Monitoring and Evaluation Plan

2014-2017

GHANA HEALTH SERVICE

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FOREWORD

The Ghana Health Service has over the years been implementing different programme of Work and have been reporting on its performance. There is an elaborate system to ensure that the Ghana Health Service accounts for its stewardship. The processes involved in doing this are in various documents. This effort to document these monitoring and evaluation processes in one document is one of the important steps in the overall attempt to improve the monitoring and evaluation within the service and ensure accountability within the service.

It is hoped that this document will provide direction for Districts, Regions, Divisions and Programs to better monitor and evaluate the implementation of their programme of work.

Thank You

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List of Acronyms

ACT	Artemesinin Combination Therapy
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCG	*Bacillus Calmette-Guérin* Vaccine
BMC	Budget Management Centers
CEmONC	Comprehensive Emergency Obstetrics and Neonatal Care
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
CHO	Community Health Officers
CHPS	Community-based Health Planning and Services
CHW	Community Health Workers
CSO	Civil Society Organization
CYP	Couple Years of Protection
DA	District Assembly
DDHS	Director of District Health Services
D-G	Director General
DHIMS	District Health Information Systems
DHMT	District Health Management Team
DHS	Demographic and Household Survey
EmONC	Emergency Obstetrics and Neonatal Care
EPC	Environmental Protection Council
EPI	Expanded Programme on Immunization
FHD	Family Health Division
GHS	Ghana Health Service
GOG	Government of Ghana
HASS	Health Administration and Support Services
HIO	Health Information Officer
HIRD	High Impact Rapid Delivery
HIV	Human Immunodeficiency Virus
HO	Health Sector Objective
HRD	Human Resource Division
HRDD	Health Research and Development Division
HSMTDP	Health Sector Medium-Term Development Plan
ICD	Institutional Care Division
ICT	Information and Communications Technology
IGF	Internally Generated Funds

IALC	Inter-Agency Leadership Committee
IME	Information, Monitoring and Evaluation Department
IPT	Intermittent Preventive Treatment
IT	Information Technology
ITN	Insecticide Treated bed-Net
LDP	Leadership Development Programme
LI	Legislative Instrument
MDG	Millennium Development Goals
MICS	Multi-Indicator Cluster Survey
MLGRD	Ministry of Local Government and Rural Development
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOWAC	Ministry of Women and Children's Affairs
M&E	Monitoring and Evaluation
NACP	National AIDS Control Programme
NCD	Non-Communicable Disease
NDPC	National Development Planning Commission
NGOs	Non-Governmental Organization
OPD	Out-Patient Department
OPV	Oral Polio Vaccine
NMCP	National Malaria Control Programme
NTP	National Tuberculosis Control Programme
PHD	Public Health Division
PNC	Post Natal Care
POW	Programme of Work
PPME	Policy Planning Monitoring and Evaluation Division
PPP	Public Private Partnerships
RDHS	Regional Director of Health Services
RDT	Rapid Diagnostic Test
SBS	Sector Budget Support
SD	Skilled Delivery
SP	*Sulfadoxine Pyrimethamine*
TB	Tuberculosis
TBA	Traditional Birth Attendance
USB	Universal Serial Bus
WIFA	Women in the Fertile Age

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1. INTRODUCTION

1.1. BACKGROUND

The Ghana Health Service (GHS) POW-2014-2017 is developed from the Health Sector Medium-Term Development Plan (HSMTDP- 2014-2017) of the Ministry of Health. The HSMTDP, 2014-2017 is in turn based on the National Medium Term Development Policy Framework (NMTDPF, 2014-2017) which defines the medium term vision and development of the country. The HSMTDP, 2014- 2017 outlines the health sector's contribution to government's development priorities and projections in the area of human development, productivity and employment. It builds on the efforts towards the attainment of Universal Health Coverage for all persons living in Ghana. The 4 year plan provides a post MDG agenda and highlights on geographical and financial access to Quality and Efficient health services to improve the sector's responsiveness to the health needs of persons living everywhere in Ghana. Importantly it addresses equity gaps and continuum of care in service delivery.

The HSMTDP (2014 – 2017), builds on the Ghana Shared Growth Development Agenda (GSGDA, 2010-2013) and was developed through an elaborate consultative process involving key stakeholders including development partners, and non-governmental actors in Ghana's health industry. It is based on the broad guidelines provided by the National Development Planning Commission (NDPC).

The GHS, which is the largest of the service agencies of the Ministry of Health (MoH) will contribute significantly to the achievement of the sector indicators. GHS provides public health and clinical services at both primary and secondary levels. The Service operates at the national, regional, district, sub-district and community levels. It serves as the main representative of the MoH at these levels, providing supervisory, monitoring and evaluation (M&E) support to the CHAG and Private Health Facilities. Through its Centre for Health Information Management (CHIM), service data is collected using DHIMS2 at all levels. The District Health Information Management System (DHIMS2) database is the platform for collecting, collating and analyzing health data. The reports generated from this database feed into the sector-wide indicators, milestones and programme indicators used for monitoring and evaluation.

1.2. RATIONALE

The GHS is accountable for its stewardship as defined in the HSMTDP. There is the need therefore for arrangements and processes that will measure performance, track objectives, milestones and set targets to ensure that resources are efficiently and effectively deployed to achieve the greatest impact, and keep the Service on track. The development and implementation of an M&E plan will provide guidance in the implementation of GHS POW derived from the HSMTDP to achieve set objectives and targets as in the previous 4- year HSMTDP (2010-2013). It will also make an allowance for identifying challenges to implementation for timely and appropriate remedial measures to be taken. The GHS M&E plan will also delineate the roles of Divisions and Programmes in the M&E process and guide overall stakeholder involvement in measuring health sector performance.

1.3. PROCESS OF DEVELOPING THE M&E PLAN

The 2014-2017 GHS POW M&E plan is built on existing M&E arrangements and processes in the health sector and seeks to improve on the developed GHS' M&E plan for the POW 2010-2013. The indicators and milestones for assessing the performance of the Service are derived from a revised sector wide indicators which were developed through elaborate consultations with stakeholders facilitated by the Ministry of Health. Indicators and targets from other strategic documents and some existing M&E plans including the 2010-2013 Plan were also adopted.

Existing documentation on the M&E processes within the Service were pulled together. A three-day review and writing workshop was held at the Splendor Hotel, Kumasi from19th-22nd April, 2015 to review the previous M&E Plan put together at Dodowa Forest Hotel in September 2011 to align it to current Health sector objectives and priorities. Malaria Care provided financial support to facilitate to the workshop. The Splendor team comprised the following:

Table 1: Participants at Writers Meeting

No	Names	Designation
1	Dr. Anthony Ofosu	Ag. Deputy Director, IME/PPME
2	Ms. Emma Hammond	M&E Officer, GHS HQ
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7	Mr. George Frimpong	M&E Advisor
8	Mr. Michael A. Neequaye	Programme Manager
9	Mr. Henry Safori	Data Manager
10	Dr. Kyei Faried S.	Dep. Director Public Health
11	Dr. Beatrice Heymann	SMO, M&E
12	Stephen Duku	PPME, HQ
13	Peter Obiri-Yeboah	HRDD,HQ
14	Walyib Mohammed	M&E, NMCP
15	Bernard Asamang	Dep. Director,
16	Solomon Atinbire	M&E Database
17	Isaac Akumah	Dep. Director, PPME HQ

2. SITUATIONAL ANALYSIS

Monitoring and Evaluation within the GHS depends largely upon monthly routine service data generated from all districts and sub-districts. Data is collected from all facilities, both public and private at the district level. In Ghana, almost all the yearly health sector reviews and the aide memoires have called for an improvement in the existing health information system for better decision-making and to support the health system to deliver on key interventions and to achieve set objectives within the PoW and the MDGs.

Apart from these routine data, the health sector also collaborates with stakeholders such as the Ghana Statistical Service (GSS) and research institutions to undertake periodic health surveys and sentinel studies including the Demographic and Household Survey (DHS) and the Multi-indicator Cluster Survey (MICS). Such surveys provide the health sector with additional information for monitoring and evaluation that contributes to policy-making and re-strategizing.

The Health Sector, in an attempt to improve access to an integrated service data, reviewed and successfully deployed DHIMS2 in 2011 to replace the DHIMS1 software instituted in 2008 within the health sector. This was to help district, regional and national managers to improve on the collection, collation, transmission and analysis of routine service data.

Service registers are provided at service delivery points in all health facilities to accumulate client demographic and healthcare information. This information constitutes the primary data sources for monitoring and evaluation within the service. Standard forms are used to manually summarize data from these service registers monthly for transmission to the District level. At the District level, the DHIMS2 is used to collate and analyze the data and it also provides the platform for sending this data to the Regional level.

Regional Hospitals and Specialist Hospitals such as the Mental Hospitals are to do monthly direct electronic entries. Regional monthly data should be submitted monthly through DHIMS2 to National.

2.1 SWOT Analysis of the GHS Monitoring and Evaluation System

2.1.1. Strengths

♠ *Planning of the M&E process*

- M&E plans included in majority of service delivery activities and POW
- M&E being done for service delivery at all levels

♠ *Implementation of M&E plans and activities*

- Data collation and analysis usually takes place at all levels
- Reduced vertical data reporting system and multiple databases
- Standardized data entry forms available
- Specialized programmes have designated budget for M&E
- DHIMS is used at all levels in the health sector.
- Data quality improvement is included in performance reviews

♠ *Evaluation of POW and Sector Performance via M&E activities*

- National Division PPME tasked with coordinating M&E in the health sector
- Annual Health Summit of stakeholders' that evaluates health sector performance
- An annual Independent Review of sector performance
- Outcomes of performance reviews jointly addressed
- Joint monitoring visits among MOH and its agencies institutionalized.

♠ *Dissemination of Information*

- Results of M&E activities at all levels collated and published periodically.
- Periodic Performance Reviews and data validation meetings organized at all levels in the health sector
- Reports of Independent reviews widely disseminated.
- Routine monitoring and evaluation of submitted data and feedback from higher to lower levels to enhance Quality

2.1.2. Weaknesses

♠ *Workforce gap*

- *Inadequate* understanding of M&E procedures and processes
- Inadequate M&E skills and capacity to conduct M&E activities.
- Inadequate numbers and distribution of M&E staff
- Programme-sponsored M&E staff do not have permanent tenure of office

♠ *Resource Management gap*

- Occasional stock-outs of data *collection tools*
- Data collection tools not regularly updated.
- Inadequate linkage between input, output and outcomes within sector/programme budget
- Inadequate guidance and processes for setting targets.
- Inadequate tracking of resources
- Inadequate documentation on existing M&E processes

- The incomplete use of the DHIMS2 software by districts to collate and report on routine service data
- Low coverage of private facilities service data
- Inadequate ICT infrastructure and financial support

♠ *Leadership and Governance gap*

- M&E is not given the needed attention at all levels.
- Inadequate monitoring of M&E plans at all levels
- Very little commitment to M&E processes
- M&E not included in planning at all levels
- Inadequate platform to link service parameters to governance parameters
- Inadequate two-way accountability at all levels
- No sector goals for M&E system
- Weak feedback mechanisms and use of data to revise planning and implementation activities

- Programme-sponsored M&E staff not utilized to strengthen M&E system generally
- Weak monitoring of Input and process indicators with over-concentration on output indicators at lower levels
- Low levels of involvement of private sector in data submission

2.1.3. Opportunities

♠ Health Training Institutions available to deepen understanding on M&E
♠ Global interest for results tracking and data management.
♠ Increasing availability of ICT solutions.
♠ Formation of functional Regional, District and Facility Data Validation and Audit Teams
♠ Presence of Programme M&E personnel in Districts and Facilities
♠ Special programmes M&E provide platform for strengthening general health system M&E

2.1.4. Threats

♠ Political influence and government's priorities
♠ Global economic instability

- Donor driven parallel M&E systems
- Irregular, inadequate and Delayed fund flow at all levels

To address these gaps strategies will be developed to address issues relating to Health Workforce, resource management and Leadership and governance

3. PROGRAM DESCRIPTION AND FRAMEWORK

PROGRAMME	SUB PROGRAMME	BROAD ACTIVITES	Division Responsible	Output Indicator	Outcome Indicator
Health service delivery	Primary and secondary health services	Improve quality of logistics, financial, human and administrative support services	Finance/Internal Audit/Human Resource	Proportion of BMCs submitting annual financial report by March of the following year	Equity geography:(Resource) Doctor to population
			SSDM/HASS	Logistics "Average percentage difference"	Equity geography: Nurse to population
					Equity geography:(Resources) Midwife to WIFA population
		Implement health financing policies and support planning and budget	Finance/Internal Audit/ PPMED		
		Sustain and expand outreach servcies including specialist outreach services	HRD-GHS	Specialist outreach registrants	
			ICD-GHS	Number of specialist for outreach services	
			Finance		
			PPMED		
Health Service Delivery	Primary and secondary health services	Increase access to primary health services	PPMED-GHS	Number of demarcated CHPS zones.	Equity geography: .Penta 3 coverage
			PHD-GHS	Number of functional CHPS	
			FHD	Proportion of demarcated CHPS zones that are functional	
			ICD		
			HASS		
			HRD		
		Increase access to quality home care	PPMED	Number of home visits conducted	X

		and outreach services	PHD		
			FHD	CWC Registrants	
			ICD	Inventoty of capital investments	
			HASS		
			HRD		
		Improve quality of logistics, financial, human and administrative support services	Finance/Internal Audit/Human Resource	Proportion of CHPS zones with more than one staff.	X
				Proportion of functional CHPS with basic equipment	
		Scale up mobile health initiatives and teleconsultation programme based on lessons from pilot sites	ODG	Proportion of health facilities in underseved areas on teleconsultation	X
			ICD		
			PPMED-		
		Implement modular hospital systems automation in a phased manner	ODG	Proportion of hospitals implementing the modular electronic medical records system	x
			ICD		
			PPMED		
		Upgrade data management capacity at all levels	PPMED	Number of key staff trained in data management within the last 3 years	
			HR	Proportion of Key staff with updated data management capacity in the last 3 years	
Management and Administration	Health financing , policy formulation, planning , budgeting , monitoring and evaluation	Finalise the health financing strategy	PPMED-ODG	Health financing strategy finalized	Budget execution rate (Goods and Service as proxy)
			Finance	Availability of implementation plan	Budget execution rate (Employee compensation)
					Execution rate of funds allocated through the GIFMIS (Goods & Service)

					Proportion of GOG compensation of employees budget to total GHS budget
		Disseminate and implement the health financing policy	PPMED ODG Finance	Health financing policy disseminated and implemented	
				X	
Management and Administration	Finance and Audit	Institutionalise Health Accounts	Finance PPMED	Health accounts published Proportion of total budget financed through IGF % of IGF revenue from NHIA clients	X
		Disseminate, Implement and evaluate the sector PFM plan	Finance and Audit PPME	PFM plan disseminated and implemented	X
		Review and implement framework of resource allocation for the sector	PPME ODG Finance		Proportion of total MTEF health allocation to GHS
Management and Administration	Health financing ,policy formulation, planning , budgeting , monitoring and evaluation	Develop and implement a comprehensive leadership and management program	HRD ODG	Leadership and management program developed GHS routine service utilization Reports disaggregated by gender.	Number of management staff trained with the program
		Review the sector gender policy and develop implementation plan	PPMED	Sector gender policy reviewed Gender policy implementation plan implemented	x
		Scale up the implementation of performance contract across the sector and at all levels	PPMED HRD ODG	Number of management staff with signed performance contract	x
Management and Administration	Health policy formulation planning, budg-	Orient and develop capacity of health workers, managers and	PPMED ODG	Orientation for health workers and managers conducted	District mangers knowledge on sector decentralization program.

	eting monitoring and evaluation	other stakeholders to operate within the new decentralization program	HRD		
		Develop health sector response to decentralisation	PPMED	Health sector response to decentralization developed	
			ODG		
			HRD		
Management and Administration	Health policy formulation planning, budgeting monitoring and evaluation	Review and monitor implementation of MoUs with CHAG and expand to cover other provider groups including Private Sector and CSOs	DG-GHS	MoU with CHAG and other care providers reviewed	x
			ODG	Reviewed MoU with CHAG and other care providers implemented	
Human resource development	Human resources management and development	Review, disseminate and implement staffing norm for the sector	HRD	National and Regional HR rationalization plan	Equity index: Nurse to population ratio: (region with highest ratio, region with lowest ratio)
			PPMED	Reviewed staffing norm disseminated and implemented	
			HRD_	Proportion of BMC meeting the staffing norms	x
		Disseminate and implement the sector HRH policies and strategies on equity distribution and retention of personnel	HRD	Sector HRH policies disseminated and implemented	
Management and Administration	Health research , statistics and information management	Work with other national agencies and relevant stakeholders to produce relevant health documents eg. DHS, MICS etc.	PHD	Collaboration with relevant agencies for production of health documents strengthened.	X
			PPMED		
			RDD		
			FHD		

		Review and roll out the divisions research agenda	RDD	Percentage of research approved by the ethical review committee that is disseminated locally (at all level)	Proportion of GHS budget allocated to research.
		Expansion of the health information system to include the private sector	PPMED-	Number of private health facilities reporting in DHIMS	Timeliness of service data reporting
					Data completeness
Management and Administration	Health financing Policy formulation, planning, budgeting, monitoring and evaluation	Strengthen M&E in the sector by Implementing the integrated M&E frame work	PPMED	Integrated M&E framework implemented	Data completeness
Management and Administration	Health finance policy formulation, planning , budgeting ,monitoring and evaluation	Review, disseminate and enforce quality of care standards and patient safety strategy	ICD	Quality of care standards and patient safety strategy reviewed	Institutional Malaria Under 5 Case Fatality Rate
					Proportion of facilities reporting on adverse drug reaction.
		Scale up and enforce infection prevention and control standards and practices in all health facilities	ICD		Surgical site infection rate
		Enhance availability and use of clinical care standards, protocols and guidelines	ICD	Average number of drugs per patient encounter	x
Health Service delivery	Primary and secondary health service	Disseminate and implement hospital emergency and referrals, protocols and guidelines	ICD	Hospital emergency and referrals, protocols and guidelines disseminated and implemented	Case fatality rate for RTA
			FHD		

	Pre-hospital services	Strengthen capacity of accident and emergency department of health facilities	ICD	Number and percentage of public hospitals with trained emergency team	x
	Primary and secondary health services	Promote local initiatives to further expand emergency transport for pregnant women, children, etc	ICD/FHD /HASS	Proportion of districts with local transport initiatives	x
	Tertiary health services	Strengthen specialist outreach and mobile services eg ENT, Eye and dental etc	ICD HASS HRD	Number of cataract surgeries done	x
		Introduce mentorship program for specialist / Consultants to support lower levels	ICD HRD	Number of district hospitals with mentorship program.	x
Management and Administration	Procurement supplies and logistics	Improve the supply chain management in the sector	SSDM	% stock out of essential health commodities) at service delivery point lasting more than 7 days	x
Health Service delivery	Tertiary hospital services	Implement the Mental Health strategy	ICD Mental Health Authority ODG	Proportion of hospital with beds for mental health patients.	x
Service delivery	Primary and secondary health service	Expand the integration of traditional medicines into the exiting health service delivery	ICD	Proportion of PH offering traditional medicines	x
Health Service delivery	Primary and secondary health services	Coordinate the implementation of maternal neonatal, child health and nutrition services with special emphasis on MAF	FHD ICD PHD HASS SSDM	Implementation of maternal neonatal, child health and nutrition services with special emphasis on MAF coordinated	Family Planning Acceptor rate
		Improve skill de-	FHD		Percentage of

		livery in under-served areas and low performance facilities	ICD PHD		skilled delivery
		Improve the coverage of EmONC services	FHD ICD PHD HASS SSDM	Number and proportion of health facilities implementing EmONC services	x
		Increase availability and improve safety of blood and blood products	ICD		x
		Follow up on action plans and commitments from RCC and MMDAs on the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)	ODG FHD	x	x
Health services delivery	Maternal neonatal and child health and nutrition Primary and secondary health services	Increase access to quality home care and outreach services. Improve quality of care and management of new born and childhood illness in health facilities and community levels	FHD/ICD/PHD	Selec from newborn and child health strategic plan"	x
Health services delivery	Primary and secondary health services	Strengthen coordination of new vaccine introduction	PHD PHD	Penta3 coverage 0-11 months BCG coverage 0-11 months	x
Health services delivery	Primary and secondary health services	Eliminate vaccine preventable diseases eg. Maternal and neonetal tetanus and measles	PHD PHD	Measles Coverage 0-11 months Fully immunized 12-23 months	x

Health service delivery	primary and secondary health services	Disseminate and implement the adolescent sexual and reproductive health policy.	FHD	Adolescent sexual and reproductive health policy desseminated and implemented	x
Health service delivery	Primary and secondary health services	Strengthen preventive activities and scale up effective diagnosis, treatment and rehabilitation of malaria, TB and HIV/AIDS	PHD	Registered confirmed OPD malaria cases	Under-5 malaria case fatality rate
			ICD	Malaria admissions	
			FHD		
					HIV sero-prevalence rate
				Proportion of HIV/AIDS patients on ARV.	
					TB case notification rate
					TB Treatment success rate
		Disseminate and implement the non communicable disease policy and strategy	PHD ICD PPMED FHD	Policy and strategy for non communicable disease disseminated and implemented	x
		Strengthen surveillance of non communicable risk factors	PHD ICD	Monthly morbidity record of Hypertension, Cancers, Diabetes and Chronic respiratory lung diseases	Proportion of OPD attributable to Hypertension. Diabetes. Cancer, Asthma
Health service delivery	Primary and secondary health services	Finalize, disseminate and implement national nutrition policy	PPMED FHD PHD	National nutrition policy finalized National nutrition policy disseminated and implemented	x
		Intensify health promotion and education activities to strengthen behavioural change	FHD		x
Strategic national health	Non Communicable	Disseminate and implement inter-	PHD	International conventions and trea-	x

programs	disease	national conventions and treaties including frame work convention on tobacco control (FCTC)	RDD	ties including frame work convention on tobacco control (FCTC) disseminated and implemented	
Management and Administration	Health policy formulation	Finalise, disseminate and implement the health sector Aging Policy	ICD	Health sector Aging Policy finalized	x
			FHD	Health sector aging policy disseminated and implemented	
			PPMED		
Service delivery	Secondary and tertiary health services	Revitalize and expand orthotics and prosthetic services and other services for persons with disabilities	ICD	Number of skilled staff rendering orthotics and prosthetic services and other services for persons with disabilities	x
	Specialised services	Develop a strategic plan for under provided specialist services eg dermatology, physiotherapy	ICD	Strategic plan for under provided specialist services developed	
			HRD		
Strategic health program	Communicable diseases	Intensify efforts towards achieving WHO certification for guinea worm & polio	PHD	WHO Certification obtained for guinea worm	x
				WHO Certification obtained for polio	
Management and Administration	Health policy formulation, planning budgeting monitoring and evaluation	Develop policies and guidelines to guide planning on climate change in health	PPMED	Policies and guidelines to monitor climate change in health developed	
			PHD		
		Scale up the lessons learnt from the pilot sites into implementable activities at the regional and district levels	PHD	Number and proportion of districts incorporating and implementing CCH strategies in annual plans	
			PPMED		
		Build district level capacity in advocacy on climate change on health	PHD	Number and proportion of districts trained in CCH	
			PPMED		

IMPACT INDICATORS

OBJECTIVES	DIVISIONS RESPONSIBLE	IMPACT INDICATORS TO MEASURE
OBJECTIVE 1. Bridge the equity gaps in geographical access to health services	ODG PPMED FHD ICD PHD HRD RDD IAD FD SSDM HASS	Institutional neonatal mortality rate Neonatal mortality rate Institutional Maternal Mortality Ratio Maternal mortality ratio Still birth rate Infant mortality rate Child mortality rate Under five mortality rate Equity poverty: U5MR
OBJECTIVE 2: Ensure sustainable financing for health care delivery and financial protection for the poor		
OBJECTIVE 3 : Improve efficiency in governance and management of the health system		
OBJECTIVE 4: Improve quality of health services delivery including mental health services		
OBJECIVE 5 :Enhance national capacity for the attainment of the health related MDGs and sustain the gains		
OBJECTIVE 6 :Intensify prevention and control of non communicable and other communicable diseases		

4. INSTITUTIONAL ARRANGEMENT

4.1. MANDATE OF THE GHANA HEALTH SERVICE

The mandate of the GHS is to implement services, monitor and evaluate those services, and report to the MoH. The PPME division of GHS provides the leadership role through the coordination of all monitoring and evaluative activities in the Service. The main focus of the PPMED is to monitor the implementation of key policies and allocate resources to other divisions within the GHS.

GHS has also been given the mandate to collect health service data from private, mission, and quasi-government facilities. To facilitate this, an elaborate system for gathering service data and other information is operational within the Service. GHS also uses the DHIMS as its central software for collecting data from the districts. There are however, other parallel data collection systems, largely driven by the Global initiatives.

Data is gathered from the community, sub-district, district, regional, and national levels through the DHIMS2. The DHIMS2 is built on the DHIS2 platform which is an open source web-based software. DHIMS2 is used at the District, Regional and National levels to collate, transmit and analyze health data. Each health facility and administrative unit gathers such information as required and enters it into the DHIMS2. The data when entered into DHIMS2 can be collated and analyzed at all levels of the service. The data collected from these levels provide the basis for monitoring performance in the Service. This also feeds into the sector wide performance review process which is organized annually. There are also parallel data collection systems from the facilities through the sub-district, districts, regions to the national level to address peculiar programme needs

4.2. MONITORING AND EVALUATION FRAMEWORK OF GHANA HEALTH SERVICE

LOGICAL FRAMEWORK

		Strategies	Broad Activities	Verifiable indicators	Means of verification	Assumptions
HEALTH SECTOR GOAL	**To improve access to quality health care**			Maternal Mortality ratio	GDHS and MICS	An assumption is made that improvement in access to quality health care will reduce mortality
				Under five mortality rate		
				Neonatal mortality rate.		
				Life expectancy at birth		
				Infant Mortality rate		
PURPOSE 1	**HO1: Bridge the equity gaps in geographical access to health services**	***Strengthen the district and sub-district health systems as the bedrock of the national primary health care strategy***	Improve mechanisms for engaging the private sector providers.			
			Sustain and expand outreach services including specialists outreach services	Number of outreach points	Routine report	
				CWC Registrants	Routine report	
				Specialist outreach registrants	Specialized report	
				Proportion of communities within 2km of outreach points	Routine report	
			Strengthen specialist out-	No of Specialized services	Activity/Routine Report	

			reach and mobile out-reach services e.g. ENT, Eye and dental etc	Specialized service population ratio	Routine Report	
			Introduce mentorship program for specialist / Consultants to support lower levels	Inventory of Men-tors	Activity Report	
				No of lower level staff mentored and areas mentored in	Activity Report	
			Strengthen planning, budgeting and Public finan-cial manage-ment and re-porting	Proportion of BMCs submitting annual plan and budget by Sept each year	Routine report	
				Proportion of BMCs submitting annual financial report by March following year	Routine report	
			Improve quali-ty of logistics (financial, human and administra-tive) support services	Logistics "Average percentage differ-ence"	Routine report	
				Proportion of staff receiving in-service training in 3 years	Survey	
				Proportion of med-icine types expired	Periodic moni-toring	
			Implement health financ-ing policies and support planning and budget			
		Accelerate the implementa-tion of the revised CHPS strategy espe-cially in un-derserved areas	Increase ac-cess to prima-ry health ser-vices by focus-ing on under-served areas	No. of demarcated CHPS zones	Routine report	New CHPS Policy Disseminated.
				No. of functional CHPS zones	Routine report	
				Proportion of func-tional CHPS zones	Routine report	
			Strengthen Community based inter-ventions eg: Use of volun-teers	Total OPD regis-trants	Morbidity re-port	
				Total OPD attend-ants	Morbidity re-port	
				OPD attendance per capita		

				U5MR in lowest wealth quintile / U5MR in highest wealth quintile	DHS	
			Rezone CHPS based on reviewed CHPS strategy	Proportion of districts with CHPS zones aligned to Electoral areas	Routine reporting	
				Proportion of functional CHPS zones to Electoral areas	Routines reporting	
			Increase access to quality home care and outreach services	Proportion of targeted individuals receiving the defined Home care	Survey	
		Formulate and implement health sector capital investment policy and plan		Inventory of Capital Investments	Survey	
				Proportion of Capital Investments completed on schedule	Survey	Funds for capital investment will be made available
		Implement the health sector ICT policy and e-health strategy focusing on under served areas	Review, finalize and adopt health sector ICT policy including legal framework for health data handling	Health Sector ICT Policy finalized	Finalized Policy	ICT Policy will be finalized and disseminated
			Scale up mobile health initiatives and tele-consultation programme	No of health facilities on tele-consultation	Routine Report	
			Implement modular hospital systems automation in a phased manner	No of Hospitals with electronic medical records system	Activity/Routine Report	

			Upgrade data management capacity at the CHIM and Disease Control & Prevention Department	Proportion of key staff at CHIM and DCD with updated data management capacity in last 3 years	Training Report/In-service Training Log-book	

		Strategies	**Broad Activities**	**Verifiable indicators**	**Means of verification**	**Assumptions**
PURPOSE 2	**HO2: Ensure sustainable financing for health care delivery and financial protection for the poor**	***Finalize and implement a comprehensive health financing strategy***	Finalize the health financing strategy	Health Financial Strategy document	Report	Health Financing Strategy finalized and Disseminated
			Disseminate and implement the health financing strategy			
		Strengthen public financial management and accountability systems in the health sector	Institutionalize Health Accounts	Annual National Health Accounts produced	Report	
			Disseminate, Implement and evaluate the sector PFM plan	Number of dissemination of PFM done	Activity Report	
		Strengthen capacity for Monitoring and Evaluation in the health sector	Strengthen M&E in the sector by Implementing the integrated M&E framework	Number of staff trained in the use of M&E Framework	Training / Activity Report	

		Strategies	Broad Activities	Verifiable indicators	Means of verification	Assumptions
PURPOSE 3	**HO 3: Improve efficiency in governance and management of the health system programs**	***Review and restructure the health sector leadership development and management programs***	Develop and implement a comprehensive leadership and management program	Proportion of senior managers trained in LDP.	Activity Report	
					Activity Report	
			Review the sector gender policy and develop implementation plan	Reviewed Gender Policy Gender policy Implementation Plan	Activity Report	
					Activity Report	
					Activity Report	
			Scale up the implementation of performance contract across the sector and at all levels	Proportion of BMCs with Performance Contract signed	Performance Contracts Signed	
			Review to strengthen inter agency leadership and coordination mechanisms within the health sector	Reviewed Inter-Agency coordination and leadership mechanism	Activity Report	

			Scale up the implementation of performance contract across the sector and at all levels	Proportion of senior mangers with Signed Performance contracts	Periodic monitoring	
			Disseminate and implement the HRH policies and strategies on production of quality health professional with focus on neglected disciplines	Inventory of dissemination	Periodic monitoring	
		Develop and implement health sector response to the national decentralization program	Review and implement the National Health Policy	Reviewed National Health Policy	Activity Report, Periodic monitoring	Decentralization Bill passed into an Act
				Implementation plan of National Health Policy	Activity Report	
			Develop and implement health sector response to national decentralization	Health Sector response document on Decentralization	Activity Report, Periodic monitoring	
			Orient and develop capacity of health workers, managers and other stakeholders to operate within the new decentralization program	Number of health workers trained or sensitized on decentralization	Activity Report, Periodic monitoring	
					Activity Report, Periodic monitoring	

			Carry out periodic data validation and standardization of measuring tools	Percentage data completeness Percentage Timeliness Verification factor	Activity Report	
		Deepen stakeholder engagement and partnership (public, private and community) for health care delivery	Strengthen mechanisms to for improving collaboration between MOH and MDAs, MMDAs, Private sector, Parliament in the development of policies, implementation and monitoring of programs	Signed MOU between GHS and the Private Sector	Activity Report, Periodic monitoring	
			Review and monitor the implementation of MoUs with CHAG and expand to cover other provider groups including Private Sector and CSOs	Availability of reviewed MoU	Activity Report, Periodic monitoring	

		Implement the human resource development strategy to improve production, distribution retention of critical staff and performance management	Disseminate and implement the HRH policies and strategies on production of quality health professional with focus on neglected disciplines	Proportion of BMCs meeting the Staffing Norms. Equity index: Nurse to population ratio: Region with highest ratio / region with lowest ratio Equity index: Doctor to population ratio: Region with highest ratio / region with lowest ratio	Periodic reporting Periodic Surveys	Staffing norms completed and Disseminated
			Review, disseminate and implement staffing norm for the sector			
		Improve health information management systems including research in the health sector	Work with other agencies and relevant stakeholders to produce relevant health statistics and analytical reports e.g. DHS, MICS	Maternal and Reproductive Health Survey 2016 MICS 2017	Activity Report, Periodic monitoring	
			Review and roll out the sector research agenda	Proportion of proposed research in agenda implemented	Activity Report, Periodic monitoring	
			Expansion of the health information system to include the private sector	Proportion of private facilities reporting in DHIMS2.	Monthly Report, Periodic monitoring	

		Strengthen capacity for Monitoring and Evaluation in the health sector	Strengthen M&E in the sector by implementing the M&E framework	Proportion of Divisions reporting using framework	Activity Report, Periodic monitoring	

		Strategies	**Broad Activities**	**Verifiable Indicator**	**Means of verification**	**Assumptions**
PURPOSE 4	**HO4; Improve quality of health services delivery including mental health services**	***Develop and implement a comprehensive national strategy for quality health and patient safety***	Develop and implement national strategy for quality health and patient safety	Surgical infection rate All cause mortality rate Under five malaria case fatality rate	Routine Reporting, Periodic monitoring	
			Scale up and enforce infection prevention and control standards and practices in all health facilities			
			Enhance availability and use of clinical care standards, protocols and guidelines			

		Improve response and management of medical emergencies including road traffic accidents and strengthen the referral system	Disseminate and implement hospital emergency and referrals, protocols and guidelines		Routine Reporting	
			Strengthen capacity of accident and emergency department of health facilities			
			Promote local initiatives to further expand emergency transport for pregnant women, children, etc			
			Develop, disseminate and implement national strategies and guidelines for response to accident and medical emergencies			
			Train emergency medical teams for districts, regional and tertiary hospitals			

			Introduce mentorship program for specialist / Consultants to support lower levels			
		Expand specialist and allied health services (e.g. diagnostics, ENT, Eye, physiotherapy etc.)	Strengthen specialist outreach and mobile outreach services e.g. ENT, Eye and dental etc	Number of specialist outreach services organized	Routine Reporting	
		Improve supply chain, ensure commodity security and availability of quality medicines	Improve the supply chain management in the sector			
		Implement the Mental Health Act, finalize and implement the mental health strategy	Implement the Mental Health strategy	Proportion of Public Hospitals with mental health **units**	Routine Reporting	

		Scale up the integration of traditional medicine into existing health service delivery system	Expand the integration of traditional medicines into the exiting health service delivery	Proportion of Public Hospitals with traditional medicines practitioners	Activity Reporting	

		Strategies	**Broad Activities**	**Verifiable indicators**	**Means of verification**	**Assumptions**
PURPOSE 5	**Ho5: Enhance national capacity for the attainment of the health related MDGs and sustain the gains**	***Accelerate the implementation of the Millennium Development Goals Acceleration Framework (MAF)***	Improve and expand the implementation of maternal neonatal, child health and nutrition services with special emphasis on MAF	Skilled delivery rate Number of Facilities offering EmONC services Institutional Maternal mortality ratio Maternal Mortality ratio Still Birth rate	DHS MICS Routine Reporting Maternal and Reproductive Health Survey	Funds for activities under MAF implementation plan are released
			Improve skill delivery in underserved areas and low performing facilities			
			Improve the coverage of EmONC services			

			Increase availability and improve safety of blood and blood products			
			Follow up on action plans and commitments from RCC and MMDAs on the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)			
		Scale up community and facility based interventions for the management of childhood and neonatal illnesses	Improve quality of care and management of new born and childhood illness in health facilities and community levels	Institutional Neonatal mortality rate Neonatal mortality rate Infant mortality rate Under five mortality rate	DHS MICS Routine Reporting	
		Intensify and sustain Expanded Programme on Immunization (EPI)	Strengthen coordination of new vaccine introduction	Penta3 coverage 011 months	Routine reporting	
				BCG coverage 0-11 months	Routine reporting	
				Measles Coverage 0-11 months	Routine reporting	

				Fully immunized 12-23 months	DHS, MICS	
		Scale up quality adolescent sexual and reproductive health services	Disseminate and implement the revised adolescent sexual and reproductive health policy	Percentage of teenage pregnancy	Routine Reporting	
		Scale up the implementation of national malaria, TB, HIV/AIDs control strategic plans	.	Proportion of suspected malaria cases tested (microscopy and RDTs) Confirmed OPD malaria cases Malaria admissions Under5 malaria case fatality rate HIV seroprevalence rate Proportion of AIDS patients on tretament Proportion HIV+ women put on ARV Proportion of babies born to HIV+ women put on treatment. Proportion of children born to HIV+ women who are positive. TB case notification	Routine reporting Periodic monitoring	
			Strengthen preventive activities and scale up effective diagnosis, treatment and rehabilitation of malaria, TB and HIV/AIDS			

			Implement Revised Strategic Plan for Malaria Control in Ghana (20142018)	rate TB Treatment success rate		
			Implement National Strategic Plan for HIV/AIDS Control			
			Implement the National TB control Strategy			

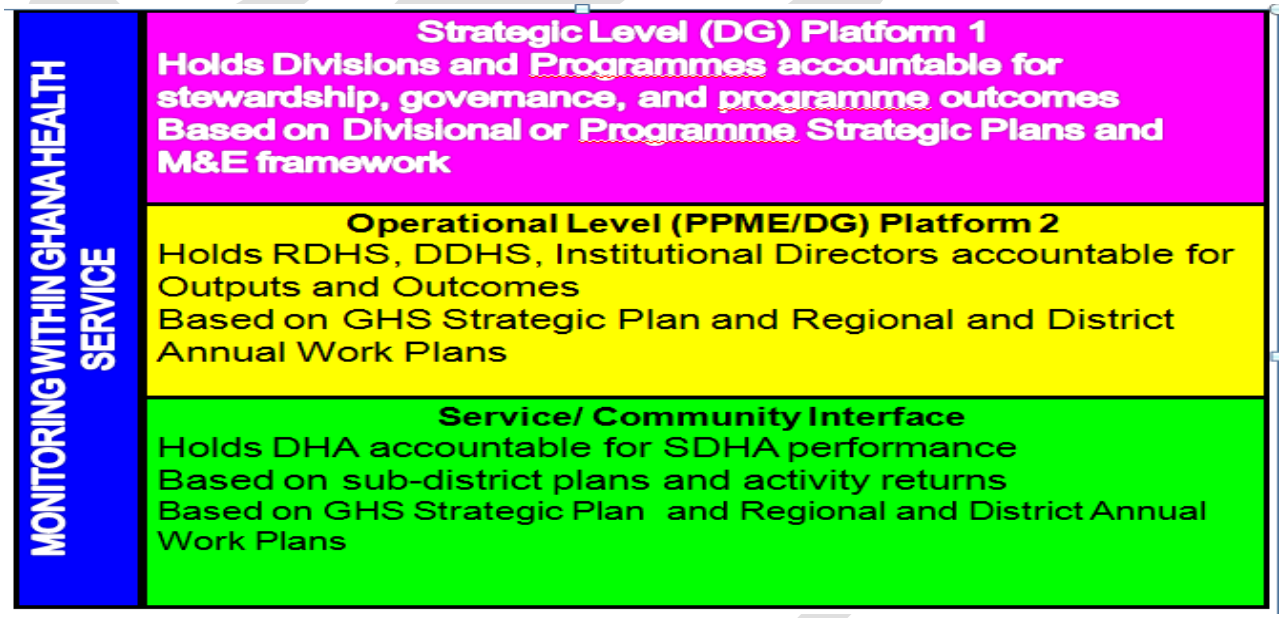
		Strategies	**Broad Activities**	**Verifiable indicators**	**Means of verification**	**Assumptions**
PURPOSE 6	**HO6: Intensify prevention and control of non communicable and other communicable diseases**	**Implement the NonCommunicable Diseases (NCDs) control strategy**	Disseminate and implement the non communicable disease policy and strategy	NCD strategy implementation plan	Periodic monitoring	
			Strengthen surveillance of non communicable risk factors	Monthly morbidity record of Hypertension, Cancers, Diabetes and Chronic respiratory lung diseases	Routine reporting	
		Review and Scale up Regenerative Health and Nutrition Programme (RHNP)	Finalize, disseminate and implement national nutrition policy		Periodic reporting	

			Intensify health promotion and education activities to strengthen behavioural change		Periodic reporting	
		Implement international conventions and treaties including framework convention on tobacco control (FCTC)	Disseminate and implement international conventions and treaties including framework convention on tobacco control (FCTC)	World No Tobacco day reports	Periodic reporting	
				Evidence of Tobacco use monitoring	Periodic reporting	
		Develop and implement the national health policy for the Aged	Finalize, disseminate and implement the health sector Policy on the Aged	Health Sector Policy on the Aged.	Periodic reporting	
		Strengthen rehabilitation services	Revitalize and expand orthotics and prosthetic services and other services for persons with disabilities	Orthotic and prosthetic centres providing services to persons with disabilities	Periodic reporting. Activity reporting	

			Develop a strategic plan for under provided specialist services eg dermatology, physiotherapy	Strategic plan for under provided specialist services developed	Periodic reporting. Activity reporting	
		Intensify efforts for the certification of eradication of guinea worm and polio	Intensify efforts towards achieving WHO certification	WHO Certificate	Periodic reporting	
		Formulate national strategy to mitigate the effect of climate change related diseases	Develop policies and guidelines to guide the response on effect of climate change on health	Availability of Climate change and Health Monitoring Tool	Periodic reporting, Periodic Monitoring	
			Scale up the lessons learnt from the pilot sites into implementable activities at the regional and district levels	Proportion of Districts incorporating CCH in annual plans	Periodic reporting, Periodic Monitoring	
			Build district level capacity in advocacy on climate change and health	Number and Proportion of Districts trained in CCH	Periodic reporting, Periodic Monitoring	

				Proportion of Districts conducted CCH assessment	Periodic reporting, Periodic Monitoring	
				Proportion of Districts considered Climate Change and Health Resilient	Periodic Monitoring	

Fig 1.Levels of Monitoring in Ghana Health Service



4.3. M&E MANDATE AND FUNCTIONS OF DIVISIONS

Monitoring and Evaluation within the Divisions and Programs, is designed to provide managers and stakeholders with the information necessary to guide the implementation of their action plans. It is therefore mandatory for all Districts, Regions, Programs and Divisions to include monitoring and evaluation activities in their respective action plans.

The Divisions within the Ghana Health Service are:

- Policy Planning Monitoring and Evaluation (PPMED)
- Public Health (PHD)
- Institutional Care (ICD)
- Family Health (FHD)
- Finance (FD)
- Internal Audit (IA)
- Health Administration and Support Services (HASS)
- Stores and Supplies Drugs Management (SSDM)
- Human Resource Division (HRD)
- Health, Research and Development (HRDD)
- Office of the Director General

Table 3: MONITORING AND EVALUATION CALENDAR

Activities	Time Frame												Actors
	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Sub-district data validation meetings													Sub-district Teams
District data validation meetings													DHMT
Regional data validation meetings													RHMT
Supervision and Monitoring visits													DHMT,RHMT and IME-PPMED
District performance reviews													Sub-District Teams ,DHMT and RHMT
Regional Annual and Half year performance reviews													DHMT, RHMT ,GHS Headquarters , MOH and DPs
National GHS Head-quarters Annual and Half year Performance reviews													Divisions in GHS
Senior Managers Meetings													GHS Headquarters , RHMTs,
Technical Review meetings(TB, HIV, Malaria,													Specialized programs Programme Managers, RHD, GHS

RCH)													Headquarters
Joint Monitoring Visit													MOH, Agencies of MOH, DPs
Health Summit													MOH, Agencies of MOH, DPs
IME working Group Meeting													MOH, Agencies of MOH, DPs
IALC meetings													
ICC meetings(EPI, FP)													

5. MONITORING & EVALUATION RESPONSIBILITIES

5.1. Monitoring Responsibilities of Divisions within GHS

The Divisions within the Ghana Health Service in implementing their mandate contribute to monitoring and evaluation process. The Divisions monitor a wide range of indicators to determine the progress that they are making in executing their mandate. Table 4 shows the various indicators monitored by the divisions within Ghana Health Service.

Table 4: **LIST OF INDICATORS EXPECTED TO BE MONITORED BY THE DIVISIONS**

Category of service provision	Division	Information	Frequency

1. Clinical Care	ICD	▪ Outpatient attendance ▪ Outpatient Registrants ▪ Outpatient morbidity ▪ Admissions ▪ Inpatient morbidity ▪ Inpatient mortality ▪ Death Audits and response ▪ Differential use of services by patient categories ▪ Discharges and Deaths ▪ Institutional under five mortality rate. ▪ ▪ Total number of beds ▪ Bed Occupancy Rates ▪ Bed Turnover Rate ▪ Average length of stay ▪ Surgical Operation Returns ▪ Surgical site infection rate ▪ Numbers of different types of laboratory tests conducted ▪ Numbers of different imaging done. ▪ RUM Survey Results ▪ Emergency Response in all Hospitals ▪ Percentage of public hospitals with trained emergency team ▪ Infection Prevention & Safety at Work place ▪ Functional QA in Hospitals ▪ Mental Health Services delivery in Health Facilities (Health Facilities delivering MH services) Specialist outreach/ mentoring ▪ NCD Clinics (DM & Hypertension, SCD, etc) ▪ Technical Support visits ▪ Health Sector ICT Policy (eHealth strategy) – incorporation in Health Facilities POW ▪ Organization of Family District Forums ▪ Organization of Providers Forum/ Open Days by Hospitals ▪ Peer Reviews	Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly Annual Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly **Quarterly; Half year/Annual** Monthly Quarterly Quarterly Quarterly Monthly Quarterly Quarterly Quarterly Quarterly Quarterly

	FHD	• Midwifery Returns • Supervised delivery rate • Caesarian section rate • Institutional Maternal mortality ratio • Proportion of maternal deaths audited • Stillbirths • Proportion of Stillbirths audited • Institutional Neonatal Mortality rate • Institutional Infant Mortality rate • Antenatal care coverage 4+ • Postnatal coverage care coverage • IPT coverage • Family planning coverage • School Health coverage (% of School children examined, referred & schools that have received 3+ HE talks) • Adolescent Health (coverage of adolescent health corners & percentage early/late teen pregnancies) **Nutritional Status of children** • Proportion of Children U5 who are Underweight • Proportion of Children U5 who are Stunted • Proportion of Children U5 who are wasted • Vitamin A supplementation (0-11months; 12-59 months & post partum women) **School Feeding Programme** • # of Children enrolled • # of Children fed • # Underweight • # with normal BMI • # Overweight • # Obese Community Management of Acute Malnutrition cases (Severe Acute Malnutriton -SAM) • # of SAM cases Cured • # of SAM cases Defaulted • # of SAM cases Died • % Household usage of Iodated salt • % Market availability	Monthly; Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly Monthly **Then Quarterly; Half year/Annual** **Quarterly; Half year/Annual** Monthly, Quarterly, Half-Yeraly & Annually Monthly, Quarterly, Half-Yeraly & Annually Monthly Monthly Monthly Quarterly, ,

Public Health	PHD	▪ Immunization (specifically Measles and Penta-3 coverage) ▪ Trend of other communicable and non-communicable diseases. ▪ Disease surveillance indicators (Timeliness, completeness, accuracy)	Monthly; Monthly Monthly Monthly Then Quarterly; Half yearly/Annuly
		▪ Public Health Emergency Management Committees ▪ Public Health Units – functional ▪ District Epidemic Preparedness plans ▪ IDSR Training ▪ -CBS - TB/DOTS, MDR ▪ -NTD Mass administration	Quarterly Quarterly
		▪ Trend on Diseases earmarked for eradication and or elimination. ▪ Technical Support visits	Weekly Quarterly
		▪ Proportion of suspected malaria cases tested ▪ < 5 Malaria Case Fatality Rate ▪ TB case detection & cure rates ▪ HIV sero-prevalence (among reproductive age 15-19 & 20-24 years) ▪	Monthly Monthly Quarterly, Half-Yearly, Annuall y,

Support services	Finance	▪ Trend in government funding for the health sector ▪ GIFMIS for IGF ▪ Trend in donor support to the health sector ▪ Trend in overall generation of internally generated funds ▪ Trend in reimbursement from the National Health Insurance Authority (NHIA) ▪ Financial data (revenue and expenditure, Fund flow). ▪ Revenue and expenditure data Funds for Monthly Capitations for Primary care by the NHIA	Quarterly/ Half Yearly/ Annually Monthly

	HASS	▪ State of public health facilities ▪ State of Central & Regional Medical Stores ▪ Equipment and logistics situation of the public health facilities ▪ Cost of replacing equipment ▪ Equipment Maintenance in the public health facilities ▪ Planned preventive maintenance activities ▪ Status of projects under implementation in the sector	Quarterly/ Half-yearly/ Annually
		▪ Number of health facilities by level and location, including CHPS compounds and ownership ▪ Proportion of Vehicles that are roadworthy ▪ Proportion of Vehicles 0-5 years ▪ Proportion of Vehicles 6-10 years ▪ Proportion of Vehicles > 10 years ▪	Quarterly/ Half-yearly/ Annually
		▪ Proportion of Motorbikes that are roadworthy ▪ Proportion of Motorbikes 0-3 years ▪ Proportion of Motorbikes 4-5years ▪ Proportion of Motorbikes > 5 years ▪	

	SSDM	▪ Procurement Plan availability	Annually
		1. Accuracy of Logistics Data for Inventory Management (LMIS).	Monthly
		2. Percentage of facilities that received their orders according to schedule (Distribution).	Quarterly
		3. Percentages of facilities that completed and submitted LMIS report (LMIS). -	Half - Yearly Annually
		4. Percentage of facilities that maintain acceptable storage conditions (Warehousing)	Monthly Half-Yearly
		5. Percentage availability of Tracer medicines (Product Availability) – half yearly	Half-Yearly
		6. Percentage availability of non-medicine consumables (Product Availability)	Half-Yearly
		7. Mean Absolute Percentage Error (MAPE) between forecasted consumption and Actual consumption (Forecasting)	Half-Yearly
		8. Average percentage difference between consumption forecasts and actual consumption (Forecasting)	Half-Yearly
		9. Percentage of stock wasted due to expiration or damage (Warehousing and Inventory management).	Annually
		10. Average Delivery Time (Distribution)	
		11. Percentage Procurement spent to total expenditure (Procurement)	Half-Yearly
		12. Average lead time for Procurement Methods (Procurement)	Annually
		• ICT -	Annually
		• NCT	
		• RFQ	
		13. Average lead time from Award of Contract to delivery (Procurement)	
		• ICT	Annually

Human Resource	▪ HR Planning – ▪ Availability of HR posting plans ▪ % of postings based on identified HR needs ▪ Resourcing ▪ % of service delivery points with requisite staff for service delivery ▪ # of key of vacancies of key staffing positions filled ▪ % of staff undergoing performance appraisal process (360° & Group Appraisal) ▪ % of wastage staff replaced ▪ Training and capacity building ▪ # of staff benefitted from in-Service Trainings programmes ▪ Equity in the award of training opportunities ▪ Staff welfare and benefits schemes ▪ Availability of functional staff welfare schemes ▪ # of reward systems in place ▪ Occupational Health & Safety ▪ Availability of occupational health and safety programmes in place ▪ # of regions/facilities implementing Employee Assistance Programme	Half-yearly/ Annually Quarterly; Half-yearly; Annually Quarterly; Half-yearly; Annually Half-yearly; Annually
Policy Planning Monitoring and Evaluation	▪ Proportion of Policies translated into implementation Technical guidelines & SOPs and disseminated ▪ Proportion of copies (hard/soft) available, out of Catalogue of health sector policies ▪ Proportion of old Policies reviewed & disseminated ▪ Strategic & Annual POW developed & disseminated ▪ Proportion of budgeted Resources received and disbursed. ▪ Annual Calendar developed & disseminated ▪ Proportion of Regional Teams given Capacity building in planning and budgeting ▪ M & E framework developed & disseminated ▪ Proportion of Senior and Middle Level Managers in the Health Sector trained to use DHIMS2 ▪ Annual Performance Reviews and integrated nonitoring ▪	Quarterly; Half-yearly/ Annually Monthly, Quarterly; Half-yearly; Annually

5.2. SUPPORT FOR M&E PROCESS FOR DIVISIONS AND PROGRAMMES

The Centre for Health Information Management (CHIM) should coordinate the collection, collation and availability of health information for the Divisions and Programmes to assist the monitoring and evaluation processes.

5.3. STAKEHOLDER ANALYSIS

There are several stakeholders collaborating with the GHS providing financial and technical support to the process of policy formulation, planning, and monitoring and evaluating performance. There is a second group of stakeholders who consume healthcare services and/or information for the improvement of personal and/or their community's health and then provide valuable feedback to the service.

Table 7.2 highlights key stakeholders in the health sector indicating the roles they play.

TABLE 5. STAKE HOLDERS IN THE HEALTH SECTOR

STAKEHOLDERS	ROLES AND RESPONSIBILITIES
Local community	Demand accountability, assist in community surveillance, community mobilization and other infrastructural support, etc.
District Assembly	Policy formulation, development planning and financial, infrastructure and equipment support and under the proposed Decentralisation Bill the District Assembly will deliver health services in their locality
Ghana Health Service Council	Coordinates and approves Policy formulation. Provides authorization and guidance for the Director General of the Service
Regional Coordinating Council	Implement National Policies coordination of planning resource mobilisation and development,
Ministries, Departments and Agencies in the health sector	Policy formulation and coordination & collaboration, resource mibilisation and policy implementation
Parliamentary Select Committee on Health	Supports planning, monitoring and evaluation of health programs, resource mobilisation & allocation and advocacy

Political Parties	Influence Policy formulation, monitoring Governments performance and providing feedback, advocacy and lobbying
Development Partners	Provides technical assistance, financial support. Advocacy & lobbying
Civil Societies	Advocacy for health, community and resource mobilization, community empowerment through education, demand accountability advocacy & lobbying and implementation
Academia	Support research, training, policy formulation and technical assistance
Faith Based Organisation	Support service delivery, capacity building, advocacy & lobbying
Private Providers	Support service delivery, capacity building, advocacy and lobbying
Media	Influence policy formulation, and dissemination, advocacy & lobbying

6. M&E CONDITIONS AND CAPACITIES

6.1. CAPACITY FOR MONITORING AND EVALUATION

Traditionally, the GHS utilizes medium term plans (POW) drawn from the HSMTDP. Annual POW is also developed to guide the activities of the Service for each year. GHS has personnel at all levels involved in the M&E processes. However, the workload especially at sub-district, district and regional levels overwhelms staff strength and capacities at these levels. The National level has an M&E unit within the PPMED but no similar arrangement exists to support M&E activities at the Regional and District levels. The M&E roles at these levels tend to form part of the shared responsibility of the District and Regional Health Management Teams. M&E is an integral part of programme activities at all levels of service provision. There is therefore the need to build the capacity at regional and district levels to be able to perform the role adequately. These should include monitoring of inputs, activities, outputs, and outcomes of programme activities.

At the Regional level and within the Headquarters Divisions, staff have varying competency in M&E. The Global Fund supported Programmes have a relatively more elaborate set-up, which is well resourced for M&E activities.

Training and capacity development in data management and analytic software, M&E and report writing skills for M&E officers is therefore very relevant in all the Divisions. This would necessitate building capacity for M&E functions within the Regional Health Management Team (at all levels). Capacity should also be built within the District Health Management Teams to carry out M&E activities.

Following on these, financial support will be required to resource the PPMED to undertake regional monitoring and to equip the national, regional and all districts with much needed ICT infrastructure, internet access and anti-virus software and other logistics to facilitate the full adoption of the DHIMS 2 software.

6.2. TECHNICAL ASSISTANCE

The Health Sector has completed the process of adopting the DHIMS 2 as the main software for data management collection and analysis; however some technical assistance is still required to address post implementation challenges. There would be the need for technical assistance to roll out electronic register to replace the paper registers at the facility level.

GHS will also require some technical assistance to evaluate the HSMTDP implementation at the end of 2017 to determine the scope of the Service activities and how these have contributed to the overall reduction in morbidity and mortality in the Ghanaian population.

6.3. STORAGE OF INFORMATION

The category of M&E information that is stored depends on the level of the management centre managing the data as well as the sub-level at which the specific activity generating the data is being carried out. This in turn is dictated by the information and data requirements at that particular level.

Although the data collection process is well developed within the GHS, there is a challenge in using this data to adequately inform management decisions, especially at the facility and district level. It is therefore imperative that the Service intensify its efforts in creating the environment and platform to strengthen the use of data to make evidence-based decisions. Training on the use of data to generate information for evidence based decision making should be prioritized (refer).

The type and category of Service information stored at the National level is determined by a set of sector-wide indicators. These sector-wide indicators also enable relevant information gathered from all budget management centers (BMC) to be transmitted to the district, regional, and national levels monthly. However, the mode of data transmission varies with internet accessibility and availability at the various levels. . This manual collection and transmission of data by courier has adversely affected data completeness, quality, and timeliness.(elaborate on internet challenge.). The development and deployment of web-based software (DHIMS2) is expected to improve data completeness and timeliness.

6.4. EQUIPMENT AND LOGISTICS

To gain from the efficiency of real-time data collection requires that computers be placed within the consulting rooms of hospitals, and mobile devices like phones set-up within the smaller health facilities and for other public health programmes. These systems will require internet access for efficient data transmission. Currently there is dire need for computers and accessories at all levels but especially at the facilities and District Health Directorates. For most districts there is a reliance largely on internet access via USB modems available on various mobile phone networks, raising issues with connectivity and reliability.

Following these, there is the need to support facilities and districts with computers and reliable internet access. There will also be the need to support and resource the ICT

department to maintain the existing computers and accessories in the Service. Additionally, the GHS needs to make investments in infrastructure and personnel to strengthen the capacity at its Center for Health Information Management (CHIM) and the other levels to be able to maintain and run the web-based data collection, analysis and reporting tool, including the electronic medical records.

The information, monitoring and evaluation (IME) unit of the PPMED should be provided with dedicated funds and vehicles to facilitate regular field and technical support visits to all management centers to enhance the M&E capacity at all levels.

7. THE MONITORING AND EVALUATION PROCESS

7.1 COLLECTION, COLLATION AND ANALYSIS OF DATA

GHS collects and collates routine data monthly from the districts. Reports from CHPS zones, health centers and hospitals as well as private facilities are sent to the districts monthly using the prescribed reporting forms. The Centre for Health Information Management (CHIM) has been given the mandate by the Ministry of Health to collect health service data from all facilities in the district, including Private and CHAG facilities. These are sent as hard copies to the district level and entered into the DHIMS2 or the facilities do the entry directly into the DHIMS2 themselves. Facility/District validation teams validate the reports before or after it has been entered into the DHIMS2 (refer to the standard operating procedures manual for detail). It is envisaged that with the full deployment of the e-tracker for the public health interventions and hospital information systems for the hospitals, data entry into the DHIMS2 will be automated.

To augment the routine data collected, the health sector works with some of its stakeholders to undertake joint periodic health surveys such as the Demographic and Health Survey (DHS) and the Multi-indicator Cluster Survey (MICS). These surveys generate additional indicators for monitoring and evaluation.

7.2. REVIEW PROCESS IN THE GHANA HEALTH SERVICE

The annual review process begin at the level of the Budget and Management Centres. The process involve an internal review of the BMC performance based on their annual plans and specific activities and achievements. These are reviewed against the targets set over the review period. Review of performance include trend analyses of performance over a minimum period of three years. However, five years trend analysis is preferred.

The first level of data collation and analysis is completed at the facility, sub-district and district levels. This provides a synthesis of all reports from the facilities, sub-districts, district hospitals and District Health Directorates, CHAG facilities, NGOs and private health facilities. These reports include the various activities undertaken in collaboration with the District Assemblies and other decentralized agencies. The District Performance Review involves all stakeholders in health working at the district level. This forum affords each stakeholder including the private health care providers the opportunity to present an account of their performance and to highlight their key challenges in order to fashion out

sustainable solutions to them. This review culminate in a final district report based on the guidelines provided by the PPMED which is submitted to the regional level.

The second level of collation and analysis take place at the Regional level. This is preceded by the regional performance review sessions, involving all District Health Directorates, district and regional hospitals, training institutions, CHAG facilities, Regional Health Directorates and other stakeholders at the regional level. National teams attending these reviews include health information officers, policy-makers, clinical and public health specialists, health and development partners. These reviews culminate in a final regional report based on the guidelines provided by the PPMED. The report is sent to the National level- PPMED.

At the National level, the first Senior Managers' Meeting (SMM 1) is organized within the first quarter of the ensuing year and focused to reviewing Regional and National Performances through series of regional and divisional presentations. This forms the basis for preparing the GHS Annual Report. The National level Performance Sessions are attended by the GHS Council.

The GHS makes presentations on the performance of the year-under-review at the MoH-Inter-agency review. There is annual independent performance review of the entire Health Sector by an independent team of consultants. This is done using the Holistic Assessment Tool. The results of this review is presented at the Health Summit which is the final review of the Health Sector where the MOH engages its partners and other stakeholders. This independent review includes a review of the performance of the M&E System of the GHS.

7.3. USE OF DATA FOR DECISION-MAKING

Good data is essential in planning and ensures proper accountability and reporting. Quality data forms the essence and foundation of decision-making process and it is imperative for all decision-makers to make use of the relevant data at all levels. However, data utilization in the Service is often hindered by weak organizational structures and a myriad of challenges both inherent and external. This includes minimum data utilization mores among decision-makers, low motivation, inadequate trained staff, inadequate technical skills and technology, particularly, at the lower levels, and poorly-funded M&E activities.

The Data Utilization Manual developed by the PPMED-GHS is utilized to provide the necessary skills for decision-makers to enable optimal data use at all levels.

7.4. DATA REQUEST/RELEASE

As part of encouraging data utilisation for decision-making, external data request and release can be granted for the purposes of knowledge generation and dissemination. In such instances however, the procedure for external data request should be appropriately followed (refer to SOP for health information management for details).

7.5. PLAN FOR EVALUTAION

Evaluation is at the heart of the decision-making process and determines the value of an intervention or programme, to inform its adoption, rejection or revision. Evaluation makes use of assessment data in addition to many other data sources and measures how well activities have met expected objectives. The evaluation process provides valuable information for management and draws lessons for future actions.

At the end of the implementation of the HSMDP, the Ghana Health Service together with other agencies of the Ministry of Health are involved at all levels to evaluate the performance of the sector.

The following steps are used at all levels in the service to evaluate programme implementation within the GHS

- Identify and engage stakeholders
- Involve partners to work on the Logic Model for the evaluation
- Define the outcome objectives and impact objectives
- Gather credible data/evidence
- Organize and interpret results and draw conclusions
- Prepare and disseminate reports

The reports received from all beneficiaries and districts are prepared, analyzed and a progress report produced and disseminated. The information generated is used for re-planning and advocacy and also shared with all beneficiaries, districts and other partners

8. QUALITY ASSURANCE

8.1. Ensuring Data Quality

Data veracity, put in a nutshell, its completeness, consistency, accuracy, integrity is pivotal to effective planning, implementation and improvement of health services as well as programme evaluation. Authentic data informs enhanced patient care, better use of health insurance, more appropriate and better defined priorities of the service.

Poor data quality is common in the health sector. The trail of upward reporting to each level is beset with an array of data quality issues that range from inadequate documentation and storage, poor analysis and improper interpretation, poor presentation and non-dissemination in many cases. The lack of integrity of data generated from the lower levels may well be in part the direct consequence of its low utilization in decision-making in the service. These have been identified by a number of health sector assessments in Ghana[1]. It becomes tempting to blame the original source of data for any and all errors that appear downstream. However, any efforts to improve data quality will only be meaningful when these are part of an overarching quality culture that must emanate from the apex of the organization.[2] This is what is being encouraged and promoted since the introduction of DHIMS2.

Currently, existing GHS data quality audit activities conducted is collected into a useful data repository (DHIMS2) and these have been used to develop tools and training modules to ensure correct and consistent data at every level in the Service. Refer to current efforts. (*Date validation manual*)

8.2. Improving the quality of data collection

Enhancing data quality and integrity begins with standardizing the source documents designed for data collection and then effectively integrating the myriad of disparate data sources. This also requires the regular review of source documents by schedule and providing training on how to use the data collection tools.

A regular schedule is prepared to review and update the standardized data collection tools. Subsequent training using the data collection tools is also standardized with compulsory participation of all service providers and supervisors. These activities is

[1] Agana et al., 2009; Institutional Care Division (ICD), Rapid Assessment Report on Clinical Information, 2007; and Data Quality Audit for Malaria in Ghana by JSI 2009)

further augmented by institutions through monthly data validation sessions at all service delivery points before data reports are signed, stamped and forwarded by the officer designated for the purpose.

Where data is submitted upwards and to succeeding levels in hard copy, a hard copy of the original is kept in the submitting institution's file. This is well-labelled (dated, stamped, named, batched) and stored in an orderly fashion for easy retrieval. Where the data are transmitted electronically using external storage devices (pen/flash drive, CD-Rom, external hard drive) the copy of the original is filed properly in clearly identifiable folders with regular backup. Where data is transmitted by email, the original email should not be deleted (refer to Standard Operating Procedures for Data Management).

8.3. Standard Operating Procedures

GHS has developed a set of Standard Operating Procedures (SOPs) to guide data management. These SOPs for improving data quality are a set of written instructions that document the routine or repetitive activities to be followed by the various levels of data collection and aggregation in the GHS. It details regularly recurring work processes that are to be conducted for data collection, data processing, analysis, use and transmission. The SOP also facilitates the way activities are performed to enhance compliance and maintain consistency with technical and quality guidelines for quality data. Training is organized at all levels in the service in the use of the SOPs for data management.

8.4. Improving Timeliness, Completeness and Accuracy of Transmitted data

Data is collected, collated, analyzed and delivered within an agreed period. To ensure adherence to deadlines, a data collation and validation team is responsible for data management and submission at each level.

Timeline for data submission within the service is as shown in the Table below

TABLE 6: TIMELINES FOR DATA SUBMISSION BY LEVEL

Reporting Level	Receiving Level	Frequency	Deadline
Facilities/Sub districts to Districts	District	monthly	5th of the following month
District to Regions	Regions	monthly	15th of the following month
Regions to GHS Headquarters	GHS Headquarters	monthly	25th of the following month

GHS Headquarters to MOH	MOH	Quarterly	Two month after the quarter

Transmitted data must be complete. The reported data must include inputs from all reporting units, all required fields must have valid data, and the document must be signed stamped and dated by the officer responsible.
All data submitted must be consistent with what is on the original file at all times. The deployment of the web-based DHIMS2 has contributed significantly to improving the timeliness and completeness of reporting.

8.5. Data Quality Audit

GHS has initiated its process of periodic audit of reported data at point of data generation, collection or aggregation. The audit teams is made up of personnel from a higher level (e.g. national to regional; regional to district, district to facilities). These teams make scheduled visits to data aggregation levels or facilities and audit their reported data. This exercise provides the platform for a more robust and rigorous data management system that reveals strengths and identification of gaps in data.

This exercise include a data verification process to track published data to the generation level while checking on all the dimensions of data quality (consistency, accuracy, completeness and timeliness). The data verification process include the examination of all source documents to ascertain the various dimensions of data quality (refer to guidelines for data verification).

In addition, the data quality audit process is a capacity-building activity and offers technical assistance to develop action plans that addresses the gaps identified in the data management system.

8.6. Feedback Processes

Immediate feedback should consist of a quick eyeballing looking at completeness (all relevant fields completed, availability of signature, date and stamp), timeliness and accuracy of the report and submit a quick report to the sender. This immediate feedback to the sender offers the opportunity for quick updates for completeness and correction of minor errors and it serves as a capacity building activity.

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Written feedback is based on more in-depth analysis of data from various sources. This technique of feedback unearths data inconsistencies, enables analysis and comparison of trends and performance with peers. The process looks at the standards, the performance of the various districts and facilities and the gaps that are to be filled.

A technical data quality team preparing the feedback reports pays attention to all the data quality dimensions. Districts, Regions and National are supposed to send monthly feedback to the lower levels detailing data quality issues as well performance issues.

Regular feedback on all reports submitted is encouraged at performance review meetings. These review give opportunity to carry out peer comparison, receive explanations and opportunities for learning.

8.7. Documentation

Any feedback given, whether in relation to completeness, accuracy, timeliness or consistency is filed. In addition, any suggestions made to guide the resolution of observed gaps in the report should be documented and filed.

Data already submitted should only be changed when there is enough documentation on the reasons for change and the updates transmitted to all levels at the same time. This documentation should be appropriately filed.

9. REPORTS

9.1. REPORTING MILESTONES

All districts, regions and divisions are expected to provide quarterly updates on their routine activities and any new initiatives planned for the year. All Divisions, Regions, Districts and Hospitals are expected to produce half-year and annual reports.

9.2. PROGRAMMES/PROJECT MONITORING

Regions and Divisions implementing programs and/or projects are to provide quarterly updates using the project/programs-monitoring matrix. The required information includes budget execution regarding the project or program, and the status of implementation.

9.3. FINANCIAL REPORTS

All BMCs in the GHS submit monthly and quarterly updates on their revenue and expenditure depending on the type of financial data and the reporting level - as indicated in the table below. Receipts from donors are reported as schedules in the consolidated financial reports for the period under review.

TABLE: FINANCIAL REPORTING FRAMEWORK - CONSOLIDATED FINANCIAL REPORT

Type of Report	Recipients	Frequency	Deadline
Consolidated GOG Expenditure Budget status Report	Partners, MOF, CAGD MoH	Quarterly / annually	3 months after period
Consolidate Donor (SBS) Expenditure Budget status Report	"	Quarterly / annually	3 months after period
Consolidated IGF Expenditure Budget Status Report	"	Quarterly / annually	3 months after period
Consolidated IGF Revenue Budget Status Report	"	Quarterly / annually	3 months after period
Consolidated Balance Sheet (By BMCs, SoF)	"	Quarterly / annually	3 months after period

Consolidated Revenue and Expenditure Statement	"	Quarterly / annually	3 months after period
Consolidated Cash Flow Statement (By BMCs, SoF)	"	Quarterly / annually	3 months after period
Consolidated Programme Financial Reports (By disease burden, By donor type)	"	Quarterly / annually	3 months after period

9.4. FINANCIAL AUDIT REPORTS

9.5. GHANA HEALTH SERVICE REPORT

An annual progress report indicating the extent to which goals and objective of the POW are being achieved should be prepared every year by Districts, Regions, Programmes, Divisions and National. The report will rely on the various reviews carried out in the service. Half-year reports should also be written by the various levels to track the performance against set targets.

10. GOALS AND OBJECTIVES OF THE MONITORING AND EVALUATION SYSTEM WITHIN THE GHANA HEALTH SERVICE

The overall goal of the Ghana Health Service M&E system is to support the Ghana Health Service to achieve the outcomes and impact articulated in the Health Sector Medium Term Development Plan, as well as the programme of works developed from it. This will be done by:

Improving Data management over the next four years
Developing Human capacity for M&E over the next four years.
Supporting Facilities, Districts, Regions and the National level with resources to monitor performance of the sector over the next four years.
Improving Leadership and governance at all levels over the next four years to enhance the use of data for decision making

However there are gaps in the attainment of M&E objectives in the areas of Work force, Resource Management and leadership and governance that need to be addressed,

STRATEGIES TO ADDRESS MONITORING AND EVALUATION GAPS

Work force gap

a. Build and continue to improve human capacity for M&E at all levels
b. Increase human resource for M&E activities
c. Put in place continual in-service training in M&E for all staff

1. **Resource Management Gap**
   a. Develop and ensure adequate deployment of data collection tools to improve data management
   b. Revise and update data collection tools to improve data quality
   c. Revise and align inputs, outputs and outcomes within sector PoW
   d. Encourage joint target-setting
   e. Collate, harmonize and document existing M&E processes
   f. Expedite documentation and circulation of Standard Operating Procedures (SOP)
   g. Improve and support ICT infrastructure base at all levels

2. **Leadership and Governance gap**
   a. Make M&E a priority in PoW

b. Advocate for increase budget allocation from internal and external sources to create a more robust M&E system.
c. Strengthen two-way feedback mechanisms to identify gaps requiring revision, greater coordination and alignment of process indicators.

11. M&E ACTIVITIES, TIMELINES AND BUDGET

TABLE 8: M&E Activities and Timelines

DESCRIPTION OF MAJOR ACTIVITIES	KEY DELIVERABLES	TIMEFRAME				COMMENTS
		2014	2015	2016	2017	
RESOURCE MANAGEMENT GAP						
1. Improve Data Management						
a. Improve systems for data collection, storage analysis and use at all levels of the health system	1. The DHIMS2 Software improved. 2. Electronic registers introduced at all levels improved to improve data collection. 3. Feedback and technical support to the Regions on DHIMS2 provided. 4. Technical boot camp organized to address issues in DHIMS2 5. Staff trained on data collection, analysis, reporting and use of data		X	X	X	Raise enough funds to execute these activities effectively and efficiently

b. Continue the Printing and distribution of primary data capture forms/registers to both private and public health facilities in the Districts.	Registers and data capture tools available at all facilities/districts in Ghana both private and public		X	X	X	Monitor to see every facility is using the prescribed primary data capture forms/registers
c. Integrated Monitoring (Managerial) Visits to Regions and District	Integrated monitoring visits held.		X	X	X	Will be done twice in a year
d. Technical Monitoring visits to Regions and Districts by the Divisions	Technical Monitoring visits by the Divisions held.		X	X	X	Will be done twice in a year
2. Improve the Infrastructure for Data Management and Reporting						
a. Procure office/ICT equipment (desk top, lap tops, printers scanners, accessories, smart phones and internet modems	1. Computers /laptops/tablets, procured for the various levels of service delivery. 2. National infrastructure improved to support DHIMS2. 3. District internet access improved		X	X	X	ICT equipment are very critical to data management. Adequate funds must be raised to provide the equipment needed to undertake data management activities
b. Host and maintain Server for DHIMS2	Server for DHIMS hosted and accessible for data entry, analysis and reporting.		X	X	X	Quarterly maintenance of the Server
HEALTH WORKFORCE						

GAP						
1. Develop Human Capacity for M&E						
a. Train National, Regional and District Teams on Monitoring and Evaluation	National, Regional and District Teams trained in Monitoring an evaluation		X	X	X	Personnel involved in M &E should be given refresher training twice a year aimed to build capacity over the four years of the HSMTDP implementation
b. Train National, Regional and District Teams on Data Quality Audit	National, Regional and District Teams trained in data quality audit		X	X	X	National focal persons for the regions should conduct data quality audit twice a year
c. Train District and Regional Teams on SOPs on data management and Data Utilization.	Regional and District Teams trained		X	X	X	
c. Develop pre-service training modules for health service records/data management for health training schools	Pre-service modules developed in use in the health training institutions		X	X	X	Train tutors and provide necessary material for them to teach the students
LEADERSHIP AND						

GOVERNANCE GAP						
1. Improve the use of Data for decision making						
a. Support M&E process in the Ghana Health Services	*1*. M & E Plan reviewed to align with new HSMTDP 2. Capacity built in M &E at all levels. Train Regions in the use of routine data or operational research.		X	X	X	Regional and district M&E officers capacity should be built
b. Annual Regional performance reviews	District and Regional Annual reviews held		X	X	X	Regional and District Managers should analyze and use their data for decision making at their level. National Observer Teams to the regional reviews should make a copy of their findings to the region
c. Senior Managers Meetings	Senior Managers Meetings Held		X	X	X	Decisions taken at senior management meetings that concern the institutions at lower level should be communicated timely

d. GHS Headquarters Annual review meeting	GHS Headquarters annual review meeting held		X	X	X	Invite some regional and district directors to observe the headquarters review
e. Half Year Review performance review meetings held at the Regional and District Levels	Held once a year					

TABLE 9: BUDGET FOR THE MONITORING AND EVALUATION PLAN

			2015		2016		2017		
Number	Programmed Description	Description of Item or activity	Detail Descriptions	Cost $	Detail Descriptions	Cost $	Detail Descriptions	Cost $	Total Cost $
A	**Improve Data Management**								
	Improve systems for data collection, storage analysis and use at all levels of the health system	1. The DHIMS2 Software improved. 2. Electronic registers at all levels improved to improve data collection. 3. Feedback and technical support to the Regions on DHIMS2 provided. 4. Technical boot camp organized to address issues in	1.Improvement of DHIMS2 Software 2.Improvement of Electronic register at all levels to improve data collection 3. Training of staff on data collection, analysis, reporting and use of data	500,000	Organization of refresher training on data collection analysis, reporting and the use of data at all levels	200,000	Organization of refresher training on data collection analysis, reporting and the use of data at all levels	200,000	900,000

		DHIMS2 5. Staff trained on data collection, analysis, reporting and use of data							
	Print and distribute primary data capture forms/registers to both private and public health facilities in the Districts.	Registers and data capture tools available at all facilities/districts in Ghana both private and public	Printing of registers and data collection tools (once a year)	160,000	Printing of registers and data collection tools (once a year)	200,000	Printing of registers and data collection tools (once a year)	200,000	560,000
	Integrated Monitoring (Managerial) Visits to Regions and District	Hold Integrated-monitoring visits.	Will be done twice in a year	80,000	Will be done twice in a year	80,000	Will be done twice in a year	80,000	240,000
	Technical Monitoring visits to Regions and Districts by the Divisions	Hold Technical Monitoring visits.	Will be done twice in a year	100,000	Will be done twice in a year	100,000	Will be done twice in a year	100,000	300,000

B	**IMPROVE THE INFRASTRUCTURE FOR DATA MANAGEMNET AND REPORTING**								-
	Procure office/ICT equipment (desk top, lap tops, printers scanners, accessories, smart phones and internet modems	1. Procure Computers /laptops/tablets, for the various levels of service delivery. 2. Improve National infrastructure to support DHIMS2. District internet access	Aim to continually equip all districts with ICT equipment	350,000	Aim to provide servers for all Regions and strengthen CHIM	1,000,000	New districts equipped	75,000	1,425,000
	Host and maintain Server for DHIMS2	Server for DHIMS hosted and accessible for data entry, analysis and reporting.	Payment will be annually	50,000	Payment will be annually	50,000	Payment will be annually	50,000	150,000
Workforce Gap									
	Develop Human Capacity for M&E								

	Train National, Regional and District Teams on Monitoring and Evaluation	National, Regional and District Teams trained in Monitoring an evaluation	Aimed to build capacity over the four years of the HSMTDP implementation	200,000	Aimed to build capacity over the four years of the HSMTDP implementation	150,000	Aimed to build capacity over the four years of the HSMTDP implementation	80,000	430,000
	Train National, Regional and District Teams on Data Quality Audit	National, Regional and District Teams trained in data quality audit	Training of Regional Teams to train district teams	200,000	Training of Regional Teams to train district teams	150,000	Training of new districts	100,000	450,000
	Train District and Regional Teams on SOPs on records/data management and Data Utilization.	Regional and District Teams trained	SOPs will be reviewed and District/regional teams trained	50,000	Refresher training of District/regional teams SOPs	20,000	Refresher training of District/regional teams SOPs	20,000	90,000
	Develop pre-service training modules for health service records/ data management for health training schools	Pre-service modules developed in use in the health training institutions	Modules will be developed	15,000	Training of tutors of schools in five Regions	100,000	Training of tutors of schools in another five Regions	100,000	215,000
Leadership And Governance Gap									

	Improve the use of Data for decision making								
	Annual Regional performance reviews	District and Regional Annual reviews held	Once a year in all the Regions	80,000	Once a year in all the Regions	100,000	Once a year in all the Regions	100,000	280,000
	Senior Managers Meetings	Senior Managers Meetings Held	Four times in the year	50,000		50,000		60,000	160,000
	GHS Headquarters Annual review meeting	GHS Headquarters annual review meeting held	Once a year	5,000	Once a year	5,000	Once a year	5,000	15,000
	Half Year Review performance review meetings held at the Regional and District Levels	Half year review meetings held	Regions and Districts once a year	50,000	Regions and Districts once a year	50,000	Regions and Districts once a year	50,000	150,000
	GRAND TOTAL			**2,290,000**		**2,405,000**		**1,370,000**	**5,865,000**


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APPENDIX 1
INDICATORS, MATRIX, TARGETS AND MILESTONES FOR MONITORING AND EVALUATION

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
Objective 1: Bridge the equity gaps in geographical access to health services													
1.1	**Number of functional CHPS zones**	2226	2580	2800	**2948**	3648	6000	6000	Routine Data-District/Regional Reports	Number of CHPS zones with CHOs offering home visits and other services (Home visit entails ANC, PNC, Immunization, Growth monitoring, Nutrition counseling etc.)	Quarterly, Bi-annual and Annual	DDHS/RDHS/PPME	Construction of 400 CHPS facilities, Training of 4,000 CHOs and Community Health Committees, Procurement and distribution of motorbikes and basic equipment for CHPS, Capitation grant for CHPS from NHIA, Provision of tablets for information management, Community registers to capture all children and pregnant women

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
1.2	**Proportion of CHPS zones made functional**	37.1%	43%	46.7%	**49.1%**	66.7%	100 %	100%	Routine Data-District/Regional Reports	**Numerator:** Number of functional CHPS zones **Denominator**: Number of demarcated CHPS zones	Quarterly, Bi-annual and Annual	DDHS	
1.3	**Equity geography:(Resource) Doctor to population**	11.5	16.8	15.0	**13.3**	10.0	9.5	9.0	Routine Data-District/Regional Reports/HRD	Region with highest ratio / region with lowest ratio	Quarterly, Bi-annual and Annual	DDHS/RDHS/PPME	Seek accreditation for all Hospitals for second year house officers posting (MOU with Specialists)
1.4	**Equity geography: Nurse to population**	1.86	1.99	1.9	**1.88**	1.85	1.8	1.75	Routine Data-District/Regional Reports/HRD	Region with highest ratio / region with lowest ratio	Quarterly, Bi-annual and Annual	DDHS/RDHS/PPME	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
1.5	**Equity geography:(Resources) Midwife to WIFA population**	1.75 (1.86)	1.99	1.9	**1.84**	1.5	1.4	1.2	Routine Data-District/Regional Reports/HRD	Region with highest ratio / region with lowest ratio	Quarterly, Bi-annual and Annual	DDHS/RDHS/DG	Procure and distribute delivery equipment to facilities, Engage midwives on pension for deprived communities, Regions should train and retain midwives
1.6	**Equity geography: Supervised deliveries**	1.48	1.57	1.5	**1.45**	1.4	1.3	1.2	Routine Data-District/Regional Reports/HRD	Region with highest coverage / region with lowest coverage	Quarterly, Bi-annual and Annual	DDHS/RDHS	
1.7	**Equity poverty: U5MR**	2.04			**2.4**	1.9	1.8	1.6	DHS/MICS	U5MR in lowest wealth quintile / U5MR in highest wealth quintile			
Objective 2: Ensure sustainable financing for health care delivery and financial protection for the poor													

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
2.1	**Proportion of total MTEF health allocation to GHS**								MOF/MOH/PPME/CONTROLLER	Total GOG budget incl. IGF to GHS / total GOG budget incl. IGF to health	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	
2.2	**Budget execution rate (Goods and Service as proxy)**	86.80%		95%	**61**	65	70	80	MOF/MOH/PPME/CONTROLLER	Total disbursement from MOF to GHS / total sector (health) budget.	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	
2.3	**Budget execution rate (Employee compensation)**			100	**100**	100	100	100	MOF/MOH/PPME/CONTROLLER	Total disbursement from MOFEP to GHS / total GHS budget.	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	
2.4	**Execution rate of funds allocated through the GIFMIS (Goods & Service)**					**0%**	50%	50%	MOF/MOH/PPME/CONTROLLER	Total disbursement from GIFMIS/Total funds allocated on GIFMIS	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	Training of Divisional Directors on monitoring allocation on GIFMIS
2.5	**Proportion of GOG compensation of employees budget to total GHS budget**				**99.8%**	**95%**	94%	90%	MOF/MOH/PPME/CONTROLLER	GOG employee compensation paid over total service expenditure	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	Hold quarterly validation meetings with regions
2.6	**Proportion of total budget financed through IGF**								MOF/MOH/PPME/CONTROLLER	Total IGF in budget / total budget	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
2.7	**% of IGF revenue from NHIA clients**					80%	85%	88%	Financial Reports	Total IGF from NHIA/Total IGF	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	
2.8 .	**% of Total expenditure (Goods and Services) from Donor support**					50%	30%	25%		Total Donor inflows/Total inflow of funds from all sources	Quarterly, Bi-annual and Annual	FD/PPME/RDHS	
Objective 3 Improve efficiency in governance and management of the health system													
3.1	**Doctor : Population ratio**	1:10,452	1:10,170	1:9,500	**1:9,018**	1:8,000	1:7,500	1:7,000	Human Resource and Development Division Reports	The ratio of number doctors to total population **Numerator**: Number of doctors in the public sector **Denominator**: Total population	Annual	RDHS/Director Human Resource and Development Division	
3.2	**Midwife : WIFA Population Ratio**	1:1,611	1:1,688	1:1,500	**1:1,478**	1:1,300	1:1,200	1:1,100	Human Resource and Development Division Reports	The ratio of the number midwives to WIFA **Numerator:** Total number of midwives **Denominator**: Number of WIFA	Bi-Annual/Annual	RDHS/Director Human Resource and Development Division	Increase intake into midwifery schools, Encourage CHOs to do midwifery

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
3.3	**Nurse : Population ratio including CHNs**	**1:1,084**				1:1,800	1:1,500	1:1,000	Human Resource and Development Division Reports	Number of nurses incl. community health nurses / population	Annual	RDHS/DDHS/Director Human Resource and Development Division?	
3.4	**Percentage of research disseminated locally(at all level)**					100	100	100	Reports/Performance reviews	Number of research disseminated locally/Number of research conducted	Annual	Health facility/DDHS/RDHS/RDD	
3.5	**Percentage of tracer drug availability**					95	98	100	ICD/SSDM	Number of tracer drug available at any point in time/Expected number of tracer drugs	Monthly/Quarterly	Medical supt/DDHS/RDHS	Scale up LMIS to all RMS, Training staff in procurement and Logistic management. Institute framework Procurement for GHS
3.6	**Proportion of NHIS claims settled within 12 weeks**			0%	**0%**	2%	10%	15%	Financial returns/NHIA	Number of claims settled within 12 weeks / total number of claims settled	Half-Yearly/Quarterly	Medical supt/DDHS/RDHS	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
3.7	**Proportion of health budget (goods and services) allocated to research activities**				**0%**	**5%**	**5%**	5%	Research Reports/Budgets	Amount of MOH budget allocated for research / total MOH budget for goods and services	Quarterly	Medical supt/DDHS/RDHS	
3.8	**Proportion of BMC with approved IGF budgets**								Regional reports, copies of budgets available at regional directorate	Number with BMC with approved IGF budgets/Total number of BMC with IGF	Annual	RDHS/DG/PPME/Finance	
3.9	**Percentage of Regional BMCs with Timeliness of Financial Reports**					100%	100%	100%	Financial Returns	Number of reports received on time/total nunber expected.	Monthly/quarterly/Half-Yearly/Annually	Facility level/BMC level/District/Region/National	
3.10	**Proportion of financial audit observations resolved**					100%	100%	100%	Auditors management letter, Auditors ML status/ Clearance report	Number of audit reservations resolved/Total number of audit reservations	Annual	BMC/DDHS/RDHS/DG	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
3.11	**Timeliness of service data reporting (%)**		37.8	70	**64.8**	75	80	85	DHIMS	Number of data reported into DHIMS/Total number data expected.	Monthly/quarterly/Half-Yearly/Annually	Facility level/BMC level/District/Region	Provide feedback to regions/districts, Undertake technical support visits to Regions, Support districts with computers and modems
3.12	**Service data completeness**		74.3	85	**81.5**	95	97	99	DHIMS	Number of complete data sets received/Total number of data sets expected	Monthly/quarterly/Half-Yearly/Annually	Facility level/BMC level/District/Region	
3.13	**Proportion of vehicles from 0-5 years**				**36**	40%	42%	45%	HASS report	Number of vehicles between 0-5years/. Total number of vehicles in fleet	Annually	Facility level/BMC level/District/Region	
3.14	**Proportion of motorbikes 0-3 years old**				**45%**	45%	50%	52%	HASS report	Number of motor bikes between 0-3years/. Total number of motor bikes in the fleet	Annually	Facility level/BMC level/District/Region	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
3.15	**Proportion of in-service trainings incorporating policy orientation**					100%	100 %	100%	HRD reports, performance reviews	Number of trainings with policy orientations/Total number of in-service trainings	Monthly/quarterly/Annual	DDHS/RDHS/HRD	
Objective 4: Improve quality of health services delivery, including mental health services													
4.1	**Proportion of public hospitals offering mental health services**		115 (53.0%)	125	-	70	75	80	Hospital report/ Mental Health Authority	No. of public hospitals offering mental health services / total no. of public hospitals	Annually	Facility level/District/Region/ICD	Deployment of community psychiatrist and physician assistant psychiatrist,
4.2	**Proportion of public hospitals offering Traditional medicine service**					>8	>10	>13	Performance reviews/reports/ICD/	No. of regional and district public hospitals offering traditional medicine practice / total no. of regional and district public hospitals	Annually	Facility level/District/Region/ICD	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
4.3	**Institutional Malaria Under 5 Case Fatality Rate**	0.6	0.7	0.6	**0.52**	0.5	0.48	0.45	DHIMS/	No. of children U5 who die as a result of malaria per year / no. children admitted and diagnosed with malaria	Quarterly/Half-Yearly/Annualy	Medical supt/Medical directors/DDHS/RDHS/ICD	Train clinical staff on malaria case management, improve the availability of RDTs anti-malarials in all health facilities, BCC to encourage caregivers to bring their children promptly for treament. Encourage prompt home based treament for malaria.
4.4	**Institutional all cause mortality**					33	30	28	DHIMS/	All institutional deaths / all discharges and deaths	monthly/Quarterly/Half-yearly/Annually	Medical supt/Medical directors/DDHS/RDHS/ICD	
4.5	**Surgical site infection rate**				**5.26%**	5	4.8%	4.5%	Hospital report/ICD /DHIMS	No. surgical wound infected among inpatients / total no. surgical interventions among inpatients	monthly/Quarterly/Half-yearly/Annually	Medical supt/Medical directors/DDHS/RDHS/ICD	quality assurance,

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
4.6	**Number of cataract surgeries done**				**18,140**	25,000	28,000	30,000					
4.7	**Average number of drugs per patient encounter**	3.5	-	3	**2.8**	2.5	2.2	2.2					
4.8	**Percentage of public hospitals with trained emergency team**	-	-	100%	**-**	100	100	100	Hospital report/ICD	No. public hospitals with trained emergency team / total number of public hospitals	Quarterly/Half-Yearly/Annualy	Medical supt/Medical directors/DDHS/RDHS/ICD	emergency preparedness,creating emegency mgt centers at facilities, training of teams, 24 hr emergency service,
Objective 5 Enhance national capacities for the attainment of the health related MDGs and sustain the gains.													
5	**CYP**	1,222,920	1,592,982	1,600,000	**2,200,000**	**2,500,000**	**>2,550,000**	**>2,700,000**	DHIMS	The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period	monthly/Quarterly/Half-yearly/Annually	Facility/DDHS/RDHS/National	
5.1	**Family Planning Acceptor rate**	24.90%	26.10%	28%	**29.3**	30	32	35					

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
5.2	**Infant Mortality Rate**	53	N/A	<30	**41**	30	35		DHS/MICS	No. of deaths of infants below 1 year / 1,000 live births	Every two years	Facility/DDHS/RDHS/National	Immunnisation, Treatment of ARI/Malaria and Diarrhoea, Growth monitoring, BCC
5.3	**Institutional Neonatal Mortality Rate**	5.5	6.1		**4.3**	4	3.5	3	DHIMS/	No. of institutional deaths of neonates before the age of 28 days /1,000 institutional live births	monthly/Quarterly/Half-yearly/Annually	Facility/DDHS/RDHS/National	Kangaroo mother care, essentail noenatal care, provision of incubators,training, pediatrician champion
5.4	**Under-5 Mortality Rate**				**60**		55		DHS/MICS	No. of deaths of children below 5 years / 1,000 live births			
5.5	**Neonatal Mortality Rate**				**30**		25		DHS/MICS	No. of deaths within the first 28 days of life / 1,000 live births			
5.6	**Maternal Mortality Ratio**				**350**	185	150	130	Maternal Health Survey	No. of maternal deaths / 100,000 live births	Annually		
5.7	**Institutional Maternal Mortality Ratio**	193	154	140	**143.8**	140	137	135	DHIMS//Performance review	Institutional Maternal deaths per 100,000/Total number of live births in the year.			Focus ANC, Supervised delivery, Comprehensive

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
													emergency obstetric care, procuremnt and disttribution of equipment, LSS Training
5.6	**HIV prevalence rate**	1.30%	1.20%	1.60%	**1.30%**	<1.0%	<0.9 %	<0.8 %	NACP Sentinel survey	Proportion of the ANC clients aged 15-24 years who are tested HIV+ at NACP sentinel sites	Annually		BCC on HIV, Encourage testing for HIV, Treatment of HIV positive patients, tracking and keeping positives on treatment
5.7	**All cases of HIV+ treated with ARVs**				**51,814**	65,914	80,014	90,000	NACP/DHIMS 2	Total number of HIV+ positive patients in the country who are currently on treatment	Monthly/Quarterly/Half-yearly/Annually	DDHS/RDHS/	BCC on HIV, Encourage testing for HIV, Treatment of HIV positive patients, tracking and keeping positives on treatment
5.8	**Proportion of pregnant women tested for HIV and received results for PMTCT**					60%	66%	70%	DHIMS/NACP/FHD	Number of pregnant women tested for HIV through ANC services/ Total number of expected pregnancies	Monthly/Quarterly/Half-yearly/Annually	DDHS/RDHS/	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
5.9	**Proportion of HIV+ pregnant women who received ARVs for PMTCT**		49.30%	90%	**65.90%**	70	75%	80%	NACP	Number of HIV positive pregnant women who received ARV for PMTCT/ HIV positive pregnant women as per NACP sentinel survey	Monthly		Increase the number of facilities offering ARV to mothers, Track pregnat women, ensure availabity of ARV
5.10	**Proportion of children U5 who are underweight**				**11%**	10%	8%	7%	DHIMS	Total no. of children U5 who are weighed / total no. of children	Monthly	DDHS/RDHS	comm based rehab centers, nutrition education, growth monitoring,CMAM
5.11	**Proportion of children fully immunized (proxy Penta 3 coverage)**	87.8% (88.0%)	86.00%	95%	**90%**	95	95	95	DHIMS2	Number received Penta 3 / Estimatd population of children under 1 years			Implement strategies to reach children in urban hard to reach,identify barriers and bottlenecks to reaching every child using microplans. Use technology to facilitate the following up of all children(e-tracker), improve data management

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
													for EPI
5.12	**% of children immunized- Measles1**	89%	84%	95%	**88%**	90	95	95					
5.13	**Antenatal Care Coverage 4+**	72.3	66.30%	85%	**76%**	85	90	95	DHIMS	No. of women undergoing ANC service by a skilled health provider at least four times during pregnancy / total number of expected pregnancies	monthly/Quarterly/Half-yearly/Annually	Facilty/DDHS/RDHS/National	focused anc,registration and tracking of all pregnant women by CHOs, domiciliary deliveries, use of partograph
5.14	**Proportion of deliveries attended by a trained health worker**	58.50%	55.30%	60%	**56.70%**	60	65	70	DHIMS	No. of deliveries attended by a trained health worker / expected number of deliveries	Monthly/Quarterly/Half-yearly/Annually	Faciliyty/DDHS/RDHS/National	
5.15	**Still birth rate**	2	1.8		**1.8**	1.7	1.6	1.5	DHIMS	Number of still births (fresh and macerated) /Total deliveries	monthly/Quarterly/Half-yearly/Annually	Faciliyty/DDHS/RDHS/National	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
5.16	**% of hospitals offering Comprehensive Emergency obstetric neonatal care**	N/A	N/A	50%	**N/A**	60	70%	80%	DHIMS	Number of hospitals offering comprehensive EmOnC/Total number of hospitals			Facility surveys, procurement and distribution of equipment, Training of midwifes on LSS.
5.17	**Postnatal care coverage for newborn babies**	-	-	75%	**73.30%**	80	83	85	DHIMS	No. of newborn babies getting the services of skilled health providers within 2 and 7 days of birth/ Total number of live births	Monthly/Quarterly/Half-yearly/Annually	Facilty/DDHS/RDHS/National	
5.18	**Proportion of children under 5 years sleeping under ITN**	41.50%	N/A	80%	**54.60%**	NA	62	N/A	DHS/MICS	No. of children under 5 years who slept under an ITN during the previous night / total number of children under 5 years			Routine distribution of LLINs at CWC and schools, BCC on the use of LLINs
5.19	**TB case notification rate**	60.80%	59.83	75	**57.50%**	58	62	75	NTP/DHIMS				Awareness creation on TB, Test, treat and track strategy will be used, Transport of sputum for mi-

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
													croscopy, create more microscopy centres
5.20	**TB treatment success rate**	86.20%	87.16%	90%	**92%**	95%	95%	95%	DHIMS2		Annually		
Objective 6 Intensify prevention and control of non-communicable and other communicable diseases													
6.1	**Non-AFP polio rate**	1.60%	2.70%	≥2/100,000	**2.95%**	≥2/100,000	>2	>2	DHS/MICS	No. of non-polio AFP cases reported / 100,000 children 0 - 15 years	Annually	DDHS/RDHS/National	Clinicians sensitization on AFP,Train surveillance officers on collecting adequate samples Send speciments for testing

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
6.2	**Guinea worm surveillance system (contained)**	87.00%	93%	100%	**Certified**	**0**	**0**	**0**	GWEP/PHD	Proportion of Guinea worm cases that are contained out of the total number of cases seen. **Numerator**: Number of Guinea Worm cases contained . **Denominator**: Total number of Guinea Worm cases reported.	Quarterly/Bi-Annual/Annually	Programme Manager GWEP	
6.3	**Cholera case fatality rate**				**0.84**	<1	<1	<1					
6.4	**Proportion OPD attendance due to malaria**		52%	<45	**30.6**	30	28	26	DHIMS	No. of OPD attendants diagnosed as malaria / total OPD attendants	Monthly/Quarterly/Half-yearly/Annually	DDHS/RDHS/PPME	
	Proportion of malaria cases that is laboratory confirmed(RDTs and Microscopy)		48	45	**73.5%**	75%	78%	80%	DHIMS	Malaria cases that were confirmed (RDTs and Microscopy)/ Total suspected Malaria cases	Monthly/Quarterly/Half-yearly/Annually	DDHS/RDHS/PPME	

		2012	2013	Target 2014	Actual Performance 2014	TARGET 2015	TARGET 2016	TARGET 2017	Data Source	Measurement	Monitoring Frequency	Responsibility/Level	INTERVENTIONS THAT ARE BEING USED
6.5	**Population prevalence of hypertension**				4.2	4.5	5	5.5	DHS	No. persons BP above specified level / total no. persons surveyed	Every Five years	DDHS/RDD/PHD	

Milestones

Health Sector Objectives				MILESTONES			
				2014	2015	2016	2017
HO:1 Bridge the equity gaps in geographical access to health services				1. Capital investment plan developed	Revised CHPS strategy implemented	Coverage of specialized services at lower level expanded	One flagship telemedicine project based in one teaching hospital established

				2. Roadmap for implementation of a common targeting approach for improved identification of the poor developed with MOH support	Revised staffing norms and deployment plan developed and implementation begun	Review of CHPS strategy undertaken with stakeholders, and rezoning of CHPS completed	Financing strategy developed for the sector to ensure effective resource mobilization
HO:2 Ensure sustainable financing for health care delivery and financial protection for the poor				Develop implementation plan for Health Financing Strategy	Resource allocation criteria developed	Implement the Health Financing strategy	Appropriate mix of provider payment mechanisms established

				Revised Health Bills submitted to Finalising the Parliament	Leadership and management in-service training initiated	System for performance contracting introduced	Composite planning undertaken in 50% of districts. 2 questions included in DHS on client satisfaction and knowledge of patient charter
HO: 3 Improve efficiency in governance and management of the health system				· Comprehensive leadership programs developed for the health sector . • Finalise the sector staffing norms	Health sector response to decentralization developed. • Staffing norms implemented . • Research agenda developed	LIs for passed health legislation developed	Private sector data fully integrated into the public system
				performance contract with Agency head	performance contact to include all senior staff	contract at all levels	performance contract

HO:4 Improve quality of health services delivery including mental health services s				Hospital strategy developed	LI for Mental Health Bill develop Mental health strategy implemented	Hospital emergency and referrals, protocols and guidelines implemented. Quality of care standards and patient safety strategy fully implemented	mentorship program for specialist / Consultants to support lower levels introduce
				Midwifery certificate course for CHNs reactivated	50% of district hospitals equipped with Comprehensive EmOC equipment	Pneumococcal and rotavirus vaccines successfully introduced	90% of district hospitals and 70% of health centres equipped with C/BEmOC equipment respectively.Adolescent health corners established in 30 hospitals
Ho5: Enhance national capacity for the attainment of the health related MDGs and sustain the gains				MAF implementation improved	Neonatal policy developed	Evaluation of new vaccines done	Maternal mortality survey carried out
				National cancer plan developed	1. Universal coverage of ITN/Ms achieved. 2. Elimination status of Guinea Worm and polio maintained	1. Healthy lifestyles integrated into basic school and teacher training college curricula. 2. 50% reduction in Yaws prevalence	1. Emergency response strategy for diseases of epidemic potential reviewed. 2. Elimination status of guinea worm and polio maintained

						achieved	
HO6: Intensify prevention and control of non communicable and other communicable diseases				Policy on climate change developed. Non communicable disease policy and strategy finalized . National nutrition policy finalized	International conventions and treaties including frame work convention on tobacco control (FCTC implemented	Strategic plan for under provided specialist services eg dermatology, physiotherapy developed	Improve orthotics and prosthetic services institutionalize
				Referral policy and guidelines developed	Community mental health strategy developed (and in place?)	Functional ambulance stations in 60% of district capitals	2 additional halfway homes established for reintegration of former psychiatric patients


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