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# ENHANCING LINKAGES WITH VERTICAL HEALTH FUNDS

COUNTRY CASE STUDIES OF GHANA AND SIERRA LEONE AND  
A COMPARATIVE ANALYSIS

**OCTOBER 2007**

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## COUNTRY CASE STUDIES OF GHANA AND SIERRA LEONE AND A COMPARATIVE ANALYSIS



**Management Systems International**

**Corporate Offices**

600 Water Street, SW

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Enhancing Linkages with Vertical Health Funds Country Case Studies  
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### **DISCLAIMER**

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## ACRONYMS

HIV/AIDS	Acquired Immune Deficiency Syndrome
CCM	Country Coordination Mechanism (GF)
DACO	Development Assistance Coordinating Office
DHMT	District Health Management Team
DMO	District Medical Officer (Sierra Leone)
DfID	Department for International Development (U.K.)
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GOG	Government of Ghana
GOSL	Government of Sierra Leone
HDI	UN Human Development Index
ICC	Inter-Agency Coordination Committee (GAVI)
IEC	Information, Education and Communications
INGO	International Non-Governmental Organization
IRCBP	Institutional Reform and Capacity Building Project (Sierra Leone)
LFA	Local Fund Agent (GF)
MOF	Ministry of Finance (Sierra Leone)
MOH	Ministry of Health (Ghana)
MOHS	Ministry of Health and Sanitation (Sierra Leone)
MSF	Médecins sans Frontières (Doctors without Borders)
NACP	National AIDS Control Program
NaCSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
PR	Principle Recipient
SPA	Strategic Partnership with Africa
SWAP	Sector-Wide Approach
TB	Tuberculosis
UNDP	United Nations Development Programme
UHHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHF	Vertical Health Fund
WHO	World Health Organization

# 1. BACKGROUND

## 1.1 Introduction

Ghana and Sierra Leone present a dramatic development contrast. The Department for International Development (DfID) calls Ghana an “island of peace and stability” while Sierra Leone is still recovering from a devastating ten-year civil war. Like other African countries, health is a major concern. A concerted effort has been made to thwart epidemic HIV/AIDS rates plaguing other parts of the continent, which have the ability to undercut a country’s social, economic, and labor base. However, other health issues receive significant attention, including malaria, the largest killer disease in both countries. The international community observed that resources needed to be increased substantially to address specific health issues. In response, they created several vertical health funds (VHFs), which entered countries vertically to target specific diseases or other health issues. These funds are supposed to be additive to the government’s existing health funding. Since their creation, these funds have been assessed from the donor perspective in various reports.<sup>1</sup> Yet, less is known about recipient government and civil society experiences and concerns with these funds and how they are integrating them into the larger framework of each country’s health care systems.

## 1.2 Purpose of the Study

Through its participation in the Strategic Partnership with Africa (SPA), the United States Agency for International Development (USAID) funded the first-ever country perspective on VHFs. Field work took place in both Ghana and Sierra Leone in late September and early October 2007. Two consultants from Management Systems International, a US-based development organization, met with numerous national government personnel, and to a more limited extent, regional and district personnel and civil society organizations working in health.

The Paris Declaration on Aid Effectiveness served as a useful reference point when discussing VHFs. The Declaration established the following principles:

- Ownership of activities by country partners
- Alignment of activities with national development strategies
- Harmonization among development partners for greater impact
- Results as the goal of management
- Mutual Accountability where both recipients and donors are held to certain performance criteria

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<sup>1</sup> One such report is “Integrating Global Partnership Programs with Country-led National Programs” by the World Bank’s Global Programs and Partnership Group.

The study's intent is to produce two country perspectives and a comparative analysis on VHF and their impact on aid effectiveness. The report will be presented by the SPA at high-level meetings in the near future.

## 1.3 Methodology

Consultants used a semi-structured interview guide for nearly all meetings where appropriate. The set questions formed a basis for comparison and analysis of key topics. Additional questions targeted to the particular interviewee formed a fuller picture of the VHF environment. The consultants spent nearly seven working days in each country. They made a one-day visit outside the capital to meet with nearby districts. Due to the limited time available, extensive travel around the country was not possible. As such, the information on regional and district levels is narrow and should not be considered comprehensive. Additionally, the purpose of the country perspective sections is to provide a mirror to local VHF views. Neither the consultants' views nor independent analyses are contained in the country reports. The perspective of donors and international non-governmental organizations (NGOs) working on health issues is only woven into the comparative section.

At the conclusion of each country visit, the consultants presented their initial findings at a Ministry of Health-sponsored roundtable. Participants included both persons met and other health actors. Discussion confirmed the consultants' findings or provided a fuller picture of a particular vein of thinking. Findings encapsulated commonly shared views and ones where there were strong differences of opinion. Additionally, the consultants solicited people's views on key requests that they would make to VHFs for their consideration.

The report is organized in the following manner. Section 2 presents the perspective from Ghana. The Sierra Leone findings follow in Section 3. Section 4 contains the comparative analysis. A list of persons met is provided in the Annex.

## 2 GHANA AND VERTICAL HEALTH FUNDS

### 2.1 Country Health Sector Context

Led by a strong Ministry of Health (MOH), Ghana has seen an improvement in the overall health system and service delivery through strong project management and national health policy planning. The Ghana Health Service/MOH lists 23 priority diseases for disease surveillance and response. Malaria, tuberculosis (TB), and HIV/AIDS are all listed among the top causes of morbidity and mortality. Under-five mortality is high with 22 percent attributed to malaria. The TB program was in serious trouble after a donor stopped funding under a Sector-Wide Approach (SWAP) arrangement; increased funds from The Global Fund for HIV/AIDS, TB, and Malaria (GF) allowed for increased capacity,

#### Sector-Wide Approaches

“A SWAP is a process in which funding for the sector – whether internal or from donors – supports a single policy and expenditure program, under government leadership, and adopting common approaches across the sector. It is generally accompanied by efforts to strengthen government procedures for disbursement and accountability. A SWAP should ideally involve broad stakeholder consultation in the design of a coherent sector program at micro, meso and macro levels, and strong co-ordination among donors and between donors and government” (DfID Key Sheets, [www.odi.org.uk/keysheets/](http://www.odi.org.uk/keysheets/)).

higher salaries, and better project management, which have filled the gap. Currently, the TB Program is a success. Dr. Gladys Ashitey, Deputy Minister of Health, said that over the past 10 years, there has been a gradual increase in TB treatment success rates, which currently stands at 73 percent from the 11 percent levels in 1996.<sup>2</sup> According to some people interviewed, vaccinations and immunizations were not seen as a main government priority and that it took the VHF to change that situation. Now the government finances about 55 percent of the total vaccines given, resulting in immunization rates among children nearing 80 percentile or higher.

The MOH recently changed the health policy framework from five pillars<sup>3</sup> to four strategic objectives. The new objectives include: healthy lifestyles and environment; coverage of high quality health, reproduction, and nutrition services; strengthened health capacity systems; and good governance and sustainable financing.<sup>4</sup> The reasons people expressed for the change were broad: a concern that the health sector had stagnated; change in the Ghanaian lifestyle; a simple refinement of the government's health policy; a document better responding to the Millennium Development Goals; and problems in measuring the pillars, especially in terms of the government's global partnerships. Regardless, many did not understand the reason, what the major differences were between the old and new frameworks, and what it meant for the overall system and their position.

The following budgetary information describes the health system-funding context. Of the government of Ghana's (GOG) total budget, health expenditures in 2006 accounted for 15 percent.<sup>5</sup> The MOH's budget is largely broken down into the following: 40 percent from the government (80 percent is allocated for salaries); 30 percent from the National Health Insurance (much is earmarked for clinical care); and 30 percent from donors (60 percent is earmarked and of this amount, 60 percent is not aligned with MOH priorities according to a key government actor). "Following the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS in 2001, the GOG earmarked 15 percent of its health budget for HIV/AIDS activities, and all ministries were asked to create an HIV/AIDS budget line."<sup>6</sup> The Paris Declaration is seen as a tool that the GOG can use to increase alignment with its national policies, subsequently reducing the amount of earmarked funds.<sup>7</sup>

## 2.2 VHFs in Ghana

There is little question that VHFs have substantially increased resources available to Ghana's health sector. In fact, interviewees frequently noted that the health system was in serious trouble and would have collapsed without their arrival. The largest funds operating in Ghana are the GF (see Annex 1 for more detailed information) and the Global Alliance for Vaccinations and Immunizations (GAVI). From MOH documents, the GF accounts for nearly thirty percent of donor funding for health.<sup>8</sup> Other funds exist, including Rollback Malaria and STOP TB, for example, but the larger funds dominate

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<sup>2</sup> "Ghana launches high advocacy and media campaign to mark World TB Day 2007." <http://www.who.org>.

<sup>3</sup> The five pillars were: to increase access; to provide better health care quality; to improve efficiency; to facilitate closer collaboration and partnerships between the health sector and communities; and to increase the overall resources to the health sector.

<sup>4</sup> "Creating Wealth Through Health: The Health Sector Programme of Work: 2007-2010." Draft, p. 8.

<sup>5</sup> Document from the Planning and Budget Unit, Ministry of Health, titled "Proportion of Health Budget by Category."

<sup>6</sup> USAID Health Profile, Ghana.

<sup>7</sup> The term used in Ghana to describe VHFs is "earmarked" funds.

<sup>8</sup> This percentage is derived from the Ministry of Health's Programme of Work, 2007.

the MOH's agenda. Smaller funds are relegated to a different level of attention due to opportunity and transaction costs. It is telling that in the MOH's Programme of Work for 2007, the GF and GAVI were the only two VHF's noted.<sup>9</sup> Additionally, when asked, the MOH could not readily identify other VHF's operating in Ghana.<sup>10</sup> With the MOH's direction, the study mainly focused on the GF and GAVI.

Ghana continues its strong GF performance since inception. "Ghana was the first country in the world to fulfill the conditions for disbursement, and hence, to receive funding."<sup>11</sup> The GOG signed the grant in December 2002; the GF disbursed funds in January 2003. The MOH is the Principle Recipient (PR) for malaria, TB, and HIV/AIDS, with the latter being implemented mainly through the National AIDS Control Program (NACP). It is important to note that there are two agencies dealing with HIV/AIDS. The Ghana AIDS Commission works more on advocacy and reports to the Office of the President. The NACP's role is largely in prevention and supervised by the Ghana Health Service, which is under the MOH.

GAVI has been in Ghana since 2002. With the money being targeted and protected, GAVI got off the ground only to stagnate. In 2004, Ghana did not receive additional funding because of poor performance in 2003. However, the MOH is now receiving GAVI funding again. The bulk of GAVI's funding is in drug procurement from the World Health Organization (WHO) Certified Drug Program. GAVI has also included limited funding to address the Expanded Program on Immunization (EPI) program delivery barriers.

However, drug funding amounts under both programs is notable, prompting some to confirm an impression in a recent article that "much of the GF money used to buy AIDS medicines simply flows back into the rich donor countries, into the coffers of GlaxoSmithKline, Bristol Myers Squibb, and other drug companies."<sup>12</sup> While many people suggested that drug programs and vaccination and immunization campaigns were a tremendous success programmatically, there were additional nuances. On procurement, there was a feeling that the MOH was not allowed enough latitude to negotiate drug costs. There was consensus that GAVI and the GF did little to help with capacity development in this area and provided no assistance to help Ghanaian pharmaceutical companies to scale up to become drug providers, further enhancing Ghana's health sector.

After a poor 2003 GAVI performance, the MOH made important changes to ensure successful application and program implementation in subsequent funding rounds. Many noted that GAVI's

#### Defining a Principle Recipient

"Once a proposal has been approved, the CCM nominates a Principal Recipient to be legally responsible for the dispersal of funds and program implementation. Principal Recipients are local entities whose nomination must be confirmed by the Global Fund. The Fund's Secretariat then negotiates a two-year grant agreement with the Principal Recipient conditioning the release of funds to the achievement of specific, measurable results. Once this agreement has been signed, the Fund releases an initial installment of grant money to the Principal Recipient, which then disburses the funds to organizations carrying out programs on the ground" ("The Global Fund To Fight Aids, Tuberculosis, And Malaria," June 2004, [www.unausa.org](http://www.unausa.org)).

<sup>9</sup> Ministry of Health, 2007 Programme of Work, The Ghana Health Sector, p. 52.

<sup>10</sup> After numerous queries to the MOH, information about what percentage VHF's comprise of the entire donor or health sector budget were not made available.

<sup>11</sup> "Ghana: Country Coordinating Mechanism: A Case Study," Dr. Pol Jansegers, Global Fund, November 26-December 5, 2003, p. 12.

<sup>12</sup> Harris, Richard. "Global AIDS Fund Boosts Health, Economy in Ghana," National Public Radio, <http://www.npr.org>, p. 4.

success could be traced to both stronger leadership and easier program delivery since performance is mostly based on vaccines and immunization numbers, and not say a HIV/AIDS sensitization program whose impact is more difficult to execute and measure. Additionally, many observed that vaccinating was not sufficient, noting GAVI was narrowly focused. Without looking at the comprehensive health care needs of children in a village in Ashanti, for example, vaccinating them with the new pentavalent-vaccine is short-sighted if they die of diarrheal diseases a short time later due to contaminated water.

MOH control program managers interviewed frequently noted that funding is mostly “predictable, reliable, and timely” and that the GF and GAVI respond to the Paris Declaration. Both funds are on plan and on budget as well as performance-based. GAVI goes so far as to offer incentives; for every child vaccinated, the government receives \$20 USD. Telling of in-country interviews, people typically spoke of the GF while GAVI received fewer or general comments. For Ghana, the GF is the largest and most critical player that interviewees wanted to talk about. Program success needs to be above 85 percentile and dominates the agenda.

### **2.3 Alignment with National Goals**

Ghana has a national health policy that outlines its objectives, principles, and goals. There was broad consensus that the GF and GAVI conformed to the national policy and priorities. For the most part, people agreed that the targeted diseases of HIV/AIDS, TB, and malaria are the highest priority. As a point of reference, the GF has three strategic objectives: to grow to meet demand; adapt to country realities; and to innovate for greater impact. GAVI has a three-year strategy starting this year with four strategic objectives.<sup>13</sup> GAVI has actually produced a report to measure its status on implementing the Paris Declaration on Aid Effectiveness by 2010. The report notes that nearly all targets are fully compliant (including aid flows being aligned to national priorities) save two areas: use of country public financial systems, which has a ninety percent indicator and the use of national procurement mechanism, which has no target.<sup>14</sup>

Government representatives observed that there is a plethora of goals, policies, and objectives that are not always well integrated. While people noted that the GF, GAVI, and other donors share their strategies, concerns about the number of strategies was often noted. Respondents wished that donors could come together and have one strategy for Ghana, which would follow the GOG’s stated health and poverty reduction strategies. The more funding agencies, the more strategies that government and other implementers have to manage. The proliferation of these frameworks is challenging, leading to what one person referred to as “too many policies that don’t always match up and not enough action.”

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<sup>13</sup> These include: to strengthen health system capacity; to accelerate the use of underused and new vaccines and improve supply security; to increase the predictability and sustainability of long-term national immunization program financing; and increase and assess the added value of GAVI as a public private global health partnership.

<sup>14</sup> “Harmonization, Report: Status on implementing the Paris Declaration on Aid Effectiveness, [www.gavialliance.org](http://www.gavialliance.org).

## 2.4 Planning and Coordination

Ghana is virtually over the natural learning curve that occurs when new funding assistance arrives with new proposal requirements, policies, and reporting procedures. Communication and collaboration have improved in the health sector since the arrival of the first VHF in 2003. Consistent and committed leadership, a strong professional cadre of mid-level MOH civil servants, and system development have aided this process. Each disease program has a strategic plan and budget, which is part of the Programme of Work. Interviewees noted that budgeting is needs based while noting some concern that this process was shifting more towards a resource-based model. Working through the country's devolution process, there is significant involvement from the district medical teams and regional coordinating councils although some noted that they wished for more time to respond to MOH's draft policies.

### Selected Health Sector Coordinating Bodies

1. Ghana Health Service Council
2. Country Coordination Mechanism (GF)
3. Inter-Agency Coordination Committee (GAVI)
4. Regional Coordinating Councils
5. National Health Insurance Council
6. Inter-Agency Coordinating Committee on Contraceptive Security
7. Ghana AIDS Commission

Earmarking has led to greater centralization in planning and disbursements.<sup>15</sup> The MOH is the GF PR and the main point of contact for GAVI and other funds. Some noted that while policies are developed, the realities of making them work by a doctor or nurse in an understaffed, under-funded clinic can be light years apart. Still, people mostly felt like they were part of some dialogue, but did note that whoever controls the money has the most power. An additional concern is that the GOG has been targeting poorer districts with significant health assistance while areas of greater population and health needs such as Ashanti, the Eastern Region, and Greater Accra have greater stresses with fewer per capita resources.

There was a wide range of comments on targeted programs under this heading. The TB and Malaria Control Programmes received high marks on planning and coordination. With the HIV/AIDS programs, however, there were a few caveats. Many noted that cooperation and the division of labor between the GAC and NACP have improved, but remained challenging. Having two agencies creates additional layers, especially since the majority of work, unlike other diseases like malaria, is done through NGOs. One source estimated that the GAC funded as many as 700 NGOs last year for all programs—not simply for VHF programs. The EPI seemed to have some challenges. Some noted that there are inter-ministerial communication issues since donors go directly to the Minister of Health, which is not always communicated to program staff. Additionally, some interviewees did not feel involved in the planning and implementation process, noting the strong-hand of the MOH. EPI uses fewer NGOs except at the district level, so fewer coordination concerns were noted.

Coordination, especially at district level, could be strengthened. With other INGOs and donor programs working in the field, there is incomplete knowledge about who is doing what. Some NGOs

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<sup>15</sup> It should be noted that the consultants did not meet with the Ministry of Finance largely due to the fact that the MOH was not supportive. The World Bank had noted that there is a lack of coordination between the MOH and a mainline ministry like the Ministry of Finance. According the Bank representatives, Ministry of Finance actors referred them to the MOH on budget issues, noting that they did not have the information.

enter districts without informing the local government or regional health offices. A NACP-funded NGO must bring a letter to the local government before beginning work. Other groups do not have the same requirement, which can lead to program duplication and miscommunication. A common theme was that there is not a complete health program map. The MOH would like all the money to come through them so that they can plan and coordinate from one source. As such, they support a more centralized approach, noting that they have strong planning and coordination measures in place to ensure comprehensive dialogue and implementation.

The main VHF's have individual coordinating bodies designed to improve the process and implementation. The Country Coordinating Mechanism (CCM) serves as the main coordinating body for the GF; there are 25 members that cut across government, donor, civil society, and private sector lines. It is noteworthy that the GAVI coordinating body, the Inter-Agency Coordinating Committee (ICC) only came up in one conversation. The chair is the Director of Public Health Service and has representatives from United Nations Children's Fund (UNICEF), USAID, DfID, etc. on the committee.

When the GF first arrived, the CCM had a difficult start. Some issues, including a lack of leadership, bylaws, targeted meeting agendas, and transparency, could be attributed to Ghana being the first GF recipient country. Now, the CCM is re-structured with strong leadership. It meets quarterly, typically has a good agenda, and rotating and permanent seats for key health actors; there are disease-specific subcommittees. Some view the GF selection process as not sufficiently transparent and claim that they do not always know selection criteria, how they are applied, and by whom. Many noted that the CCM has worked diligently to improve its bylaws, subcommittee activities, and transparency. Here, civil society organizations have a role and involvement in the GF process, but many feel access is still limited to a select few. Given the significant and increased competition between NGOs for more limited funding, there is more self-promotion as organizations position for grants to address the three main diseases. Additionally, CCM membership is almost exclusively an Accra-based arena, so districts and regions are not specifically represented save through groups working in the area; some noted that this aspect should be corrected to ensure a more comprehensive picture.

## **2.5 Human Resource Capacity**

The MOH has made a concerted effort to manage human resources in Ghana's health sector. Increased budget support from donors and the capacity building funds from the GF have reaped strong dividends. Salary levels for various positions are among the highest in Africa. More importantly, primary health care workers are remaining in Ghana to work or returning after receiving an education abroad. Reversing the previous decades of brain drain has improved the capacity of the health system. The MOH boasts experienced personnel that are able to write strong proposals to the GF, GAVI, and other groups, enabling them to capture critical funding. Additionally, they are able to implement at high levels, ensuring that funding continues since the GF and GAVI are performance-based. Given the qualified cadre in the health sector, increased capacity rolls down to the district level. While many observed that there were distinct differences in district capacity, the MOH is highly attuned to this matter. In a recent report,<sup>16</sup> the MOH listed four concerns: imbalance in health workforce distribution; migration of skilled health workers; inadequate numbers of health workforce; and low workforce productivity. The report also outlined priority objectives and practical strategies to address these issues. Both the GF and GAVI allow health system strengthening support to be built

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<sup>16</sup> "Human Resource for Health Development: 2006 Annual Report," Ghana Ministry of Health, March 2007.

into proposed programs. Dr. Addo Akewi from the NACP said that its staff has increased from six in 2003 to twenty in 2007. Increased trained staff enhances programmatic flexibility and ensures strong performance.

GF sub-recipient capacity is also noteworthy. There was consensus that NGOs in the HIV/AIDS area have many funding opportunities, directly impacting capacity. Like the districts, NGO capacity is viewed at varying levels. With funding and some capacity development, NGOs working in HIV/AIDS seem better off than other health-focused NGOs, largely due to the NACP approach. It includes a significant amount of NGOs as sub-recipients, thus spreading the wealth. NGOs in other areas such as TB or malaria speak of limited opportunities. Additional NGOs working in non-GF diseases such as onchocerciasis (river blindness) or Guinea worm see less funding, thus hurting their overall capacity. It is a vicious cycle. The fewer the opportunities, the less capacity NGOs have to compete for programs. Additionally, many NGOs raised concerns that the GF's contracting criteria is "too rigid;" subsequently, many proposals are under funded. Additionally, the MOH's perspective is that it can deliver the programs more efficiently and that stretching programs across numerous NGOs is counterproductive. Thus, some NGOs feel that the MOH does not fully appreciate what they bring to the table,<sup>17</sup> creating an impression among non-HIV/AIDS NGOs that they are not partners in addressing Ghana's health issues.

## 2.6 Health Care Delivery

Ghana's health indicators have shown improvement, especially since the GF's arrival. The Malaria and TB Control Programmes are widely seen as effective. HIV/AIDS continues to be an area where they are many players; all work towards more effective coordination and implementation. Regardless, the HIV/AIDS rate is 3.2 percent according to the NACP (2006) with the two highest areas of prevalence being the Eastern and Western Regions. Some interviewees also noted that HIV/AIDS is a concentrated epidemic with key at-risk groups.

Earmarked funding has provided additional funding and targeted support to Ghana's main health issues. Yet, despite VHF's, funding to regions and districts remains inadequate to satisfy the needs. The MOH outlined the reason. As noted previously, about 60 percent of donor funds are earmarked, reducing its flexibility to meet other requests and fill funding gaps. Additionally, when an emergency occurs, such as the recent flooding in the Northern Region, the MOH has to reallocate money from existing non-earmarked programs. The GF has a systems approach while the MOH hopes to create a systems approach to the entire health sector. These different methods lead Ghana's health sector down certain paths that are not always mutually exclusive.

Nearly everyone understood that Ghana's health care system success depended on scaling up everywhere and implementing an integrated health management system. An interesting discussion concerned non-communicable diseases. Many policy and health care practitioners see the link between the effectiveness of medical interventions and diseases associated with lifestyle issues, such as rising levels of diabetes, hypertension, obesity, tobacco use, etc. People remarked that VHF funds do not work in these areas. Long-term, they have the potential to increase healthcare costs. Additional concerns about long-term drug costs or wide scale replacement of bed nets, which only

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<sup>17</sup> The CIVICUS Civil Society Index Country Report for Ghana, Civil Society in a Changing Ghana: An Assessment of the Current State of Civil Society in Ghana also confirms this assertion. See [www.civicus.org](http://www.civicus.org) for the full report.

retain the critical preventative medication for five years, were present. Scaling up, maintenance, and rising costs were continually noted with concern.

Procurement delays sometimes occur, e.g. due to drug quality assurance procedures and the time it takes for drugs to arrive. The GF seems to be aware of this issue through other reports. While allowing funds to be used to build procurement capacity, they do not address other noted concerns. These include supporting the private sector in scaling up to be a certified GAVI or GF drug provider, which would reduce costs, increase economic impact, and ensure a more timely arrival since delays are not always due to weak in-country procurement systems. People concurred that quality assurance and cost are significant factors and are not to be underestimated. However, there was a noteworthy perspective that VHFs should support this area and aid Ghana's long-term sustainability by continuing the drug administration and vaccine and immunization programs on their own.

The perspective on district health care delivery suggested that there was less money flowing down to them and that disease silos were counterproductive. People advocated for a comprehensive view, noting that VHFs create "islands of happiness in oceans of misery." People working directly on the ground are closer to the people and less concerned about policy and rules. They are interested in saving lives and increasing quality care. The districts thought that HIV/AIDS was less critical than malaria or maternal and child health.

## **2.7 Sustainability**

Nearly everyone had concerns about sustainability, but there were decidedly mixed views on the implications and solutions. Some noted that the VHFs breed external fund dependency and can distort the national health budget. A discussion thread concerned whether VHFs create an environment where other diseases were neglected. People noted that Guinea worm is a good example. It has seen its numbers increase due to a decrease in funding after being declared nearly eradicated for some time. There was also concern that the volume of human and material resources devoted to VHF targeted diseases was disproportionate to relative disease incidence, enhancing neglect. Staff is preoccupied in areas where more funds are available and, given the high VHF transaction costs, even if they had more funds, they would still have less time to focus on other areas. Other people thought that the VHFs' targeted diseases were the right ones, but noted that more flexibility would enable them to strike a balance based on the projected levels of the three main GF diseases against other health issues that were on the increase.

For others, the GOG's increased capacity seemed to address concerns about sustainability. With more qualified health workers, health care delivery would naturally improve. Ghanaians were seeking out the system more frequently, and as Ghana's economic development continued, payment of services would be possible. The GOG has also just unveiled its National Health Insurance, which is supported by a 2.5 percent tax on goods purchased in country. The worst-case scenario, one person noted, would be that the GOG was not successful and that another donor(s) would come in and fill the gap, enabling them to do what they needed. There is a feeling that the international community will not abandon Ghana. Its place in West Africa is too critical to let slip behind to past development levels. One person hoped that Ghana would "strike oil," thus saving them from a future of unknown financial reserves.

## 2.8 Impact and Verification

While all donors to some extent assess performance as espoused by the Paris Declaration, the VHF are highly performance based with short-term, quantifiable targets. Nearly everyone thought that this aspect was positive, ensuring that “people kept on their toes.” The Local Fund Agent (LFA), Price Waterhouse Coopers, monitors performance; the CCM selected it in August 2002 and subsequently extended their contract. They work with the PRs and sub recipients to create project indicators and verify results. Numerous government health interviewees noted that monitoring and evaluation (M&E) is sometimes more concerned with outputs than impact, e.g. how many people are trained and not how they used the training to increase HIV/AIDS prevention. Having strong project management and M&E systems in place is critical. Success in future rounds of VHF like the GF depends on past performance. Nearly everyone noted that the verification process was incredibly demanding, especially when dealing with numerous VHF. All have different reporting structures, contrary to the Paris Declaration, creating significant workload. Hence, capacity is critical and something that the MOH has worked hard to address. They recognize that the money will only flow if they can implement the programs and account for every item and show project results.

Typically, the LFA verifies on a quarterly basis. However, a few people noted that the Malaria Control Programme had requested longer time frames, called a Rolling Continuation Channel, between verifications because of exemplary performance. Apparently, they received it twice. This flexibility has been deeply appreciated; more is hoped for as strong performance continues.

In addition to concerns about market shifts and rent-seeking behavior, VHF creating a budget dependency was consistently noted. One arena is where new drugs or vaccines are introduced or used on a long-term basis such as anti-retrovirals. At the moment, of the people living with HIV/AIDS, only 15 percent use these drugs. Clearly scaling up is still needed. The Clinton Foundation has included Ghana in its drug price reduction program, which many noted with gratitude. There is also concern about the rise of drug resistance, which has an impact on cost and long-term sustainability.

Another area is the VHF multiplier effect, another indication of the push and pull between a health system operating with both a service and systems approach. An example is the microscopes purchased for TB with GF money. This equipment is not used exclusively for this purpose. Thus, districts have new microscopes and a greater capacity to test children for diarrheal diseases or other health issues. Everyone stressed that the particular item is used for its primary purpose under GF terms; other uses are additional. Some noted that there was friction when some regional health officers or program managers discovered this additional use. However, the GF reports that they are supportive of this approach. “Large disease-focused investments can put pressure on the staff and administrative resources of other programs, or inadvertently lead to the creation of ‘disease silos’ within the health system. Conversely, disease-focused resources, used widely, can enable system strengthening, with benefits far beyond the diseases targeted. The challenge for the GF is, within its mandate, to allow its financing to take optimal advantage of opportunities to create such system-wide benefits.”<sup>18</sup> Thus, some funds are used for multiple purposes, improving health sector capacity and integration.

With regard to civil society, there has been a decided change in this landscape. There are more NGOs working now in HIV/AIDS as they redefine previous missions or create new organizations due to levels of funding available. This shift creates obvious distortions in the system, creating a new set of

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<sup>18</sup> “A Strategy for the Global Fund: Accelerating the Effort to Save Lives,” p. 32

risks. Even the GF notes that “increased resources for AIDS, TB, and malaria have led to a proliferation of initiatives and stakeholders, particularly for AIDS.”<sup>19</sup> However, this realization and reality on the ground has not addressed the worrisome trends that the NGO community raised. Some noted that even the larger NGO coalitions have been weakened by the creation of disease-specific NGO collations following the funding trails. As was previously noted, competition has increased, which has its positive and negative impacts. With the MOH’s strong role in VHF, some feel that dialogue around health issues has been reduced. Additionally, a centralized approach weakens community voices, which NGOs represent.

Respondents frequently noted the morale and job satisfaction factor. There is more money, which increases resources to critical human needs. People’s salaries, especially doctors and nurses, have been raised; more people are working in the sector. Additionally, due to meeting incentives,<sup>20</sup> there are more volunteers to help paid staff. However, we did hear from a select few that motivation was diminishing and that there are not enough incentives for strong GF performers in light of too much “paperwork.”

## 2.9 Key Country Requests

All interviewees had the opportunity to outline specific requests that they wished to make regarding VHF. The following represent the most commonly raised:

- Fund use flexibility was probably the most repeated request. Ministry staff felt that Ghana has proven that it is a strong performer. In many respects, they are asking for a reward. They are advocating using funds in line with national goals. Flexibility would allow them to shift to a more comprehensive care delivery system where they can meet priority needs or emergency health issues. Overall, respondents felt that flexibility would allow them to deliver better health care services across the country.
- Less paperwork for proposal preparation and verification was a recurring theme. The process of “rounds” by both the GF and GAVI has high transaction costs. Even with the GF’s Rolling Continuation Channel process, people asked whether rounds could be rolled into longer timeframes and subsequent proposal processes could be simplified once a country has already won a significant number of grants and performed well.
- Continuously, people asked for more capacity building funds, especially for equipment and infrastructure. While people noted that the GF and GAVI provide these funds, there are not sufficient. For long-term sustainability, Ghana’s health system must be able to stand on its own. Without greater capacity building at this time, the government will not be able to scale up and maintain the type of health system that they are pledging in their national health policy.
- While GF and GAVI priorities were seen as critical, people requested more funds for other diseases, e.g. Guinea worm and cholera, to offset their rising rates due to a lack of funds and attention. Addressing potential system distortions is seen as a high priority.

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<sup>19</sup> Ibid, p. 28.

<sup>20</sup> People are paid 5 Ghana cedis to come to a meeting and receive a lunch and beverage.

- There are significant actors working in Ghana’s health sector. Given the problems with coordination—something the Paris Declaration seeks to address—government staff from the ministry level to the district requested better information sharing with programs outside the MOH framework to ensure optimal VHF resource use. If the MOH does not know that a certain INGO is working in a certain district, it might dedicate critical resources that could have gone elsewhere. Mapping donor and INGO programs is a key priority.
- There were strong suggestions that the GF include more capacity building funds for NGOs or provide such funds to an umbrella NGO to build member capacity. NGOs are concerned about their future in an environment of greater MOH control. They want to ensure that they have the capacity to be effective partners in assisting and advocating for community health concerns in the national public dialogue.

## 2.10 Conclusion

VHFs have provided critical additional resources to Ghana’s health sector, improving the quality and management of health sector planning and management, allowing programs to be scaled up. VHF specificity has helped countries target priorities. However, they come with high transaction costs and create system distortions. Maintenance and sustainability are now the difficult long-term targets. Country actors expressed hope that with increased VHF performance, some funds may be open to further flexibility, allowing the MOH the opportunity to expend resources according to its overall national health plan—in line with Paris Declaration Principles. The VHFs have enabled the MOH to allocate non-earmarked funds to increase staff and salaries, building system capacity. This approach has had a direct link to Ghana’s performance on VHFs, ensuring additional funding in subsequent GF and GAVI rounds. While country actors are over the VHF learning curve, coordination and alignment continue to be important objectives as they move forward. Maintenance and increasing impact remain critical goals, especially in countering potential negative consequences in the future. Additional funding has increased job satisfaction and morale in addition to reducing the brain drain phenomenon, which people noted is a major element of the health system’s sustainability long-term.

## 3. SIERRA LEONE AND VERTICAL HEALTH FUNDS

### 3.1 Country Health Sector Context

Sierra Leone has some of the world’s worst health statistics due to a combination of poverty, a decade of civil war, and issues related to human capacity, governance, culture, and climate. While malaria is endemic, the share of children under-five using treated bed nets was just 2 percent in 2005. The HIV/AIDS rate is low at 1.53 percent and TB is around 4.5 percent. These statistics<sup>21</sup> place the country second to last on the UN Human Development Index (HDI) while their impact is magnified by a negative GINI coefficient where the bottom 40 percent of the population receives 3 percent of income while the top 20 percent receives 63 percent. Per capita income was \$220 in 2005.

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<sup>21</sup> Other statistics are noteworthy. According to UNICEF, infant mortality is 165 per 1,000 live births; child mortality is 282 per 1,000; maternal mortality is 2,000 per 100,000 pregnancies; life expectancy is just 41 years; the literacy rate is 35 percent; and more than 70 percent of the population lives on less than one US dollar a day.

The Government of Sierra Leone (GOSL) and its development partners are committed to improving these indicators. Substantial resources have recently been pledged for the health sector, including \$30 million USD from the World Bank over four years, \$100 million USD from the British DfID over 10 years, and millions more from others. The GOSL has a dozen sub-sector policy documents and is working on an integrated strategic plan to serve as a new framework for the coherent disbursement of funds from a plethora of development partners to a wide range of central and local government actors and civil society organizations. VHF that target specific diseases enter the sector with substantial resources, their own policies, coordination mechanisms, and reporting requirements. While the funding is welcomed since it enables a scale up of existing efforts, several issues were repeatedly highlighted by GOSL officials at the national and local levels and by civil society. These are synthesized below.

## 3.2 VHF in Sierra Leone

The GF accounts for ten percent of Sierra Leone's donor-supported health budget (see Annex 1 for more information).<sup>22</sup> It has financed initiatives against its three targeted diseases with the largest grant (\$9.6 million USD from Round 6) provided in October 2007 to the National HIV/AIDS Secretariat (NAS).<sup>23</sup> The GF had to terminate a smaller \$8 million USD Malaria grant in September 2007 due to performance problems; the \$5 million USD TB program continued. The MOHS believes that the GF CCM is functioning well. Among its reported strengths are broad representation and the fact that there is always a written agenda, minutes, and follow-up of actionable items.

GAVI funds are managed from their headquarters. When GAVI transfers funds to Sierra Leone, the MOHS informs the ICC, which instructs the technical team so that they can fund specific programs; actors include the EPI manager, UNICEF focal point, and WHO. The proposed allocations to various unfunded or under-funded EPI activities are then approved at the next ICC meeting after which requests are made quarterly to GAVI based upon planned allocations, disbursement levels, and performance indicators. All interviewed assessed GAVI as an effective partner for the delivery of Immunization Services Support. GAVI directly procures and pays for vaccines while funds for delivery (e.g. personnel, transport, and cold chain equipment) are disbursed through the MOHS with administrative backstopping from UNICEF and WHO technical support.

There are other smaller funds worth mentioning. Stop TB, a partnership of over 500 organizations coordinated by its secretariat based at WHO headquarters in Geneva, has provided technical assistance intermittently and supplied anti-TB drugs through the Stop TB Global Drug Facility via direct procurement. WHO monitors drug quality and manages the provision of technical assistance locally. Rollback Malaria,<sup>24</sup> founded in 1998 by WHO, UNICEF, UNDP, and the World Bank, is housed at WHO headquarters and has previously provided some technical assistance.

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<sup>22</sup> This statement represents the best estimate after significant interaction with the MOHS' health economists. Information about various funders and the overall health budget is not easy to come by, further suggesting that key Paris Principles are not being met.

<sup>23</sup> The requested amount was US\$26.5 million and the approved maximum is US\$9.63 million according to the GF website as of 28 October 2007. The approved amount was widely misreported in Sierra Leone as \$26.5 million.

<sup>24</sup> For more information about these VHF, see their websites; they provide a full explanation of their mandates, priorities, organization, funding sources, and operations.

The absence of some VHF was also noted. Sierra Leone is not a PEPFAR country.<sup>25</sup> EU funds for the health sector were included in EU projects and not disbursed separately. EU health sector funding is ending as it focuses on other sectors.

### 3.3 Alignment with National Goals

GOSL officials and NGO representatives mostly agreed that VHF targets are well aligned with national goals. The GF focus on malaria was most often mentioned since it is the leading cause of morbidity and a major cause of mortality. Some respondents felt that the funding level to fight HIV/AIDS was too high given the current low infection rate, but most concluded that the major stress on HIV/AIDS is appropriate since the top goal is prevention.<sup>26</sup> However, some also noted that it is not “politically correct” to question the volume of resources devoted to combating this disease.<sup>27</sup> Interviewees also suggested that other diseases might be neglected because there is no “strong and large advocacy group” for non-targeted diseases such as cholera, Lassa fever, and onchocerciasis. The government expressed its appreciation for recent World Bank supplemental funds for Onchocerciasis. In some discussions, it was apparent that if funds for HIV/AIDS were not targeted exclusively for that disease, some portion would probably be reprogrammed.

MOHS officials and the District Medical Officers (DMOs) queried agreed that efforts to combat TB were well aligned with national priorities since the disease is highly contagious and needs to be contained. Officials also asserted that alignment was improved by the degree of government “ownership” of the VHF programs, which results from MOHS staff and NAS personnel drafting their GF proposals.

### 3.4 Planning and Coordination

Since its creation in 2001, the GF has become the world’s largest multilateral funding source for health.<sup>28</sup> In Sierra Leone, it is the largest funder to combat HIV/AIDS, and if the government’s proposal for new funding to fight malaria is successful, it will also become the largest funder for malaria. The amount of money involved, the rapid pace of expected disbursement, and the GF’s detailed performance requirements can skew planning, complicate coordination, and lead to a supply-driven health agenda. Rather than pro-actively developing an integrated strategy that strengthens the underlying health delivery system that must address all diseases and health issues, the risk noted by some MOHS staff is that the government

#### Selected Health Sector Coordinating Bodies

1. National Health Policy Advisory Committee
2. Country Coordination Mechanism (GF)
3. Inter-Agency Coordination Committee (GAVI)
4. District Health Management Teams
5. Development Partners in Health Monthly Coordination Meeting (includes INGOs)
6. Steering Committee on Reproductive and Child Health
7. Health Task Force (MOHS Donor/NGO Liaison office coordinating group)

<sup>25</sup> This US government initiative only focuses on Nigeria and Côte d’Ivoire in West Africa.

<sup>26</sup> HIV/AIDS globally consumes more than 20 percent of all health aid, but the illness accounts for only 5 percent of disease in low and middle-income countries – less even than a disease like diabetes.

<sup>27</sup> A report in the *London Financial Times* (9/27/07) on a 2006 Rwanda study found that 75 percent of donor aid for the health sector went to combat HIV/AIDS (\$47m) while \$18m went for malaria and just \$1m for other child illnesses while government authorities there believed that malaria and child illnesses were more critical with higher mortality rates. A similar temporary distortion exists in Sierra Leone between HIV/AIDS and malaria funds.

<sup>28</sup> Nearly \$10 billion USD is now available with planned disbursements of \$8 billion USD annually from 2010.

might primarily respond to the availability of funds for target diseases. This danger is a basis for a recent GF-World Bank agreement that would see World Bank funds used to improve overall health delivery systems while the VHF focuses on specific diseases. This approach to funding made sense to government respondents. It can help clarify roles, but it does not resolve the coordination issue.

MOHS personnel are aware of the need for a strategic and demand-driven approach. However, as some said, understanding the need is easier than producing the strategy because there are many competing interests within government and among donors and civil society. In principle, for example, officials stated that they want and are supposed to provide needs-based budgets that can support a national strategic approach. However, staff is often told the amount of funds likely to be available and for what diseases. They then “save time” by budgeting for what is available. This practice is reportedly particularly the case at the district and local levels,<sup>29</sup> the foundation for national budgeting. Needs-based budgeting is crucial since it is demand-driven while the temptation to budget for what is available leads to a supply-driven agenda that is more difficult to coordinate. Needs-based budgeting reveals funding gaps to policy makers who can then seek additional funding from government and/or donors or try to reprogram other funds. The pro-active process of gap filling is an instrument for coordination as actors work to craft an optimal budget.

The MOHS Donor/NGO Liaison Office works to improve coordination and created a list of 97 NGOs active in the health sector.<sup>30</sup> However, some development partners and NGOs are viewed as paying lip service to coordination while at the same time withholding information, especially financial details, that is considered essential to good government planning.

In order to improve coordination and move toward an integrated health strategy, the government favors a Common Fund or SWAP, which exists in Ghana and more than 20 other African countries. Because of the recent war and donor perceptions about the government’s implementation capacity, however, a project-by-project approach is the norm, making effective coordination more difficult.

Despite these limitations, the government believes that its sector coordination has improved markedly in the past three years as a result, in part, of the creation of District Health Management Teams (DHMT) in every district. The DMO chairs the DHMT, which has broad membership. As a result of information generated by district-level health activity mapping exercises, some NGOs have been persuaded to revise their sub-sectoral and/or geographic focus to improve aid effectiveness.<sup>31</sup> The DHMTs also coordinate among themselves through regular meetings among the 13 DHMTs, which included 12 districts plus Freetown urban.

In contrast, at the national level, the MOF Economic Policy Research Unit, which is the SPA focal point, indicated that it is “not aware of GF activities in the country and thus cannot take their input into consideration when doing budget planning.” The GF was described as a “separate world” and coordination and information sharing between the MOF and MOHS was described as unsatisfactory.

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<sup>29</sup> Districts are involved in the Medium Term Economic Framework process and, therefore, now know what is available for each district in the proposed national budget. This engagement helps districts understand their resource envelope, but also encourages the tendency to prepare availability-based budgets.

<sup>30</sup> While 97 seems a large number, after a review of the organizations, it was apparent that the majority were local NGOs. The team estimates that this number does not include a significant portion of INGOs and faith-based organizations operating in Sierra Leone. The result is that numerous programs and resources have yet to be captured, further highlighting the lack of compliance with the Paris Declaration.

<sup>31</sup> The example of a Spanish NGO shifting its operations to Koinadugu District and positive changes in a Japanese project were cited as well as the MOHS’s recent refusal to allow an American NGO to build a training school in a location where it was not needed.

The MOF noted frustration with incomplete information that made it impossible to identify funding gaps. Some of the communication problems may, however, stem from limited internal MOF information flow since normally requests for VHF resources must be counter-signed by the Minister of Finance.

Planning for and coordination of GF fund use is the responsibility of the GF CCM. While the CCM overlaps with other coordination bodies, government respondents agreed that any coordination issues were modest<sup>32</sup> when compared to the enormous benefit to Sierra Leone from the substantial funds provided by the GF. Technical sub-committees also were seen to function well since they consider substantive issues and then present conclusions to the CCM for consideration.

Some suggested that debates about the relative merits of vertical or horizontal approaches in the health sector are unnecessary, since without the existence of VHFs, there would be no funding in Sierra Leone's resource-scarce environment. A NAS official asserted that the GF is fully aware that success through a vertical assault on a given disease depends on the broader horizontal health system. The key is to integrate vertical and horizontal initiatives into a coherent strategy blending the best of both approaches. The challenge at Sierra Leone's level was seen as gaining maximum benefit from and coordinating what exists rather than trying to alter global VHF structures that have evolved for political and developmental reasons.

Coordination of activities to combat HIV/AIDS has improved significantly since 2004 when new leadership took over at the NAS, which works closely with the CCM. This turn-around by an agency in deep difficulty is seen as a positive example of what could be accomplished with malaria with the MOHS as the PR. The cancellation of the GF Round 4 grant to fund anti-malaria efforts due to poor coordination, management failures, and poor service delivery came as a shock to the government. New staff has now been put in place and the poorly performing PR, the Sierra Leone Red Cross, has been replaced with the MOHS in the new proposal for malaria. The Ministry believes it has the capacity to manage the funds and coordinate effectively with other malaria initiatives through its National Malaria Control Program (NMCP).

To improve coordination in HIV/AIDS, the NAS holds an annual strategy forum. It also now gives final approval to disbursements by CARE International, a leading INGO, to sub-recipients working on HIV/AIDS issues. The NAS sees the relationship with CARE as a model of how coordination can be improved in the HIV/AIDS sub-sector.<sup>33</sup> In contrast, DfID works directly with communities, resulting in the NAS not always being aware of other HIV/AIDS funding and programs. The NAS has urged that the current "fragmented" project-by-project approach be replaced with a Common Fund for HIV/AIDS. It has also asked that all donors buying into the Common Fund agree to accept a single set of indicators, reporting format and timetable, and M&E process to reduce heavy transaction costs. Since the GF is the dominant partner for HIV/AIDS, it could take the lead in enabling the NAS to work toward common procedures.

The TB program was the first area to obtain GF support under Round 2 when four districts were targeted. The World Bank provided support for TB control to another four districts; other donors supported the remaining four. The geographic division by donor made coordination more difficult

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<sup>32</sup> Some MOHS officials believe that coordination would be improved if the GF would authorize payment of travel allowances to Sierra Leonean CCM members to encourage attendance, especially local NGOs.

<sup>33</sup> CARE received \$6 million USD from the USAID West Africa Regional Program in 2003 for the 2005-2008 period and added \$1.2 million USD from the GF/NAS to implement its HIV/AIDS Prevention Program in the Freetown urban area.

since some districts received more aid than others and some types of aid were available only in some districts. The GF-supported districts now have an average of 10 TB health centers per district and better TB control services while a non-GF district like Bombali District has just three centers, which are not well equipped. Not only do these discrepancies complicate national planning and coordination, but they also cause resentment by some staff and inequities in health service delivery. TB Control Program coordination is also affected by the fact that each donor has its own indicators, formats, and reporting cycles as noted previously with other diseases. This aspect makes reporting a time-consuming process that raises transaction costs and reduces the availability of staff time for other work.

Regarding GAVI, national level respondents repeatedly praised the effectiveness of its immunization campaigns. However, in meetings at the district level, some noted several problems by poor coordination. These issues are summarized below:

- Service Delivery—inequitable staff distribution within and across districts and imprecision about which staff is to perform what tasks to deliver vaccines to clients.
- Management—mismatch between plans and implementation; unsatisfactory and incomplete evidence of incidence of diseases complicates planning; and inadequate coordination between MOHS and GAVI partners (WHO and UNICEF) in the field.
- Supply/Cold Chain—cold chain breakdowns due to a lack of or broken generators because planning for and stockpiling of spare parts is inadequate. The cold chain is not just for vaccines, so better coordination and cost sharing among MOHS units is needed for improved performance.
- M&E—poor monitoring at the local level of new vaccine coverage rates by locality; and inadequate surveillance of the use of basic indicators due to weak M&E support to GAVI campaigns. M&E needs to be improved, standardized, and coordinated among health initiatives.

### **3.5 Human Resource Capacity**

There were extensive comments about the need to improve Sierra Leone’s human resources. Low salaries, poor conditions of service, and the consequent brain drain<sup>34</sup> mean that the perceived heavy demands from VHF for rapid feedback of performance data sometimes reduce the amount of human resources available for non-VHF health issues. However, the human capacity problem is well understood to be a far broader issue; any VHF impact is minor. Capacity building funds are included as a component of GF and GAVI grants, but the need is far greater than such funds can address.

At the national level, there are pockets of high performance, especially where donors have topped up salaries and support particular units within the national government or at the district level with equipment and materials, including the generators that are so essential to operate computers, printers, etc. Officials note that capacity is much weaker elsewhere within government. This reality also affects the high performance entities that depend on the broader, weaker system to achieve results. In many countries this “islands of excellence” approach has proved unsustainable.

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<sup>34</sup> One MOHS official estimated that over 50 percent of nursing and medical school graduates leave the field or the country annually, in part because doctors earn about \$180 USD per month and nurses just \$50 USD.

At the district level, local government was re-established in May 2004 when local elections were held for the first time in over 30 years. The 12 new District Councils have a range of members from well educated to non-literate. The Institutional Reform & Capacity Building Project, UNDP, and the Commonwealth Secretariat, among others, have provided management and other training to district council members and staff and to local officials at chiefdoms. However, the low educational levels in the country and the lack of local governance experience have combined to make human resource capacity building a long-term process. Within this broader context, the health sector at the chiefdom and village levels, where Primary Health Units are located, have been particularly constrained by several human resource problems, including:

- Readiness for training—low literacy levels make training at village and chiefdom levels more difficult and limits what some adults can learn, especially by reading.
- Retaining those trained—urban migration also occurs among trained rural health sector workers since, with their new skills, many hope to find higher paying work in towns and cities.
- Trainee selection sometimes not based on objective performance-based criteria—there are enormous pressures on local NGOs, Paramount Chiefs, and other local notables to recommend their relatives or those owed a favor for training rather than using strictly achievement-based selection criteria.

The Health and Sanitation Committees of the District Councils have HIV/AIDS focal points, but many have little knowledge of the subject. Workshops and short-term training is needed to upgrade their skills. The German Development Bank (KfW) “HIV/AIDS Impact Mitigation Fund” will provide some training for them and Council M&E officers. Training in other health subject areas is also needed.

Another major human capacity problem exists among NGOs. The Sierra Leone Red Cross was selected as the GF PR for malaria, but the grant was terminated early due to poor performance caused mostly by the inadequate human resources within the Red Cross and, secondarily, the MOHS. Local offices of international NGOs also have capacity problems; some were not re-selected for subsequent rounds of GF sub-recipient work due to similar performance issues (e.g. World Vision and the Christian Children’s Fund). The NGO capacity problem is compounded when grant makers take four to six months or longer to proceed from a Request for Proposal to funding an awarded grant. During that time, proposed staff for the new grant may be lost, overhead costs associated with proposal writing are not recovered, and eager staff become frustrated as weeks become months without firm decisions and fund transfers.

A strong consensus among national and district level government officials and among civil society representatives is that Sierra Leone needs a large-scale long-term, well-targeted, and integrated effort to build human capacity, not only in the health professions (including doctors, nurses, hospital and clinic administrators, birth attendants, laboratory technicians, etc.), but also in public administration and management since health personnel do not work in isolation. One DMO noted that there are at least 14 medical doctors working full-time in the MOHS in senior management positions while there is a critical doctor shortage in the country. He added that medically trained personnel are as badly needed as practicing physicians. The country needs both to build human capacity and to allocate human resources rationally for optimal effect. Local level capacity development needs to be accompanied by incentives that will increase retention rates and improve motivation.

### 3.6 VHF Programs and Delivery

The MOHS and the NAS both said that the GF LFA's role has been constructive, well targeted, detailed, practical, and supportive of their delivery efforts. The LFA, Price Waterhouse Coopers, has been a key to increasing GF aid effectiveness. At the same time, people noted that their accurate report on the non-performance of the anti-malaria initiative led directly to the grant's cancellation.

While a few people thought the shock of having the GF Malaria grant cancelled may have been therapeutic since it reminded all concerned that performance is paramount, others were frustrated by their inability to help prevent malaria from sickening and killing large numbers of people. The GF "never seems satisfied and wants the perfect proposal," said one. Another pointed out that World Bank funds for malaria control from the Health Sector Reconstruction and Development Project were exhausted; that EU funds<sup>35</sup> via WHO came terribly late and in small tranches, making management difficult; that Rollback Malaria has sent technical assistance in the past, but is not currently active; and that malaria control is now grossly under funded. The problem of the project-based assistance was highlighted by noting that the Belgian unit of Médecins sans Frontières (MSF) operates a malaria control program in four chiefdoms in Bo District, which is vital, but inequitable from a national perspective given the lack of other resources. Similarly, CARE implements a DfID-funded anti-malaria program in three districts.<sup>36</sup>

The NMCP also suggested that inadequate data collection caused part of the problem with the GF Round 4 grant. "We did not perform as badly as the indicators suggest, but we did not capture the data necessary to prove this."

Government expects malaria services delivery to improve significantly if its GF Round 7 proposal is successful. The MOHS will operate as the PR, but will contract out financial management to an accounting firm and seek external support to improve M&E. The MOHS views its internal planning process as effective and the DHMTs as functioning well in most districts. This is expected to provide a solid foundation and implementation framework for the new anti-malaria initiative. The MOHS also indicated that it has a strong working relationship with UNICEF and WHO with which it carries out joint planning exercises. This is expected to facilitate the coordination of malaria services delivery and enhance its impact.

In stark contrast to the malaria program delivery problems, the NAS has performed better according to the GF and all local observers. At present, NAS has 39 sub-recipients for GF Round 4 and another 33 remaining from phase 2 of Round 3 for its HIV/AIDS grants. The NAS notes that delivery constraints among sub-recipients stem from weak capacity in all areas, such as proposal development, management, accounting, fieldwork, reporting, and evaluation. The NAS is obtaining an international M&E consultant to improve its monitoring and support to sub-recipients, enabling them to scale up and meet the challenge of delivering larger sums under the new GF grant. The NAS issued a Request for Proposals to prepare a detailed external assessment of the civil society human and physical resources that will allow the NAS to pinpoint and correct weaknesses. The findings will allow NAS to revisit the proposed activities and budgets from local NGOs and verify their performance capacities. This review is critical since in response to the availability of new resources, there has been a rapid growth in NGOs claiming expertise in combating HIV/AIDS. Delivery will

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<sup>35</sup> For June 2006 to June 2008 the EU is providing €400,000 for malaria control.

<sup>36</sup> The Malaria Outreach and Safety Initiative (MOSI), valued at \$2 million USD, will serve Koinadugu, Bombali and Tonkolili Districts from 2006-2009.

also be strengthened by the creation of a separate storage facility for drugs and equipment to improve inventory control and directly monitor the cold chain.

Each DHMT has an HIV/AIDS focal point, but their limited understanding of the disease and its health and social implications can affect service delivery. Sometimes the focal point is from the District Council Health and Sanitation Committee; the person in question may have no health sector experience. To enhance delivery, the focal points will need more support (i.e. training, incentive allowances, etc.).

Delivery of TB medications and staff training is reported to be effective in the four districts benefiting from GF resources where 44 clinics will be in place by 2008. The Round 7 proposal to the GF includes TB with malaria in a combined request. If granted, the government will then expand the program to the remaining districts.

GAVI program delivery problems at the local level have included a lack of fuel for vehicles and generators, weak supply and inventory management, and the failure to reach remote areas. Some GAVI advocacy materials prepared were viewed as culturally inappropriate. Better communications with local politicians through sustained outreach could overcome resistance to vaccine campaigns. Weak staff capacity to adjust to new tasks or to add additional activities was also cited. Finally, M&E problems were noted, including weak information collection systems; out of date maps, leaving some villages over-looked; and a failure to monitor new vaccine coverage rates by locality and use basic indicators effectively for surveillance. While not all of these constraints are unique to GAVI, all do affect service delivery adversely. Despite this, GAVI immunization campaigns have been successful in increasing those vaccinated.

In learning about civil society delivery issues in the health sector, the Sierra Leone Association of NGOs (SLANGO) organized a meeting of about 15 local NGOs to discuss VHF delivery and issues. Local NGOs are the main NAS implementers for HIV/AIDS. They are also involved in GAVI immunization campaigns and are critical to the new DfID and World Bank-funded reproductive and child health project. They are engaged by GF PRs as sub-recipients and are also contracted directly with district councils at the local level.

Many NGOs see the GF as “bureaucratic” and believe there is a bias toward using INGOs and foreign consultants. Local NGOs would like more funds for capacity building, especially in financial management and reporting methodology, so they can do more delivery work now contracted to non-Sierra Leoneans. Also, they would prefer to receive grants directly and not through PRs like the Red Cross.

Local NGOs recommended that the GF advocate that handicapped people be targeted specifically for HIV/AIDS awareness and malaria control. Polio victims, for example, could be used to help educate others with polio on the HIV/AIDS risk factors and in support of immunization campaigns. Finally, they urged VHF be aware of the stigma attached to being disabled or HIV plus and recommended more carefully developed sensitization initiatives to address this issue.<sup>37</sup>

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<sup>37</sup> For example, in the local Krio language people say “Me na polio” meaning “I am a polio victim.” When posters say “kick polio out of Sierra Leone,” some people torment the victims, saying they will throw them out.

### **3.7 Sustainability**

The focal point for the SPA in the Ministry of Finance stressed sustainability as a key issue due to the “unpredictability of donor budgetary and project support.” In 2007, there has been a sharp fall in domestic revenues while many donor funds arrived late, in part due to donor caution around the recent election period. In addition, from a government perspective, the recent GF malaria project cancellation demonstrated the unreliability of donor funding and the sustainability problem. All interviewed, however, recognized that for a country in Sierra Leone’s condition, it will take many years before the government can replace external funds with domestic revenues. In the meantime, the best guarantee of more donor resources is the demonstrated effective use of current funds since donors want results.

MOHS economists’ greatest worry is about the sustainability of new, large VHF initiatives. For example, when the Round 7 GF grant ends in 2009, will there be a Round 8, 9, and 10 or will scaled up programs have to scale down? There are human and financial implications to scaling down as well as up, but there are no short or medium-term viable strategies other than generating new donor funds. Disease control program managers and planning staff also echoed this view. DfID has made a significant commitment to the health sector, so one recommendation was for the VHFs to consider similar longer commitments to lessen the risks of scaling up unsustainable activities.

### **3.8 Impact and Verification**

Overall, respondents positively viewed the impact of VHFs. There is no doubt that lives have been saved, suffering alleviated, and capacities built with VHF inputs. The specific impact by disease, by district, by sub-sector is detailed in LFA reports for the GF and in the government’s own assessments. Three observations on impact did recur through most interviews and are summarized below.

MOHS and district level personnel acknowledged the positive impact of the multiplier effect of VHF money. Equipment like microscopes, motorbikes, and computers are multi-purpose, so their acquisition with VHF resources benefits the health sector as a whole. Per diem to attend workshops is used to advance grant objectives, but once a field person has arrived in Freetown with expenses paid, they are able to consult with other colleagues on related issues, pick up supplies, etc.

Some respondents suggested that the GF seems more interested in funds burn rates than impact. Output is not necessarily a measure of impact. Excessive focus on disbursement rates allows for a quick measure of “absorptive capacity,” but says nothing about the sustainability of gains or whether gains were made at all. One person noted as an example that the GF asked how much money was spent on workshops, but did not ask if they achieved their purposes.

As a global organization working indirectly through LFAs, the GF seems to hold all countries to the same performance standards and time frames. Countries with the weakest institutional capacity sometimes need more time to build capacity and implement activities. An implementation pace consistent with absorptive capacities should be viewed as positive since it means less money is wasted.

### 3.9 Key Country Requests

Key requests from the government and civil society, some of which have been described above, are synthesized into the following list:

- Transaction costs related to fund application and their management and disbursement should be kept as low as possible. When VHF conclude that they need additional information or devise new procedures and forms or decide to alter their criteria and timetables, they should always think through the implications, which, by definition, fall hardest on countries with the weakest human and institutional capacities.
- When developing new initiatives and reviewing the organizational requirements of current grants, VHF should consider whether they have duplicated existing national planning and coordination mechanisms. Additionally, specific consideration should examine whether there is an alternative approach that will prevent duplication, and if so, how VHF can help reduce the emergence of parallel coordinating mechanisms. One suggestion is to provide capacity building during the creation of a national health policy, which may assist government actors in better aligning programs and enhancing coordination, a major Paris Declaration consideration.
- Whether targeting an individual disease or planning an immunization campaign or other activity, VHF should always ensure either that their grant provides funds for essential support activities or that activities are funded by the host government and/or other development partners. For example, purchase of generators and their maintenance are essential to the cold chain; bed nets cannot be distributed without fuel; and even meetings cannot be held if those expected to attend do not have travel funds. Simply stating in a grant agreement that counterpart funds will fund certain critical items is not adequate since this can often be a major cause of project delay. Both the GF and GAVI do provide funds for such support needs,<sup>38</sup> but it is recommended that this process be more systematic and comprehensive.
- Government officials freely admitted that the GF cancelled the Round 4 Malaria grant early due to poor performance by the PR and the Government's own NMCP. It tried to address non-performance issues by changing key staff, but the grant was "quickly terminated." The failure to meet most targets demonstrated the need for greater support to weak institutions. However, cancellation had the opposite effect. Some sub-recipients were performing and penalized by the poor performers. When the NAS was performing poorly in 2002-2003, the World Bank took a different approach, providing advice and helping ensure personnel changes that resulted in major performance improvements. A key recommendation, therefore, is that VHF realize that poor performance is better addressed with remedies than cancellation, since in the case of malaria and other diseases, lives are at stake.
- Human resource capacity building should be an integral part of all VHF grants and should include the national, district, and local levels. Such capacity building must go beyond training to meet the goal of sustainable performance improvement. This involves both skills development and improvement in the wages and conditions of service of health sector

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<sup>38</sup> The GAVI Executive Director stated as long ago as 2001 that an optimum balance might be 60 percent of funds for vaccines and 40 percent to strengthen immunization support services.

personnel. Government recognizes that civil service salaries are low, but it is not financially able to raise them unless VHF and others include funds for salary top-ups at least for targeted positions.

### **3.10 Conclusion**

There are only a few VHFs operating in Sierra Leone, but they provide a vital addition to the health sector resource base, especially for HIV/AIDS and TB. This statement will also be the case for malaria if the government is successful in obtaining new funds for its recent GF proposal. While VHFs in theory can distort horizontal health sector planning, this has not occurred in Sierra Leone in any major way since there is no Sector-Wide Approach or Common Fund with strong multi-donor support. The World Bank and VHFs have agreed on how to avoid overlap. The government's health policies are largely consistent with VHF goals and priorities. The sources of the key problems lie mostly outside the health sector: intense and widespread poverty combined with enormous human resource constraints. It was noted more than once that basic hygiene and better sanitation would do a lot more to raise life expectancy than TB and HIV/AIDS control programs, no matter how important they are in their own right.

## **4. COMPARATIVE ASSESSMENT — GHANA AND SIERRA LEONE**

### **4.1 Government-VHF Relationships and Experience**

The experience of Ghana and Sierra Leone with VHFs overall has been driven by their respective levels of development. Ghana, despite past political instability and economic distress, has had fifty years of independence and peace. It has managed to develop and maintain a growing middle class that provides the human capacity essential to drive down negative health indicators. It also has functioning district governments with more than a decade of local governing experience. Ghana has also benefited from high donor aid levels over an extended period. In contrast, Sierra Leone has had numerous and recent military coups d'états, a ten-year civil war, a 32-year hiatus without elected local government, heavy brain drain and, consequently, a history of inconsistent donor support. Not surprisingly, Sierra Leone is next to last on the UN HDI at 177th place; Ghana is ranked 137th and grouped among countries with a medium HDI. These critical distinctions affect health sector conditions and frame the differences in each country's relationship with VHFs at the national and local levels.

At the national level, the Paris Declaration on Aid Effectiveness underscores the need for countries to "take ownership" of the development process, yet government experience has been that the VHFs' understandable and legitimate procedural requirements and their strategic framework restrict national options with respect to VHF funds use, limiting the sense of ownership. At the same time, within the parameters set out by the VHF mandates, governments have flexibility in designing their own initiatives, and staff does have a sense of ownership within this narrower context. Greater fund use flexibility would enhance both the sense of ownership at the policy level and improve alignment with national goals beyond the target diseases.

Governments have indicated that their experience with VHF (in the case of the GF this often means experience with the LFA) is that there is a genuine commitment to support the PRs by offering practical advice and recommending ways to increase performance. However, such advice is perceived as geared more towards compliance with VHF regulations than with how to improve health service delivery more broadly. When the Paris Declaration talks about “results-based management,” it is stressing the need for managers to put performance first, yet some respondents said that the GF seemed to focus more on outputs than impact. There is little doubt that the GF’s performance standards offer donors an important model for development results. They can enhance government’s sense of ownership and mutual accountability—key Paris principles.

Yet, also based on their experience, government representatives in both countries recommended finding ways to streamline and reduce procedural complexity for obtaining grants, disbursing them, and measuring their impact. Ghana’s experience has been more positive because it is better able to meet VHF requirements. Sierra Leone’s experience has also been positive in the sense that it is learning how to bid on and win grants and how to avoid difficulties by improving its performance capacity.

The government-VHF relationship is also different at the local level in the two countries. Since 1996, the Ghana Health Service, responsible for health service delivery and the teaching hospitals, has been autonomous. This allows them to take local initiatives, but in practice, they are constrained by inadequate funding and poor participation of local government structures in planning and managing local health resources.<sup>39</sup> As a consequence, when VHF resources reach the district level, they often represent the bulk of funds available for health. Hence, some districts apply VHF funds as broadly as possible to pay for priority needs.

Local government in Sierra Leone is much more recent. It was restored after the war in the May 2004 local elections, but has taken time to become functional. Primary health care has already been delegated to the local level, but in practice the DMOs continue to manage health at that level. At some point, DMOs are to become attached to the district government. Funds are routed through the new district councils, but they are forwarded to the DMOs who then provide general reports to the district council on fund use. While funding from the MOHS to the district level is more adequate than in Ghana, the councils are less experienced in managing the practical aspects of the devolution process.

The result for the VHF-government relationship is that resources are disbursed largely through NGOs in the districts, so that a parallel vertical process is created—funds flow from the VHF to the non-government PR (such as the Red Cross) to the sub-recipient to the beneficiary. The MOHS process has funds flowing from the MOF to MOHS to local governments to service providers (including NGOs). When government is the PR, it has more management control and responsibility. The goal of decentralization is to have local governments take ownership of the grant-making process rather than be in a consultative role as is the case when the PR is not the government.

In both countries, among many donors and government officials, there is a genuine sense of urgency given high morbidity and mortality rates. VHF are under pressure to disburse funds rapidly. VHF are also results-oriented and insist on high performance levels with measurable impact. These factors, combined with limited delivery capacity, leads to a sometimes-stressful relationship between VHF and government officials. A small information request from a VHF can be time consuming when

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<sup>39</sup> Ministry of Health, Programme of Work, 2007, p. 36.

data is not readily available. A delayed response is sometimes attributed to inefficiency or disorganization. The GF LFAs make many recommendations, but the same few people implement most of them. No matter how careful or sensitive a VHF and its LFA may be, “recommendations” sometimes carry the force of law; there is always the fear that non-compliance or a different view could put a grant at risk. There is also the matter of national pride. A VHF may assume that the country or Ministry lacks capacity, but health staff can misinterpret this as a negative judgment on their education, skills, or motivation. Finally, the generalized assumption that international NGOs are better able to implement VHF activities than local NGOs or that expatriate advisors are needed is sometimes resented by local people.

## 4.2 Civil Society-VHF Relationships and Experience

Ghana and Sierra Leone present remarkably different civil society profiles in the health sector. In Ghana, civil society functions in a largely open media environment characterized by widespread citizen participation with limited government control over mainly donor-dependent, urban-based NGOs. Civil society representatives noted that their work as GF sub-recipients is diminishing as the government boasts great capacity and fewer sub-recipients in implementation save for HIV/AIDS grants, which is overloaded with organizations. The marked differences in available funding have resulted in numerous NGOs shifting away from other health issues to HIV/AIDS where money is plentiful and stable. The shrinking health market has created an environment where many NGOs “spend most of their time applying for additional funding or renewing current grants, rather than focusing more effectively on activities at the grassroots.”<sup>40</sup>

According to a recent civil society assessment, “87 percent of community survey respondents view CSOs (civil society organizations) in Sierra Leone as providing better services than the state.”<sup>41</sup> Their involvement has not always been consistent or comprehensive due to the war, which decimated local NGOs in terms of staff and infrastructure. In the immediate post-war period, international NGOs worked with local NGOs to provide emergency health care, for example. As local NGOs rebuilt their capacities with available funds from groups like the Red Cross when it was acting as a GF PR, their work and reach, while donor dependent, became more established. There are now numerous NGOs claiming health sector expertise, but many have limited human and institutional capacity. Local NGOs are now playing a major role in the transition from relief to development. This role has been strengthened with VHF resources, but the road has not always been smooth as the previously noted Red Cross example exemplifies.

The differences between Ghana and Sierra Leone’s civil societies affect the GF’s ability to apply its four strategic initiatives to strengthen the sector’s role. These include the routine use of dual-track financing;<sup>42</sup> encouraging funding for strengthening community systems; increasing participation of vulnerable groups in decision-making; and improving access to funding for CCM administration and increasing transparency about civil society access to such funding. The GF admits that “the promise of this approach has yet to be fully realized.”<sup>43</sup> The field visits suggest that the GF is the largest VHF

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<sup>40</sup> The CIVICUS Civil Society Index Country Report for Ghana, *Civil Society in a Changing Ghana: An Assessment of the Current State of Civil Society in Ghana*, Executive Summary.

<sup>41</sup> CIVICUS Civil Society Index Report for the Republic of Sierra Leone, *A Critical Time for Civil Society in Sierra Leone*, p. 8.

<sup>42</sup> This term is used to describe a GF country program where both the government and a NGOs serve as the PRs for respective grants. Sierra Leone used this model with both the GOSL’s NAS and the Red Cross acting as PRs

<sup>43</sup> “A Strategy for the Global Fund: Accelerating the Effort to Save Lives,” p. 38.

that civil society is exposed to, increasing its impact and responsibility to implementing these initiatives in a meaningful manner.

The GF's finding that NGOs are more effective PRs than government agencies is interesting,<sup>44</sup> especially in the Sierra Leone case where this assertion clearly is not supported. Without sufficient capacity and management, some interviewees suggested that the Red Cross could not perform at the expected level. Between the learning curve of another large funding agent and a multiplicity of NGOs unaccustomed to rigorous performance monitoring, a foundation was not adequately in place. Even more striking is the Red Cross situation in light of the GF's statement about support to poor performers. It notes that "there has been a desire to identify and assist grants before they fail . . . A system has been created to identify at-risk grants early in the course of their implementation, with a view to mobilize assistance for them."<sup>45</sup> While it is hard to know the entire picture of why the Round 4 Malaria grant failed and subsequently cancelled, there is little doubt that its impact was significant. The Red Cross, thought to be one of the strongest NGOs in country, did not demonstrate the ability to implement, likely making the CCM risk-averse in choosing another NGO as PR. Thus, Sierra Leone will move away from a dual-track financing model. Some noted concerns that local NGOs will be penalized for a PR's poor performance. The sector will assuredly be engaged in implementation, but the rules will change if the MOHS is awarded control.

As noted in Section 2, Ghanaian NGOs are deeply concerned about the "crowding out" factor. Watching this phenomenon will be critical to the GF and other funders; such a system distortion can have long-term negative effects that may be difficult to reverse. One person noted that donors such as the World Bank that provide the majority of their funding to the government only add to this consolidation. Sierra Leone may experience a similar path in the upcoming grants with the government as the PR. The GF appears to be conscientious about assessing trends and impact. The well-described proliferation of NGOs seeking to capture funds, especially in HIV/AIDS, may lead to a lack of sustainability should funds become scarce, which the anecdotal evidence suggests about non-HIV/AIDS Ghanaian NGOs. As the CIVICUS assessment noted, "while there is nothing wrong with the establishment of NGOs to assist the state to secure better living conditions for the people, the current ad hoc approaches, within a context of limited regulatory frameworks, is not conducive to the health and qualitative growth of the sector."<sup>46</sup> Market forces have a decided impact and provide important corrections such as increased efficiency and eliminating non-performers. Yet, preserving a space for dialogue on health issues and advocacy is an important civil society role that donors generally support. The entire sector seems to face an enormous challenge in addressing this concern; a recent assessment confirmed that "the overall policy impact of Ghanaian civil society is limited."<sup>47</sup> Specifying that NGO advocacy and policy work be included in grants could protect this money in the same way that it does for specific diseases and have a positive impact.

In examining the five Paris Declaration Principles, preserving civil society's space in health programming falls through the cracks. Narrowly interpreted, Paris exists at the government and donor level. If government has the responsibility to include civil society, then it is worrisome to hear key national-level actors in Ghana note that they would completely cut NGOs out of health implementation if they were able and have all the money come to them. The international community wants government to "own" their health systems, but it is hard to imagine that they would wish to see

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<sup>44</sup> Ibid p. 39.

<sup>45</sup> Ibid. p. 16.

<sup>46</sup> CIVICUS, Ghana report, p. 88

<sup>47</sup> Ibid, p. 11.

a targeted approach to reduce civil society's role in health programs. GOSL's relationship with civil society, on the other hand, is one of mutual recognition. Coming out of the war, communities have a strong respect and relationship with NGOs that remained in difficult areas and continued to serve them. While the MOHS stated that they are not always aware of NGO work plans or resources, they also recognize the need to work with and through them since NGOs bring additional human resources and complement government efforts, especially in rural areas. While NGOs have a place on the CCM, competition, limited decision-making, a lack of detailed technical know-how for the three main diseases, and the absence of a collective advocacy approach for key issues hamper the effectiveness of that role. More studies are needed on VHF impact on civil society to prevent unintended consequences that retard the very fabric of a country's ability to serve citizen health needs.

### **4.3 Comparative Institutional Context for Implementation**

The institutional contexts in Ghana and Sierra Leone are distinct. In Ghana, the MOH in Accra has an almost continuous power supply, vehicles and fuel available to facilitate meetings and field trips, computers, and printers with able staff. At the district level, many district capitals have electricity and new government buildings equipped with computers and well-educated staff able to manage district activities. With over 100 districts, capacity varies significantly and some districts have been comparatively neglected. Many of the poorest districts have fared better since donors and government have concentrated their support there while district capitals on paved roads and near Accra have also fared well; many places even have internet connections. In contrast, of Sierra Leone's 12 district capitals, only two have any electric supply. While development partners have funded construction of new government facilities in most district capitals, the equipment availability is uneven; many district staff still use pen and paper due to the lack of power and/or computer skills. While generators have been provided to district offices, fuel is sometimes not available, and maintenance is put off when other priorities intervene. At the MOHS headquarters, key staff is well equipped, and a generator provides most of the electricity to the Ministry's offices. There are sometimes vehicle shortages, and maintenance costs are high due to poor road infrastructure.

The different human capacity levels also define the institutional context. As noted in the sections on each country above, Ghana has a much stronger human capacity, which translates into more effective governance when compared to Sierra Leone. Ghana also pays higher staff salaries so that fewer Ghanaians leave the health field for this reason. Some positions are topped-up by VHFs, which helps retain key staff, but this can also cause sustainability problems later. When compared to the level of performance desired by both governments and their development partners, however, there is much room for improvement. Ghana's 2007 fellowship plan for health is financing ten students abroad and 150 in Ghana, most of who will remain in the sector and in country. Sierra Leone, starting from a lower base, produces fewer health science graduates and loses many to posts abroad, notably nurses. The human resource capacity also varies among districts with the poorest and most remote districts often having the least capacity when the need is just the opposite.

While these institutional differences have so far led the GF to use the NAS and an NGO as their PRs in Sierra Leone, the institutional context is dynamic in both countries. Just as Ghana is struggling to build a common, integrated approach to health sector funding, Sierra Leone is working to develop sufficient government capacity to enable it to manage and coordinate GF and other VHF resources. There is no single "right" approach to the question of how VHFs "should" relate to national institutions since conditions change constantly. What is essential is that VHFs try to work toward the

Paris Principles by engaging relevant national institutions and supporting them until they are able to serve as effective local partners in a sustainable joint effort to raise health standards.

#### **4.4 Comparative Modes of Implementation**

In Ghana, the MOH is the GF PR for HIV/AIDS, TB, and Malaria grants. The GOG has a “common fund” through which many development partners channel their aid so that the country can develop a SWAP to funding and coordination. Some donors continue to fund parallel projects;<sup>48</sup> some who contribute to the common fund have expressed reservations about government spending priorities.<sup>49</sup> However, the principle of an integrated SWAP for health care financing has been established and is being strengthened as the GOG learns to manage pooled funds more effectively. The GOG and most donors see this approach as the only way for Ghana to “take ownership” of its own development process, a key goal of the Paris Declaration.

In Sierra Leone, the GF PRs have been the NAS for HIV/AIDS and the Red Cross for TB and malaria. There is almost no pooling of resources. Sierra Leone’s numerous development partners continue to use a project approach. Leading donors have expressed the desire to move toward a SWAP as soon as the government is able to manage it. Many donors have their own project implementation units since government ministries have been viewed as weak and ineffective. This was certainly the case during and immediately after the war when government did not function outside the capital. Capacity is still far weaker than in Ghana. However, the war ended five years ago, and there has been significant external support for physical and institutional reconstruction.

In line with the Paris Declaration, an attempt to harmonize donor assistance for immediate post-war reconstruction and the transition from relief to development was made with the establishment of the National Commission for Social Action (NaCSA), whose head reports directly to the President. Since 2003, NaCSA has obtained almost \$100 million USD from the World Bank, African and Islamic Development Banks, German and French governments, and the UNDP. It has also handled some Highly Indebted Poor Country funds and managed activities funded by the UNHCR. Despite donor willingness in theory to coordinate and integrate their activities using a “program approach” through NaCSA’s funding windows, some donors continued to use a project approach while being physically located inside NaCSA’s offices. This situation complicated efforts to develop national ownership and weakened results-based management as various donors insisted on the application of their respective procedures, reporting timetables, and priorities. Accountability was mainly one-way since NaCSA was unable to obtain compliance from some donors with their own funding timetables. This experience will affect efforts to develop common funds and SWAPs since donor wariness of government capacity is still manifest and NaCSA staff has experienced difficulties involved in integrating initiatives by disparate development partners.

In addition, it should not be assumed that NGOs necessarily have more capacity than government since many of them were also affected by the war. The GF terminated the Red Cross Malaria grant because of performance problems while NAS suffered from major management problems during its

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<sup>48</sup> USAID is the principal donor still using the project approach with implementation carried out by NGOs and US-based consulting firms. The GOG would prefer that USAID participate in its common approach.

<sup>49</sup> Government used funds to raise salaries in the health sector to levels above those in other sectors while some donors thought government should have used the funds for direct care. While fund allocation is always debatable, the long-term government goal is a motivated staff with reduced brain drain and government believes better pay and working conditions are a key to achieving that objective.

first years. Several sub-recipients also had their grants cancelled due to poor performance, including at least two INGOs.

The Sierra Leone MOHS has proposed to become the PR for the next GF round grant for malaria and TB. The MOHS believes it has adequate implementation capacity, but most donors expressed reservations and argued that the GF would be better off using the MOHS as the PR only for TB in this round to test capacity since it is a smaller funding amount than malaria. Similarly, the World Bank prefers to channel its funds for the new Reproductive Health and Child Survival Project directly to the districts to build local government management and implementation capacity while the MOHS prefers that funds be routed through them. While the MOHS and its development partners have shared goals and priorities, there are different views about current government capacities. In this environment, VHF's have not been viewed as distinct from other development partners with respect to their implementation mode. In some ways, like VHF's, most donor aid to the country is vertical in the sense that they enter the country with their own objectives, priorities, funds, and reporting requirements. In Ghana, the MOH's Programme of Work for 2007 simply lists the GF and GAVI as donors along with DfID, USAID, the AfDB, and others. The GF and GAVI, like other donors, have their own coordination units, funding cycles, and procedures and objectives, so it should not be surprising that the recipient governments do not distinguish between "vertical" health funds and other funding sources that seem to operate in similar ways.

## **4.5 Comparative Impact of VHF's**

The tremendous funding levels coming into Ghana and Sierra Leone have broad impact in the health sector in both targeted and unforeseen ways. Resources to combat the three diseases have significantly increased in countries where governments would have been unable to find resources alone. More people, including children, have been vaccinated, preventing disease. The focused attention on HIV/AIDS, Malaria, and TB has served as a wake-up call that the old ways of dealing with these diseases must change for people's health to improve. Policies have been drafted after mostly broad consultation. Money for specific health issues is protected through earmarking. Programs are being rolled out across the country, using both government and civil society actors. Staff and institutional capacity have increased. Stronger systems have been developed to monitor performance.

Concerns loom about budget dependency and sustainability however. As noted previously, based on government information, estimates are that the GF alone accounts for nearly 30 percent of Ghana's donor budget for health while Sierra Leone's is 10 percent; the latter percentage would be greater if the GF grant for malaria had not been terminated. While VHF's are intended to be additive, country representatives are calling for more flexibility in fund use and seeking ways to expend targeted funds in a more integrated fashion. New vaccines and drugs are being introduced that are costly in environments like Sierra Leone where cheaper or fake drugs are common and sold from corner pharmacies boasting impressive packaging. With families living on less than \$1 USD per day, expensive drugs are not realistic for sick Sierra Leoneans without continuous external assistance. People living with HIV/AIDS are at most risk since anti-retroviral use is long-term; even then, only a small fraction of those infected are on the drugs to begin with.

Leaders like Sierra Leone's recently elected President Koroma are able to raise citizen expectations with the influx of additional money for important issues like health. The announcement of the new HIV/AIDS grant made every major newspaper's front page during the field visit. Delivering new

services to a resource-starved country can boost a government's delivery of public goods. A suspension of services can also be damaging as in the case of the Round 4 GF Grant. Malaria, the largest killer in Sierra Leone, is left largely unaddressed due to poor recipient performance. While the GF notes that it has strategies in place to work with PRs so that they won't fail, something broke down with the Sierra Leone grant. The GF, which is supposed to target the most damaging diseases in Africa, is suddenly not funding any malaria programs while funding HIV/AIDS in a country where the infection rate is remarkably low. The skewing of funding is noticeable as is the differential impact.

Ghana and Sierra Leone's diverse development levels make a one-size-fits-all approach problematic. Expectations that they could perform at the same targets were not realistic. A GF strategic objective is to adapt to country realities, yet it was not apparent from the field visit how this had occurred beyond increased flexibility through the Rolling Continuous Channel for some of Ghana's grants. In some discussions, MOH staff agreed that the GF and other VHF's should have different country categories depending on the development level. There are many types of rankings, but the recent Ibrahim Index of Africa Governance by the Mo Ibrahim Foundation placed Ghana at number 8 while Sierra Leone was 39.<sup>50</sup> Taking such rankings into programmatic account for working on health issues would involve a different approach. Ghana, whose systems are stronger and well established, could perform under the current GF expectations; however, even they had some performance issues with a GAVI grant in 2004. Sierra Leone, a country emerging from war, would have more funding dedicated in the beginning to overall capacity and critical targets such as infant mortality from malaria. Perhaps low, mid, and highly developed categories would better serve the GF and other VHF's. While increasing the complexity for the GF and the LFA and other VHF programs, it might have the advantage of better serving recipient countries.

#### **4.6 Overall National Perspectives and Conclusions**

While VHF's boost country resources in health and increase staff morale and citizen awareness, they narrowly target specific priority diseases and possess high transaction costs. Benefits have been well noted. Yet, implementation through individual disease programs narrows the lens through which a program manager sees his disease portfolio amidst the entire health sector, creating unmanageable distortions in the health system. The effect of this distortion could be seen for a long time, creating more problems than positive, short-term results. While policy makers are supposed to see the bigger picture, they are receiving direction from donors on how to spend their funds. Their own priorities are often not in sync with the earmarking, prompting significant calls for flexibility. The GF's decision to only provide health system strengthening support directly to entities combating the three diseases further narrows the impact. Not addressing the entire system's capacity creates pressure points and weaknesses across the health sector's foundation.

Attention and targeted money ensure that these main diseases have resources and are addressed. Larger funds clearly have a greater footprint. For a MOH, the bigger VHF's dominate the agenda. For a place such as Sierra Leone, emerging from a non-functioning government, earmarking and its accompanying plan appears critical; however, without the proper health strengthening support, PRs can fail like the Round 4 Malaria grant, which had enormous repercussions. Failure does have benefits from a policy perspective, however. Critical management changes are made. Greater attention and oversight is provided. Yet, Sierra Leoneans still greatly suffer as malaria is left

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<sup>50</sup> The ranking and report can be found at [www.moibrahimfoundation.org](http://www.moibrahimfoundation.org).

unaddressed by the largest funder. Performance is an important factor in development. Ghana understands that it is competing against other countries for resources and engages in strategies to maintain its comparative advantage. Countries like Sierra Leone are simply not at the same level. Further implementation of the GF strategic objective, adapt to country realities, would have a positive impact and should be examined.

The proliferation of VHF coordinating mechanisms is a major concern. With regard to the Paris Declaration, one target for alignment is to reduce the number of parallel project implementation units by two-thirds by 2010. However, each fund has its own reporting and financial systems; the GF has its own software and requires a separate financial account. The VHFs are not signatories to Paris. Thus, in some ways, the VHFs operate outside the Paris framework. While the UN is trying to harmonize its systems into one, that process will take time, and it is not clear whether GAVI will be included. Given the increase in these structures, it is not difficult to understand why the large funds dominate. As people continuously noted, they struggle to attend all the meetings as they currently stand. The opportunity costs of smaller VHFs with their own rules and regulations must be considered in the larger picture.

Lastly, a main question still looms as the effectiveness of VHFs is examined. Is the money really trickling down to the right beneficiaries? More studies are needed to look at impact in terms of the number of people that are being helped versus the number of systems being strengthened or people trained. GAVI seems to be easier to measure in these terms than the GF. The GF and GAVI appear to give serious and ongoing attention to their impact and increasing their effectiveness. However, working at a higher review level with the government and other donors working in health could help everyone see the fuller picture. Donors have serious concerns about the financial sustainability of Ghana's health sector, for example. Ensuring that VHFs are not part of the problem would be an important macro-level exercise. Unlike a failure of a targeted grant for a specific disease like in Sierra Leone, the subsequent collapse of a scaled-up health system would have lasting and far-reaching effects.

## **4.7 Recommendations**

After examining the individual country requests and concluding national perspectives, this section outlines specific recommendations for both VHFs and governments. The following suggestions are for VHF consideration as they continue to act as major change agents in developing countries' health sectors.

- More actively incorporate Paris Principles into criteria for proposal selection and performance monitoring.
- Beyond the LFAs, assign a working group at the GF to analyze and monitor system distortions, resulting in a rolling dialogue with the CCM and MOH to address potentially long-term negative impacts on the health sector.
- As a pilot with strong performers like Ghana, increase fund flexibility to potentially address major health issues beyond malaria, TB, and HIV/AIDS. If the results are positive, modify the funding conditions to serve a broader set of health concerns.

- Increase capacity building funding for countries that need assistance in creating a national health policy that responds to the Paris Declaration while also allowing funds to build NGO capacity to better implement health programs.
- Hire consultants to do a multi-country study to examine the impact of a government serving as the PR on the NGO sector to ensure that the GF and other VHF are not creating an atmosphere of “crowding out,” which has long-term negative effects.
- Working with development professionals, examine and pilot the creation of different country categories based on countries’ development level. Then, craft different proposal criteria and performance measurements to meet a country’s needs based on where they are in the development trajectory.
- More actively work with the country’s CCM to assess the actual funding needed for the three main diseases to ensure that there are no distortions promoted and that VHF priorities are aligned with the government’s national health plan in line with the Paris Declaration.

The following recommendations are for the respective governments receiving VHFs. As VHFs continue to play an important role in a country’s health system, governments should consider the following:

- Test a more integrated program manager model rather than a disease-specific platform to reduce the disease-silo phenomenon.
- More clearly track all VHFs coming into the country’s health system to ensure that the total funds available is captured and examined against the national health plans.
- More actively monitor new PRs, especially if not the government, ensuring that the right people are leading and managing the programs against the expected results.
- More interface and coordination between line ministries regarding the funding coming in for health issues; these include the MOH, MOF, and others involved in planning or international cooperation. The decided lack of coordination regarding these government resources only enhances bureaucratic rent seeking, creates additional layers for donors to work through, and reduces support for a country’s overall development in meeting the Paris Declaration.
- Communicate more frequently internally when major changes occur to the national health policy such as in Ghana. A lack of information creates unneeded speculation about the reasons for the changes, taking critical time away from daily duties. NGOs could be utilized effectively to communicate such messages from the national to the district level to ensure that all health actors are on the same page.
- Work more cooperatively with NGOs and access their strengths, reducing the sense of competition and tact of consolidation. Create capacity building plans in VHF proposals in NGO areas of weakness to improve overall service delivery.
- Work more proactively with donors to encourage them to reduce the amount of coordinating mechanisms, reducing transaction costs, and include VHF actors in this discussion, ensuring that they buy into the Paris Principles.

- Be more attentive to NGO concerns about “sweet-heart deals.” While proposal criteria may be explicit, the often the reasons for selection are opaque, encouraging negative speculation that only undermines the CCM’s objectives.
- Have annual forums on human resource strengthening and sustainability to examine these critical aspects in the larger health system, inviting donors, VHF actors, and NGOs to the table. Looking beyond individual donor and grant programs to examine the larger picture can have tremendous payoffs. Like any organization, the need to see trends, address concerns, manage risk, and innovate only increases the MOH’s leadership and management of the country’s health sector.
- Work more proactively with regional and district officers, ensuring that they are represented on health coordinating bodies such as the CCM or IACC.

## 4.8 Further Research and Next Steps

In examining the body of evidence suggested in this report, various areas of further exploration are warranted. This study only looked at two countries. Further countries should be added to establish a greater baseline and body of work from which to speak more definitively about the VHF phenomena and the impact it is having. An additional country mix should include more developed and rebuilding states, highlighting how a one-size-fits-all approach works—or doesn’t—in these two different environments. Additionally, consideration should be given to examining countries outside of Africa that receive VHFs like Bangladesh or Guatemala. It would be interesting to note whether the specific trends found in Ghana and Sierra Leone are echoed in other GF countries in other regions. Countries with President's Emergency Plan for AIDS Relief and the President’s Malaria Initiative should also be included in subsequent rounds.

Additionally, more consideration should be given to examining how these funds impact the local government and areas outside the capital. The current study had significant restrictions on its available time, so was unable to investigate this aspect in the detail it necessitates. It is in the local perspective where there were several allusions to areas of corruption and skimming that warrant further examination. Consideration should be also given to the following research questions. Are VHFs providing more resources for this type of behavior in areas with less financial controls or a culture of corruption? It might be useful to use Transparency International’s annual Corruption Perceptions Index and others as a base for examining countries receiving significant VHF resources. Other studies have documented corruption concerns in the health sector, especially in procurement. However, that is only one area of the whole. More remains to research and evaluate.

Another area that requires serious examination is VHFs’ “trickle down” effect. How much of the money is actually going directly to medical practitioners such as doctors and nurses and actual sick people? It appears that much of money seems to be going into the ministry coffers and other NGOs, e.g. the Sierra Leone’s HIV/AIDS grants which included 39 subrecipients. Proposals of that nature may be expending more labor and overhead costs than originally intended. In this vein, there should be a decided attempt to link VHF work in light of the scaling up agenda. The focus should be on the quality of the VHF programs and not the quantity.

Further research should explore alternatives to the one-size-fits all approach for the GF and GAVI. There are special distinctions between more developed and rebuilding states. Understanding these differences and the impact this approach has on a country’s health system is critical to managing or

heading off long-term negative effects. It is especially important to engage the GF on this topic. After a brief communication about Ghana's GF funding to date, it became obvious that Dr. Blerta Maliqi, the Fund Portfolio Manager for West and Central Africa, did not see the GF as a VHF. In order to address any problem, the people involved must recognize various viewpoints and concerns. More inclusive dialogue and research between the GF and others will be critical in moving ahead.

Lastly, if VHFs are actually weakening a country's health system, are the short-term gains worth the long-term consequences? This argument requires serious and insightful examination. In looking at a country's health sector funding, it is important not to lose sight of the human element amidst policy directives, proposal development, and program implementation. People's lives are at stake. Being attentive to that point is critical in any further research and ensuring that recommendations for improvements in VHFs are implemented for the benefit of all.

## ANNEX 1: FUNDING PICTURE FOR GHANA AND SIERRA LEONE

Table 1: Ghana Global Fund Funding<sup>51</sup>

Portfolio of Grants			
	Total Funding Request	Approved Maximum +	Total Funds Disbursed:
<b>HIV/AIDS</b>			
• Round 1 : The Ministry of Health of the Republic of Ghana	\$14,170,222.00	\$14,170,222.00	\$14,170,222.00
• Round 5 : The Ministry of Health of the Republic of Ghana	\$97,098,678.00	\$31,630,098.00	\$27,729,831.00
<b>Total :</b>	<b>\$111,268,900.00</b>	<b>\$45,800,320.00</b>	<b>\$41,900,053.00</b>
<b>Malaria</b>			
• Round 2 : The Ministry of Health of the Republic of Ghana	\$8,849,491.00	\$8,849,491.00	\$8,729,474.00
• Round 4 : The Ministry of Health of the Republic of Ghana	\$38,887,781.00	\$38,887,781.00	\$28,462,818.00
<b>Total :</b>	<b>\$47,737,272.00</b>	<b>\$47,737,272.00</b>	<b>\$37,192,292.00</b>
<b>TB</b>			
• Round 1 : The Ministry of Health of the Republic of Ghana	\$5,687,055.00	\$5,687,055.00	\$5,685,493.00
• Round 5 : The Ministry of Health of the Republic of Ghana	\$31,471,784.00	\$14,547,546.00	\$9,516,232.00
<b>Total :</b>	<b>\$37,158,839.00</b>	<b>\$20,234,601.00</b>	<b>\$15,201,725.00</b>
<b>Total</b>	<b>\$196,165,011</b>	<b>\$113,772,193</b>	<b>\$94,294,070</b>

<sup>51</sup> Information from the Global Fund website.

**Table 2: Ghana Donor Health Funds for 2007<sup>52</sup>**

Source of Funds	Cedis (in millions)	USD (in millions)
	<b>2007</b>	
Global Fund	357,984	\$38,630
GAVI	81,105	\$8,752
DANIDA	45,000	\$4,856
Netherlands	199,136	\$21,489
UNICEF	55,288	\$5,966
WHO	68,561	\$7,398
JICA	66,294	\$7,154
USAID	0	\$0
UNFPA	6,127	\$661
BADEA	28,500	\$3,075
AFDB	44,357	\$4,787
NDF	29,373	\$3,170
ORET	165,212	\$17,828
OPEC	31,875	\$3,440
Spanish Protocol II	108,000	\$11,654
EU	9,642	\$1,040
<b>TOTAL</b>	<b>1,296,454</b>	<b>\$139,900</b>
GF Percent Of Total Funds	27.61%	
GAVI Percent of Total Funds	6.26%	

<sup>52</sup> Ministry of Health, Programme of Work, 2007, p. 52.

**Table 3: Sierra Leone Global Fund Funding<sup>53</sup>**

<b>Portfolio of Grants</b>			
	Total Funding Request	Approved Maximum +	Total Funds Disbursed:
<b>HIV/AIDS</b>			
• Round 4 : The Sierra Leone National HIV/AIDS Secretariat	\$17,820,803.00	\$17,820,803.00	\$8,132,093.00
• Round 6 : The Sierra Leone National HIV/AIDS Secretariat	\$26,482,115.00	\$9,627,778.00	
<b>Total :</b>	<b>\$44,302,918.00</b>	<b>\$27,448,581.00</b>	<b>\$8,132,093.00</b>
<b>Malaria</b>			
• Round 4 : The Sierra Leone Red Cross Society	\$14,855,611.00	\$8,886,123.00	\$6,956,097.00
• Round 7 : Principal Recipient information will become available upon Grant Signature	\$26,108,640.00	\$10,011,250.00	
<b>Total :</b>	<b>\$40,964,251.00</b>	<b>\$18,897,373.00</b>	<b>\$6,956,097.00</b>
<b>TB</b>			
• Round 2 : The Sierra Leone Red Cross Society	\$5,698,557.00	\$5,698,557.00	\$4,047,663.00
• Round 7 : Principal Recipient information will become available upon Grant Signature	\$10,530,635.00	\$4,340,048.00	
<b>Total :</b>	<b>\$16,229,192.00</b>	<b>\$10,038,605.00</b>	<b>\$4,047,663.00</b>
<b>Total</b>	<b>\$101,496,361</b>	<b>\$56,384,559</b>	<b>\$19,135,853</b>

<sup>53</sup> Ibid.

**Table 4: Sierra Leone Donor Funds<sup>54</sup>**

Source of Funds	Leones	USD
Global Fund	10550776564	\$3,562,153
GAVI	1282957716	\$433,152
Rotary Club	0	\$0
DFID	1639930275	\$553,673
World Bank	19983361074	\$6,746,782
ADB	0	\$0
USAID	3196700605	\$1,079,270
UNICEF	17191146717	\$5,804,075
UNFPA	2008174980	\$678,000
UNDP	1194651765	\$403,338
UNAIDS	96113980	\$32,450
WHO	1512771837	\$510,742
IRISHAID	6334615683	\$2,138,693
IDB	2675611779	\$903,340
CORDAID	4158867440	\$1,404,117
WFP	7425417813	\$2,506,969
EU	28501923831	\$9,622,819
<b>TOTAL</b>		<b>\$36,379,573</b>
GF Percent Of Total Funds	10.21 %	
GAVI Percent of Total Funds	0.01%	

<sup>54</sup> Information provided by MOHS staff.

## ANNEX 2: LIST OF PERSONS MET

### Ghana:

Dr. Edward Addai (Director PPME, MOH)  
Dr. George Amofa, (Deputy Director, Ghana Health Service/GHS)  
Dr. Maureen Martey (MOH)  
Dr. Irene Agyapong (Greater Accra Regional Health Director)  
Dr. Frank Bonsu (National TB Program Manager/GHS)  
Dr. Appiah Denkyira (Eastern Regional Health Director)  
Dr. Marfo (New Juaben District Health Director)  
Dr. Winful (Akuapem North District Health Director)  
Prof. Awuku Sakyi (Ghana AIDS Commission)  
Dr. Antwi Agyei (EPI Program Manager, GHS)  
Prof. Awuku Sakyi (Ghana AIDS Commission)  
Mr. Herman Dusu (Financial Controller, MOH)  
Mr. Samuel Boateng (Director Procurement, MOH)  
Mr. Frimpong (Malaria Control Program)  
Ms. Beth Ann Moskov (USAID)  
Dr. Harry Opata (World Health Organization)  
Dr. Evelyn Awittor (World Bank)  
Mr. Benson Okundi (Price Waterhouse Coopers)  
Ms. Lydia Clemmons (Chief of Party, Strengthening HIV/AIDS Response Partnerships)  
Mr. Richard Killian (Project Director, Quality Health Partners, EngenderHealth)  
Mr. Charles Acquah (NGO representative)  
Dr. F.N. Awua-Siaw (Director, Institutional Care Directorate, GHS)  
Dr. Nii-Akwei Addo (Programme Manager, National AIDS Control Programme)  
Dr. Nicholas Adjabu (Deputy Director, CED, GHS)  
Dr. Patrick Aboagye (RH Coordinator, GHS)  
Mr. Andreas Bjerrum (DANIDA)  
Mr. Mark Young (UNICEF)

### Sierra Leone:

Mr. Michael Amara (Health Economist, MOHS)  
Dr. Samuel Baker (National Malaria Control Program)  
Mr. Alimamy Bangura (Economist, EPRU, Ministry of Finance and SPA Focal Point)  
Mr. Geert Cappelaere (Representative, UNICEF)  
Mr. Yayah Conteh (Director, Donor/NGO Liaison Office, MOHS)  
Dr. Foday Daffay (National Tuberculosis Control Program)  
Ms. Ruth Davies (Right to Play, NGO)  
Ms. Sheila Davies (SLANGO Chairperson)  
Mr. Martin Farmah (Bombali District Council)  
Ms. Sarah Fox (Health Economist, MOHS)  
Mr. Engilbert Gudmudsson (World Bank Country Representative)  
Ms. Jeneh Jalloh (USAID)

Mr. Abu Kamara (Sierra Leone Red Cross)  
Mr. Brima Kamara (War Wounded Association)  
Dr. Clifford Kamara (Director of Planning and Information, MOHS)  
Mr. David Kamara (Youth Arising Disabled Organization)  
Mr. Ibrahim Kamara (Polio Victims Association)  
Mr. Ousman Kamara (War Wounded Association)  
Mr. Marx Kanu (National AIDS Secretariat, GF Project, Admin/Finance Officer)  
Dr. Brima Kargbo (National AIDS Secretariat Director)  
Mr. Thiam S. Kargbo (Youth Welfare & Development Organization)  
Dr. Enamul Karim (UNICEF Consultant)  
Ms. Fatmata Massaquoi (Sight Savers International)  
Ms. Emma Parker (Society of the Blind)  
Ms. Joanna Reid (DfID, Health Sector Team Leader)  
Ms. Mbalu Sesay (President, Action for Development)  
Mr. Unisa Sesay (IEC Director, NaCSA)  
Mr. Victor Sesay (AIDS Coordinator, NaCSA)  
Dr. Smith (District Medical Officer, Bombali)  
Ms. Yuki Suehiro (Health and HIV/AIDS Coordinator, CARE)  
Dr. Haroun Thuray (Global Fund CCM Coordinator)  
Ms. Theodora Wilkinson (SOS Children's Village)  
Dr. Arthur C. Williams (Director-General, Medical Services, MOHS)  
Dr. F.R. Zawaira (Representative, WHO)