacinadas	
3						Reforço das acções necessárias para expandir a estratégia AIDI (Atenção Integrada às Doenças da Infância) ao nível primário	
4						Empreendimento das acções necessárias para reduzir a mortalidade por desnutrição grave nas crianças 0-5 anos	MISAU-DNSP/DNAM
5						Melhoria e expansão da vigilância nutricional, com vista a detectar atempadamente as situações de risco.	MISAU - DNSP
6	*Reduzir o rácio de mortalidade materna*	**INDICADOR B**:Rácio de mortalidade materna [IDS]	408 por 100 000 (IDS 2003)	358 por 100.000	310 por 100 000	Reforço das acções com vista ao aumento do acceso das mulheres grávidas ao parto institucional	MISAU - DNSP
7							
8						Aumento da disponibilidade, acesso e qualidade no tratamento das complicações obstétricas através da acreditação de US para prestarem Cuidados Obstétricos de Emergência Básicos	
9						Reforço das acções para o aumento do acesso aos serviços e métodos de Planeamento Familiar e contracepção através de intervenções a nível das comunidades e do Sistema Nacional de Saúde	
10						Expansão do tratamento intermitente presuntivo (TIP) nas mulheres grávidas que correm o risco de contrair malária	
11	*Reduzir a taxa de incidência da malária grave em crianças de menos de 5 anos de idade*	**INDICADOR C**:Taxa de incidência de malária grave em crianças de menos de	55 por 10 000 (2001)	Não será colhido neste ano	33.6 por 10.000	Reforço das acções de protecção pessoal e colectiva para toda a população, através de intervenções que sejam acessíveis e de baixo custo	MISAU - DNSP
12		**INDICADOR D**% de mulheres grávidas e crianças menores de 5 anos que dormem sob protecção de REMTILD [IIM]	Crianças menores de 5 anos: 6.7% (2007) Mulheres grávidas: 7.3% (2007)	Crianças menores de 5 anos: 10% Mulheres grávidas: 15%	Crianças menores de 5 anos: 85% Mulheres grávidas: 85%		
13	*Reduzir a taxa de prevalência da tuberculose*	**INDICADOR E**:Taxa de prevalência da tuberculose [Programa da Tuberculose-Estudo	636 por 100.000 (2006)	450 por 100.000	390 por 100.000	Expansão acelerada da estratégia DOTS	MISAU - DNSP
14							

nº ordem	Indicador de Produto/ Execução	Desagregado por:	Base 2005**	Meta 2007	Realizado 2007	Meta 2008	Realizado 2008	Meta 2009	Realizado 2009	Meta 2010	Realizado 2010	Meta 2011	Meta 2012	Meta 2013	Meta 2014	Sist. de recolha de inf.
1	Taxa de cobertura com DPTHepBHib3 em crianças menores de 1 ano de idade		95%	95%	100%	95%	**87%**	95%	94%	89%	68%	90%	90%	90%	90%	SIS -Módulo básico
2	% de crianças menores de um ano de idade completamente vacinadas		44%	65%	69%	80%	**68.0%**	90%	77%	72%	72%	73%	**75%**	**78%**	**80%**	SIS -Módulo básico
3	% de US de nível primário em que a estratégia AIDI está implementada		60%	70%	70%	75%	**90%**	80%	79%	93%	95%	98%	98%	98%	98%	Saúde Infantil
4	Taxa de mortalidade institucional por desnutrição grave		15.2%	14.0%	11.5%	13.5%	**10.5%**	13.0%	11.8%	8.0%	9.3%	7.0%	<10%	<10%	<10%	Programa de Nutrição
5	Nº de postos sentinelas de vigilância nutricional estabelecidos e em funcionamento		0	11	0	15	**0**	20	38	38	38	38	38	40	40	Programa de Nutrição
6	Taxa de cobertura de partos institucionais		49%	52%	53.8%	53%	**55%**	60%	55%	62%	62%	63%	63%	65%	66%	SIS -Módulo básico
7	% das US com maternidade em que existe uma casa de espera para as mulheres grávidas		NA	NA	NA	NA	**37,8% (primeiro semestre-2009)**	NA	40,8%	40.0%	47.0%	42.5%	45.0%	47.5%	50.0%	Saúde Sexual e Reprodutiva
8	Nº de US que prestam COEmB/500. 000 habitantes no último trimestre		1.23	1.9	1.13	2.3	**1.44**	2.74	5.9	3	Não avaliado em 2010. Em revisão critérios de certificação das unidades sanitárias para prestar COEmB	3.2	3.4	3.6	3.8	Saúde Sexual e Reprodutiva
9	% de novas utentes em métodos modernos de Planeamento Familiar		419726	Mudanca do indicador (no passado: Taxa de cobertura anticoncepcional com metodos modernos)	568760	580'135	**554,373 (12.5%)**	591,738 (13.5%)	**598,786 (13.9%)**	15%	686,873 **(23%)**	16%	25%	26%	27%	SIS -Módulo básico
10	% de mulheres grávidas que recebem pelo menos duas doses de TIP dentre as utentes das consultas pré-natais		0%	60%	27%	Não será colhido neste ano	**77%** (Apesar de não ter meta para o 2008, o resultado do 2008 ultrapassa a meta do 2009. a meta pode ser classificada como atingida e ultrapassada)	50%	67%	60%	14%	65%	70%	75%	80%	SIS
11	% de casas que foram pulverizadas com insecticida nos últimos 12 meses em relação às casas alvo		N/D	40%	53%	Não será colhido neste ano	Não foi colhido neste ano	55%	74%	75%	81%	80%	85%	85%	90%	Inquérito Indicadores Programa da Malária
12	% de mulheres grávidas que recebem pelo menos uma REMTILD (na consulta Pre-natal)		18%	40%	41%	45%	82%	45%	76.6%	>95%	77%	>95%	>95%	>95%	>95%	Programa da Malária
13	Taxa de detecção de casos com BK+		48%	51%	47%	55%	**50.0%**	60%	53%	53%	53%	56%	58%	62%	65%	Programa de Tuberculose
14	Taxa de cura com tratamento DOTS		78%	80%	82%	81%	**82%**	82%	82.3%	83%	85%	84%	85%	85%	86%	Programa de Tuberculose

QAD REVISTO 9 Março DE 2011 — 07.12.2011

MATRIZ DE DESEMPENHO DO SECTOR SAÚDE: METAS REFERENTES AO PERÍODO 2007 - 2014;																							
Objectivo	Indicador de Resultados [Fonte de Verificação]	Base (ano)	Meta		Realizações(Acções)	Responsável	nº ordem	Indicador de Produto/ Execução	Desagregado por:	Base 2005**	Meta 2007	Realizado 2007	Meta 2008	Realizado 2008	Meta 2009	Realizado 2009	Meta 2010	Realizado 2010	Meta 2011	Meta 2012	Meta 2013	Meta 2014	Sist. de recolha de inf.
			2009	2012*																			
	de prevalência]				Implementação das intervenções para fazer face à co-infecção TB/HIV, com vista a aumentar o Nº de doentes com TB e HIV com acesso ao TARV		15	% de doentes com TB aconselhados e testados para HIV		24%	25%	68%	39%	79%	54%	84%	88%	88%	90%	92%	94%	95%	Programa de Tuberculose
Reduzir o risco de transmissão vertical do HIV de mãe para a criança	**INDICADOR F:Pertentagem de crianças infectadas pelo HIV nascidas de mães HIV positivas** [Programa PTV - Impacto demografico]	N/D	Por definir	Por definir	Aumento do Nº de US que prestam serviços de PTV	MISAU - DNSP	16	Nº de US's administrando PTV		96	250	386	550	**744**	781	832	900	909	963	1022	1063	1063	Programa PTV
					Aumento do Nº de mulheres HIV+ que recebem ARV com vista a reduzir o risco de transmissão da mãe para a criança		17	% e (Nº) de mulheres grávidas HIV+ que receberam medicamentos ARV nos últimos 12 meses para reduzir o risco de transmissão de mãe para o		6.1% (8244)	22'500	17.1% (24320)	20.8% (30,400)	**32% (46,848)**	33.7% (50,185)	45.7% (68,248)	75'099	(93%)69880	81'428	88'658	95'456	102'395	Programa PTV(em 2007 95%)
Aumentar o Nº de doentes beneficiários do tratamento antiretroviral	***INDICADOR G:** % de adultos elegiveis para o tratamento que recebem o TARV combinado segundo os protocolos nacionais*	5.7% *(2005)*	35.4%	*Por definir*	Aumento do nº de crianças sob tratamento antiretroviral no país	MISAU - DNAM	18	Nº de crianças que beneficiam do TARV pediátrico.		1 686	11'820	6210	20'826	**9'393**	11'500	13'510	19'426	17'395	23'818	29'058	34'258	39'743	Programa HIV/SIDA
					Aumento do nº de adultos legíveis para o tratamento que recebem o TARV combinado segundo os protocolos nacionais no país		19	Nº de adultos com infecção HIV avançada que recebem o TARV (terapia anti-retroviral) combinado segundo os protocolos nacionais (desagregados por sexo)	ambos sexos	15900	96000 (incluindo criancas)	88211 (incluindo criancas)	132'280	**118'937**	148'500	156'688	194'440	218'991	241'240	282'040	321'640	360'257	Programa HIV/SIDA
									Sexo Masculino	6360		N/D	52'912	**43'616**	89'100	63'306	71'590	79'553	88'821	103'843	118'423	132'641	Programa HIV/SIDA
									Sexo Feminino	9540		N/D	79'368	**75'321**	59'400	106'892	122'850	139'438	152'419	178'197	203'217	227'616	Programa HIV/SIDA
Contribuir para a redução da taxa de prevalência de HIV nos jovens 15-24 anos	**INDICADOR H:** Taxa de prevalência de HIV/SIDA nos jovens de 15-24 anos	11,3% (2007)	10.50%	9.30%	Aumento da capacidade das Unidades Sanitarias para aconselhamento e testagem aos jovens sobre o HIV/SIDA	MISAU-DNAM	20	% de Adolescentes e jovens que foram testados para o HIV, nas US's (SAAJ + ATS)		NA	NA	40% (207,256/519,638)	NA	**41% (221,245/538,685)**	43%	41% (249,675/ 602,171)	46%	**24 %** (153.635/638741)	49%	Este indicador só será avliado em 2011			Programa HIV/SIDA
		NA	NA	NA				% de Adolescentes e jovens que foram testados para o HIV/SIDA US's		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	27%	30%	33%	Programa HIV/SIDA
Aumentar o acesso aos cuidados de saúde e de qualidade reduzir a iniquidade no consumo dos mesmos (35)	**INDICADOR I**% da população com fácil acesso à 1 US (< 30 mins a pé) [IAF]	36% (2005)	45%	Por definir	Melhoria e expansão da rede sanitária para junto das comunidades e parceiros de cooperação	MISAU - Departamento de Infra-estrutura	21	Nº de novos CS tipo 2 e tipo C finalizados e equipados, incluindo Postos de Saúde elevados CS II ou C		24	6	37	30	**71**	137(meta do Quinquenio)	26(anual)/183(quinquenio)	20	39	25	30	35	40	Departamento de Infra-Estruturas
	INDICADOR J: Rácio de consultas externas por habitante entre os distritos rurais e urbanos [MISAU-DPC]	NA	NA	NA	Aumento dos cuidados de saúde oferecidos à população, com destaque para as camadas mais desfavorecidas	MISAU - DPC	22	Rácio de consultas externas por habitante		1.01	1.1	1.06	1.15	**1.02**	1.2	1.06	1.2	1.2	1.3	1.4	1.5	1.6	SIS -Módulo básico
		N/D	N/D	N/D	Melhoria da alocação de recursos, através da revisão dos critérios de alocação destes	MISAU - DPC	23	Índice de iniquidade		3.9	??	3.31	3.00	**2.83**	≤3.00	2	≤3.00	1.06	≤3.00	≤3.00	≤3.00	≤3.00	SIS -Módulo básico
	INDICADOR K: Grau de satisfação dos utentes de saúde componente farmácia (QUIB)	N/D	Por definir	Por definir	Fornecimento atempado e em quantidade suficiente de medicamentos essenciais a todas as US do país	MISAU-CMAM	24	Percentagem de satisfação das requisições de medicamento vitais		NA	NA	NA	NA	NA	85%	79,9%	86%	85%	87%	90%	90%	90%	Relatório da CMAM
	INDICADOR K: Grau de satisfação dos utentes de saúde componente farmácia (QUIB)	N/D	N/D	100%	Fornecimento atempado e em quantidade suficiente de medicamentos vitais com qualidade a todas as US do país	MISAU - DF	**25**	Percentagem de medicamentos vitais dentro das especificações de qualidade		NA	NA	NA	NA	NA	100%	100%	100%	11%	100%	Este indicador só será avliado em 2011			Recolha de amostras e envio para análise em laboratório de controlo de qualidade
		N/D	N/D	N/D		MISAU - DF		% de amostras com qualidade num total de amostras analizadas de medicamentos		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	>95%	>95%	>95%	Certificados Análise - DF
	INDICADOR L:Percentagm de CS tipo 2 e C que dispõem de serviços de abastecimento de água e fonte de energia	Nº e percentagem de CS tipo2 e tipo C que passam a dispor de serviços de abastecimento de água e fonte de energia permanente	46.70%	50%	Empreendimento das acções necessárias para garantir que as US estejam equipadas com infra estruturas básicas (esp. água e energia)	MISAU_DPC	**26**	Nº e percentagem de CS tipo2 e tipo C que passam a dispor de serviços de abastecimento de água permanente		0	0	**346 CS 53.8%**	10 CS	**417 (71) 58.4.1%**	**598CS (83,8%)**	**422 (5) 58.7%**	50	507(85) 59.4%	50	50	75	75	Relatório anual da DNAM/DPC
							27	Nº e percentagem de CS tipo2 e tipo C que passam a dispor de serviços de fonte de energia		0	0	**249 CS (38.7)**	10 CS	**320 CS (44.8%)**	676	**325 (45%)**	50	427 (102) 50.**1%**	50	50	75	75	Relatório anual da DNAM/DPC

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MATRIZ DE DESEMPENHO DO SECTOR SAÚDE: METAS REFERENTES AO PERÍODO 2007 - 2014;																							
Objectivo	Indicador de Resultados [Fonte de Verificação]	Base (ano)	Meta		Realizações(Acções)	Responsável	nº ordem	Indicador de Produto/ Execução	Desagregado por:	Base 2005**	Meta 2007	Realizado 2007	Meta 2008	Realizado 2008	Meta 2009	Realizado 2009	Meta 2010	Realizado 2010	Meta 2011	Meta 2012	Meta 2013	Meta 2014	Sist. de recolha de inf.
			2009	2012*																			
Melhorar a disponibilidade de Recursos que contribuem para acções de qualidade nos serviçcos de Saude oferecidos a população a todos os níveis	**INDICADOR M:** Habitante por pessoal especifico da área de Saúde	13'056	16'344	2'418	Formaçao e colocacao de pessoal adequado e em quantidade suficiente em todas as US do SNS, com vista a criar equipes de saude equilibradas a todos os niveis.		**28**	Rácio de trabalhadores de saúde das áreas de medicina, enfermagem e saúde materno-infantil (SMI) por 100.000 habitantes		N/A	N/A	N/A	N/A	N/A	N/A	61	63/100.000	63/100.000	65	66	68	69	SIP, Relatório Anual da DRH
							29	Numero de novos graduados das carreiras especificas da saúde		N/A	N/A	N/A	N/A	N/A	N/A	1525	2321	2322	1650	2145	1550	1700	Relatório Anual da DRH
Reforçar e melhorar a gestão financeira em todas as suas componentes e a todos os níveis do sector saúde	**INDICADOR N:** Despesa executada como % do orçamento aprovado para o sector saúde	62% (2008)	80%	85%	Melhoria dos processos de gestão do orçamento	MISAU-DPC	**30**	Taxa de execução orçamental dos fundos sob a gestão do MISAU	NAO DESAGREGADO	60%	75%	70%	78%	75%	82%	68%	87%	90%	90%	Este indicador só será avliado em 2011			Relatório da execução da DAF/Avaliacoes rapidas do grau de implementacao das auditorias
								Taxa de execução orçamental dos fundos sob a gestão do MISAU	Taxa de execução das despesas correntes do OE (Central e Provincial)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		≥80%	≥85%	≥90%	Relatório da execução da DAF/Avaliacoes rapidas do grau de implementacao das auditorias
									Taxa de execucção de fundos PROSAUDE (Central e Provincial)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		100%	100%	100%	Relatório da execução da DAF/Avaliacoes rapidas do grau de implementacao das auditorias
									Taxa de execucção orçamental das Despesas Correntes de Investimento - Componente Interna (Central e	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90%	≥95%	≥95%	≥95%	DAF/DPC
	INDICADOR O: % de auditorias efectuadas com OPINIÃO SEM QUALIFICAÇÕES	73% (2006)	95%	Por definir	Melhoramento dos instrumentos de gestão Financeira, sujeitos a auditoria (Registos Contabilisticos, Reportes Financeiros e Arquivos)	MISAU-DAF	**31**	% das recomendações das auditorias do ano n-2 implementadas anualmente a nível provincial		N/D	75%	84%	75%	**Indicador não avaliado**	75% (nao sera possivel avaliar)	N/A	75%	Não avaliado em 2010. Nao houve auditorias implementadas	75%	≥80%	≥85%	≥90%	Relatório da execução da DAF/Avaliacoes rapidas do grau de implementacao das auditorias
		N/D	20%	40%		MISAU-DAF	**32**	% das recomendações das auditorias do ano n-2 implementadas anualmente ao nível Central		N/D	100%	47%	≥95%	**78%**	≥95% (não sera possivel avaliar)	89%	≥95%	Não avaliado em 2010. Nao houve auditorias implementadas	≥95%	100%	100%	100%	Relatório da execução da DAF/Avaliacoes rapidas do grau de implementacao das auditorias
Melhorar a previsibilidade de fundos externos para o sector saúde e promover a harmonização entre MISAU e parceiros de cooperação	**INDICADOR P**:% de parceiros bi e multi-laterais com compromissos financeiros multi-anuais (pelo menos 3 anos) [Relatório de avaliação do desempenho dos doadores]	79% (2006)	80%	85%	Melhorar a aderência dos parceiros do sector ao ciclo e metodologia de planificação do Governo de Moçambique	Parceiros	**33**	% dos parceiros do PROSAUDE II que desembolsam de acordo com o Plano de desembolso anual existente entre o MISAU e os Parceiros		N/D		N/D	≥95%	**60%**	≥95%	86%	≥95%	97%	≥95%	≥95%	≥95%	≥95%	DAF/DPC
						Parceiros	**34**	Percentagem de parceiros bi e multilaterais do sector da saúde que disponibilizam informação acuradamente (PREDICTAVEL) ao MISAU sobre o seu financiamento no CFMP		NA	NA	NA	NA	NA	NA	POR DEFINIR	> 80 %	87%	> 80 %	> 80 %	> 80 %	> 80 %	Cenario Fiscal de Medio Prazo
						Parceiros	**35**	Nº total de missões conjuntas por ano das sedes dos parceiros que apoiam o Sector Saúde (parceiros bi e multi-laterais)	individuais	N/D			N/D	**37**	32 (75%)	18(67%)	28 (70%)	13 (43%)	23 (65%)	19 (60%)	15 (55%)	12 (50%)	Relatório do inquérito aos doadores
					Redução da carga de trabalho sobre o MISAU causada pelas missões de parceiros bi e multi-laterais ao nível central, provincial e	Parceiros			conjuntas	N/D			Por definir	**9**	11 (25%)	9(33%)	12 (30%)	17 (56.6%)	13 (35%)	13 (40%)	13 (45%)	12 (50%)	Relatório do inquérito aos doadores

6.4 Country example of M&E process (Uganda)

Table 4: HSSIP Monitoring and Review process

Methodology	Frequency	Output	Focus	Level of monitoring and review
Performance Assessment	Quarterly	Quarterly progress reports; transmitted to next higher level of supervision	Done by Joint (public + private) Performance Assessment Teams and peers, and planning entity. A review of progress against targets and planned activities.	Inputs, process, output and outcome
Technical Review meeting	Six months after the JRM	Progress report submitted to next higher level of supervision	Done by Joint (public + private) Performance Assessment Teams and peers, and planning entity. A review of progress against targets and planned activities.	Inputs, process, output and outcome
Joint Annual review and planning	Annually	Annual progress reports, transmitted to next higher level of supervision; District and hospital performance league tables	Done Jointly with development Partner, key stakeholders, and planning entities as from sub district level onwards Review progress against set targets outcomes	Input, process, output, and outcome levels
National Health Assembly	Every 2 years	Progress report and resolutions for the next 2 years	Done by sector. Review progress against resolutions	Input, process, output, and outcome levels
Mid Term Review	After $2^1/_2$ years	Midterm Review report	Done by sector Review progress against planned impact	Input, process, output, outcome and impact levels
End Term Evaluation	At end of HSSIP	End Term Evaluation report	Independent review of progress, against planned impact	Input, output, outcome and impact levels

6.5 Example of Holistic Assessment used in Ghana

Holistic Assessment of performance in the Health Sector 2010

Introduction

The holistic assessment of performance in the health sector is a structured methodology to assess the quantity, quality and speed of progress in achieving the objectives of the POW 2007-2011. The primary objective of the assessment is to provide a brief but well-informed, balanced and transparent assessment of the sector's performance and factors that are likely to have influenced this performance. The assessment is based on indicators and milestones specified in the operational annual POW, derived from the strategic POW 2007-2011 which is linked with the GPRS II. More specifically, the analysis underlying the holistic assessment is based on the following elements:

- POW 2007-2011 Sector Wide Indicators, targets and milestones
- Annual POW including budget
- Annual Performance Review Reports from MoH and its Agencies
- Annual MoH Financial Statement
- National survey reports (Ghana DHS, MICS etc.)

Process

As part of the annual independent health sector review process, the IRT conducted an initial assessment of milestones' realization and indicator trends. The assessment was guided by a predefined methodology that ensured full transparency of calculations.
The assessment will be presented at the April Health Summit where overall performance of the sector and possible factors, which may have influenced the performance, can be discussed.
The purpose of the initial assessment is to form basis for a balanced discussion with the goal of reaching a common conclusion of sector performance during the subsequent business meeting between the Ministry of Health and its agencies and development partners.

Method

The method of the holistic assessment is specified by the Ministry of Health. The initial assessment has three steps:

First, each indicator and milestone is assigned a numerical value of -1, 0 or +1 depending on realization of milestones and trend of indicators. While indicators which normally are measured on annual basis are included in each year's assessment, indicators which are not measured on annual basis (e.g. survey based information like MICS, DHS etc.) are only included in the assessment if new information is available.
Milestones are assigned the value **+1** (colour coded green) if the review team is provided with evidence from the relevant authority that documents the realization of the milestone; otherwise it is assigned the value **-1** (colour coded red).

Indicators are assigned the value **+1** (colour coded green) if

- The indicator has attained the specified annual target regardless of trend, or

- The indicator has experienced a relative improvement by more than 5% compared to the previous year's value

Indicators are assigned the value **-1** (colour coded red) if

- The indicator is below the annual target and has experienced a relative deterioration by more than 5%, or
- No data is available (only applies to annually measured indicators and not to survey indicators)

Indicators are assigned the value **0** (colour coded yellow) if

- The relative trend of the indicator compared to previous year is within a 5% range, or
- The indicator was not reported in the previous year (for annually measured indicators) or the previous survey (for survey indicators)

Second, the indicators and milestones are grouped into Goals and Thematic Areas as defined in the Programme of Work and the sum of indicator and milestone values are calculated. Goals and Thematic Areas with a positive score are assigned a value of +1, -1 if the total score is negative and 0 if the total score is 0.

Third, after assigning a numerical score to each of the Goals and Thematic Areas the scores are added to determine the sector's score. A positive sector score is interpreted as a highly performing sector, a negative score is interpreted as an underperforming sector and a score of zero is considered to be sustained performance.

Issues with the holistic assessment in 2010

Final service data was not available to the IRT before 2 weeks into the review, and no financial data or data on NHIS was available in the period of the mission. Due to the late availability / non-availability of data, there was insufficient time for the IRT to engage with MOH to collaboratively analyse data and perform the holistic assessment, as was envisaged during the briefing of the review mission.

The Programme of Work for 2010 was developed during the transition from the 5-Year Programme of Work 2007-2011 (5YPOW) to the Health Sector Medium Term Development Plan 2010-2013.

Most of the indicators for the 5YPOW have been sustained in the annual POW 2010, but the indicators have been clustered under new Thematic Areas 1 to 7.

The Ministry of Health has informed the IRT that the holistic assessment tool has not been redefined, and the holistic assessment of POW 2010 will therefore be based on the 5YPOW indicators and milestones as well as the 5YPOW indicator clusters.

Data sources of the indicators have increasingly been aligned, and all service data for the POW 2010 analysis was provided by CHIM. The 2009 values were recalculated for the indicators where the source changed to enable a more reliable year-on-year comparison. For the rest of the indicators, the values from 2006-2009 were updated based on the CHIM publication "Facts & Figures" from 2010.

The milestone specified in the 5YPOW for Thematic Area 1 does not appear in the POW 2010:

Working group representing private and public sectors established to propose private investments to promote wellness

Progress towards achieving this milestone is therefore not measured in the holistic assessment of POW 2010. A new milestone was added to the POW 2010:

Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas.

The IRT considered this milestone to be part of Thematic Area 3 (Capacity Development) in the holistic assessment.

Results

Step 1: Results individual indicators and milestones

Goal 1 – Ensure that children survive and grow to become healthy and productive adults that reproduce without risks of injuries or death

Goal 1 indicators are not measured on annual basis, and for 2010, there was no new information available.

Infant mortality rate

2010 Performance: No new data for 2010

2010 Target: n/a

Source: DHS 2008

Outcome: n/a

Survey indicators are not measured on annual basis.

1998	2003	2008	**2010**
57	64	50	-

Under-five mortality rate

2010 Performance: No new data for 2010

2010 Target: n/a

Source: DHS 2008

Outcome: n/a

Survey indicators are not measured on annual basis.

1998	2003	2008	**2010**
108	111	80	-

Maternal mortality rate

2010 Performance: No new data for 2010

2010 Target: n/a

Source: Maternal mortality survey 2008

Outcome: n/a

Survey indicators are not measured on annual basis.

2008	**2010**
451	-

Under-five prevalence of low weight for age

2010 Performance: No new data for 2010

2010 Target: n/a

Source: DHS 2008

Outcome: n/a

2006	2008	**2010**
18%	13.9%	-

Total fertility rate

2010 Performance: No new data for 2010

2010 Target: n/a

Source: DHS 2008

Outcome: n/a

1998	2003	2008	**2010**
4.4	4.3	4.0	-

Goal 2 – Reduce the excess risk and burden of morbidity, disability and mortality especially in the poor and marginalized groups

HIV prevalence among pregnant women 15-24 years

2010 Performance: No data
2010 Target: <1.9
Source: NACP - GHS
Outcome: +1

2006	2007	2008	2009	2010
2.9%	2.6%	2.2%	2.9%	**2.0%**

Guinea Worm

2010 Performance: 8
2010 Target: <100
Source: GWEP - GHS
Outcome: +1

2006	2007	2008	2009	2010
4,136	3,358	501	242	**8**

Compared to 2009, the number of Guinea Worm cases reduced by 97% to only 8 cases in 2010. The indicator achieved the POW 2010 target.

All cases were reported in Northern Region. Last case was reported in May 2010.

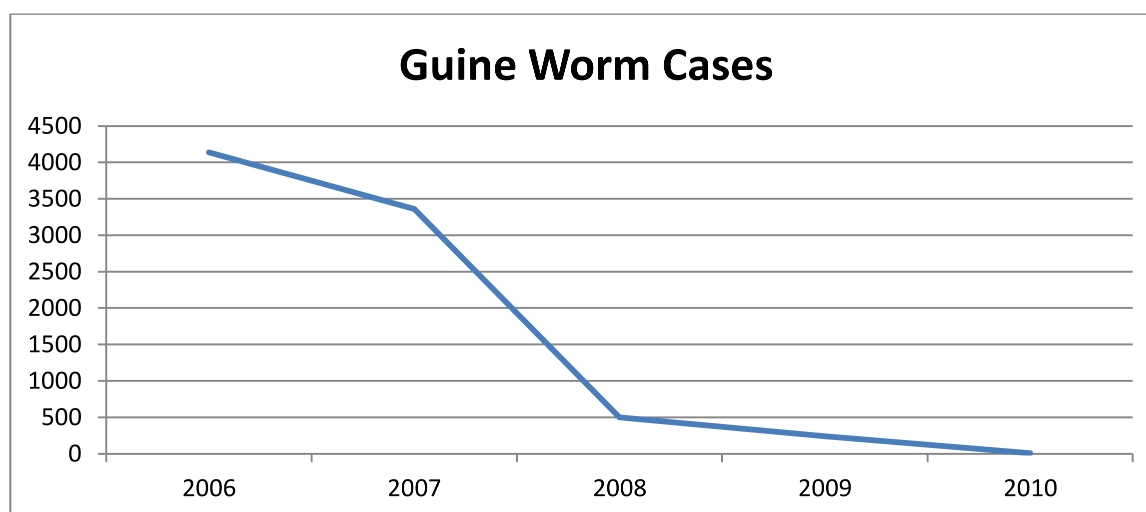

Figure 1: Guinea Worm cases, 2006-2010, CHIM

Goal 3 – Reduce the inequalities in access to health services and health outcomes

Indicators which are not measured on annual basis (e.g. survey based information like MICS, DHS etc.) are only included in the assessment if new information is available.

Equity – Poverty (Richest/Poorest U5 mortality rate)

2010 Performance: No new data for 2010
2010 Target: n/a
Source: DHS 2008
Outcome: n/a

Survey indicators are not measured on annual basis.

Wealth Quintile	2003	2008	2010
Lowest	128	103	-
Second	105	79	-
Middle	111	102	-
Fourth	108	68	-
Highest	88	60	-
	1.45	1.72	-

Equity – Geography (Supervised Deliveries)

2010 Performance: 1:1.79
2010 Target: 1:1.9
Source: CHIM
Outcome: +1

In 2010, the gap between the regions with the highest and the lowest performance widened. The indicator for geographical equity (supervised deliveries) worsened and reversed the previous 4 years' improving trend. Despite the worsening of the indicator trend, the indicator ratio achieved the target of being below 1.9.

	2006	2007†	2008†	2009	2010
CR	74.0%	-	56.3%	-	-
UER	-	43.5%	-	-	59.9%
BAR	-	-	-	53.7%	-
WR	-	17.6%	-	-	-
NR	25.1%	-	26.0%	36.1%	-
VR	-				33.4%
	1:2.95	1:2.47	1:2.17	1:1.49	**1:1.79**

†Updated in 2010 with new information from CHIM

Figure 2 visualises the trend in supervised deliveries by region from 2006 to 2010.

Six of Ghana's ten regions improved coverage of supervised delivery, but four regions experienced negative trends. While Western Region, Eastern Region, and Greater Accra Region experienced a minor decrease, Volta Region reduced coverage with over 15%.

Many regions experienced a dramatic drop from 2006 to 2007, but all regions except Volta Region have improved performance significantly since 2007.

Upper West Region reverse the negative trend experienced in 2009 and improved coverage of supervised deliveries with more than 25% in 2010.

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
'06	40.8%	34.8%	25.1%	47.4%	74.0%	35.4%	38.4%	38.7%	28.8%	42.2%	**44.5%**
'07	26.7%	17.6%	27.7%	34.5%	22.3%	33.3%	43.5%	43.1%	32.9%	43.1%	**32.1%**
'08	35.0%	39.1%	26.0%	49.8%	56.3%	37.5%	40.4%	48.0%	40.6%	50.2%	**42.2%**
'09	42.4%	42.6%	36.1%	53.7%	52.5%	39.4%	52.6%	52.1%	36.7%	47.9%	**45.6%**
'10	↑44.6%	↓42.0%	↑37.5%	↑55.2%	↑54.1%	↓33.4%	↑59.9%	↓51.3%	↑46.1%	↓45.0%	**48.2%†**

Table 1: Coverage of supervised deliveries by region, 2006-2010, Source CHIM. † The national figure for 2010 includes Korlebu and Komfo Anokye Teaching Hospitals.

Central Region reported large variations over time, but plateaued at approximately 52% over the past three years. The large variations could either be a result of changes in service delivery (demand/supply) or challenges with the routine health management information system. It is recommended to do an analysis into the causes of the observed variation in order to identify and promote good practices and discourage malpractices.

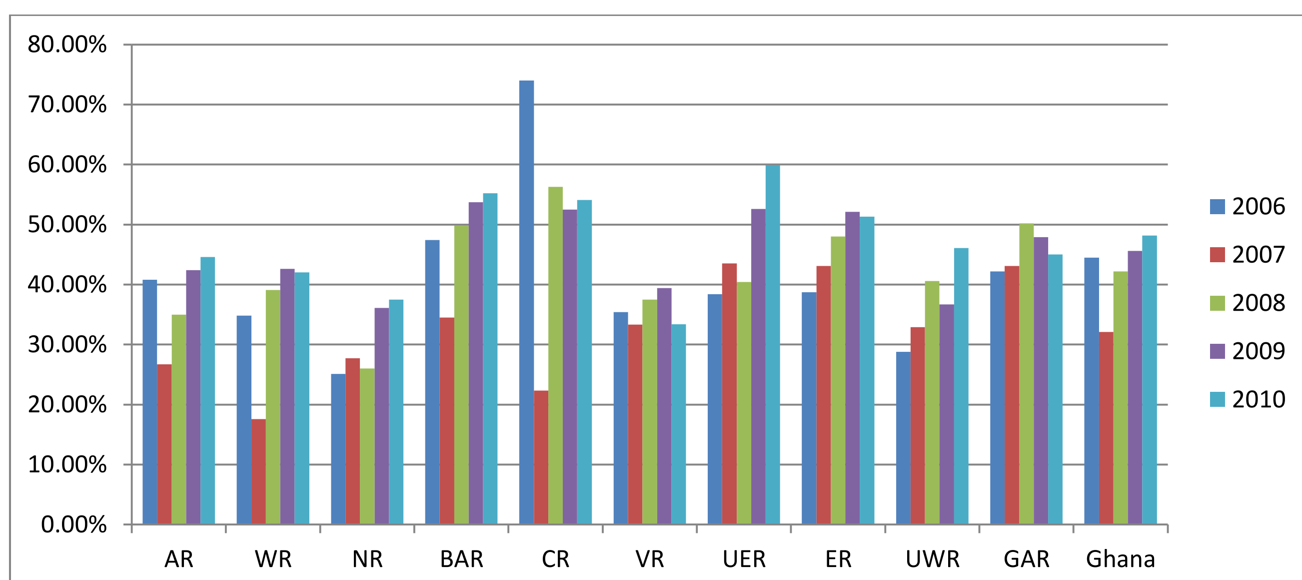

Figure 2: Supervised deliveries by region 2006-2010, source CHIM

Equity – Geography (Nurses/Population ratio)

2010 Performance: 1:1.83

2010 Target: 1:2.0

Source: HR – MoH

Outcome: ***+1***

The trend towards more equitable distribution of nurses continued previous years' improvements and attained the target of a ratio below 2.0.

	2007†	2008†	2009	2010
GAR	-	1:952	-	
AR	1:1,429	1:1,932	1:2,171	1:2,045
UER	1:3,225	-	1:1,151	1:1,121
	1:2.26	1:2.03	**1:1.87**	**1:1.83**

†2007 and 2008 figures include midwifes.

Upper East Region continued to have the highest number of nurses per regional population with one nurse per 1,121 inhabitants. Like in 2009, Ashanti Region had the lowest number of nurses per population, but continued last year's increase in total number of nurses with 6.2%.

All nurses on government payroll were included in estimating this indicator, i.e. GHS, CHAG and Teaching Hospital nurses. Community Health Nurses are included but midwifes are excluded. For a discussion of the exclusion of midwifes please refer to the indicator "*Nurse:Population Ratio*" below.

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
Total no. of nurses 2009	2,325	1,422	1,191	1,214	1,373	1,533	892	1,994	586	3,698	16,228
Total no. of nurses 2010	2,468	1,393	1,208	1,235	1,385	1,505	916	1,942	595	3,877	16,524
% change 2009-2010	6.2%	-2.0%	1.4%	1.7%	0.9%	-1.8%	2.7%	-2.6%	1.5%	4.8%	1.8%
Indiv. per 1 nurse (2010)	2,045	1,893	1,987	1,882	1,417	1,312	1,121	1,247	1,147	1,153	1,510

Table 2: Total number of nurses in 2009 and 2010 and nurse/population ratio for 2010 (lower is better), source HR - MoH

Equity – Gender (Female/Male NHIS Card Holder ratio)

2010 Performance: No data

2010 Target: Target not specified in POW 2010

Source: NHIA

Outcome: ***-1***

2006	2007	2008	2009	2010
-	-	1.22	-	-

Equity – Poverty (Richest/Poorest NHIS Card Holder ratio)
2010 Performance: No new data - Recalculated
2010 Target: n/a
Source: DHS 2008
Outcome: n/a

Wealth Quintile	2009	2010
Lowest	29.3%	-
National	38.8%	-
	1.3	-

The equity indicator for poverty (NHIS Card Holder ratio) was measured for the first time in 2009 based on the DHS 2008 results, and the indicator defined is the proportion of cardholders in the total population divided by the average proportion of card holders in the nation. The DHS has separated the sample into male and female cardholders. Female card holders were chosen for the analysis.

Unfortunately, in 2009 the indicator was estimated as the ratio between the lowest against the highest wealth quintile and not the national average. Therefore, the indicator has been recalculated this year.

Thematic Area 1 - Healthy Lifestyle and Healthy Environment
Indicators which are not measured on annual basis (e.g. survey based information like MICS, DHS etc.) are only included in the assessment if new information is available.

Milestone: No milestone was specified for Thematic Area 1 on the 2010 POW
2010 Performance: n/a
Source: MOH
Outcome: n/a

Obesity in adult population (women age 15-49 years)
2010 Performance: No new data
2010 Target: n/a
Source: DHS
Outcome: n/a
Survey indicators are not measured on annual basis.

2003	2008	2010
8.1%	9.3%	-

Thematic Area 2 – Provision of Health, Reproduction and Nutrition Services

Milestone: Essential Nutrition actions implemented in all regions with emphasis on complimentary feeding
2010 Performance: Achieved
Source: MOH
Outcome: +1

% Deliveries attended by a trained health worker
2010 Performance:
2010 Target: 50.3%
Source: CHIM
Outcome: +1

2006	2007	2008	2009	2010
44.5%	32.1%	42.2%	45.6%	**48.2%**

The proportion of deliveries attended by a trained health worker increased by 5.6% and continued the positive trend experienced since 2007. The target of 50.3%, however, was not met.

A detailed discussion of the regional breakdown of the indicator is found above under *"Equity – Geography (Supervised Deliveries)"*.

2010 Performance: 23.5%
2010 Target: 35%
Source: CHIM
Outcome: -1

	1998	2003	2007	2008	2009	2010
CPR[†]	13%	19%	-	17%	-	-
FP acceptors[‡]		-	23.2%	33.8%	31.1%	**23.5%**

[†] Ghana Demographic and Health Survey. [‡] Routine HMIS – CHIM

Contraceptive Prevalence Rage (CPR) is a survey indicator. In the previous years, the indicator has been estimated using Family Planning acceptors as a proxy.

Family Planning acceptors decreased significantly in 2010 compared to 2009 by almost 25%.

GHS has raised concern about underreporting of this indicator. The assumption is that there has been an increased uptake of long term methods e.g. IUDs and implants, which presumably only are registered in the year the intervention is performed. Individuals who receive these interventions are therefore not registered as Family Planning acceptors in the years following the intervention where the intervention still is effective. On the other hand, some districts reported out of stock of FP commodities in 2010. A deeper analysis is needed to estimate the causes of the low coverage.

Family Planning indicators have been excluded from the draft HSMTDP 2010-2013 provided to the IRT. Family Planning is an essential component of the strategy to reach the MDGs, and the IRT recommends reintroducing a Family Planning indicator in the HSMTDP monitoring framework.

Antenatal Care Coverage

2010 Performance:
2010 Target: 70% (4+ ANC visits)
Source: CHIM
Outcome: 0

	2006	2007	2008	2009	2010
ANC registrants	88.1%	91.1%	97.8%	92.1%	**90.6%**
4+ ANC visits	-	62.8%	62.8%	81.6%	-

In 2010, the coverage of pregnant women, who received one or more antenatal care visits, continued the previous two year's negative trend and dropped by 1.6% to 90.6%. The decline was within the 5% range of sustained performance, which resulted in a neutral outcome of the indicator.

In the POW for 2010, the definition of this indicator has changed compared to previous years. Before POW 2010, the indicator was defined as the proportion of pregnant women attending *one or more ANC visits*. In POW 2010 this was changed to the proportion of pregnant women attending *at least 4 antenatal visits.*

The IRT was notified that the indicator, which covers the number or proportion of pregnant women attending at least 4 antenatal visits, provided by the DHIMS was unreliable due to erroneous reporting. The present analysis is therefore a continuation of previous years' practice based on women attending *one or more antenatal visits*. This practice, naturally, renders the POW 2010 target of 70% inappropriate. For the holistic assessment, the POW 2010 target was therefore not considered, and the analysis was based on trend alone.

%U5s sleeping under ITN

2010 Performance: No new data
2010 Target: 50%
Source: -
Outcome: n/a

2006	2007	2008	2009	2010
41.7%	55.3%	40.5%	-	-

The percentage of children under 5 years sleeping under ITN is a survey indicator, and in 2010 no survey was conducted.

% children fully immunized by age one - Penta 3

2010 Performance:

2010 Target: 87.9%

Source: CHIM

Outcome: 0

2006	2007	2008	2009	2010
84.2%	87.8%	86.6%	89.3%	**84.9%**

The proportion of fully immunized children by age one can only be established by surveys. Penta 3 coverage, as reported through the routine system, has in the previous years been used as proxy. This practice in continued for the assessment of POW 2010.

Penta 3 coverage in 2010 was reduced by 4.9%. The decline was within the 5% range of sustained performance, which resulted in a neutral outcome of the indicator, however, the decline is substantial and the trend is worrying.

A regional analysis revealed that 9 out of 10 regions experienced a drop in DPT 3 coverage. Only Eastern Region maintained performance in 2010. The most significant drop was seen in Upper East Region with 16% decline from 106% to 89% DPT 3 coverage. Upper East Region however continued to perform above the national target and better than the national average at 84.9%.

Like in 2009, Greater Accra Region had the lowest coverage of DPT3 at 69.9%. In 2009, an EPI survey in Greater Accra Region showed significantly higher coverage of Penta 3 compared to the routine reports, which indicates a possible underreporting within the routine health management information system.

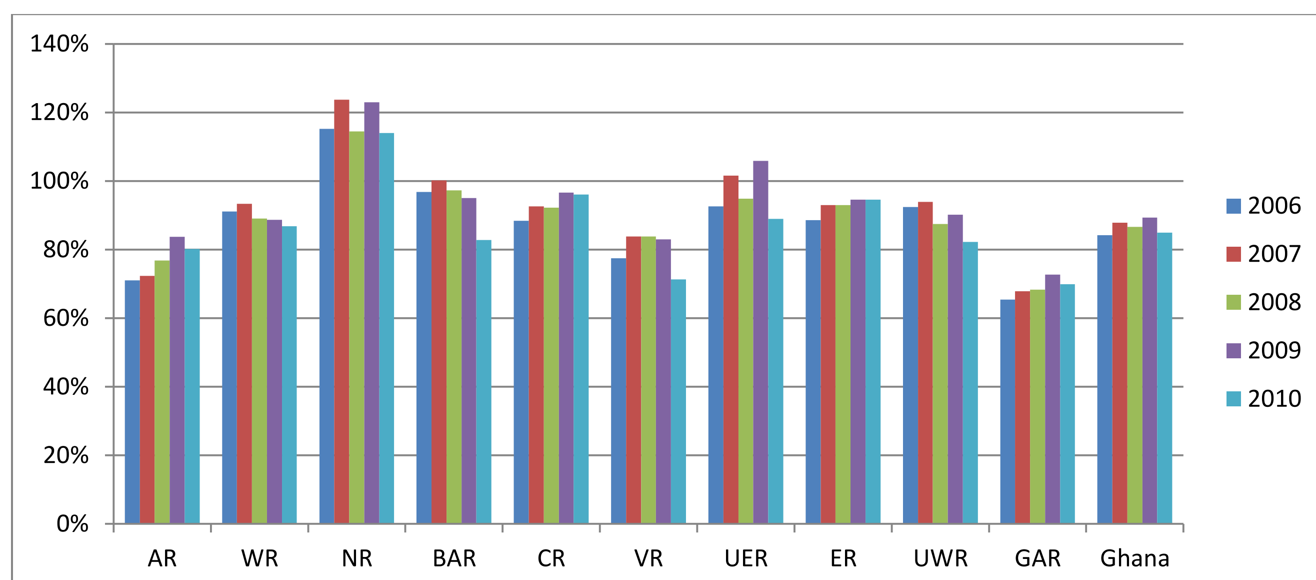

Table 1: Penta 3 by region 2006-2010, source CHIM

Only BCG coverage increased in 2010 compared to 2010. Penta 3, OPV 3, Measles and Yellow Fever all saw significant decreases in coverage.

Immunization	2009	2010	Trend
BCG	103.8%	106.0%	+2.1%
Penta 3	89.3%	84.9%	-4.9%
OPV 3	88.7%	85.3%	-3.8%
Measles	89.1%	86.1%	-3.4%
Yellow Fever	88.8%	82.5%	-7.1%

Table 2: Trend of EPI 2009-2010, source CHIM

The IRT did not identify the cause of the national performance drop, and recommends the MOH/GHS to do a deeper analysis into this worrying trend.

HIV Clients receiving ARV therapy

2010 Performance: 47,559

2010 Target: 51,814

Source: NACP

Outcome: +1

	2006	2007	2008	2009	2010
Cumulative initiated on ART	7,338	13,429	23,614	33,745	**47,559**
Currently on ART	-	-	-	-	**40,575**

The cumulative number of patients initiated on antiretroviral treatment continued to increase and was 41% higher in 2010 compared to 2009.

85% of patients who ever started ARV therapy were receiving treatment in 2010. About 9% were lost to follow-up, 5.4% died and 0.5% stopped treatment.

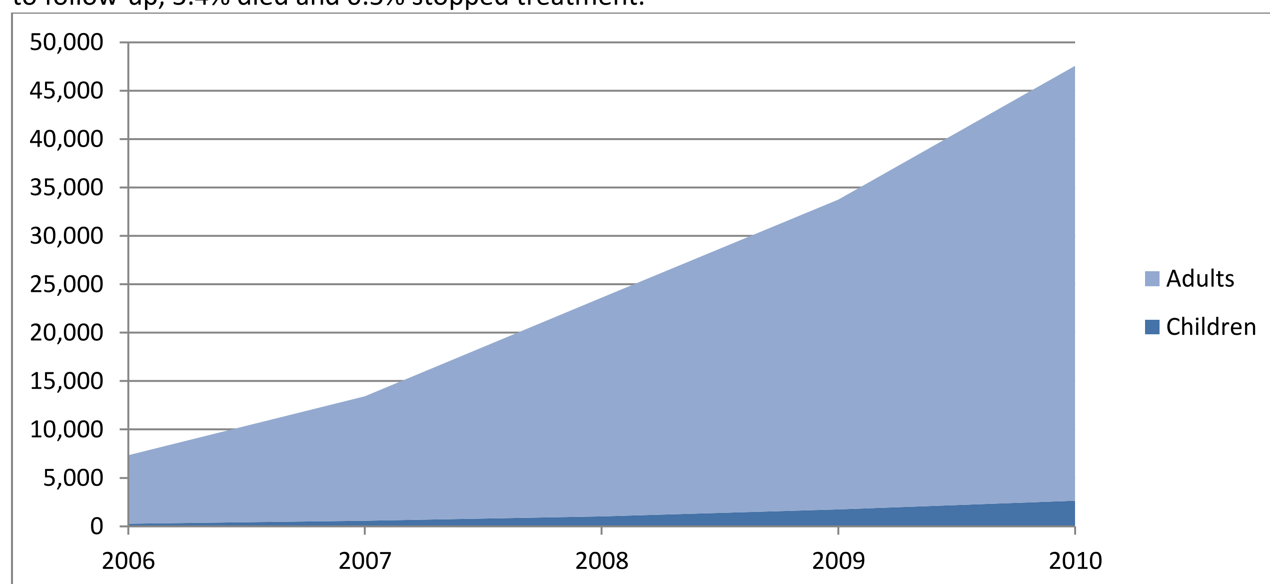

Figure 3: Antiretroviral treatment, children and adults, 2006-2010, NACP annual report 2010

Out Patient Visits

2010 Performance: 0.89

2010 Target: 0.82

Source: CHIM

Outcome: +1

2006	2007	2008	2009	2010
0.55	0.69	0.77	0.81	**0.89**

Outpatient (OPD) visits per capita continued previous years' increase and reached the 2010 target. Upper East Region continued to have the highest OPD utilisation with almost 1½ visit per capita. Since 2006 Upper East Region has almost tripled the OPD per capita rate. On one hand, this is could be an indication of significant improvement in access to health services in the region, but on the other hand the steep and rapid increase could result from a cross-border effect from Burkina Faso and Togo or overprescribing and overuse of services. The increased utilisation of services puts a large pressure on both human and financial resources, which should be a subject for closer assessment.

Greater Accra Region has the lowest rate at 0.52, but this may partly be explained by exclusion of Korlebu Teaching Hospital's OPD visits from the regional figure and by presence of a strong private sector for which data are only exceptionally collected. Northern Region experienced stagnation from 2009 to 2010 and maintained performance at a low 0.53 visits per capita.

Both Korlebu and Komfo Anokye Teaching Hospitals were included in the national figure but not in the respective regional figures. With the set-up of the reporting system, OPD visits at Tamale Teaching Hospital were included in Northern Regions figure.

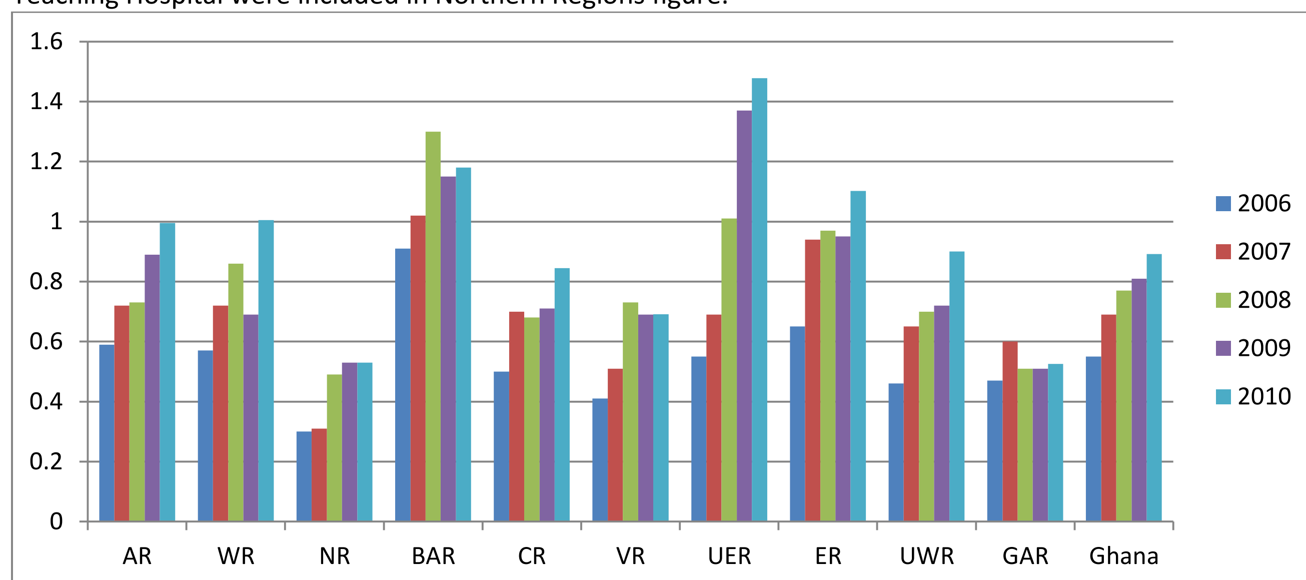

Figure 4: OPD per capita by region, 2006-2010, Source CHIM

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
2006	0.59	0.57	0.30	0.83	0.50	0.41	0.55	0.65	0.46	0.47	**0.54**
2007	0.72	0.72	0.31	1.02	0.70	0.51	0.69	0.94	0.65	0.60	**0.69**
2008	0.73	0.86	0.49	1.30	0.68	0.73	1.01	0.97	0.70	0.51	**0.77**
2009	0.89	0.99	0.53	1.15	0.71	0.69	1.37	0.95	0.72	0.51	**0.81**
2010	1.00	1.01	0.53	1.18	0.85	0.69	1.48	1.10	0.90	0.52	**0.89**

Table 3: OPD per capita by region, 2006-2010, Source CHIM

Institutional MMR

2010 Performance:

2010 Target: 185

Source: GHS

Outcome: +1

	2006	2007	2008	2009	2010
GHS + TBAs	187	230	200	**170**	**164**
GHS +TBAs + THs†		-	-	**-**	**187**
GHS† + THs† -TBAs		-	-	**-**	**224**

† MMR based on number of *supervised deliveries*

The institutional MMR declined by 3.5% to 164, which is below the target of 185. For the purpose of year-on-year comparison, the previous years' estimation practice has been continued for the holistic assessment. There are, however, challenges with estimating this indicator as discussed below.

The institutional MMR indicator is defined as the number of institutional deaths divided by number of institutional *live births*.

The figure of total live births provided by the Centre for Health Information Management (CHIM) includes TBA assisted deliveries, and is therefore not limited to *institutional* live births. The estimation of *institutional* live births is, therefore, challenging since this figures includes an unknown number of TBA deliveries that are registered as part of the health institutions reports. The IRT considers the number of *supervised deliveries* to be a more reliable proxy for the indicator of institutional MMR.

It is unclear whether the number of reported maternal deaths also includes deaths in the community reported by TBAs, or whether this number is limited to maternal deaths that occur in health institutions.

In the previous years, institutional mortality data from the teaching hospitals was not available to the review team. This year, CHIM provided teaching hospital data. Korlebu and Komfo Anokye Teaching Hospitals conducted 5.2% of all registered supervised deliveries in the country, and 16.0% of all recorded maternal deaths occurred in these two hospitals.

Because of the above mentioned issues, the reliability of this indicator can be questioned. To ensure transparency and to improve reliability, the IRT has estimated the indicator based on three different definitions.

The first figure (MMR 164) is a continuation of previous years' practice, which is based on *live births* and maternal deaths as reported by CHIM including TBAs. The figure does not include Korlebu and Komfo Anokye Teaching Hospitals.

For the second figure (MMR 187) the teaching hospitals are added. The figure is based on the above described data from CHIM (including TBAs) plus *supervised deliveries* and maternal deaths reported by Komfo Anokye and Korlebu Teaching Hospitals. The IRT does not have access to the number of *live births* at the teaching hospitals, and therefore the number of *supervised deliveries* has been used for the estimation.

For the third figure (MMR 224) the teaching hospitals are added and the TBAs are excluded. The figure is based on the number of *supervised deliveries* reported by CHIM instead of the number of *live births* plus above described data from the teaching hospitals (See Table 4). Because some of the registered supervised deliveries result in still births, the total number of *live births* is expected to be lower than the number of supervised deliveries, and the institutional MMR as originally defined would therefore be higher than the estimate.

All the three estimations have flaws, but the IRT considers the third figure to be the most robust and reliable estimation.

	Korlebu TH	Komfo Anokye TH	GHS incl. TTH and CHAG	National
No. of maternal deaths	62	111	906	1,078
No. of deliveries	10.913	14.014	455.608	480,535
Institutional MMR	568	791	199	224

Table 4: Estimation of institutional MMR at KTH, KATH and GHS including Tamale TH and CHAG, source KATH, KTH and CHIM

TB success rate

2010 Performance: 86.4%

2010 Target: 80%

Source: National TB Programme

Outcome: +1

The TB success rate slightly increased to 86.4% in 2010, which is above the target of 80%.

2006	2007	2008	2009	2010
73.0%	79.0%	84.0%	85.6%	**86.4%**

Thematic Area 3 – Capacity Development

Milestone (from 5YPOW): Health Industry strategy developed within the framework of public private partnership (PPP)

2010 Performance: Not achieved

Source: MOH

Outcome: -1

Milestone (new in 2010 POW): Roundtable dialogue with the Universities (medical schools) and other key stakeholders on effective specialist services in deprived areas

2010 Performance: Achieved

Source: MOH

Outcome: +1

Doctor : Population Ratio

2010 Performance: 11,479

2010 Target: 11,500

Source: HR - MOH

Outcome: +1

2006	2007	2008	2009†	2010
1:15,423	1:13,683	1:13,449	1:11,981	1:11,479

† Recalculated based on HR – MOH data

The doctor/population ratio increased from 2009 to 2010 by 1.5% and achieved the target of less than 11,500 individuals per one doctor (lower is better).

The indicator only includes doctors on government payroll (e.g. GHS facilities, CHAG facilities and Teaching hospitals).

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
No. of docs. 2009	600	80	50	140	87	78	34	157	17	839	2082
No. of docs. 2010	568	94	85	151	90	87	36	164	17	881	2173
% change	-5.3%	17.5%	70.0%	7.9%	3.4%	11.5%	5.9%	4.5%	0.0%	5.0%	4.4%
Indiv. per 1 doc	8,886	28,055	28,234	15,390	21,800	22,691	28,513	14,762	40,144	5,073	11,479

Table 5: Total number of doctors and doctor/population ratio (lower is better), source HR - MoH

Doctors trained outside the country must pass a medical licensing examination before they can practice in Ghana. The pass rate has been very low in the past, and a satellite training centre was established in Tamale to improve the professional qualifications and prepare doctors trained in foreign countries for the licensing examination. The programme is optional and in 2010 fifteen doctors were trained.

Northern Region experienced 70% increase of doctors from 50 to 85, which likely can be attributed to the expansion of Tamale Teaching Hospital and the satellite training centre, and the region is no more having the poorest doctors to population rate.

The annual report of the Tamale Teaching Hospital stipulated a total of 110 doctors in 2010, which is well above the figure of 85 doctors recorded by the HR department of MOH. The MOH explained this discrepancy by significant delays in registration of interregional staff transfers and delays in “mechanisation” of salaries onto the payroll for new doctors.

The lowest number of doctors in total and also per population was registered in Upper West Region. 17 doctors provide services to 682,451 inhabitants, and the doctor to population ratio was calculated at 1:40,144. This is almost 8 times worse the Greater Accra Region with one doctor per 5,073 inhabitants. With a total of 881 doctors, 41% of Ghana’s doctors were practising in Greater Accra Region.

The MOH has set up a distribution committee, which allocates health personnel to the ministries agencies and CHAG. Distribution of health personnel within the agencies, e.g. distribution of nurses and doctors to GHS facilities in the ten regions, is managed by the individual agencies. The newly established Human Resource Practitioners Forum, which is convened by the MOH, comprises HR practitioners from all agencies at HQ and regional level. The purpose of this forum is to collaborate and improve HR monitoring, distribution, retention and attraction to remote areas.

Nurse Population Ratio
2010 Performance: 1,510
2010 Target: 1:1,100
Source: HR - MOH

Outcome: 0

	2006†	2007†	2008†	2009	2010
Nurses & midwifes	1:2,125	1:1,537	1:1,353	-	-
Nurses only		-	-	**1:1,537**	**1:1,510**

†For 2006-2008 the number included midwifes

The nurses to population ratio improved from 2009 to 2010, but the indicator did not reach the target for 2010, which was 1:1,100. The improvement was within the 5% range of sustained performance and resulted in a neutral outcome of the indicator.

In previous years, the data provided to the review team included both nurses and midwifes. In 2010, the MOH provided precise data for 2009 and 2010 that separated nurses and midwifes, and the indicator for 2009 has been recalculated based on data from the improved source. Since the data quality has improved and now only counts nurses, the target for the coming years may have to be adjusted downwards. As an example, in order to attain the target of 1:1,100 the work force must be increased with an additional 5,500 nurses. This corresponds to an increase of 34%.

Regional distribution of nurses is discussed above under “Equity – Geography (Nurses/Population ratio)”.

The indicator is based on information from HR of MoH, and does only include nurses on government payroll (e.g. GHS facilities, CHAG facilities and Teaching hospitals).

Since midwifes have been isolated from the indicator, it was possible to do an analysis of regional distribution of midwifes for 2010. Volta Region and Upper West Region both experienced significant reduction in the number of midwifes, but are still above the national average. Midwifes are much needed in these two regions since Volta Region had Ghana’s lowest coverage of supervised deliveries and Upper West Region had Ghana’s highest rates of neonatal and infant mortality[38].

Northern Region experienced a significant increase of midwifes in 2010, but still has Ghana’s second lowest number of midwifes per population. This is reflected in the proportion of supervised deliveries, which is far below national average at only 37.5%.

The IRT recommends to follow the regional and national trends of midwifes over the next years to inform strategic decisions towards achieving MDG 4 and 5.

	AR	WR	NR	BAR	CR	VR	UER	ER	UWR	GAR	Ghana
Total no. of midwifes 2009	606	276	279	341	291	381	197	478	153	792	3794
Total no. of midwifes 2010	630	277	299	356	284	353	190	462	145	784	3780
% change 2009-2010	4.0%	0.4%	7.2%	4.4%	-2.4%	-7.3%	-3.6%	-3.3%	-5.2%	-1.0%	-0.4%
Indiv. per 1 midwife (2010)	8,012	9,520	8,026	6,528	6,908	5,592	5,402	5,240	4,707	5,701	6,599

Table 6: Total number of midwifes in 2009 and 2010 and midwife/population ratio for 2010 (lower is better), source HR - MoH

Thematic Area 4 – Governance and Financing

Milestone: New organizational architecture for the sector agreed; organizational change roadmap agreed; organizational development plans completed
2010 Performance: Achieved
Source: MOH
*Outcome: **+1***

[38] Ghana Demographic and Health Survey 2008

% MTEF on Health

2010 Performance: 15.1%

2010 Target: 11.5%

Source: MoH

Outcome: +1

2007	2008	2009	2010
14.6%	14.9%	**14.6%**	**15.1%**

	MOH[†]	GOG	% on health
Discretionary			
Item 1	377.600.000	3.112.950.000	12%
Item 2	7.033.629	408.607.760	2%
item 3	7.356.788	226.474.240	3%
Item 4	8.460.295	399.476.000	2%
Sub-total GOG	**400.450.712**	**4.147.508.000**	**10%**
Foreign Item 4	110.240.429	1.528.427.100	7%
IGF	208.180.300	595.700.000	35%
HIPC	8.000.000	209.312.000	4%
MDRI	-	103.834.500	0%
Sub-total Discretionary	***726.871.441***	6.584.781.600	11%
Statutory			
GetFund	-	326.693.250	0%
NHIF	480.907.660	480.907.660	100%
Road Fund	-	145.230.400	0%
DACF	-	434.484.803	0%
Petroleum Related Fund	-	5.186.800	0%
Sub-total Statutory	***480.907.660***	1.392.502.913	35%
TOTAL BUDGET	**1.207.779.101**	**7.977.284.513**	**15.1%**

Table 7: MTEF on Health, Source MoH-PPME

This score was calculated in a similar manner as last year. However, since we know about the double counting of NHIF, it should have been corrected (alternative figures have been provided, but MoH formal submission has not changed).

The target for 2010 has been brought down significantly to 11.5% (compared to 15% in earlier years). Explanation for this downward revision is not clear and points at a change in methodology.

% Non-wage GOG recurrent budget allocated to district level and below

2010 Performance: 46.8%

2010 Target: 50%

Source: MoH

Outcome: -1

2007	2008	2009	2010
49%	49%	62%	46.8%

The proportion of non-wage GOG recurrent budget allocated to district level and below decreased by 25% from 62% in 2009 to 46.8% in 2010, which was below the target of 50%. Score calculated based on budgeted figures, which have not been provided to Independent Team. This indicator is only meaningful if based on actual expenditure.

In any case, the target has been missed beyond the 5% interval.

Per capita expenditure on Health (USD)

2010 Performance: 28.6

2010 Target: 26 USD

Source: MoH (draft financial statement – exhibit B, p. 5)

Outcome: +1

2007	2008	2009	2010
21.7	23.2	25.6	28.6

The per capita expenditure on health increased significantly from 2009 to 2010 and exceeded the annual target of 26 USD.

Budget Execution Rate of Item 3

2010 Performance: 94%

2010 Target: 95%

Source:

Outcome: +1

2007	2008	2009	2010
110%	**115%**	**80%**	**94%**

The indicator includes the following sources:

Source	Revised budget	Disbursed	Execution
GOG/SBS/ Health Fund	65,792,000	57,162,039	86.9%
NHIF	413,044,000	393,009,500	95.1%
- Subsidy/Distress	384,520,000	380,930,000	
- MoH	28,524,000	12,079,500	
HIPC	1,948,733	1,948,733	100%
Total Item 3	**480,784,733**	**452,120,272**	**94.0%**

Table 8: Budget Execution Rate by Source

This target is largely determined by the sheer size of the NHIF. However, NHIF reimbursements are financially very different from GoG/SBS releases, such that this indicator is somehow adding apples and oranges. Nevertheless, the improved NHIS reimbursements are well reflected in the score.

Target is close to being met, and shows a marked improvement from last year's score.

% of annual budget allocations to item 2 and 3 disbursed by end of June

2010 Performance: 31%

2010 Target: >40%

Source: MoH

Outcome: -1

2007	2008	2009	2010
n/a	23%	**39%**	**31%**

		Revised budget	Disbursed by end June	% disbursement by June
Item 2				
	GOG	7,034,000	2,381,000	34%
	SBS/FH	8,535,000	1,343,000	16%
Item 3				
	GOG	7,357,000	5,014,000	68%
	SBS/FH	58,485,000	16,371,000	28%
TOTAL				

Table 9: Percentage disbursement by June

Initial score is based on data from regions, excluding teaching and psychiatric hospitals. Figures from Komfo Anokye have been provided to the Review Team (NHIA: 19,671,066 or 80%; C&C 5,052,421 or 20%). Scores from Tamale and Korle Bu or likely to be in line with their respective regional scores. Full data are yet to be submitted.

% Population with valid NHIS card
2010 Performance: No Data
2010 Target: 60.2%
Source: NHIA presentation
Outcome: -1

	2007	2008	2009	2010
Card holders	8,291,666	10,417,886	12,123,338	-
Population	22,933,235	23,291,360	24,252,441	-
% Card holders	36.2%	44.7%	**50.0%**	**-**

% of claims settled within 12 weeks
2010 Performance: No data
2010 Target: 40%
Source:
Outcome: -1

2007	2008	2009	2010
n/a	n/a	n/a	-

% of IGF from NHIS
2010 Performance: 79.4%
2010 Target: >70%
Source:
Outcome: +1

2007	2008	2009	2010
n/a	66.5%	**83.5%**	**-%**
n/a	66.5%	**83.5%**	**79.4%**

Step 2: Grouping of indicators and milestones and group score calculated

GOAL 1	
Goal 1 total	**n/a**
GOAL 2	
HIV prevalence	+1
Guinea Worm	+1
Goal 2 total	**+1**
GOAL 3	
Equity – Poverty (U5MR)	n/a
Equity – Geography (supervised deliveries per region)	+1
Equity – Geography (nurses per region)	+1
Equity – Gender (NHIS female/male ratio)	-1
Equity – Poverty (NHIS wealth quintile)	n/a
Goal 3 total	**+1**
THEMATIC AREA 1	
Obesity in adult population	n/a
Milestone	n/a
Thematic Area 1 total	**n/a**

THEMATIC AREA 2	
Milestone	+1
% supervised deliveries	+1
Family Planning – new acceptors	-1
ANC	0
Penta 3	0
HIV+ receiving ART	+1
OPD per Capita	+1
Institutional MMR	+1
TB success rate	+1
Thematic Area 2 total	**+5**
THEMATIC AREA 3	
Milestones	(+1, -1) 0
Doctor to population	+1
Nurse to population	0
Thematic Area 3 total	**+1**
THEMATIC AREA 4	
Milestone	+1
% MTEF on health	+1
% non-wage recurrent to districts	-1
Per capita expenditure on health	+1
Item 3 budget execution rate	+1
% item 2+3 disbursed by end June	-1
% population with valid NHIS card	-1
% NHIS claims settled within 4 weeks	-1
% IGF from NHIS	+1
Thematic Area 4 total	**+1**

Table 10: Goal and Thematic Area group scores

Step 3: Sector score

The outcome of the holistic assessment of the health sector's performance in 2010 is positive with a score of +5, which is interpreted as a highly performing sector.

GOAL 1	n/a
GOAL 2	+1
GOAL 3	+1
THEMATIC AREA 1	n/a
THEMATIC AREA 2	+1
THEMATIC AREA 3	+1
THEMATC AREA 4	+1
Sector score	**+5**

Table 11: Sector score

6.6 Example of League Table used in Uganda

3.11 District League Table 2010/11

District	Total Population	Coverage and quality of care (75)																Management (25)												
		Pentavalent Vaccine 3rd Dose Coverage[i]		Deliveries in govt and PNFP facilities		OPD Per Capita		HIV testing in children born to HIV positive women[ii]		Latrine coverage in households		IPT2		ANC4		TB cure rate[iii]		Approved posts that are filled[iv]		HMIS reporting completeness and timeliness					DHMT meetings held as planned[v]		Medicine orders submitted timely		Total Score	Rank
			15		15		10		10		10		5		5		5		10					5		5		5		
		%	Score	%	Score		Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	% Monthly reports sent on time (2)	% Completeness monthly reports (1)	% Completeness facility reporting (1)	Completeness of the annual report (1)	Score	%	Score	%	Score		
KAMPALA	1,597,800	136	15.0	94	14.0	1.1	10.0	61	6.1	86	8.6	59	3.0	72	3.6	67	3.3	123	10.0	100	100	80	0	3.8	0	0.0	0	0.0	77.5	1
BUSHENYI	241,500	93	13.9	56	8.4	1.0	9.5	103	10.0	91	9.1	29	1.5	65	3.3	78	3.9	53	5.3	75	100	81	1	4.3	0	0.0	100	5.0	74.2	2
KABAROLE	403,200	113	15.0	63	9.5	1.3	10.0	118	10.0	77	7.7	40	2.0	52	2.6	75	3.8	79	7.9	92	100	92	1	4.8	0	0.0	0	0.0	73.1	3
MBARARA	427,200	98	14.7	55	8.2	1.0	10.0	106	10.0	93	9.3	39	2.0	45	2.3	59	2.9	35	3.5	75	92	79	0	3.2	0	0.0	84	4.2	70.3	4
GULU	374,700	110	15.0	70	10.5	1.8	10.0	69	6.9	50	5.0	63	3.1	30	1.5	77	3.8	73	7.3	100	100	100	1	5.0	0	0.0	17	0.9	69.0	5
BUTALEJA	206,200	106	15.0	50	7.5	1.2	10.0	47	4.7	85	8.5	78	3.9	18	0.9	75	3.7	38	3.8	100	100	100	1	5.0	0	0.0	100	5.0	68.0	6
LYANTONDE	77,100	93	13.9	71	10.6	2.8	10.0	27	2.7	84	8.4	95	4.7	88	4.4	96	4.8	38	3.8	67	100	99	1	4.3	0	0.0	0	0.0	67.7	7
BULIISA	76,900	97	14.6	30	4.6	1.0	9.7	118	10.0	64	6.4	69	3.4	46	2.3	81	4.1	74	7.4	92	100	73	1	4.6			0	0.0	67.0	8
JINJA	475,700	84	12.5	67	10.0	1.7	10.0	41	4.1	84	8.4	59	2.9	44	2.2	75	3.8	57	5.7	92	100	93	0	3.8	0	0.0	67	3.4	66.7	9
KATAKWI	163,000	91	13.7	36	5.4	1.0	10.0	75	7.5	50	5.0	46	2.3	17	0.9	96	4.8	71	7.1	92	100	100	1	4.8	0	0.0	100	5.0	66.4	10
ABIM	55,200	191	15.0	55	8.3	2.4	10.0	57	5.7	39	3.9	59	3.0	40	2.0	92	4.6	61	6.1	75	100	92	1	4.4	0	0.0	67	3.4	66.4	11

6.7 Criteria for country selection

Sources used for selection country case studies

A. JAR database HERA (47 countries worldwide, all regions): 29 countries have a structured regular process of JAR or sector review in place
B. Missing countries in database added: Mozambique, Rwanda, Nepal
C. EU countries / non ODA receivers excluded (for discussion)
D. “Interview fatigue” countries, part of the “Compacts, is it worth the effort” review, excluded

Criteria used for selection

a. Joint sector review in place vs. (national / not joint) sector review in place
   - Definition of ‘joint’ means that at a minimum both government and development partners are involved in the JAR; preferably all stakeholders are involved; a sector review process, supported by a WHO or WB consultant, but where other DPs do not participate have been excluded

b. Independent review element as part of JAR Y/N
   - Definition of ‘independent’ means that experts who are not involved in the specific country’s health sector have been invited to perform an ‘unbiased’ sector review

c. Decentralized level involved in JAR Y/N
   - Definition of ‘decentralized level involved in the JAR’ means that districts or provincial health teams / officials have a formal and documented active role to play the JAR (e.g. district health teams do an annual performance assessment and/or peer review and information feeds into the JAR; or JAR results are formally fed back to provincial or district health teams for them to take into account in their planning / implementation)

Applying those criteria to the database, we got the following breakdown

JAR includes independent review	Sector review includes independent review
• ~~Benin~~ • **Ghana** • ~~Ethiopia~~ (check decentralized) • Tanzania (check decentralized) • Nicaragua (check decentralized) • Bangladesh • ~~Nepal~~ (?) • PNG •	• South Africa (check decentralized) • Azerbaijan (check decentralized)
JAR without independent review	**Sector Review without independent review**
• DRC • Gabon • Lesotho • Madagascar • Malawi • Mali • ~~Mauritania~~ • Mozambique • Rwanda (?) • ~~Sierra Leone~~	• Eritrea • Armenia (check decentralized) • Estonia (check decentralized) • Maldives

• ~~Togo~~ • **Uganda** • Zambia • Afghanistan • Kyrgyzstan • Indonesia • Cambodia • Vietnam	

Note: a) **bold** = decentralized level involved
b) ~~strike through~~ = "compacts is it worth the effort?" review countries excluded
c) proposed list of 10 countries for case study; choice to be made between 3 francophone countries in Africa
d) possible alternatives

The above choice provided us with 4 JARs with an independent element and 6 JARs without independent element; at least 4 JARS with the decentralized level involved. It also provides a mix of longstanding JAR and more recent JAR processes.

Finally, the above list was adapted as follows:

- Between Kyrgyzstan and Afghanistan, Kyrgyzstan was chosen as it is a recent SWAp.
- It was felt that either Uganda or Tanzania should be part of the sample as both have a long experience. As Uganda is an IHP+ country, preference was given to Uganda.
- DRC was chosen as the Francophone country, mainly because there is not yet a formal SWAp in place, while a joint sector review has been ongoing for several years.

The final list, after consultation with the local WHO CO and after confirmation of interest in the review by the MoH, is as follows:

- Bangladesh
- Cambodia
- Vietnam
- Papua New Guinea
- Democratic Republic of Congo
- Ghana
- Mozambique
- Uganda
- Nicaragua
- Kyrgyzstan

Given the pre-election period in Nicaragua (and consequently the limited availability of senior staff), it was later decided to postpone the review in Nicaragua.