



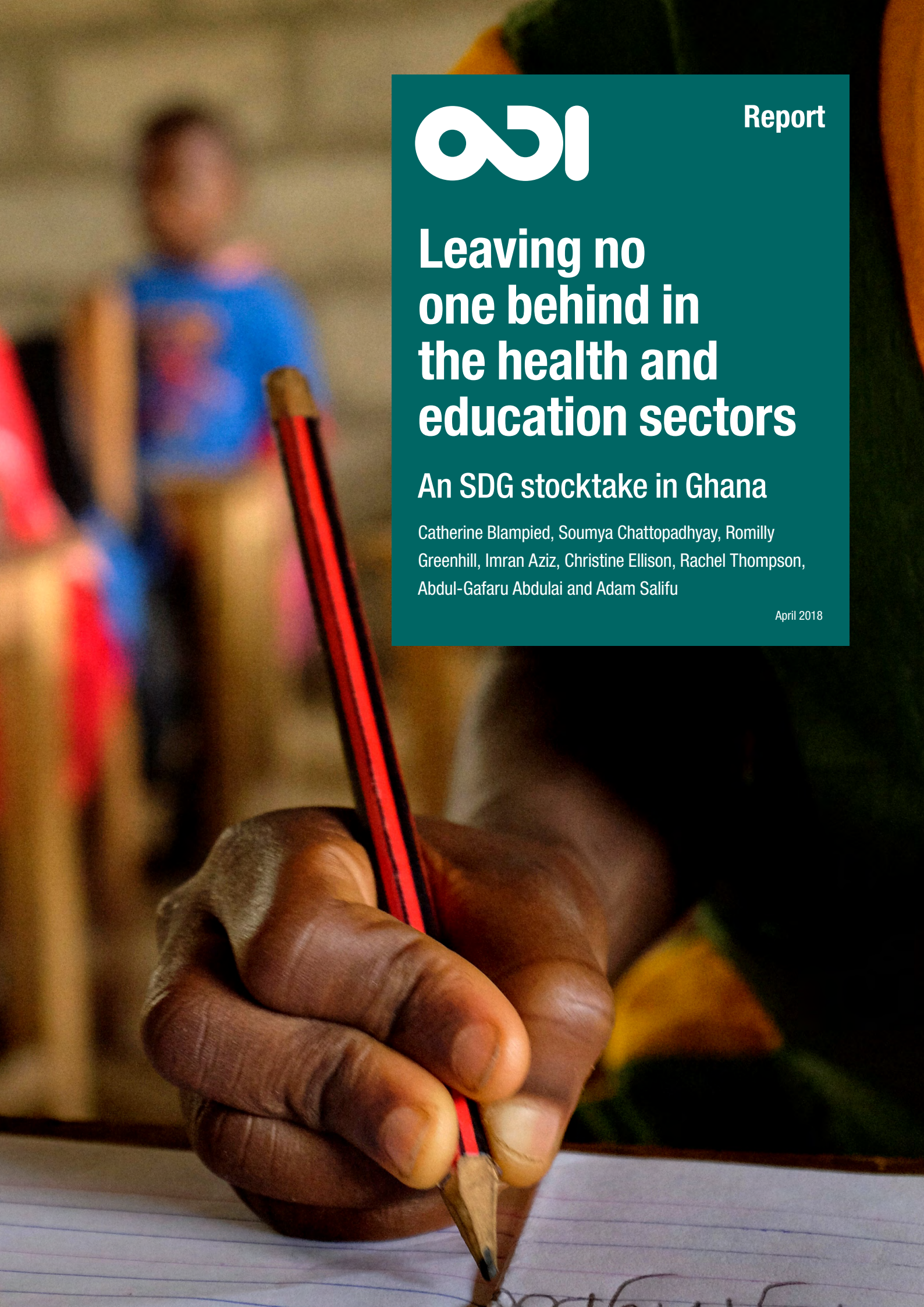
Report

Leaving no one behind in the health and education sectors

An SDG stocktake in Ghana

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Cover photo: A student writes in an exercise book at the Finger of God Preparatory School in Madina, a suburb of Ghana's capital, Accra.
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Executive summary

Ghana has been widely acknowledged as one of sub-Saharan Africa's 'rising stars' during the era of the Millennium Development Goals, and has made substantial progress in improving access to health care and education over the past two decades (Lenhardt et al., 2015). However, a step change is now needed to 'reach the furthest behind first', as committed in Agenda 2030, if Ghana is to leave no one behind in its progress towards the Sustainable Development Goals. This report contributes to that debate by addressing the questions of who is being left behind, and why – integrating analysis of data, policy, financing and service delivery, and offering concrete recommendations for change.

The report highlights three main risks to leaving no one behind in health care and education in Ghana:

First, Ghana has been reversing away from universal health coverage in recent years, which disproportionately impacts poor and marginalised groups. A key metric of basic maternal and child health coverage, the Composite Coverage Index (CCI), declined slightly between 2008 and 2014. Ghana's CCI score is now closer to Nepal's – a least developed country with roughly half its gross domestic product per capita – than to Kenya's (ODI, 2016). Over the same period, the share of out-of-pocket payments in total health expenditure has grown, while coverage of the population under the National Health Insurance Scheme (NHIS), which is supposed to be universal, has stagnated around 40%. Women in Banda, a poor, rural district in Brong Ahafo region, told us that 'informal' charging for services that are supposed to be free sometimes left them unable to access them – for example, they choose to stay at home to give birth rather than pay 60 Cedis (\$14) to cover the cost of supplies.

Second, there is a quiet crisis in the quality of public pre-primary and primary education, the two most critical stages for improving equity. Mothers we spoke to in rural Banda complained of kindergartens and primary schools resembling 'death traps', with walls or floors missing, or with no drinking water available. Mothers in Zabzugu district in Northern region described their children as regularly returning home from school as the teacher was absent. Even on paper, Zabzugu has a trained teacher-to-pupil ratio of 1:103 at primary level, and this does not account for the reality of pervasive teacher absenteeism. Between 2012 and 2015, per pupil government funding for kindergartens and primary schools flatlined, but it grew rapidly for secondary and tertiary education. By 2015, senior high pupils were being funded at nearly six times the level of primary pupils. Families with the means to do so are turning to the private sector at the basic levels – the share of total primary enrolments accounted for by

private schools has risen by a third in five years – before transitioning across to better-quality public high schools (MoE, 2016). Yet, for the poorest households or those in some remote areas, this is not an option.

Third, the geography of inequity in Ghana remains a striking problem, with Northern region left the furthest behind. Almost a fifth of 13-15 year olds in Northern region have never had formal education, more than four times the national rate. In health, adequate basic service coverage for maternal and child health in Northern region is under 50%, and there are just 2.1 health centres per 1,000 km². Some regional disparities have been shrinking – particularly enrolment figures in education – but health coverage declined in Northern region between 2008 and 2014. In our analysis of financing, we found large variations in per capita health and education budget allocations between regions and districts, which were not correlated with poverty, need or performance. The predominant practice of incremental budgeting is likely entrenching existing disparities between regions and districts.

This report demonstrates that, despite a range of ambitious policies promoting equity and inclusion in both the health and education sectors, resources have not been allocated to match this intent. Ghana's highly competitive electoral dynamics have resulted in an entrenchment of universal policies that are extremely ambitious and that are not being implemented in line with the principle of *progressive universalism*. For example, the NHIS has a very broad benefits package, covering 95% of the diagnosed disease burden, but excluding family planning, which is known to be a highly cost-effective and pro-poor intervention. The NHIS' precarious financial situation and inefficiencies in its administration have led to extreme delays in reimbursing health facilities and widespread and regressive 'informal charging' (Atim and Amporfufu, 2016). Similarly, the roll-out in 2017 of an election campaign promise to launch free senior high school nationwide is laudable, but could harm equity unless more is done to first address the hundreds of thousands who will never enter school at all, or the millions of poor and vulnerable children receiving a sub-standard primary education before they even arrive at high school.

Given its strong and laudable commitment to equity and inclusion, the Government of Ghana (GoG) should now seize the opportunity to ensure that resources are allocated efficiently towards tackling these disparities. The story of health care in Ghana's Upper East region highlighted in the report illustrates the point that a lot can be achieved in a short space of time, with determination and innovation backed by financial resources. In 2008, the Upper East

region had one of the lowest CCI scores in the country; by 2014, it had recorded the highest CCI performance in the entire country, bucking the national trend of decline. Drawing lessons from what worked in such examples of success in Ghana and elsewhere, we offer a set of policy options for data, policies, financing and service delivery.

- In terms of **data**, the most urgent implication of ‘leaving no one behind’ is data disaggregation. This is necessary both to capture ‘invisible’ groups such as people with disabilities, and to align data representativeness with the unit of local governance (i.e. districts). Lessons can also be learned from innovative use of data to influence policy-making, planning and media reporting, such as the District Scorecard and League Table Initiative (UNICEF and CDD-Ghana, 2016).
- In terms of **policies**, we highlight the need to explicitly recast Ghana’s health and education systems in the model of ‘progressive universalism’, which would enable the GoG to prioritise improving equity within a universal policy framework, through smart sequencing, targeting and rationing of resources. The other priority is improving human resource distribution, which was successfully achieved in Upper East region through a combination of targeted material incentives, mentoring and coaching, and hybrid combinations of top-down and peer accountability for performance. The Untrained Teachers Diploma in Basic Education initiative nationwide has also been successful in training and retaining teachers from local deprived communities (Associates for Change, 2016).
- In terms of **financing**, the GoG should prioritise a more efficient allocation of funding within the health and education sectors to components of these systems that are critical for equity. In health, this includes better funding for district and sub-district facilities, especially Community-Based Health Planning and Services in districts with the lowest levels of provision per capita and per area. In education, it includes redressing the growing imbalance between funding for the primary and pre-primary sectors compared to the secondary and tertiary sectors. We recommend implementing, over time, a transparent and needs-based budget formula; while in the meantime prioritising the most glaring gaps in provision, especially in Northern region. Development partners, even as many transition away from concessional support to Ghana, should prioritise strengthening systems at points where diagnosed weaknesses, such as those highlighted in this report, are most likely to undo past gains and disadvantage vulnerable and marginalised groups.
- Finally, in terms of **service delivery**, our overall finding is that the main bottleneck is on the supply side rather than a lack of demand. But in notable exceptions where there are demand-side challenges, initiatives and programmes backed by strong evidence of effectiveness include equitably and transparently implemented school feeding programmes; public transport for children to reach school in remote and lightly populated areas; and incentives such as cash transfers to encourage mothers to deliver in health facilities.

1. Introduction

This chapter sets out the background and rationale for the study, and describes our conceptual framework, research methods and case selection.

1.1. Rationale for the study

The Sustainable Development Goals (SDGs) paint an inspiring vision of what the world could look like in 2030 (UN, 2015). A fundamental tenet of the SDGs is the concept of ‘leaving no one behind’. Most notably, in signing up to these goals as part of Agenda 2030, governments have pledged to ‘reach those furthest behind first’ (Ibid.) – a quite different paradigm to that of the Millennium Development Goals (MDGs), which focused on average or aggregate progress. Yet, despite multiple references to the concept in Agenda 2030 and in other policy discourse at international and national levels, there is a risk that the concept is left open to a very broad range of interpretations. While its achievement is pivotal to the success of Agenda 2030, the concern is that ‘leaving no one behind’ will not be implemented or monitored in the same way as other aspects of the SDGs.

To address this problem, ODI is conducting a series of ‘leave no one behind stocktakes’ to identify who is left behind, to what extent and what can be done about it, in different countries and sectors. The purpose of these case studies is two-fold: first, to understand the state of existing data and the extent to which these tell us about who is being left behind in certain sectors, augmented by the perspectives of marginalised groups themselves concerning their own circumstances and needs; second, to provide an integrated assessment of the effectiveness of policies, financing and service delivery in making progress towards the goal of leaving no one behind, considering both political and technical challenges. The intention is both to identify country-specific recommendations and to contribute to a multi-country knowledge base on how to implement the commitment to leave no one behind effectively in national and local contexts.

This report presents the main findings of our third stocktake, in the education and health sectors in Ghana. It builds upon earlier research in the health sectors in Kenya and Nepal, and the roads sector in Kenya (ODI, 2016).

1.2. What is the leave no one behind agenda?

The leave no one behind agenda is not only about ensuring that the minimum absolute standards of living in societies are met, although this is vital, especially in countries where large swathes of people continue to live in deprivation. Rather, the concept is explicitly relational in the sense that people who are left behind are deliberately prioritised or targeted such that they progress faster than those who are better off (Stuart and Samman, 2017). The commitment thus addresses three related concerns: ending absolute poverty in all its forms; ensuring that those who have been left behind can catch up with those who have experienced greater progress; and stopping group-based discrimination that has resulted in unequal opportunities and outcomes for some disadvantaged or marginalised populations. It entails an explicit prioritisation and fast-tracking of action for the furthest behind (Ibid.).

In a country such as Ghana, which has achieved sustained economic growth and good overall progress in combatting poverty and expanding basic health and education, we take the leave no one behind concept to examine which groups (geographic, social, economic) are lagging furthest behind in access to services and why, and the prioritisation of solutions that explicitly benefit these groups.

Certain groups have been historically excluded from the benefits of development. Some demographic characteristics of these marginalised groups are country-specific. However, there are markers of excluded groups that are nearly universal across countries – such as those in chronic poverty, those living in rural locations, women, children and older people, ethnic and religious minorities and indigenous populations, and those with minimal formal education. The likelihood of marginalisation is even more acute for sub-groups that experience multiple dimensions of exclusion – such as poor, rural women.

The SDG Declaration is clear that those ‘left behind’ refers to people whose identity means that they face specific discrimination, and who lack both voice and power. It states:

Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 per cent live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants. (UN, 2015)

Elsewhere it states:

We emphasize the responsibilities of all States ... to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status. (Ibid.)

If this vision to leave no one behind becomes a reality, it will correct the current trajectory of development, which has been one of extraordinary progress but deepening inequality within many countries (Dabla-Norris et al., 2015; Hoy, 2015; UNESCAP, 2013; Vandemoortele, 2009). A focus on average progress has masked major disparities between groups and individuals, including that different forms of marginalisation intersect and compound one another (Kabeer, 2012; Bhatkal et al., 2015). Agenda 2030 recognises that a lack of disaggregated data, especially at sub-national levels, has hampered the construction of strategies to address issues faced by marginalised groups (UN, 2015).

1.3. Health and education in the SDGs

For this stocktake, we focus on health and education (see Annex 2 for the full set of SDGs and associated targets for health and education).

The SDG that directly relates to health is Goal 3: ‘Ensure healthy lives and promote well-being for all at all ages’, which has 13 associated targets. In this report, we focus our attention on target 3.8, universal health coverage (UHC). This was chosen because it underpins efforts at leaving no one behind across the other targets. In addition, one of the most challenging aspects of achieving the goal is delivering services to those most in need and more specifically to the poorest and most marginalised groups (Wong, 2015). Furthermore, it is now well documented that expanding health coverage towards universality, and diminishing health inequities, is associated with improved health outcomes for the overall population (with the largest gains accruing to poor people) (Moreno-Serra and Smith, 2012).

Education is recognised in the SDGs as both a fundamental human right and an enabling right that is central to the realisation of the whole Agenda 2030. The education goal is SDG 4: ‘Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all’, but it is also mentioned as a key enabler under many other goals. SDG 4 covers learning from early childhood through adulthood, while stressing the key themes of education quality, learning, inclusion and equity. In this report, we focus on targets 4.1 (‘ensure that all girls and boys complete free, equitable

and quality primary and secondary education leading to relevant and effective outcomes’) and 4.5 (‘eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations’).

In this study, we focus predominantly on basic education, i.e. pre-secondary level.¹ This is because a good-quality basic education lays the necessary foundation for a child’s progression through the rest of the education system, and for myriad life opportunities beyond. It will be impossible to ensure that all children complete free, equitable and quality secondary education – as pledged in SDG 4.1 – unless all children can first complete free, equitable and quality primary education (which also facilitates a smooth transition to lower secondary school, at a juncture when some children are particularly vulnerable to dropping out). Moreover, evidence shows that inequalities in educational attainment generally emerge even before the end of primary school; improving equity and inclusion rests on addressing these as early on as possible (Rose and Alcott, 2015). Children’s learning outcomes and the quality of education are increasingly recognised as critical issues, including for equity (World Bank, 2017d). Owing to issues relating to data availability, we focus primarily on indicators of coverage and access; however, we do examine some dimensions of quality and learning, such as examination pass rates, where the data allows this at a disaggregated level.

As discussed further below with respect to our conceptual framework, the scope of this study is limited to analysis of who is being left out of health and education services and why. We recognise that differential health and education outcomes are caused by a huge range of factors beyond access to services, including nutrition, income and infrastructure, among others (Tangcharoensathien et al., 2015; WHO, 2015, 2016a; World Bank, 2017d; Rose and Alcott, 2015). However, access both to quality public health and to education services is taken to be a necessary factor in improving outcomes for vulnerable and marginalised groups. It is important to identify a clear set of policy levers for the improvement of health and education service provision, even if these services are not in themselves sufficient to improve health and education outcomes.

The metrics used to measure health and education access in this study do not correspond exactly to the relevant SDG indicators (UN Statistical Commission, 2017). This is largely because, despite Agenda 2030’s commitment to data disaggregation,² data for most of the agreed SDG indicators are still not available at the disaggregated level that is required to undertake an investigation of who is being left behind. For many indicators, even national-level data are not available.

1 In Ghana, government policy of free ‘basic education’ also encompasses (unusually) the secondary level, but we focus explicitly on primary and pre-primary levels.

2 Agenda 2030 committed to review SDG progress using data ‘disaggregated by income, sex, age, race, ethnicity, migration status, disability and geographic location and other characteristics relevant in national contexts’; <https://sustainabledevelopment.un.org/post2015/transformingourworld>

This is an urgent policy problem.³ In the next section, we describe our methodology, including which datasets and indicators were selected and why.

1.4. Definitions and terminology

In our primary data analysis, we took a deductive approach: we posited a set of factors likely to constitute marginalisation, based on those most commonly identified in the literature as significant across different contexts, and taking into account the disaggregation and representativeness of available datasets. We then looked at how service coverage – and, where possible, quality – differ among these groups. The factors we analysed were: regions within Ghana,⁴ urban versus rural location, household wealth (bottom wealth quintile versus the rest), level of education (for health sector analysis only) and whether the household respondent belongs to an ethnic minority (for health sector analysis only).

There is no universally accepted method for determining ethnic minorities. Consistent with our approach in the 2016 stocktakes, ethnic groups were designated as minorities if they constituted less than 10% of the national population – in other words, all groups except for Akan

(47.5%), Mole-Dagbani (16.6%) and Ewe (13.9%).⁵ These three groups make up the largest share of the population both nationally and in the populous and relatively affluent regions of Greater Accra and Ashanti. The classification of ethnic minorities in local reports also matches the outcome of our strategy.⁶ However, we recognise that this is not a perfect classification strategy. In some cases, small-sized groups may still have a large degree of power and influence (nationally or in particular areas of the country); in others, a relatively large group within the population may face considerable discrimination and marginalisation.

We are also aware that our quantitative analysis does not examine other important characteristics of marginalisation, notably disability, for which the survey-based and administrative datasets used for our quantitative analysis do not disaggregate.⁷ We covered this issue, to some extent, in our qualitative fieldwork, but it would bear further examination in dedicated research.

Our analysis investigated these dimensions of marginalisation separately, rather than in conjunction with one another. This is primarily due to the limited sample size of the Ghana Demographic and Health Surveys (GDHS), which means that the number of instances of households at the overlap of multiple dimensions of marginalisation is very small. Estimating the marginal effect of each

Table 1: Defining ‘marginalised’ and ‘non-marginalised’ groups in the Ghana Demographic and Health Surveys

	Marginalised group	Non-marginalised group
Wealth: Quintile of the household wealth distribution	Bottom 20%	Top 80%
Education: Highest level attended in the household and self-reported (does not denote completion)	Primary or below	Secondary or above
Used only for health sector analysis		
Location of household	Rural	Urban
Ethnicity of household: Based on self-identification and no option to report mixed ethnicity as a separate category, except ‘Other’ (< 2% of the sample)	Ethnic minority Defined as groups that each constitute less than 10% of the national population in the 2010 Census	Ethnic non-minority Defined as groups that constitute more than 10% of the national population: Akan (47.5%), Mole-Dagbon (16.6%) and Ewe (13.9%) in the 2010 Census
Used only for health sector analysis		

3 Overcoming this particular data gap is covered by SDG target 17.18, which requires countries to ‘enhance capacity-building support to developing countries, including for least developed countries and small island developing states, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts’, by 2020. Hardly any country in the world has yet achieved this degree of data disaggregation.

4 Ghana has 10 administrative regions (see Chapter 2).

5 See page 34 of GSS (2012).

6 Asante and Gyimah-Boadi (2004).

7 As far as we are aware, no survey using Washington Group on Disability Statistics tools has yet been implemented in Ghana, and it was beyond the scope of our study to generate quantitative data on health and education access for people with disabilities.

dimension would have been very sensitive to the limited sample size, which may produce misleading results. However, we recognise that marginalisation is often most acute for those segments of the population experiencing multiple kinds of deprivation or exclusion at the same time, such as women and girls living in poverty in rural areas. This phenomenon was reinforced in our qualitative fieldwork, particularly in Northern region.

For health coverage, the main metric we used to identify who is left behind is the Composite Coverage Index (CCI) of reproductive, maternal, newborn and child health (RMNCH) service delivery. We drew data to compute CCI performance from the two most recent surveys in 2014 and 2008, supplemented with data from Ghana's administrative District Health Information Management System (DHIMS2). The CCI is a widely used index measuring the coverage of maternal and child health services, first introduced in 2008 as one useful indicator of progress towards UHC. It calculates a weighted average of eight key preventive and curative interventions received along the continuum of RMNCH care. The advantages of the CCI are that it covers one key set of UHC elements, is an internationally comparable indicator and can be computed from GHDS and other data sources, and is therefore possible to disaggregate by different population groups and sub-nationally (unlike many other comparative health metrics).⁸ This was critical for our purposes. The main disadvantages are that the CCI covers only women of child-bearing age and children under five years, and therefore precludes any analysis of coverage for men, older people or older children and adolescents, and it also excludes a large range of other health services. For further details about the CCI, see Wehrmeister et al. (2016).⁹

Following the first set of stocktakes undertaken in 2016, we reviewed alternative metrics in consultation with experts. For example, the World Health Organization (WHO) has proposed developing an index that combines and summarises tracer indicators of health service coverage into a single metric mapping to SDG target 3.8.1.¹⁰ It has called for this data to be disaggregated by sub-populations to gauge the equity of health service coverage. However, such data do not yet exist on a consistent and comparable basis. Existing efforts to impute such a metric (Wagstaff et al., 2015) are based on computations using income distribution patterns as (sophisticated) proxies for health coverage.¹¹ In the interim, we decided that CCI is the

best indicator available for our purposes. However, we acknowledge this important limitation to our primary data analysis. In our qualitative fieldwork, we were able to somewhat address these limitations, for example through focus groups with men from marginalised communities.

In education, we examined the highest level of education and average years of education of household members (isolating those aged 6-18 to better gauge the effects of recent education policy); and the time taken and mode of transport used to reach school. These data are from the GDHS, permitting disaggregation (as above) by household wealth quintile, location (region; urban/rural) and gender. Using administrative data from the Education Management Information System (EMIS), we also examined school enrolment rates and examination pass rates at primary and secondary level as a measure of quality of education. These data are available disaggregated by region, urban/rural location and gender. We were unable to compare enrolment rates from the two main databases since the EMIS excludes children not enrolled in school, and only records enrolled students by school level, not age, making it difficult to map to the reported school-aged population based on the 2010 Census. There are other sources of divergences between administrative data and survey-based data, for example highlighted by Sandefur and Glassman (2014), but such an assessment was beyond the scope of analysis here.

Unfortunately, neither the education data module of the GDHS database nor the EMIS database record ethnicity, hence we could not disaggregate by ethnicity for the education analysis. There is a further range of additional factors that could cause exclusion from health and education services. Some of these may be missing from the GDHS and DHIMS/EMIS datasets (such as disability), or they may be highly context-specific within Ghana (such as a particular livelihood group). One of the central purposes of the complementary qualitative research in this study was to explore any such additional factors.

1.5. The centrality of politics

Knowing who is left behind in a country is one thing, actually doing something about it is another. Insofar as politics is about 'who gets what, when and how' (Laswell, 1936), creating policies to improve the lives of marginalised people is an inherently political process. For instance, how

8 RMNCH is one of four service coverage categories proposed by the World Health Organization (WHO) and has the best data availability. The option to calculate an equity-adjusted UHC index – computing the coverage levels in the disadvantaged population – is 'largely confined to RMNCH coverage indicators in low- and middle-income countries' (Hogan et al., 2016), owing to data limitations with other indicators.

9 The CCI results we compute differ slightly from those published by WHO (<http://apps.who.int/gho/data/node.main.nHE-1581?lang=en>) primarily on account of how missing data and non-applicable responses are coded and treated.

10 See <https://unstats.un.org/sdgs/files/meetings/iaeg-sdgs-meeting-03/3rd-IAEG-SDGs-presentation-WHO--3.8.1-and-3.8.2.pdf> for a discussion on the target, its constituents and a proposed timeline to develop and implement the necessary indicators. Slide 6 highlights the lack of disaggregated health data particularly in low- and middle-income countries.

11 Asante and Gyimah-Boadi (2004).

should governments go about financing health care that is available to and affordable for all? What package of services should be offered? Sophisticated curative care may be of significant interest to doctors and the middle classes, but preventive and primary health services are likely to be more important to the poor. In education, if fees are to be charged, in which levels of the health system should this be implemented and how much should be charged? How should public funding be split between pre-primary, primary, secondary and tertiary levels? Should a new hospital or school be built in this or that location? If the overall percentage of national resources spent on health or education is to increase, resources must be taken away from something else. Prioritisation and difficult trade-offs need to be decided – and all are political.

Furthermore, there is no guarantee that money will be spent effectively or equitably. Different institutions and actors need to coordinate effectively. Finances must be managed efficiently, and make their way through the system to the right people. Human resources must be distributed to the right places and staff motivated to do their jobs well. Indeed, getting health workers and teachers to take up posts in deprived or rural areas where the marginalised people often live is frequently a challenge in developing countries (World Bank, 2003) and, indeed, in wealthier countries as well (Ono et al., 2014). Institutional coordination, monitoring and supervising, and incentivising demand – activities inextricably bound up with health and education governance – are all inherently political.

Assessing a country's readiness to achieve the leave no one behind agenda must therefore take political economy into account. As seen in our conceptual framework below, this study takes an explicitly political as well as technical focus.

1.6. Conceptual framework

To frame our inquiries, we slightly adapted the working model from our first set of stocktakes in 2016 (ODI, 2016). The conceptual framework (Figure 1) is based on the assumption that, in an ideal world, there would be reliable, comprehensive, timely and detailed **data** about who is left behind and where they are living (Chapter 3). These data would be used to inform government **policies**, which would prioritise the needs of the poorest and most vulnerable in accessing education and health care (Chapter 4). These policies would need to be fiscally realistic and sustainable.

Also taking into account the data, sufficient **financing** would be required to translate these policies into reality (Chapter 5), even if reaching marginalised groups appears costlier than reaching the rest of the population – for example, having to provide schools with disabled access, or smaller pupil–teacher ratios in more remote areas. Thus,

we might expect to see over-weighting to groups or areas with larger left-behind populations, not simply an equal per capita share.¹² Policies and financing are also required to establish a strong data ecosystem. There is therefore a mutually reinforcing relationship needed across data, policies and financing.

Again, in our ideal world, data, policy and financing would together translate into effective **service delivery** for vulnerable and marginalised groups (Chapter 6). Service delivery can be thought of in two dimensions, supply and demand. On the **supply** side, provision can be categorised into human resources (doctors, nurses, teachers, supervisors, and so on); goods and equipment (such as drugs, books); and buildings and infrastructure (health facilities, schools). In budgeting terms, these three aspects correspond to wages, non-wage recurrent and capital spending. All three need to be delivered effectively in order to provide good quality services.

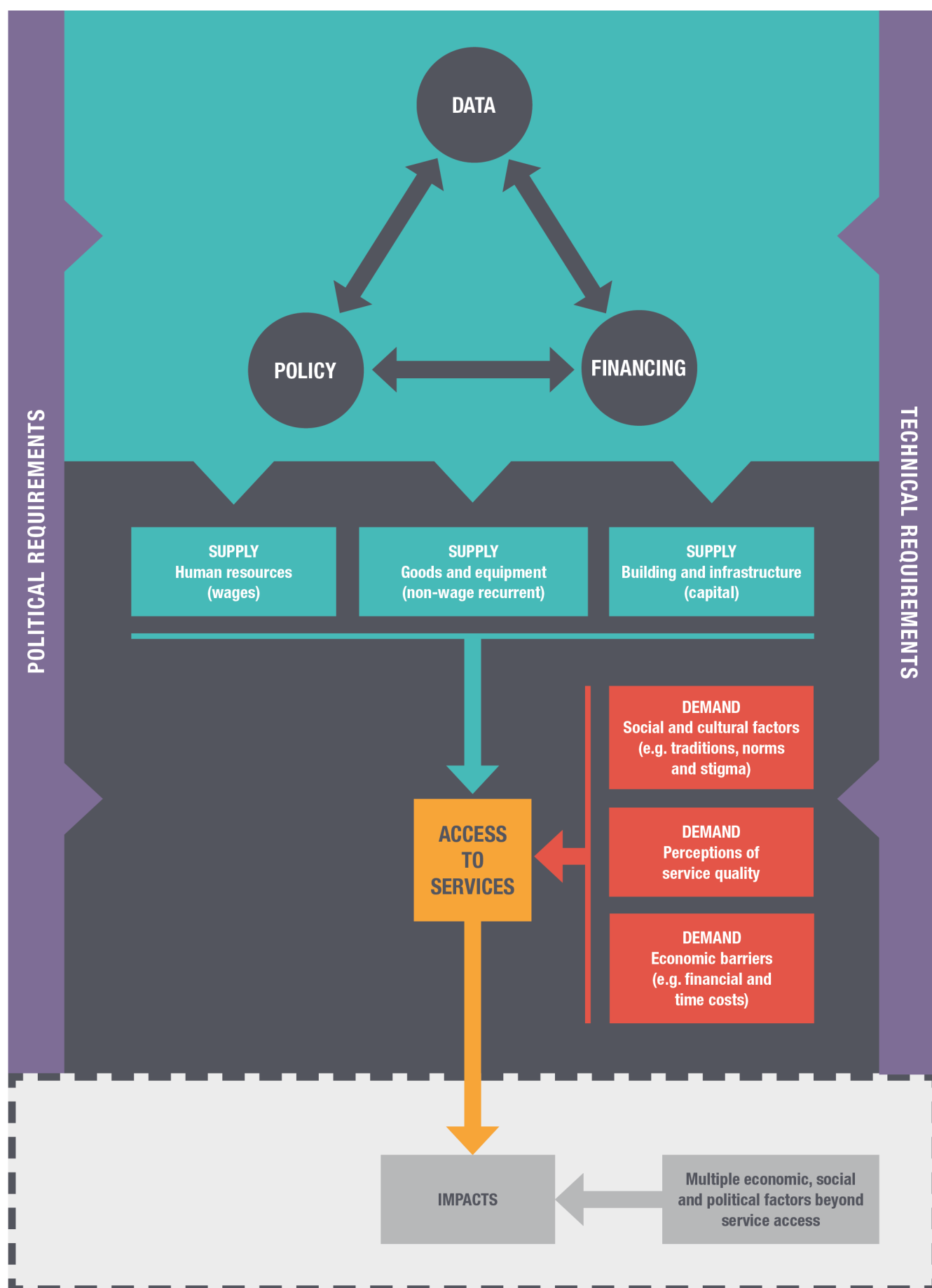
On the **demand** side, there are a number of key factors that could spur or impede access to services – these include social and cultural factors, such as traditions, norms and stigma; the associated financial and time costs of accessing services such as transport, fees and uniforms; and perceptions of service quality (whether accurate or not), such as how reliably a health centre can provide the drugs it is supposed to, or whether a teacher will come to the school on any given day. While such barriers may be universal, we would expect that they might disproportionately affect vulnerable and marginalised groups – for example, the poorest quintile would be the least able to afford fees or transport costs; teacher absenteeism is more common in rural and remote areas.

Our conceptual framework recognises that there are both political and technical requirements at each stage of the causal chain outlined above. For example, there must be political will to define and monitor who is being left behind, and there must also be the technical capacity to implement effective data systems, centrally and locally. Whether a pro-poor policy is actually implemented relies both on favourable political dynamics and accountability to avoid elite capture or blockage by adverse interests, and a strong administrative system that can allocate resources efficiently. We identify bottlenecks along the way in each of the areas of the conceptual model, and conclude with a set of policy recommendations (Chapter 7).

Another important aspect of the stocktake framework is to listen to the perspectives of poor and marginalised communities about their own needs and priorities, and what they perceive as the main points of progress and challenges in accessing health and education services. Such information is rarely gathered with respect to official policy-making, planning and evaluation processes, especially for typically vulnerable and left-behind groups, but it is important for guiding efforts to improve service delivery. We held eight community focus groups across two

12 In fact, it may be that the 'returns' on these larger investments to reach the unreached are ultimately greater, meaning that they are more cost-effective; see UNICEF (2017).

Figure 1: Conceptual framework



locations in rural Ghana, as well as additional focus groups with community health workers and teachers (see more in research methods section below).

Finally, we stress that the scope of this study is limited to service coverage and access in the health and education sectors. We consider the effective delivery of these services to vulnerable and marginalised groups to be one – though not the only – crucial component of achieving the commitment to leave no one behind in SDGs 3 and 4.¹³ However, clearly, health and education outcomes are affected by a very wide range of economic, social and political factors, not just access to services (as shown in the dotted line section of Figure 1).

1.7. Research methods

As described above, we undertook quantitative data analysis to determine who is being left behind in the health and education sectors, and also to identify specific sub-national sites for further investigation. The second quantitative aspect to the research was analysis of budget data from both government and donors to trace financial flows and reveal the extent to which declared policies were translated into actual expenditure. (It should be noted that our analysis of government financing, particularly over time and at sub-national level, was limited by the lack of comprehensive, harmonised and machine-readable sources of information.)

Our qualitative research used a combination of desk-based literature review, semi-structured key informant interviews and semi-structured focus group discussions (FGDs) to explore the political and technical dimensions of our conceptual framework. We identified a list of key stakeholders in government institutions and other organisations, augmented in Ghana through snowball sampling. The FGDs were intended to explore the nature

of the supply and demand problems – including societal constraints – faced by marginalised communities in their own words, and to enrich our analysis of the issues in public service delivery from the perspectives of community health volunteers and teachers at its front lines. The sets of FGDs in each district (Table 2) were designed to differentiate where possible the experiences of women and men, and those with or without access to key basic services.¹⁴ We developed a list of selection criteria for inclusion in the FGDs¹⁵ and a topic guide for semi-structured discussion (taking as a starting point those used in our previous stocktakes in Kenya and Nepal). A literature review was undertaken to fill in gaps, supplement contextual information and test our findings against the existing literature.

We undertook research at both national and sub-national (regional and district) levels. In Accra, we held key informant interviews with a total of 36 stakeholders across central government institutions, development partners and civil society organisations. We then undertook fieldwork in two regions, Northern and Brong Ahafo. The rationale for our case selection is described in the next section. We conducted a total of 22 interviews in regional health and education directorates and then at the district level with government and civil society stakeholders in two selected districts, Zabzugu (Northern) and Banda (Brong Ahafo). We held FGDs with members of marginalised communities in Zabzugu and Banda (Table 2). See Annex 1 for a full list of those who agreed to be on the published list.

1.8. Case selection

Ghana was selected as a case study primarily because of data availability: it has had two Demographic and Health Surveys within the past decade (2014 and 2008). It was expected that sufficiently disaggregated input, output and outcome data

Table 2: Focus group discussions

Banda, Brong Ahafo	Code	Zabzugu, Northern	Code
Women – health (access – gave birth at a facility)	FGDBWHA	Women – health	FGDZWH
Women – health (no access – did not give birth at a facility)	FGDBWHNA	Women – education (access for their children)	FGDZWEA
Women – education	FGDBWE	Women – education (no access for their children)	FGDZWENA
Men – health and education	FGDBMHE	Men – education	FGDZME
Community health workers	FGDBCHW	Community health workers	FGDZCHW
Teachers and Ghana Education Service (GES) staff	FGDBT	Teachers and GES staff	FGDZT

13 For example, recent research relating to high- and middle-income countries in the Organisation for Economic Co-operation and Development (OECD) indicates that core components of universal health coverage and higher levels of health financing are positively associated with health outcomes and life expectancy; see OECD (2016).

14 Basic services including skilled birth attendance, antenatal visits, child immunisation and the completion of basic education.

15 The FGD selection criteria included adults with children or wards under the age of 16; marginalised in terms of low educational status, and poverty or ethnic minority status; or perceived as having low status/decision-making power in the community.

would be available at national, regional and district levels; however, we found that financing data remains a challenge. It was also expected that Ghana, as a democratic and relatively open country with a clear political investment in the SDGs by successive governments, would be receptive to the research findings. Existing ODI knowledge and contacts in the country, as well as pragmatic considerations (including language and the timing of the research in relation to budget and policy processes), were additional considerations.

The two regions selected for sub-national investigation were Northern and Brong Ahafo. These were identified because they had different levels of health access (as measured by the CCI), but similar levels of financing and facilities (see Table 3). Moreover, Northern region forms part of the north of Ghana and is predominantly Muslim, while Brong Ahafo is considered part of the south and is predominantly Christian. Although the study was not set up to be explicitly and exclusively comparative, we considered that such differences would be useful to explore possible supply- and demand-side barriers beyond the apparently similar levels of financing and facilities.¹⁶ Our hypothesis was that the quality and effectiveness of the supply-side inputs would be found to vary across regions, and/or there would be context-specific demand-side barriers undermining access. We made the case selection based on health criteria, rather than education, to keep the analysis simple and for consistency with the approach used in the previous case studies. However, as we will see in Chapter 3, education access is also much better in Brong Ahafo than in Northern. After selecting two regions, we also chose one district in each region for more detailed investigation: Banda in Brong Ahafo region and Zabzugu in Northern region. The main criteria for selecting these districts

was the existence of reputable local partners who would be able to facilitate access to decision-makers and arrange FGDs. We also checked that financial, economic and health access indicators in each district were broadly representative of their respective regions as a whole.

Overall, Brong Ahafo and Northern region have a very similar population size, and a similar level of per capita spending, just below the national average. GoG facilities are only slightly more numerous in Brong Ahafo. However, the total number of health facilities is significantly higher in Brong Ahafo, partly as a result of a larger number of facilities run by the quasi-public, faith-based provider, the Christian Health Association of Ghana (CHAG). CHAG does not operate in the predominantly Muslim Northern region.

A major divergence concerns health worker distribution. Brong Ahafo has 33% more doctors per capita than Northern region, and 38% more midwives per woman of fertile age. The other big difference between the regions is their territorial size. Northern region covers an area of 70,384 km², almost twice the size of Brong Ahafo, and thus the population density of the former is significantly lower. This typically makes providing equivalent services more expensive and logistically challenging. For example, to ensure health facilities are available within a given distance of each community, Northern region would need considerably more health facilities per capita than Brong Ahafo.

Inequality in CCI between groups is considerably higher in Northern region than Brong Ahafo. Whereas Brong Ahafo seems to have achieved remarkably similar coverage for the bottom wealth quintile as the top four quintiles, Northern is more similar to (and slightly worse than) Ghana's national gap, with an 11.4% gap in CCI between the bottom quintile

Table 3: Average CCI score and health resources in Northern and Brong Ahafo regions

	CCI (%) (2014)	Population (millions) (2010)	Per capita annual health spending (2015)	No. of government facilities per 50,000 people	No. of all health facilities (including private) per 50,000 people	No. of doctors per 50,000 people	No. of midwives per 50,000 women of fertile age
Brong Ahafo	68.8	2.31	33 Cedis (\$7.50)	4.67	5.8	3.14	54
Northern	49.5	2.48	32 Cedis (\$7.30)	4.05	4.7	2.36	39
National	65.9	24.66	39 Cedis (\$8.90)*	3.79	5.7	6.02	53

* Calculated as the population-weighted average, i.e. the aggregate total budget to regions divided by the total population of Ghana.

Note: Per capita spending is based on a definition of primary health care, which includes transfers to Community-Based Health Planning and Services (CHPS), health centres and polyclinics, district and metropolitan health directorates, district and municipal hospitals. It excludes multi-region spending on national health recruitment, regulatory agencies, national public health services, subventions, national health infrastructure, national health procurement, national blood service, headquarter spending and health teaching, all of which cannot be disaggregated to the region and district level.

Sources: CCI computed by ODI from GDHS 2014; doctors and midwives figures from MoH Holistic Assessment 2016; population from Ghana Population and Housing Census 2010; spending from 2015 National Budget; health facilities from government data available at: <http://data.gov.gh/dataset/health-facilities>

¹⁶ For instance, there is an extensive quasi-governmental faith-based network of additional health care providers that is significant in Ghana's health system, the Christian Health Association of Ghana (CHAG), which operates in Brong Ahafo but not in the predominantly Muslim northern regions.

Table 4: CCI by wealth quintile in Brong Ahafo and Northern regions, 2014

	Bottom wealth quintile	Top four wealth quintiles	Difference
Brong Ahafo	67.7%	69.5%	1.8%
Northern	47.3%	58.7%	11.4%
National	58.1%	68.4%	10.2%

Source: GDHS (2014).

and the rest. In fact, the average CCI of the top four wealth quintiles in Northern is just marginally higher than the bottom quintile of the national average – indicating poor overall health service access in the entire region.

In Northern region, CCI coverage also varies more significantly than in Brong Ahafo across urban versus rural groups, ethnic minorities versus non-minorities and those with more versus those with less education. This may be because the larger distances between communities and health facilities cause greater direct and/or indirect barriers to the poorest households, which, for example, are less able to afford to pay for transport. Rural households and ethnic minorities are also more likely to live in remote locations further from health facilities, on average.

In education, we see large divergences between Northern and Brong Ahafo regions. Brong Ahafo falls close to the national average in each case, while Northern falls far below. The gross primary enrolment rates (at least on paper) appear quite similar – 113% in Brong Ahafo versus 115% in Northern. However, nearly a fifth (18%) of 13-15 year olds in Northern have no formal education, compared to just 2% in Brong Ahafo.

While the total size of the populations of Brong Ahafo and Northern regions are fairly similar, the school-age population is much larger in Northern region, which is consistent with the higher fertility rates there (6.6 in Northern, compared to 4.8 in Brong Ahafo).¹⁷ Thus, while the overall budget for education is slightly higher in Northern region, public spending per school-age child is lower. Another factor is that there appear to be many more non-public (i.e. private or non-governmental) primary schools in Brong Ahafo region, meaning the number of children per school is 40% lower. Finally, the much larger physical area of Northern region also means that the average distance between schools and children's households will also be greater, combined with poorer road infrastructure and transport options.

Table 5: Key differences in selected health resources between case study districts – Banda and Zabzugu

	Banda district, Brong Ahafo region Population = 23,249	Zabzugu district, Northern region Population = 63,815
Health centres	4	0
CHPS compounds	4	6
Population per health facility	2,906	10,636
Technical officers	4	2
Physician assistants	1	2
Community health officers/nurses	28	14
Registered community nurses	1	0
Health assistants clinical	3	0
Enrolled nurses	20	12
Midwives	4	5
Psychiatric nurses	1	2
Total health workers	70	43
Population per midwife	4,649	12,763
Population per health worker	332	1,556
Average number of outpatient consultations per capita	2.36	0.46
Outpatient consultations covered by National Health Insurance Scheme (NHIS)	92.5%	95.0%

Source: Banda and Zabzugu District Annual Reports

17 GDHS (2014).

Table 6: Education access and financing in Brong Ahafo and Northern regions, 2015 or closest previous year with available data

	Share of 13-15 year olds who have not attended formal education	Average years of formal education for 13-15 year olds	Gross primary school enrolment rate	Population (millions)	School-age population	Public education spending per school-age child (Cedis)	Public primary schools per 1,000 school-age children	Total primary schools per 1,000 school-age children
Brong Ahafo	2%	5.2	113%	2.3	0.38 million	272 (\$62)	4.4	7.4
Northern	18%	4.1	115%	2.5	0.50 million	242 (\$55)	4.2	5.3
National	4%	5.3	111%	24.7	3.93 million	246 (\$56)	3.7	7.2

Source: EMIS (2014-2015; 2015-2016); 2015 National Budget; GDHS (2014)

Note: Total primary schools includes private schools. Spending on primary education is defined by spending under the Classifications of the Funds of Government classification in the 2015 budget under the department regional and district school services in the GES.

2. The political, social and economic context

This chapter is intended as reference material to contextualise the research findings in Chapter 3 onwards. We briefly cover Ghana's political context and Constitution, overall trends in poverty and inequality, the national development strategy, the macroeconomic and fiscal context, and the implications of Ghana's limited decentralisation. The chapter concludes by describing the structures and institutions of Ghana's health and education sectors. Readers already familiar with these topics may wish to skip to the next chapter.

2.1. Political context

Ghana's post-independence history was characterised by long periods of military rule. In the late 1980s, after nearly one decade of quasi-military rule, strong internal and external pressures on the government led to a return to multi-party politics and the promulgation of a new Constitution in 1992. Since then, Ghana has held seven successful multi-party elections, including three that resulted in an alternation of power between the country's two dominant political parties, the New Patriotic Party (NPP) and the National Democratic Congress (NDC).

Ghana's Constitution calls for power to be balanced among a president (who is head of both government and state), a unicameral Parliament and an independent judiciary. The president appoints the vice president and ministers, as well as a significant number of members to the Council of State – which is the highest advisory body to the President. The Constitution also makes an attempt to prevent sectional division and promote nationally inclusive politics, including by mandating that all political parties have branches in every region and an organised presence in at least two-thirds of the districts of each region.

Despite deepening democracy and electoral accountability in Ghana, some scholars have characterised its political environment as one of 'competitive clientelism', in which two dominant parties compete in the use of elections as a mechanism for the distribution of patronage and state resources to reward followers (Hirvi and Whitfield, 2015; Abdulai and Hulme, 2014; MacLean, 2014; Lindberg, 2010; Lindberg and Morrison, 2008). Given the fiercely competitive nature of recent elections – the 2008 presidential run-off produced a winner by 0.5% of total valid votes (Abdulai and Hickey, 2016) – elected politicians have increasingly

pressurised public bureaucrats to distribute public resources in line with their political agenda rather than through planned policy strategies (Abdulai and Hickey, 2016: 65). In this political environment, influential public officials often 'ignore what the budget says and dispose of public monies according to quite other decision processes' (Killick, 2008: 28).

Some commentators have argued that much government social spending in Ghana suffers from politically motivated targeting and does not necessarily benefit the poorest or most marginalised people (Abdulai and Hickey, 2016; Abdulai and Hulme, 2014; World Bank, 2011; Jones et al., 2009). Many ordinary citizens rely on patron–client relationships in gaining access to basic social services such as education, health and electricity (Abdulai, 2012; Briggs, 2012; Abdulai and Hickey, 2016). Critics have argued that these underlying power relations are preventing Ghana from achieving further developmental progress and redressing deep-seated inequalities in access to basic services (Oduro, 2014; Abdulai and Hickey, 2016). The problem of poor targeting is acknowledged in the Ghana Shared Growth and Development Agenda (GSGDA II, 2014-2017), but it is attributed to the limited availability of high-quality data (GoG, 2014: 135).

2.2. Constitutional provisions on marginalisation and inequality

The 1992 Constitution contains extensive provisions aimed at curbing the promotion of sectional interests in Ghanaian society and fostering the political inclusion of all regions and in the distribution of government-controlled resources. The Constitution mandates the state to protect and promote 'all ... basic human rights and freedoms, including the rights of the disabled, the aged, children and other vulnerable groups in development process'. A number of articles enshrined in the Constitution address inclusion and the equality of citizens in various spheres of life, some generally and some with reference to specific groups such as women (Republic of Ghana, 1992).

With respect to health, the Constitution acknowledges citizens' 'right to good health care' (Article 34). The provision of health services is increasingly being demanded as a basic right that governments have the responsibility to deliver. With reference to access to education, Article 25(1) accords all citizens 'the right to equal educational opportunities and facilities'. Basic education is to 'be free, compulsory and

available to all' (Article 25(a)), while both secondary and higher education are to be 'made generally available and accessible to all' (Articles 25(b) and (c)). Provisions of the 1992 Constitution have played key roles in inspiring several recent programmes aimed at reducing vulnerabilities and fostering inclusion in Ghanaian society, including the National Health Insurance Scheme (NHIS), a national school feeding programme aimed at providing one balanced meal per school attendance for public primary school pupils in poorer communities, capitation grants to expand free primary education and the Livelihood Empowerment Against Poverty (LEAP) cash transfer programme that targets households living below the national extreme poverty line.

2.3. Trends in poverty and inequality

Ghana's national income poverty rate declined from 31.9% in 2005-2006 to 24.2% in 2012-2013. The extreme poverty rate declined even more quickly, dropping from 16.5% in 2005-2006 to 8.4% in 2012-2013 (GSS, 2014b).¹⁸

However, while overall levels of poverty have declined, they remain high in some places and among certain groups; for example, 'women and girls [are] performing worse across all the main social indicators' (GoG, 2014: 3). On the Multidimensional Poverty Index, 49% of Ghana's rural population is estimated to live in multidimensional poverty, compared to less than 18% in urban areas.¹⁹ The three northern regions of the country (i.e. Northern, Upper East and Upper West regions) experience significantly higher levels of poverty than the rest of the country. In the most recent Ghana Living Standards Survey (GLSS), undertaken in 2012-2013, 45.1% of the population in the Upper West region was deemed as extremely income-poor compared to a national average of 8.4% (GSS, 2014b). Nearly 74% of people in Northern region are estimated to live in multidimensional poverty, compared to 14% in Greater Accra, for example.²⁰ The GoG acknowledges high levels of inequality as a major problem, describing it as 'a dangerous sign that the poverty reduction effort is not being properly targeted at those who need it most' (GoG, 2012).

The north of Ghana has also continued to lag far behind the rest of the country in educational attainment and health outcomes (GSS et al., 2015; MoE, 2016). The under-five mortality rate (per 1,000 live births) is 128 in Northern region, compared to a national average of 82. Chronic malnutrition (stunting) affects 22% of children under five nationwide, but 37% of children in Northern region (World Bank, 2016).

In the 2016 National Education Assessment, in Greater Accra, only about 5% of students recorded less than

minimum competency rates in mathematics and English, but the corresponding figures for the Upper East and Upper West regions were 47% and 51% respectively (MoE and GES, 2016). These inequalities have their roots in British colonial policies that subordinated the interests of the north to those of the south (see Box 1).

2.4. Ghana's national development strategy

The GSGDA II, 2014-2017 is the fifth in the series of medium-term national development policy frameworks prepared over the past two decades. It guides the preparation of annual development plans and budgets at sector and district levels. It also serves as a platform for donor coordination. While much of the framework is focused on macroeconomic stability and other drivers of growth, such as private sector competitiveness and industrial development, one of the seven policy priorities is 'Human Development, Productivity and Employment' and another is 'Transparent, Responsive and Accountable Governance' (GoG, 2014).

The GSGDA II advocates a position of national unity and inclusive development, recognising the problem of 'growing inequality in socioeconomic and spatial development'. Reflecting the leave no one behind agenda, it states that, 'It is imperative that the dividends of growth benefit all Ghanaians, irrespective of gender, location, socioeconomic and physical status' (GoG, 2014).

Ghana is currently going through a process of localising the SDGs by adapting the SDG targets to the Ghanaian context and then incorporating these into national and district development plans. According to a senior official in the National Development Planning Commission, '70% of the SDGs are already aligned in the Ghana Shared Growth Development Agenda (GSGDA) II 2014-2017, while, at the metropolitan, municipal and district levels, the targets are being aligned where gaps have been identified' (in Kudo-Agyemang, 2017).

There is an architecture established to implement and monitor the SDGs in Ghana, comprising a High Level Inter-Ministerial Coordinating Committee chaired by the president to provide strategic guidance, a National Implementation Coordinating Committee, made up of representatives of public institutions and key civil society organisations, and a National Technical Steering Committee with members drawn from other relevant institutions, to support the work of other committees. Meanwhile, the Ghana Statistical Service (GSS) has a mandate to develop the data ecosystem for official SDGs monitoring and reporting.

18 Ghana uses two national poverty lines: an upper one, below which an individual is considered to be unable to meet all their food and non-food needs, and a lower poverty line, below which an individual is considered unable to even meet just their food needs. In the most recent GLSS undertaken in 2012-2013, the upper poverty line was set at 1,314 Cedis per adult per year, and households below it are simply referred to as living in poverty. The lower poverty line is set at 792 Cedis per adult per year, and households below it are referred to as living in extreme poverty (Cooke et al., 2016).

19 See Oxford Poverty and Human Development Initiative, Global Multidimensional Poverty Index data: <http://ophi.org.uk/multidimensional-poverty-index/global-mpi-2017/mpi-data/>

20 Ibid.

2.5. Macroeconomic and fiscal context

Ghana's economy boomed in the late 2000s, buoyed in part by oil discoveries, strong agricultural production and exports, an expanding services sector and rising foreign investment. During this period, it was one of the fastest-growing countries in sub-Saharan Africa. In 2011, Ghana was reclassified from a low-income country (LIC) to a middle-income country (MIC). However, the rate of gross domestic product (GDP) growth has dropped every consecutive year since 2011, and fell to 1.3% in per capita terms in 2016, its lowest level since 2000.²¹ This marked slowdown has been triggered by falling global prices in all three of the commodities that dominate Ghana's economy – oil, gold and cocoa – as well as inflation and currency depreciation, ballooning public debt (which stood at 70% of GDP in 2014 and is rising) and a widening fiscal deficit that reached 10.2% in 2014 (AfDB, 2017, 2016; IMF, 2016).

Ghana's fiscal discipline has tended to slip with regularity during election periods. The fiscal deficit widened by an average of 1.5 percentage points of GDP during each of the five elections between 1992 and 2008. In the lead-up to the December 2016 election, the fiscal deficit widened to an even higher order of 3 percentage points of GDP, with the government accumulating sizeable arrears as a result (World Bank, 2017a). '... Election-driven expenditure pressures generated a recurring pattern of rapid fiscal expansion followed by consolidation and the tightening of expenditure controls. Past elections have also repeatedly distracted administrative effort and political attention away from the [fiscal] reform program' (Ibid.).

In 2015, Ghana entered into an Extended Credit Facility (ECF) with the International Monetary Fund (IMF), entailing a stringent fiscal consolidation programme to address the budget deficit and improve public debt management, and the tightening of monetary policy to bring

Box 1: Historical origins of inequality in Ghana

During the period of British colonisation, the southern regions received the bulk of capital investment, especially in the form of public infrastructure such as roads and railway links. These investments were driven by the pursuit of colonial economic interests in the extraction of primary commodities such as cocoa and gold. In contrast, the colonial administration dismissed the north as poor and possessing no resources.

However, the most consequential of all policies during this period, in terms of its post-colonial legacy of inequality, concerned education. In line with the objective of sustaining the peripheral role of the north as a reservoir of cheap labour, European-style education was only introduced in the north much later than elsewhere. For example, the first secondary school in the Gold Coast was established in 1876 whereas 'Northern Territories' (as present-day northern Ghana was called) saw their first government secondary school only in 1951 (Quist, 2003). Moreover, although Christian missionaries made significant contributions to the development of education in the south, 'the Missions were not allowed freely into the north to develop educational and social work as elsewhere' (Kimble, 1963); in fact, they initially prevented and later slowed down the extension of Christian missionary education in the north (Plange, 1984).

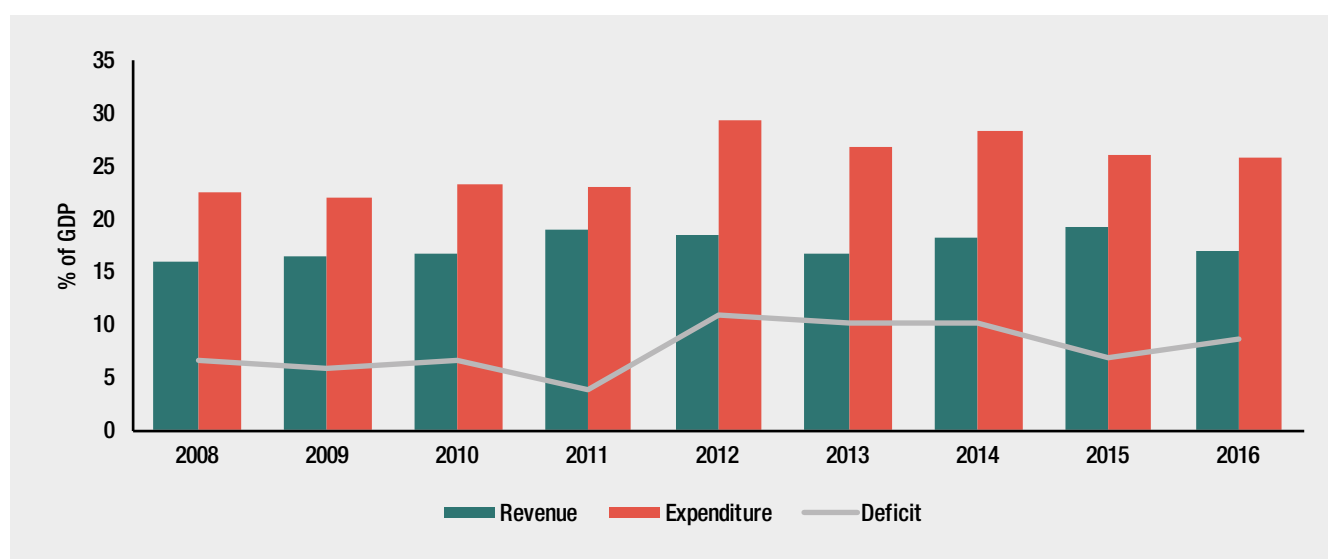
The first post-colonial regime under Kwame Nkrumah made significant efforts to bridge these north-south education gaps, particularly by establishing a Northern Scholarship Scheme in 1961, which provided grants to people of northern extraction at various levels of the educational system. However, by the early 1980s, the Northern Scholarship Scheme had come under severe attack, with the result that only one

component of it remains operational today. Songsore and Denkabe (1995) note that part of the hostility towards the scheme relates to a growing feeling among some elites in the south that the continuous special treatment of the north constituted a subtle form of discrimination against the south.

Moreover, the economic decline of the 1970s affected the provision of many social services across the country, in ways that further resulted in regressions from earlier achievements in northern education during the 1960s. However, it was the era of structural adjustment programmes (SAPs) in the 1980s and early 1990s that worsened the plight of the poorer northern regions. One reason was that the cost-recovery element attached to the provision of education and health services under SAPs made access to such services unaffordable. These policies resulted in significant declines in both school and hospital attendance across the country. The impact was particularly felt in the northern Savannah, where the rise in the share of costs borne by households seriously eroded the ability of subsistence croppers to access quality education and health services for their children. Although a rhetoric of inclusive national development characterises political discourse in Ghana, public expenditures have in fact been insufficiently targeted at addressing the problem. During much of the 1990s and 2000s, the distribution of educational expenditures was not driven by a needs-based criterion, with average per capita spending in the historically deprived north often lower than the national average. This has been an important contributor to continued north-south educational and economic disparities.

Sources: Abdulai (2017, 2012); Abdulai and Hickey (2016)

Figure 2: Trends in GoG revenues and expenditures



Source: Word Bank (2017a) using data from MoF

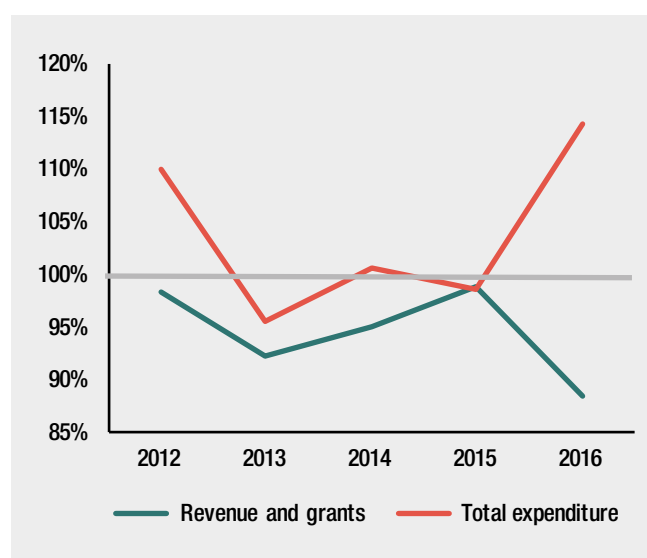
inflation under control. The new government has placed a high priority on fiscal reform, including limiting earmarking in the budget, advancing the enforcement of the new public financial management law enacted in 2016, removing 50,000 ‘ghost workers’ from the public sector payroll and attempting to increase reliance on domestic (rather than foreign) financing as part of the Medium Term Debt Strategy (IMF, 2016). The authorities did successfully conclude the Fourth Review of the ECF, but failed to meet some of the performance criteria. In particular, the fiscal deficit was 8.7% in 2016, missing the target of 5.3% by a wide margin (AfDB, 2017). The IMF recently concluded that more is needed in terms of ‘ambitious and sustained reforms across key policy areas’ (IMF, 2017).

The growing fiscal deficit and debt burden has resulted from a steady increase in recurrent expenditure (Figure 2), not matched by growing revenues (which have remained relatively flat). In particular, the wage bill ballooned in the wake of reforms to the public sector compensation structure – the Single Spine Pay Policy – implemented from 2010. Another important change occurring around the same time was Ghana’s reclassification to a lower MIC (LMIC) in 2011. This was precipitated not only by the economic growth boom of the 2000s, but also by the 2010 rebasing of Ghana’s GDP (which led estimates of GDP to rise by 60%) (Jerven and Duncan, 2012). Since the MIC threshold is significant in the aid eligibility and graduation frameworks of many bilateral and multilateral donors, this change triggered a process of aid transition in Ghana. Grants and concessional finance have been diminishing, and Ghana’s obligations to co-finance certain programmes, such as immunisation with Gavi, have been increasing (see more in Chapter 5). With concessional resources dwindling, the GoG has substantially increased its non-concessional borrowing, pushing up interest payments.

Despite the government’s consolidation efforts, it was unable to prevent the accumulation of arrears.

These trends have had a destabilising effect across the public sector, given the stop-start nature of funding releases from the Ministry of Finance (MoF). As Figure3 shows, this has led to actual expenditure diverging widely from the budget in many years. Ministries and their agencies must adjust their budgets and cash flows several times in-year. This is compounded by the fact that Ghana has a large number of earmarked ‘statutory funds’, each with its own set of rules and earmarking, that are managed outside of the standard budget process (Institute for Fiscal

Figure 3: Actual revenue collected and expenditures (as share of planned)



Source: Budget statements (various years)

Studies (Ghana, 2016).²² Together, this produces a great deal of uncertainty among ministries and agencies around which sources their funding will come from and when it will arrive. In recognition of these problems, in 2017, the government announced that earmarked funding would be capped at 25% of the budget. Since 2013, during the challenging fiscal period, these statutory funds have not primarily been used for their intended purpose of investment in development, but instead to repay debt and clear arrears. As discussed further in the financing chapter, both the health and education sectors rely heavily on these funds to support their non-salary investment.

2.6. Decentralisation

Ghana is a unitary state; its administrative divisions consist of 10 regions: Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta and Western (Figure 4). These are divided into 216 districts, each with its own district assembly (DA). At the sub-district level, there are various types of structures, including town councils, zonal councils and area councils, and below this more than 16,000 unit committees.

Public sector activities operate under a mix of centralised, deconcentrated and decentralised frameworks. The government embarked on a decentralisation policy in the 1980s, which was strengthened and amplified by the Local Government Act of 1993. The Ministry of Local Government and Rural Development (MoLGRD) has the role of promoting the development of the decentralised system of local government. Metropolitan, municipal and district assemblies (MMDAs) perform their functions through an Executive Committee, which includes departments for social services, works, finance and administration and development planning, among others (UCLG and OECD, 2016). However, Ghana's decentralisation process is far from complete and its public sector remains less decentralised than comparable countries (UCLG and OECD, 2016; Couttolenc, 2012). The progress and effectiveness of decentralisation has been hampered by issues related to regulatory inconsistencies, unclear policies, incomplete implementation, resistance to change, weak managerial capacity, centralised authority over key resources, weak capacity at central and regional level to monitor and support implementation, and the weak economic base of many districts – which have led to overlapping of central and local responsibilities (Couttolenc, 2012).

In practice, many MMDAs do not have the capacity and resources to act autonomously (UCLG and OECD, 2016). MMDAs can raise their own revenues ('internally

generated funds' or IGFs) from local taxes, fees and fines, which can be used entirely at their discretion. But, in reality, most MMDAs struggle to raise a meaningful amount and remain reliant on transfers from central government. The main channel for such transfers is the District Assemblies Common Fund (DACF), distributed by central government to districts using a needs-based formula. The formula allocates a 45% share equally to each district, with another 45% on a needs basis calculated using data on health and education service coverage (ratio of facilities and workers to population) and tarred roads and water coverage, with the remaining 10% allocated on the basis of revenue improvement and population density.²³ However, the DACF is not fully discretionary; only around half is in the form of 'direct transfers' to be used as determined by the MMDA; the remaining half is in the form of 'indirect transfers', i.e. funds for the district-level implementation of 'Priority Intervention Programmes' and other centrally determined programmes, such as school feeding.²⁴ In addition, the DACF is largely directed for capital spending, with a 10% cap on recurrent spending. MMDAs also receive financing from the District Development Facility – a performance-based grant for capital investment through donor basket funding – and a few other GoG statutory funds, which are heavily earmarked (such as the GET Fund in education), or through donor programmes, many of which must be approved by central government. The vast majority of MMDA funding must be used for development (capital) projects, rather than recurrent expenditure.

In the health and education sectors, local government is primarily responsible for relatively small capital projects such as the construction of primary schools, Community-Based Health Planning and Services (CHPS) compounds and accommodation for workers (Williams, 2017). However, the majority of functions in the health and education sectors have not been decentralised; they are carried out on a centralised, but partially deconcentrated basis, i.e. administered by regional and district offices that are instructed by and accountable to central authorities. For more on financing flows in health and education, see Chapter 5.

In both cases, the line ministry sets strategic direction, policies and regulations, formulates the budget and maintains a role as the overall oversight and coordination entity. Service delivery is mostly undertaken through the Ghana Health Service (GHS) and the Ghana Education Service (GES), respectively. These are autonomous executive agencies responsible for implementing policy in their respective sectors. The GHS and GES both operate through a deconcentrated system of regional and district-level offices, but remain centralised and very hierarchical. Despite periodic decentralisation efforts, the consensus in the literature is that policy is still largely formulated at the

22 For further details about the rules and guidelines governing the earmarked funds relevant to the health and education sectors, see Chapter 5.

23 Formula for sharing the DACF: http://www.commonfund.gov.gh/index.php?option=com_content&view=article&id=337&Itemid=442

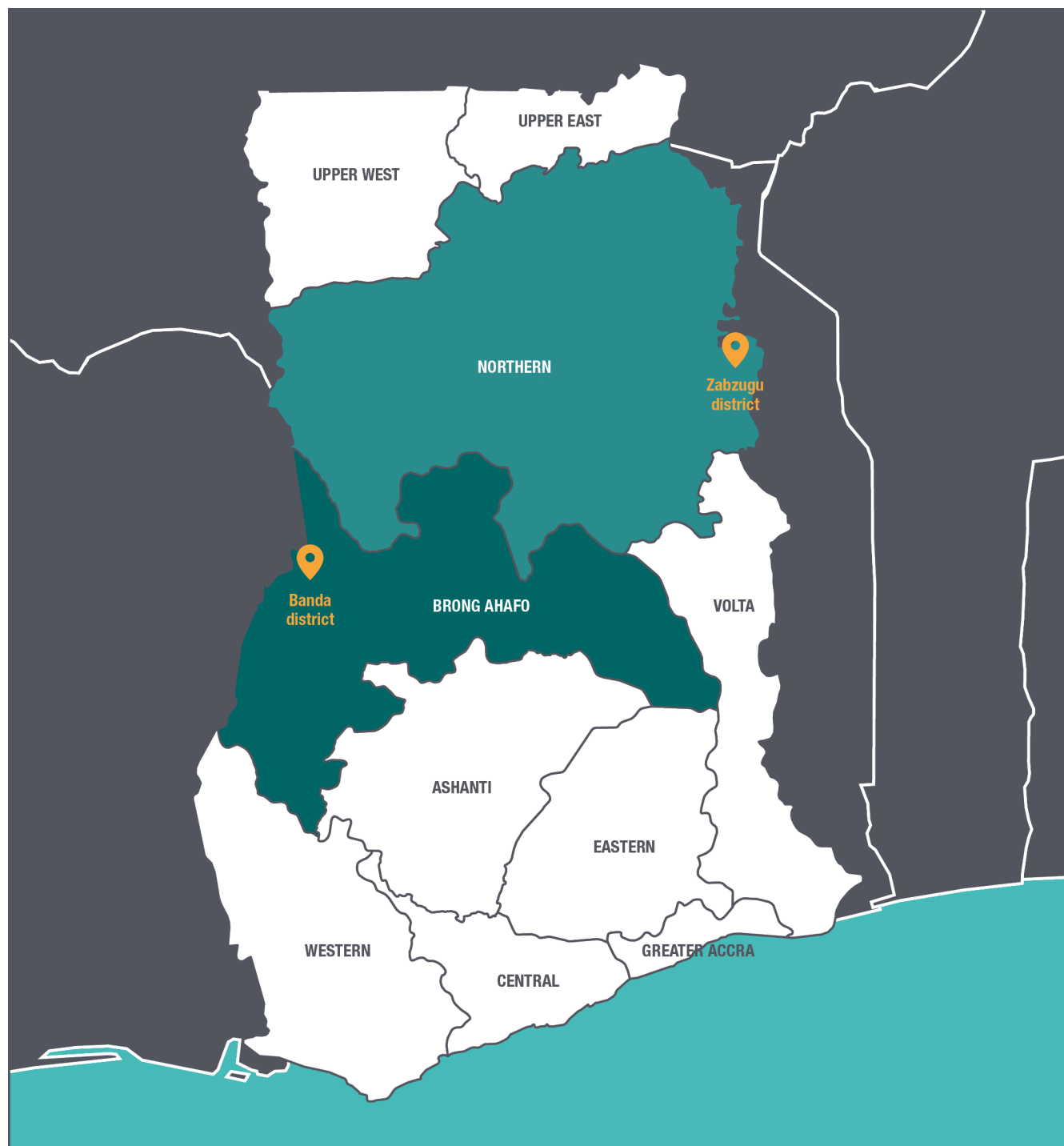
24 <http://www.commonfund.gov.gh/>

national level by political figureheads and technocrats and ‘pushed down’ for implementation at the local level through regional and district representatives (Nudzor, 2014; ESID, 2016). Recruitment and payroll are also both centralised in the health and education sectors.

This structure means that there are ‘parallel lines’ of authority at district level – local government authorities (DAs) and district offices of the centralised GHS and GES – as shown in Figure 6. In practice, this means that any

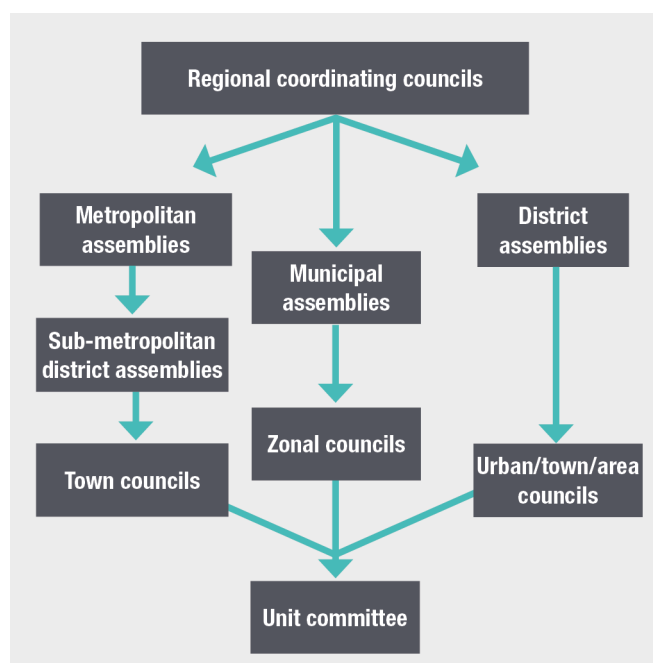
coordination between two sets of entities – the GHS/GES that are predominantly responsible for recurrent funding, and the DA that is predominantly responsible for capital spending – is entirely at the discretion of their personnel in a given district, and therefore does not always optimise service delivery. While DAs report on health and education, they have no influence on policy-making and are limited to implementing minor reforms locally within the overall national policy framework (Nudzor, 2014).

Figure 4: Map of Ghana



Note: The two case study regions and districts, Brong Ahafo (Banda district) and Northern (Zabzugu district), are indicated.

Figure 5: Ghana's sub-national governance structure



Source: Boachie-Danquah (2011)

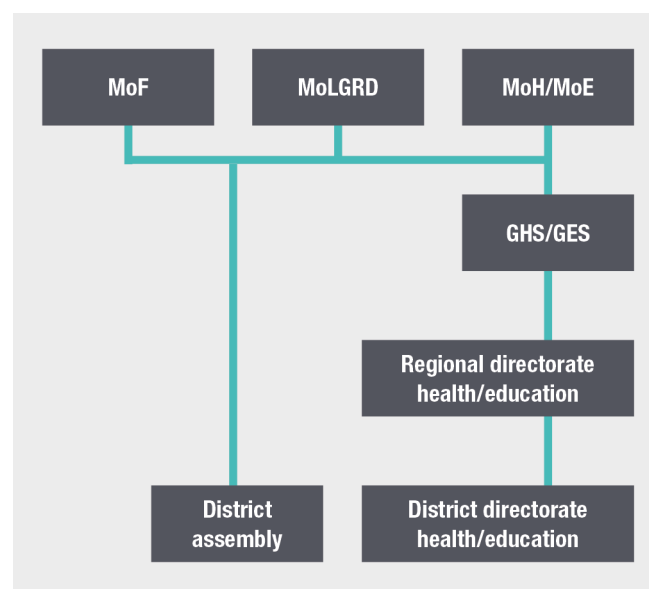
2.7. The health sector in Ghana

Ghana's Ministry of Health (MoH) is the main coordinating entity, responsible for headquarters, tertiary hospitals, subventions and health worker salaries. Coordination between the many different bodies in the health sector (Figure 7) is a challenge. Public health service delivery is the responsibility of the GHS, teaching hospitals and quasi-governmental institution hospitals. Although the private sector plays a major role in delivering Ghana's health services, the focus of the stocktake was the publicly funded GHS, as this is the vehicle through which most policies to leave no one behind are implemented, and where the findings of this research are most relevant.

The GHS is an autonomous executive agency (i.e. it stands outside the regular civil service), under the control of the MoH. The GHS is responsible for implementing health policy, managing and administering public health resources and delivering health services. It is characterised by a deconcentrated, hierarchical structure, overseeing and (in theory) transferring budget to regional health authorities and regional hospitals, as well as district health authorities, sub-district governments, district hospitals and polyclinics (primary care facilities in urban areas).

The district health office – the GHS representative at district level – is headed by the District director of health who is responsible for the implementation of GHS policies and programmes within the district, and reports up to the centre via the regional director of health. District health

Figure 6: Parallel lines of governance in Ghana's health and education systems



Source: Authors' own representation

Note: MoF – Ministry of Finance; MoLGRD – Ministry of Local Government and Rural Development; MoH – Ministry of Health; MoE – Ministry of Education; GHS – Ghana Health Service; GES – Ghana Education Service

services comprise those delivered by the district health administration, including district hospitals, health centres and polyclinics, as well as the community care services associated with CHPS compounds, which combines public health and basic clinical care activities at community level, under the sub-district budget allocation. District and sub-district services tend to cover the basic diseases that are most common in our case study districts. For example, in Zabzugu, malaria and diarrhoea covered more than two-thirds of outpatient attendance in 2016 (Zabzugu District Assembly, 2016).

In addition, some rural areas are served by CHAG, a faith-based network organisation comprising almost 200 member institutions, which operates mostly in rural areas. CHAG is a recognised agency of the MoH and works within its policies, guidelines and strategies. It receives subsidies from the MoH to provide services to under-served areas, although its presence is not evenly distributed across the country (it is present in Brong Ahafo region, although not Banda district, and not at all in Northern region).²⁵

The NHIS is the main financing mechanism of Ghana's public health system; it currently covers around 38% of the population (NHIA, 2013; Atim and Amporf, 2016) (Chapter 4 explores this further).

Doctors in Ghana are well respected, well paid and powerful. The Ghana Medical Association is the main labour union, which commands influence over the health sector. It strongly resists handing control of, for example, salary payments, to local government, which complete decentralisation would involve (Abdulai, forthcoming).

25 For more on CHAG, see Yeboah and Buckle (2017).

2.8. The education sector in Ghana

The Ministry of Education (MoE) has overall responsibility for education sector policy formulation, planning, monitoring, evaluation and budgeting, as well as coordination across the sector including with other ministries/agencies and development partners. However, many key decisions affecting education – for example teacher salary negotiations, quotas for admissions into colleges of education, and the recruitment and posting of National Youth Employment Programme teachers – are made outside the MoE (Darvas and Balwanz, 2014). The MoE manages budget transfers to national and regional bodies, and also to vocational and special needs education. The National Council on Tertiary Education formulates the tertiary education budget.

The key agency for implementing all educational policies at the pre-primary, primary and secondary levels is the GES. The president appoints the GES director-general and the governing Council. The GES is a highly centralised and hierarchical organisation (Darvas and Balwanz, 2014; Nudzor, 2014) with directorates in all regions and districts. The district education office (DEO) – the GES representative at district level – is headed by the district director of education who is responsible for implementing GES education policies and programmes within the district, and reports up to the centre via the regional director of education.

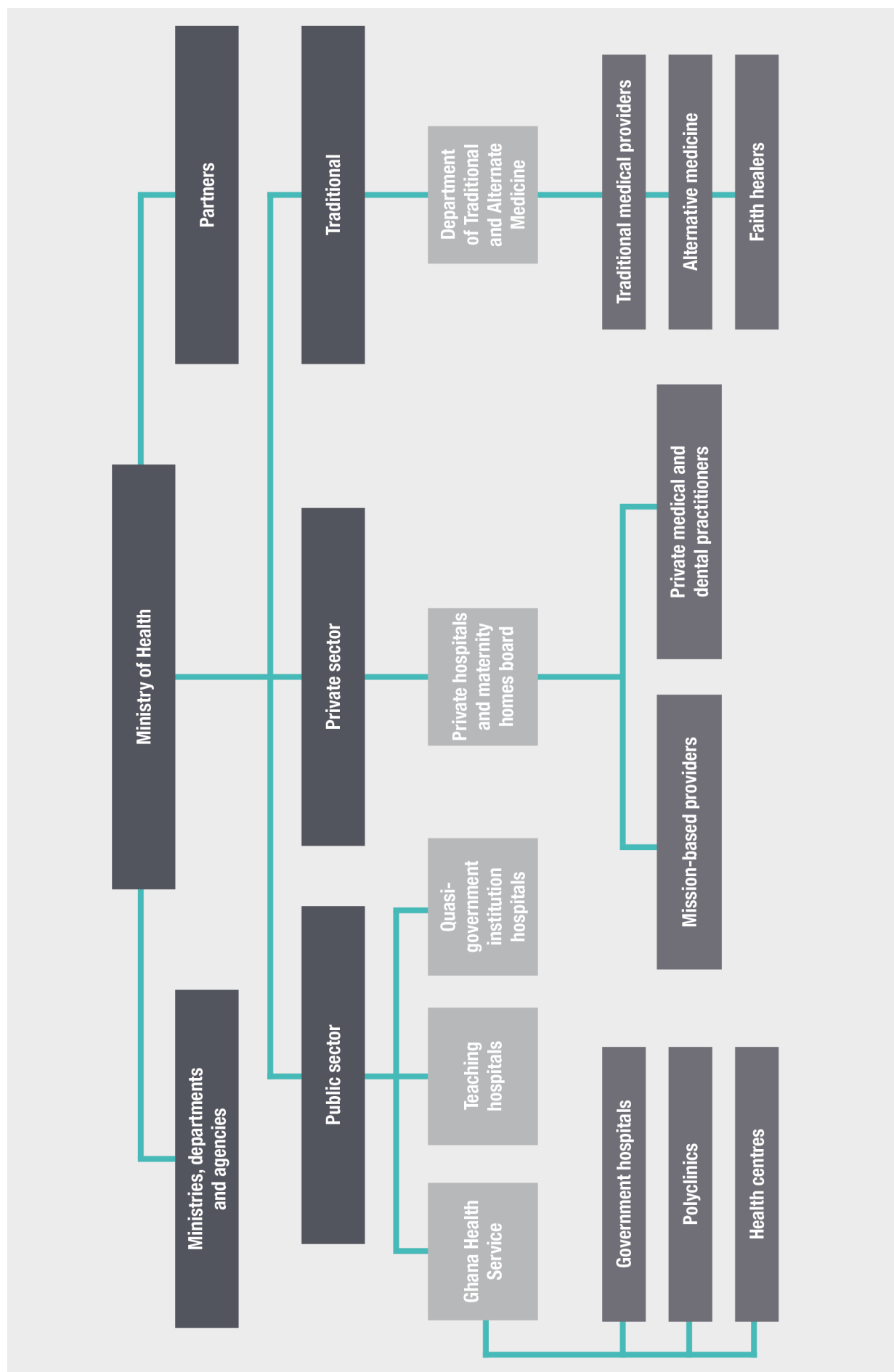
The GES Act (1995) and the Education Act (2008) provide the legal framework for the government's efforts

to deconcentrate line management functions to the district education department and to devolve decision-making and financing authority to the district assemblies, as organs of local government. However, this is not happening in practice. Recruitment, management and oversight of teachers is all done by the GES, the payroll is controlled centrally and recurrent expenditure for books and other supplies are also the responsibility of the GES, meaning that, in practice, the DAs have very limited influence. Indeed, there can often be strained relations, or simply a lack of coordination, between the DAs and the DEO.²⁶ District education oversight committees (DEOCs) are designed to be the coordination mechanisms between the two sides, yet – as described further in Chapter 6 – they are often dormant, as this is not seen as a priority.

A final key group of stakeholders is the teacher unions such as the Ghana National Association of Teachers, the National Association of Graduate Teachers and the Concern Teachers Association. They have offices at all levels throughout the country and have a strong voice, particularly in terms of influencing budget decisions. Their strength and effectiveness stem from their membership numbers – employees of the education sector are the largest single group of employees in the country, numbering possibly more than 300,000, if the staff of the MoE, GES, the National Council for Tertiary Education and all the other agencies reporting to MoE are counted (Casely-Hayford, 2017).

26 For example, see ESID (2016) for a discussion of how very different power relations and local alliances between these sets of actors in two different districts led to divergent education outcomes.

Figure 7: Structure of the health sector in Ghana



Source: Abor et al. (2008)

3. Who is left behind in access to health and education in Ghana?

This chapter first discusses the nature of Ghana's data ecosystem, before presenting the results of our quantitative data analysis of who is being left behind in access to health and education, using data drawn from the GDHS and the respective administrative information systems in each sector.

3.1. The data ecosystem

The advent of the SDGs has fuelled calls for a global data revolution. At its highest political level, Ghana is one of the countries at the forefront of this movement – President Nana Akufo-Addo was appointed by the UN Secretary-General as co-chair of the Sustainable Development Goals Advocates, a group of appointed eminent persons whose role is to champion the universal nature of the SDGs and the commitment to leave no one behind.²⁷ Vice-President Bawumia is a board member for the Global Partnership for Sustainable Development Data, a network of governments, civil society organisations and businesses working to strengthen the generation, openness and use of data to achieve the SDGs.²⁸ Nationally, the GoG has also established an SDG Implementation Coordination Committee that includes a range of government ministry representatives, non-governmental organisations (NGOs) and civil society organisations, research and academic institutions, and the private sector. This committee is headed by the National Development

Planning Commission. The GSS is the 'data champion' for most data streams required to monitor progress towards the SDGs. As part of this process, the GSS is tasked with incorporating metrics into the stream of routine surveys it conducts, and then disseminating information to relevant government ministries as well as to the wider group of stakeholders within the country.

The GSS maintains and manages probably the most comprehensive data system in the country. This includes publicly available databases, periodic summary statistics and reports based on them.²⁹ The online portal in the National Data Archive links to external donor-funded surveys and meta-data from international institutions that gather data on key development indicators across countries.³⁰ The GSS also coordinates with thematic multilateral institutions to make the relevant databases and official statistics publicly available. The GSS is collaborating with other national statistical offices (such as Statistics Denmark) to trial, adapt and adopt data management systems designed specifically for the SDG needs.

The most recent survey data from the GSS includes the Population and Housing Census (PHC) for 2010.³¹ The GSS collaborates with external agencies and institutions for other household surveys. Among them, the most recent publicly accessible databases are the GLSS for 2012-2013,³² the GDHS,³³ based on the United States Agency for International Development (USAID) template, for the years 2008 and 2014, and UNICEF's

27 See <http://www.un.org/sustainabledevelopment/blog/2017/04/secretary-general-announces-president-nana-akufo-addo-of-ghana-as-co-chair-of-sustainable-development-goals-advocates/>

28 See <http://www.data4sdgs.org/master-blog/2017/6/29/gpsdd-announces-board>

29 See <http://www.statsghana.gov.gh/databases.html>

30 See <http://www.statsghana.gov.gh/nada/index.php/home>

31 See <http://www.statsghana.gov.gh/nada/index.php/catalog/51>

32 See <http://www.statsghana.gov.gh/nada/index.php/catalog/72/study-description>

33 See <https://dhsprogram.com/what-we-do/survey/survey-display-437.Cfm>

Multiple Indicator Cluster Survey (MICS) for 2011.³⁴ Another notable survey not affiliated to the GSS is the Socioeconomic Panel Survey conducted in Ghana by the Institute of Statistical, Social and Economic Research at University of Ghana, and the Economic Growth Center at Yale University. This was last undertaken in 2009-2010. There is also increasing publication of perception-based data from other international household surveys such as the Afrobarometer³⁵ and the World Values Survey³⁶ (both of which have survey modules administered in Ghana). Below we incorporate data from the Gallup World Poll, which records households' and individuals' perceptions on a range of topics, including health and education services. These non-GSS surveys all use nationally representative samples, and some have been disaggregated to regional levels, but none have been disaggregated sub-regionally.

In addition, line ministries have their own administrative data systems and processes. The GHS and the GES – the implementing agencies under the health and education ministries respectively – have digitised these administrative records into national databases. The DHIMS2³⁷ records monthly data about inpatients and outpatients using public health facilities (Nyoator et al., 2013). The EMIS³⁸ records on an annual basis a variety of indicators for children attending public schools from pre-primary (kindergarten) through senior high school, as well as technical and vocational education and training (TVET) institutes. These data include selected aspects of academic performance and some features of the students' demographic background. UNESCO Institute for Statistics (UIS)³⁹ also provides annual national education statistics as a part of a global database.

3.1.1. Assessing the main data sources

The databases and systems we have outlined above have their own characteristics, strengths and weaknesses.

Table 7 identifies some systematic gaps in the data ecosystem that limit our ability to identify those left behind and the extent of their marginalisation. The administrative

service database, while providing details of service provided, is not designed to capture any data on those not using schools and health facilities – in other words, those who by definition are excluded. It also omits to capture most demographic and other information that would be useful for determining the individual's vulnerability (such as ethnicity and income). A frequent complaint particularly by non-governmental stakeholders, but even by some local government officials, is that administrative data are not publicly accessible; only a few top officials have access. Such lack of transparency prevents verification or scrutiny by other stakeholders. This is a missed opportunity for administrators to actively engage external stakeholders who can be strong allies with the official efforts in achieving the SDGs.

Data from household surveys, in turn, are particularly constrained by their focus on the household as the unit of observation. This makes it difficult to establish intra-household differences (such as gendered poverty within the household). It also makes it difficult to capture information about those not living in conventional household arrangements, including key marginalised groups such as migrants, displaced people and other mobile populations, the homeless and those living in institutions (Chavez Villegas and Samman, 2015).⁴⁰ Furthermore, the main survey instruments used internally pre-date the SDGs, and the indicators they use may not always match well to tracking progress towards the SDGs. In addition, the relative infrequency of such surveys and their methodological rigidities (which are needed for consistency over time and across countries and hence are also a strength) limit how quickly these issues can be addressed. Finally, surveys are not representative at a sub-regional level, hampering assessment of how policies and financing may be delivering different outcomes in different geographical communities. The direct impact of specific policies becomes much more difficult to isolate statistically at a regional or national level of aggregation as communities and conditions become more heterogeneous.⁴¹

34 See https://www.unicef.org/ghana/Ghana_MICS_Final.pdf

35 See <http://afrobarometer.org/countries/ghana-1>

36 See <http://www.worldvaluessurvey.org/wvs.jsp>

37 See <http://www.ghanahealthservice.org/ghs-item-details.php?cid=5&scid=55&iid=63>

38 See <http://www.ghanaeducationdata.com/>

39 See <http://data.uis.unesco.org/>

40 This has direct policy relevance – for example, one of the categories of people for whom national health insurance premiums are waived are 'indigents' (one of the conditions is no abode); these individuals would be, by definition, likely to be excluded from household surveys.

41 One fruitful avenue may be linking survey data to censuses to yield small area estimations. Another helpful avenue for examining statistical patterns of marginalisation would be to further develop techniques for combining household survey-based and administrative datasets; however, this is beset by a number of methodological challenges.

In Ghana, the GSS recently announced a plan to establish district-level statistical offices to collect and share data. Once operational, this could help overcome the substantial numbers of current data gaps that we have identified above.

For our analysis, we used GDHS 2014 and 2008 for identifying the differences in key health and education indicators for cohorts typically left behind. The GDHS, which takes the household as the unit of observation, is representative to national and regional levels. It is more detailed on demographic characteristics of the household, and includes households regardless of whether they use health and education services. We also compared our results from GDHS 2014 with its previous round in 2008 to look at changes over this six-year period. To complement the survey-based analysis, we used administrative data from the GHS and GES. Neither DHIMS2 nor EMIS is publicly accessible, so we used the annual summary reports generated at our request by the GHS and GES.

The administrative databases use the point of service delivery (e.g. health centre, hospital or school) as the unit of observation, thereby missing out those who are not using these services. The data are disaggregated to a district level, which allows us to look at service variation in more detail and also to map to the finance data available at the district level.

3.2. Who is using health services and who is left behind?

3.2.1. Provision and use of health facilities

Public health services in Ghana are administered primarily in three types of facilities, with the CHPS being the most prevalent in number, followed by health centres and clinics, and then hospitals.

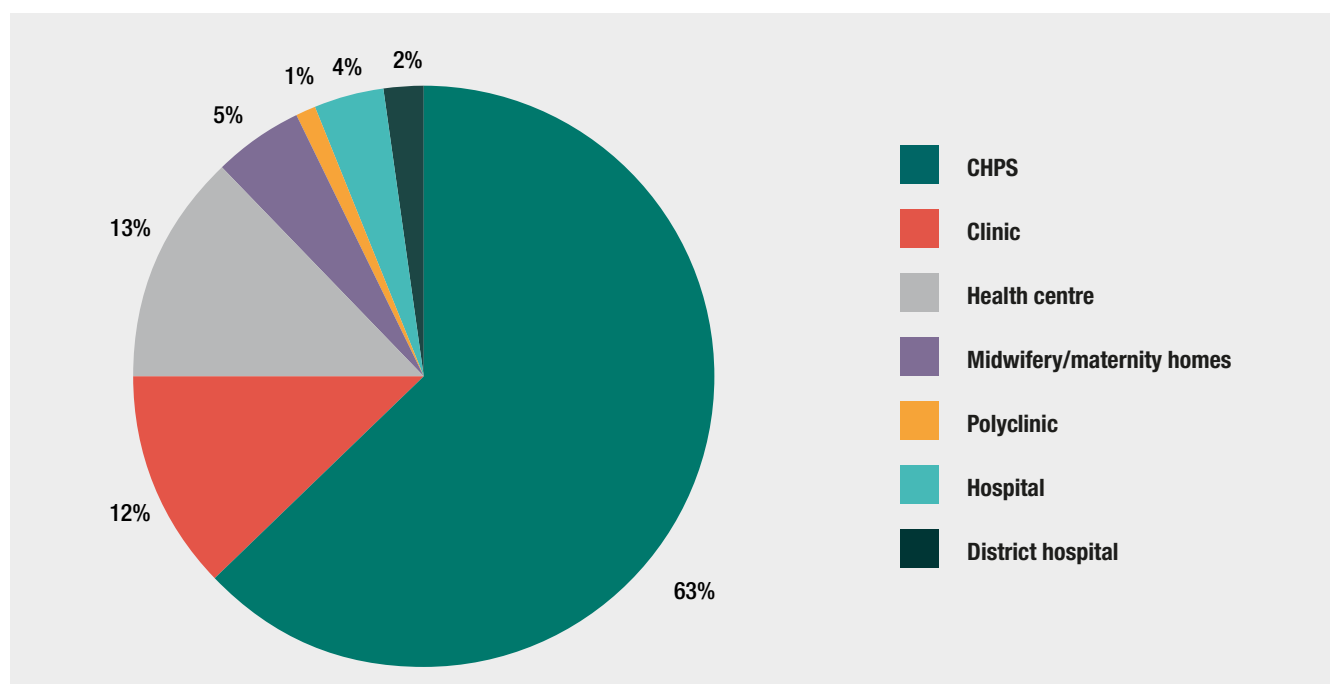
Figure 8 shows the number of public health facilities relative to population in each region.⁴² Given the intended role of CHPS in bridging health equity gaps by bringing basic health services into rural and under-served areas (see Chapter 4), one would expect to see that regions with these characteristics have the highest number of CHPS compounds. The regions with above the national average numbers of CHPS per capita do indeed include the poorest and most rural – such as Brong Ahafo, Northern, Upper East and Upper West – whereas Greater Accra and Ashanti, the two wealthiest and most urban regions, with above-average provision of hospitals, have the lowest number of CHPS. However, the relationship is not strictly inverse – for example, Northern region is only very slightly above the national average in terms of CHPS per capita, yet also has the lowest number of health centres and clinics and the second-lowest number of hospitals.

Table 7: Key characteristics of household surveys and administrative databases in health and education in Ghana

	Household surveys (GDHS, GLSS6)	Administrative data (DHIMS2, EMIS)
Unit of observation	Household members	Point of service delivery: schools, hospitals, clinics
Sampling and coverage	Nationally or regionally representative sample; thus reflects the entire population	Service recipients: enrolled students, admitted inpatients and outpatients. Contains up to 31.27 million hospital records for 2016, covering 6,757 public facilities. Does not include private health facilities
Metrics	Household demographic details such as size, age, wealth/income, consumption choices, behaviour, preferences	Usage data and counts; details of service delivery centre such as quality of hospital and school facilities
Frequency	Infrequent; roughly every five years; partly governed by budget	Routine – at least annual; can be continuous monitoring
Customisation and control	Designing survey instruments take time and resources to develop and implement; frequent changes are not feasible nor desirable	Much more flexible
Standardisation	Survey instruments and methodology are standardised and used across countries, and hence allow international comparison and benchmarks	Indicators are established by the end-user (service agencies) and hence non-standardised; useful for tracking changes over time, but limited comparability across countries
Harmonisation with other datasets	Possibility exists if surveys borrow the same sampling methodology; some are administered as modules to existing large surveys that makes it possible to append additional sectors, markers of marginalised communities and access indicators	Limited scope, other than at geographic/administrative level and above
Accessibility	Publicly available; requires data analysis skills and hence useful for research and policy guidance but only after proper data analysis	Overall data accessible to only few service administrators; line managers/administrators have access to the data for their geographic region

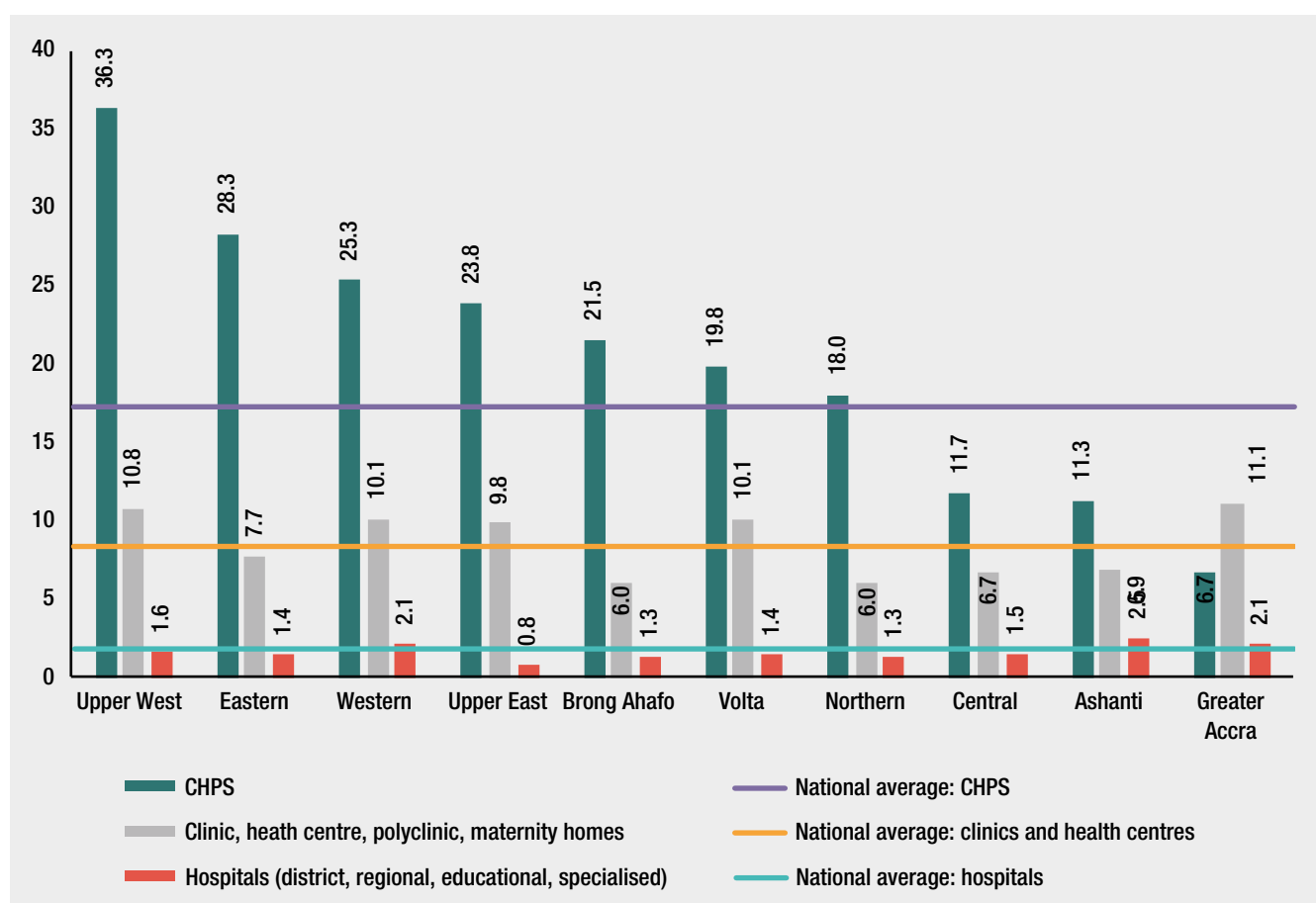
42 Similar data on private health facilities are not available – however, it is likely that these would be much more heavily prevalent in wealthier and more urban areas such as Greater Accra.

Figure 8: Public health facilities across Ghana by type, 2016



Note: Regional, educational and specialised hospitals and polyclinics all account for less than 0.5% of the national total and are hence not visible in the distribution chart.

Figure 9: Number of public health facilities per 100,000 population by region, 2016



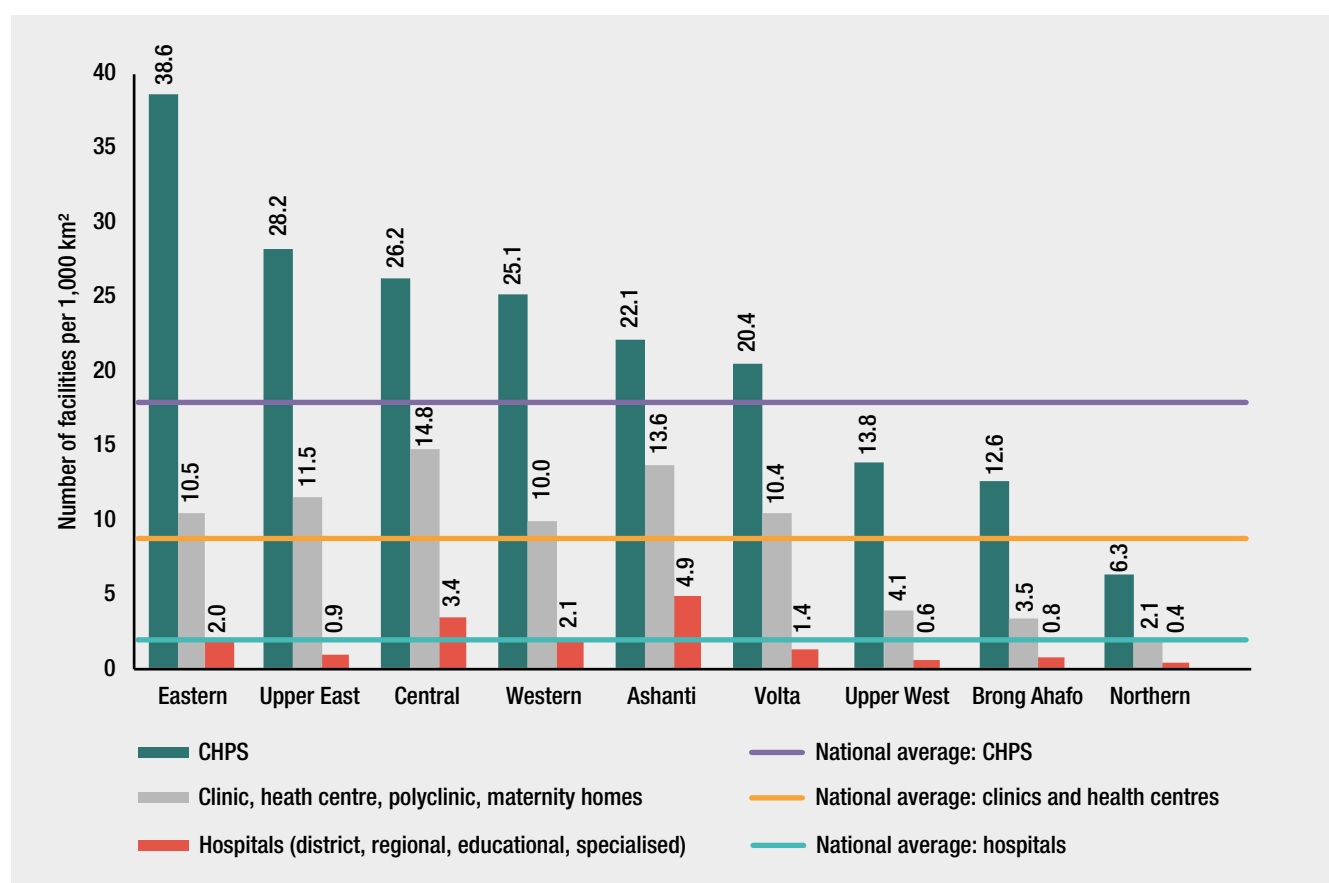
Source: Authors' calculations based on DHIMS2 database summary (2016) and Census (2010)

Furthermore, the extent of provision relative to terrain size sheds further light on the supply-side inequalities between regions. As shown in Figure 10, the vast Northern region ranks lowest in terms of CHPS facilities per 1,000 km² – considerably below all other regions at just 6.3 per 1,000 km² – while also having the lowest geographic density of all other types of health facilities (2.1 health centres and clinics, and 0.4 hospitals). This means that many sick patients would need to travel for up to several hours, potentially by foot, to reach a facility. Brong Ahafo⁴³ and Upper West also fall below the national average density by area for all types of facilities. These figures bring to light the nature of the challenge of providing equitable access to health care in low population density regions such as Northern region, and suggest that the CHPS programme – which is precisely intended to bridge these gaps in remote areas – is far from being adequately

implemented in areas with the highest need. By contrast, the Upper East region, which has similar geographic remoteness and economic conditions, has been successful in its efforts to improve the provision of health facilities and has a relatively high density: 40% more CHPS compounds, health centres and clinics per capita than Northern region, and almost five times as many per square kilometre. These deliberate efforts to boost supply in Upper East have indeed been associated with improved health access.

Overall, public health service utilisation rates – measured by the number of outpatient visits and incidence of hospitalisation by population size⁴⁴ – remained fairly stable nationally and within most regions over the period 2013 to 2016.⁴⁵ These data cover all publicly owned or managed facilities: CHPS compounds, health centres, public clinics, district and regional public hospitals, public

Figure 10: Number of public health facilities per 1,000 km² area by region, 2016



Note: Greater Accra not shown as an outlier – 82.9 CHPS, 137.5 health centres and clinics and 26.5 hospitals per 1,000 km².

Source: Authors' calculations based on DHIMS2 database summary (2016) and Census (2010)

43 During our fieldwork in Brong Ahafo (July 2017), we were told about several new CHPS compounds that had recently been or were being finalised, which would not yet be reflected in these data.

44 Note that these data do not record unique patients, but rather simply the total number of visits/points of use. Given that in some regions there may be a much higher repeat utilisation by the same individuals, whereas in other regions total utilisation may be spread over a greater population, they are not strictly comparing utilisation rates per person.

45 Data from DHIMS2 are available only since 2013, so it is not possible to compare trends in this recent period with the previous period.

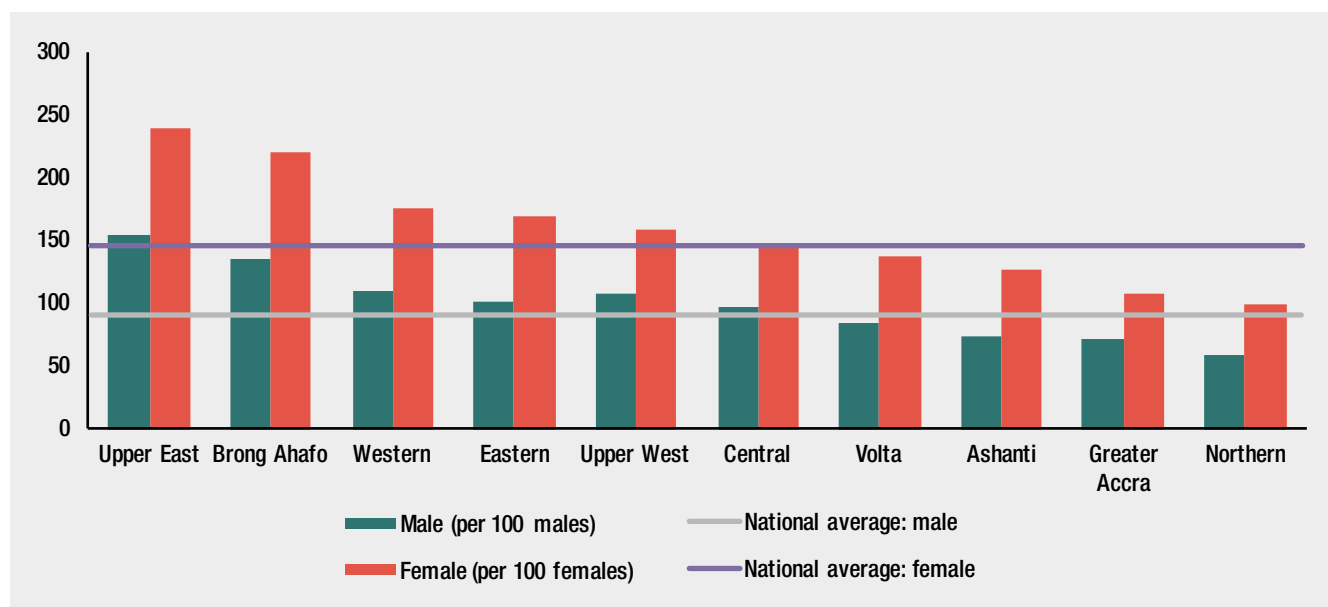
hospitals (general and specialised) and teaching and university hospitals.⁴⁶

The region with the lowest rate of utilisation of public health facilities for both men and women is Northern region, which is not surprising given the very low density of health facilities noted above. Greater Accra has the second-lowest utilisation rate – but the most likely explanation here is rather a much higher supply of and ability to pay for private health services (which are much

more densely concentrated in Accra, and very scant in Northern region). At the other end of the spectrum, Upper East region has the highest utilisation rate – again, this correlates with the good supply of facilities, as noted above, and of health workers (see Box 3) – followed by Brong Ahafo, which was selected as our case study region because it has relatively good CCI performance.

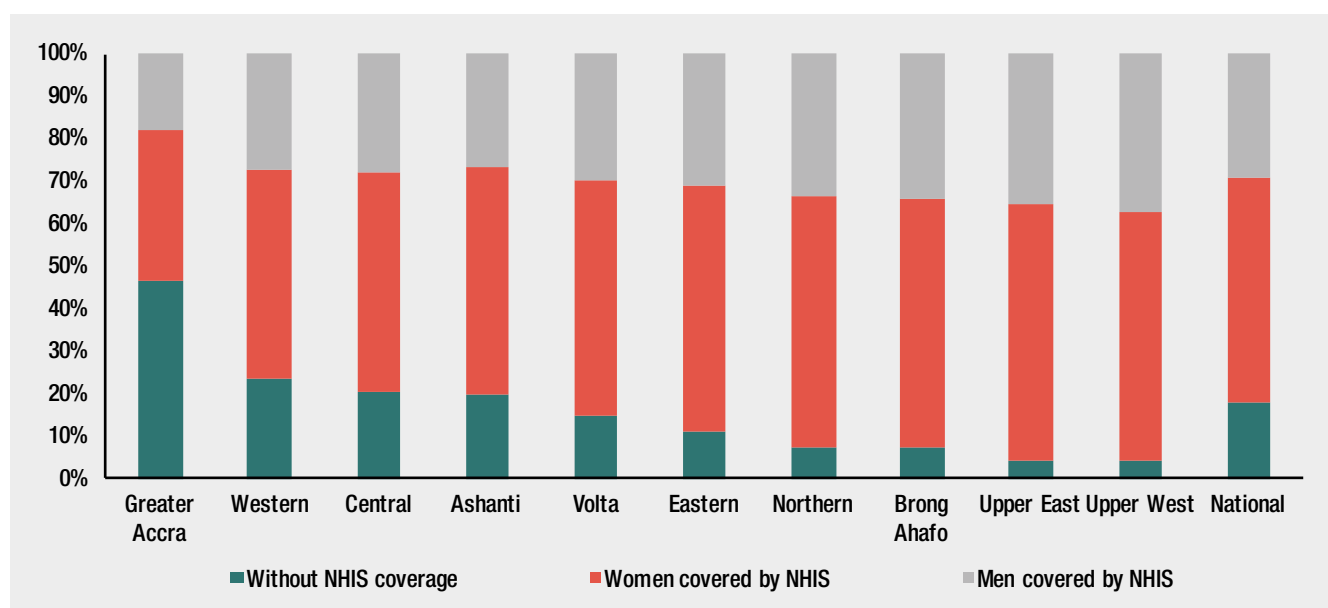
With regard to financing health care access, DHIMS data reveal that, nationally, as many as 82% of outpatients using

Figure 11: Outpatient service utilisation rates among men and women by region, 2016



Source: Authors' calculations based on DHIMS2

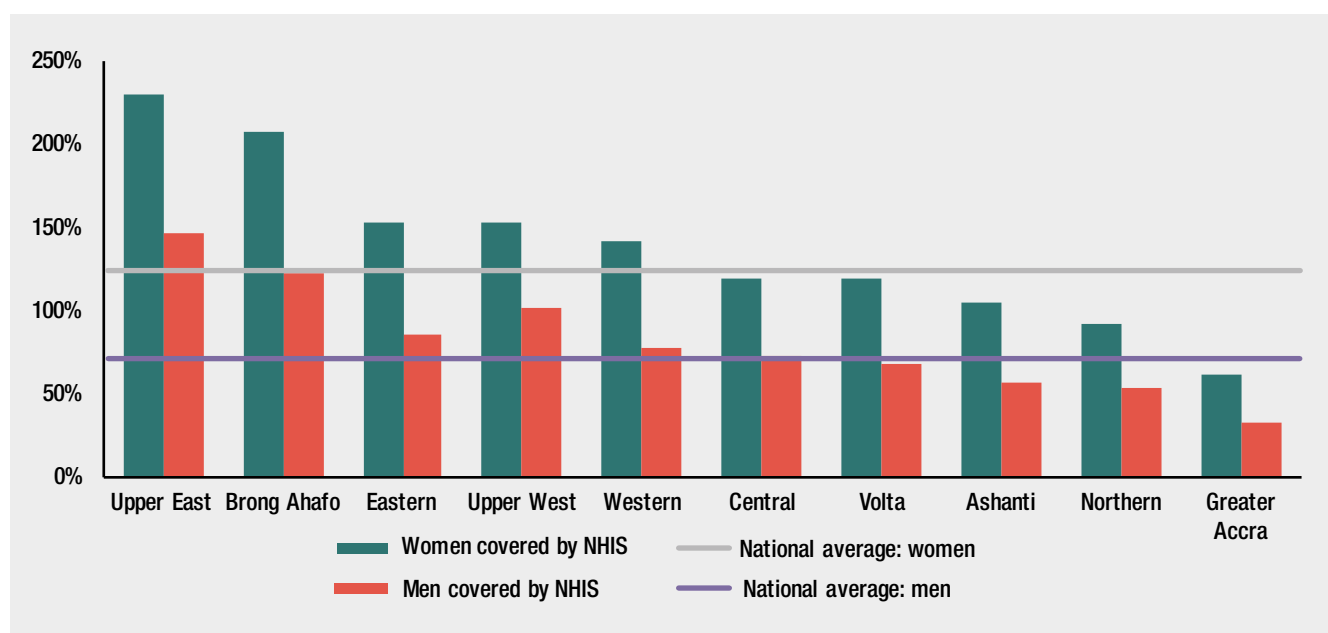
Figure 12: NHIS coverage of outpatients by region, 2016



Source: Authors' calculations based on DHIMS2

46 The data omit utilisation of private health care facilities.

Figure 13: NHIS coverage in outpatient service use for men and women by region, 2016, as proportion of population



Source: Authors' calculations based on DHIMS2

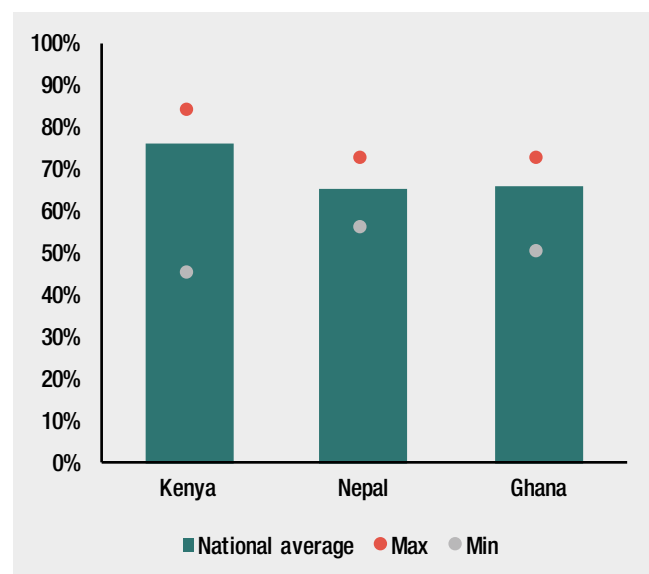
public health facilities have NHIS coverage. The coverage level is highest in the poorest regions of the country – Northern, Upper East and Upper West – where it rises to nearly 92%. In contrast, Greater Accra had the highest levels of outpatients not covered by the NHIS, at 46%.⁴⁷

There is, however, an important caveat when examining utilisation rates since the data reflect the overall incidence of usage and not unique individuals. To the extent that NHIS members are more likely to use services, they are ‘over-represented’ in the data. This is why there is such a large divergence between total NHIS enrolment rates (only 38% nationally, and as low as 31% in our case study district of Zabzugu in Northern region) and the apparently high NHIS coverage among outpatients. For example, pregnant women are one of the categories of people exempt from paying NHIS premiums. Women are therefore likely, on average, both to have NHIS membership and to use services, as shown in Figure 13.

3.2.2. Assessing health coverage – the Composite Coverage Index

The next section of analysis uses the CCI of access to eight key reproductive, maternal, newborn and child health services (see Chapter 1 for a fuller explanation) as the main metric to examine who is being left behind in health service coverage. We analyse patterns of CCI by region and population group, both for the most recent data point available (2014) and over time, referring back to the results of the previous GDHS (2008).

Figure 14: Spread of CCI across best and worst regions, selected countries



Source: ODI (2016) and authors' calculations using GDHS 2014

As explained in Chapter 1, we take a deductive approach: first selecting dimensions of marginalisation and vulnerability that are commonly identified in the literature and additionally possible to isolate within GDHS data, and then assessing the CCI picture for these different groups. These dimensions are location by region, and by urban versus rural; household wealth (bottom wealth

⁴⁷ Note that these findings do not give any indication of the quality and scope of services provided, and whether they were truly free of any ‘informal charging’ of patients, merely of the fact that the outpatients had active NHIS membership.

quintile versus the rest);⁴⁸ the level of education of women receiving RMNCH services; and whether the household belongs to an ethnic minority. We aware that there are other important characteristics of marginalisation, such as disability and refugee or migrant status. The GDHS data do not allow for these to be included in calculating the CCI; however, we did cover some of these issues to some extent in our field interviews and focus groups.

Ghana's overall CCI performance in 2014 was 65.9% – this falls below the median among all LICs and MICs of 70.6%. Comparing Ghana's score with the results from our earlier stocktakes for Kenya and Nepal also suggests poor performance. Ghana's CCI score is considerably below that of Kenya, another sub-Saharan African LMIC, at 76.0%, and virtually the same as Nepal's score, despite the latter being a least developed country with GDP per capita equal to roughly half that of Ghana.

The biggest differences in health access in Ghana are associated with regional variation. Northern region's average CCI is just 49.5%, 16 percentage points behind the national average. There is currently a 22 percentage point gap between the best-performing (Upper East) and worst-performing regions (Northern). This is a lower level of geographic inequality than in Kenya, where the gap between best and worst-performing regions was 38

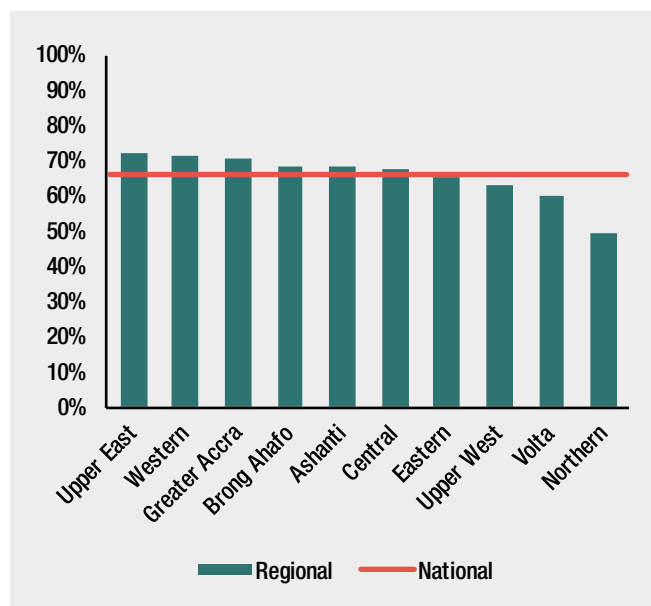
percentage points; but more unequal than Nepal, where the gap was 16 percentage points.

Ghana's best-performing region, Upper East, is one of the three that comprise the historically marginalised north of Ghana and is home to high levels of deprivation. However, there is a particular story of exceptional leadership and local innovation in Upper East (see Chapter 4) and, as shown in Chapter 5, it has in recent years received an above-average per capita health budget.

Even groups we posited as 'non-marginalised' fare worse in Northern region than most marginalised groups in other regions, suggesting that exclusion from health coverage in Ghana is predominantly a regional phenomenon. In this, our findings reinforce a well-established literature that emphasises the historical deprivation and marginalisation of Ghana's north (Abdulai and Hulme, 2014; Saleh, 2013).

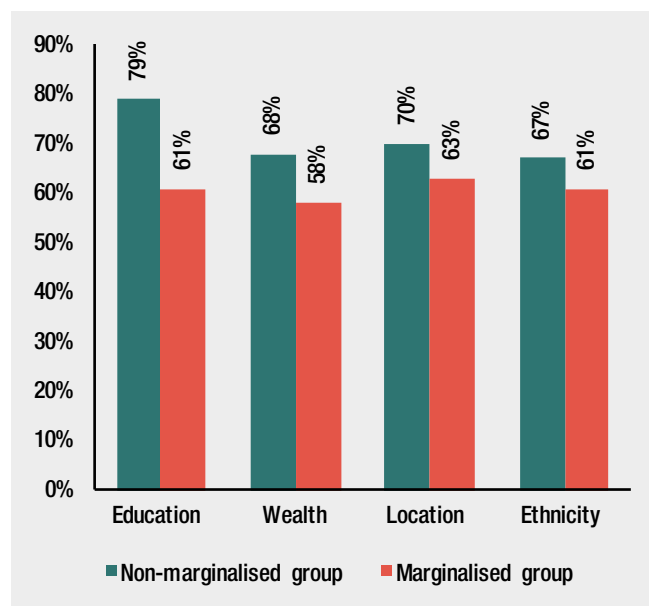
On a national basis, the highest level of education attended in the household is the next most significant factor associated with health service coverage, followed by household wealth. In households where the highest level of education attended was primary (or none), the average CCI was 61%, compared to 79% in households where the highest level attended was secondary or above.⁴⁹ In the poorest quintile of households, the average CCI was 58%, compared to 68% for the rest of the population. Among

Figure 15: CCI by region, 2014



Source: Authors' calculations based on GDHS 2014

Figure 16: CCI by marginalised versus non-marginalised groups, 2014



Source: Authors' calculation using GDHS 2014

48 We look at the bottom wealth quintile versus the rest on the premise that those in higher quintiles may still be living in poverty, but those in the bottom quintile are in the most severe poverty and left furthest behind. Data limitations of the GDHS do not allow us to disaggregate below quintiles (e.g. deciles).

49 Ideally we would have tested whether Ghana follows a well-established result in the literature – that the education level of the mother in the household strongly determines the level of education achieved by the children. However, we were not able to test that hypothesis directly as GDHS 2014 does not provide data on the education level of mothers specifically. The highest attended education level in the household overall, however, was a proxy for the intergenerational influence on children's education.

Figure 17: CCI by household wealth in each region, 2014

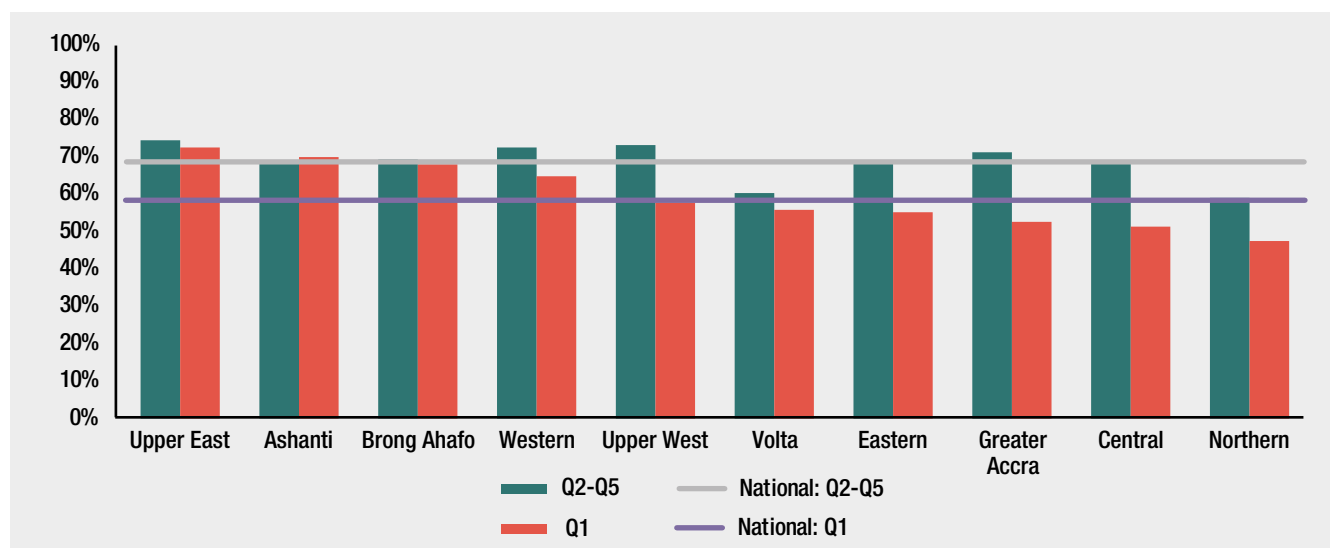


Figure 18: CCI by urban versus rural location in each region, 2014

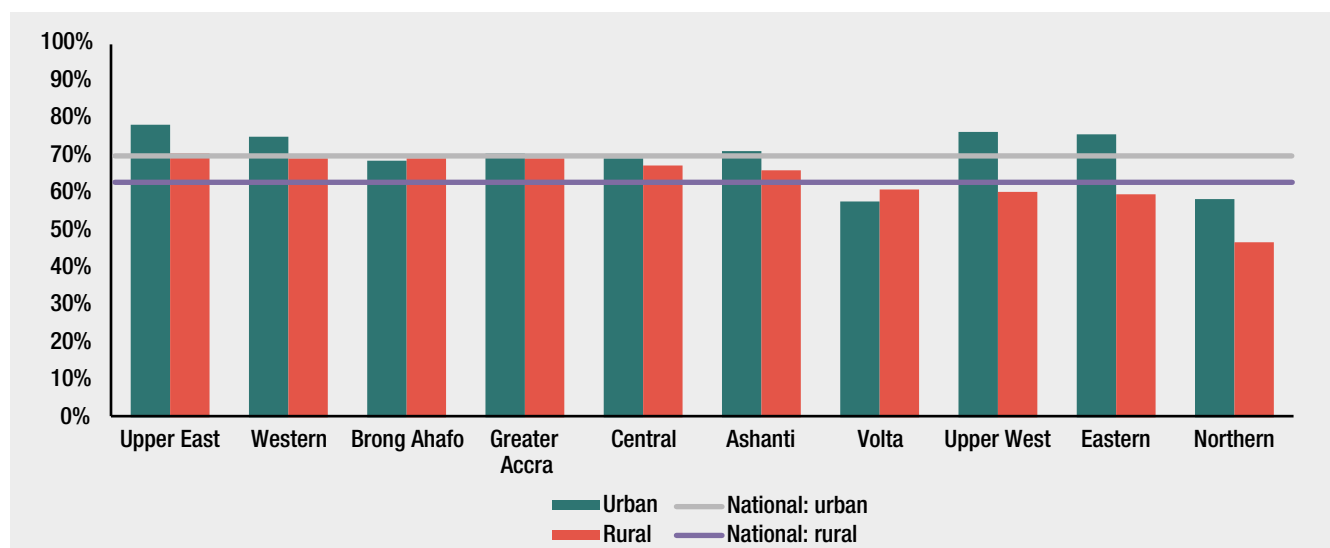
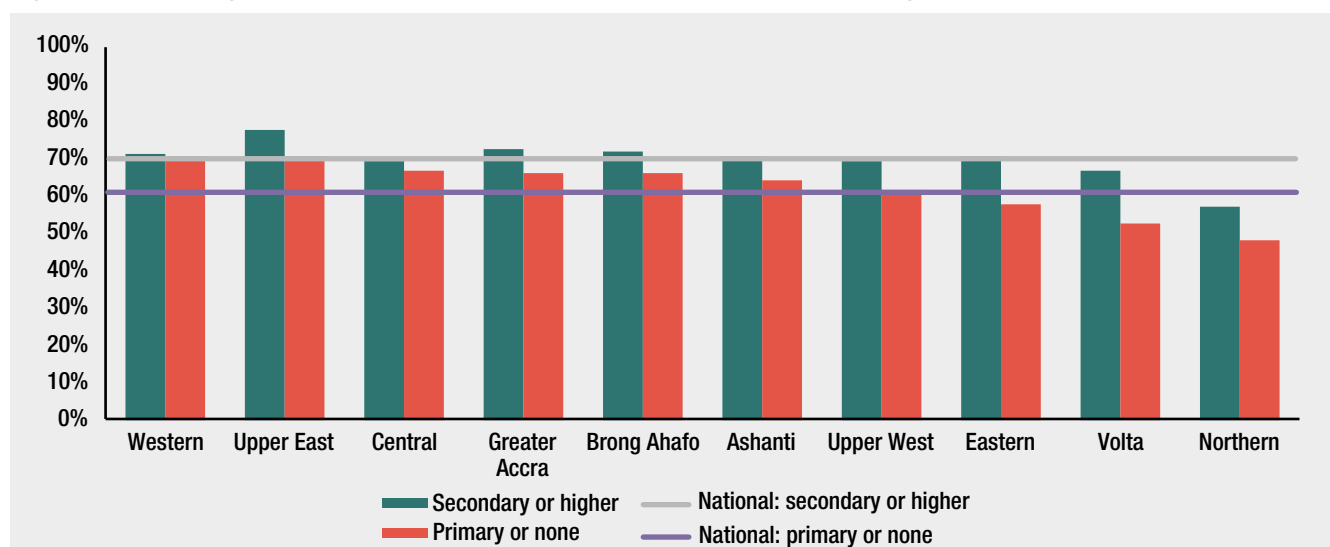
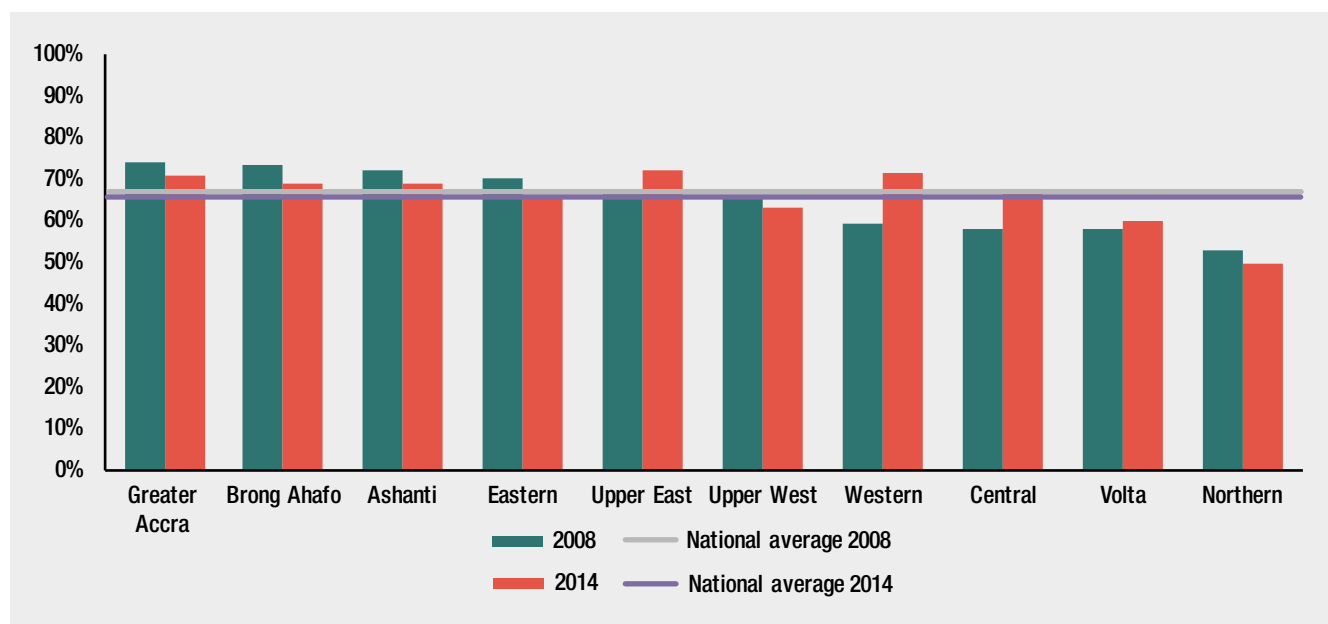


Figure 19: CCI by highest level of education attended in the household in each region, 2014



Sources this page: Authors' calculation using GDHS 2014

Figure 20: Average CCI in 2008 and 2014 by region



Source: Authors' calculations using GDHS 2008 and 2014

rural households, average CCI was 63%, compared to 70% among urban households. For ethnic minorities, CCI was 61%, compared to 67% for non-ethnic minorities.

Comparing this picture with that in Kenya, Ghana has lower absolute CCI levels and larger CCI percentage point gaps between the poorest households and the rest, rural and urban households, and ethnic minorities and the rest (see ODI, 2016). Fenny et al. (2018) also find household wealth to be associated with relatively large disparities in health service coverage (skilled birth attendance) in Ghana compared to Rwanda, which has achieved wide coverage of the poor under its Community Based Health Insurance and 'Ubudehe' social targeting initiative.

Using Ghana's 2008 DHS as a baseline, our analysis shows that its overall CCI performance declined slightly between 2008 and 2014, from 67.2% to 65.9%. This finding is concerning, especially given the economic and fiscal expansion the country experienced over this period. This finding suggests that Ghana is, if anything, reversing away from achieving UHC and must accelerate its efforts to improve access to basic health services.

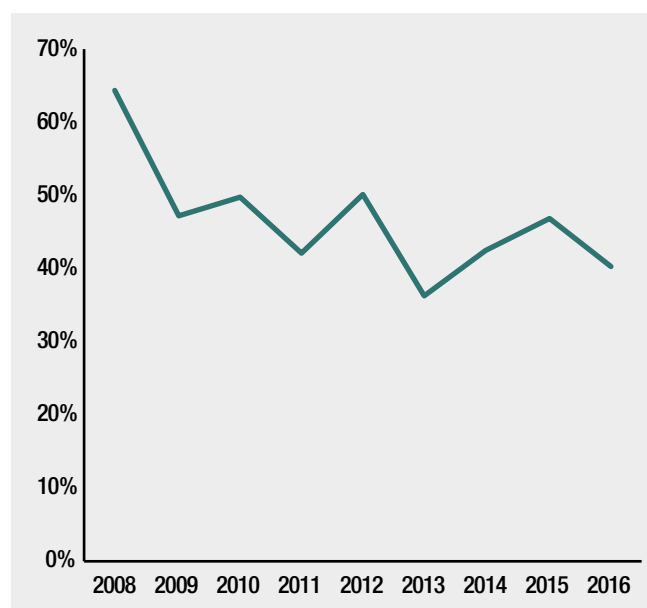
This finding of declining health coverage as measured by the CCI is further supported by evidence from the Gallup World Poll, a large-scale survey recording people's perceptions about many different topics ranging from public services to politics. Data for Ghana from the Gallup World Poll show a notable decline in the percentage of people who described themselves as 'satisfied' with health care, from 64% in 2008 to 43% in 2014. Data for 2016 suggests an ongoing decline, with just 40% described as satisfied. This figure is lower by a quarter than the equivalent proportion who consider themselves satisfied with education.

Between 2008 and 2014, CCI performance declined in both of our case study regions, Brong Ahafo and Northern, as

well as in Greater Accra and Ashanti. The result is particularly striking for Northern region, which was already the lowest performing in 2008 and by 2014 had by far the lowest CCI score among all of the regions. This trend is worrying and suggests that the pattern of regional marginalisation at best is stagnant and, at worst, may be deepening.

Several regions, however, did improve their CCI score, among them Upper East. A comparison between Upper East and its neighbour, Upper West, is telling. In 2008, these two regions had very similar CCI scores (66.2%

Figure 21: Percentage of respondents 'satisfied' with the quality of health care



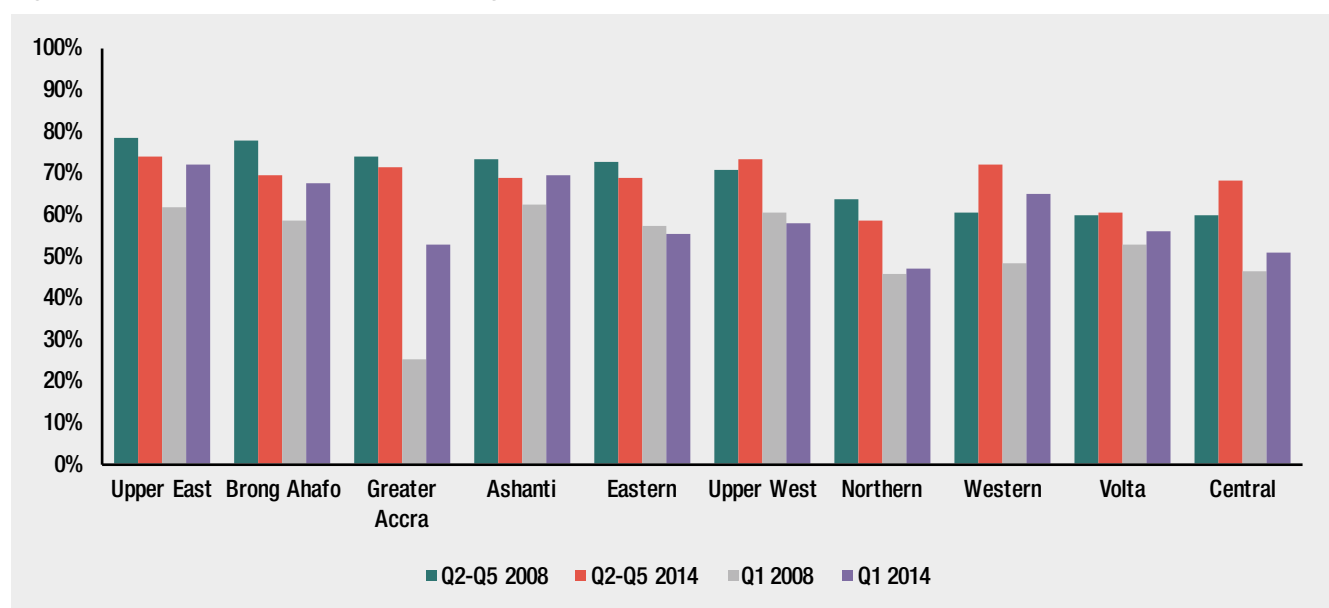
Source: Authors' calculation using GDHS 2014

and 65.8%, respectively). By 2014, Upper East region had the highest CCI (72.3%) in the entire country, opening up a 9.2 percentage point gap with Upper West. During this period, health authorities in the Upper East region energetically drove through a series of initiatives to tackle issues of health worker recruitment and retention, and to better target and reach the poorest households, among others (see Box 3). At least in terms of CCI outcomes, this suggests that determined policy initiatives backed by increased financial resources can indeed make a positive difference in a relatively short space of time and – in this case – buck a national trend.

Over time, the CCI gaps between marginalised and non-marginalised groups have very slightly narrowed – but this has been driven mostly by declining coverage among the non-marginalised groups, rather than improvements for the marginalised groups. Only two regions – Western and Central – saw overall progress in health coverage combined with a shrinking gap between marginalised groups and the rest of the population.

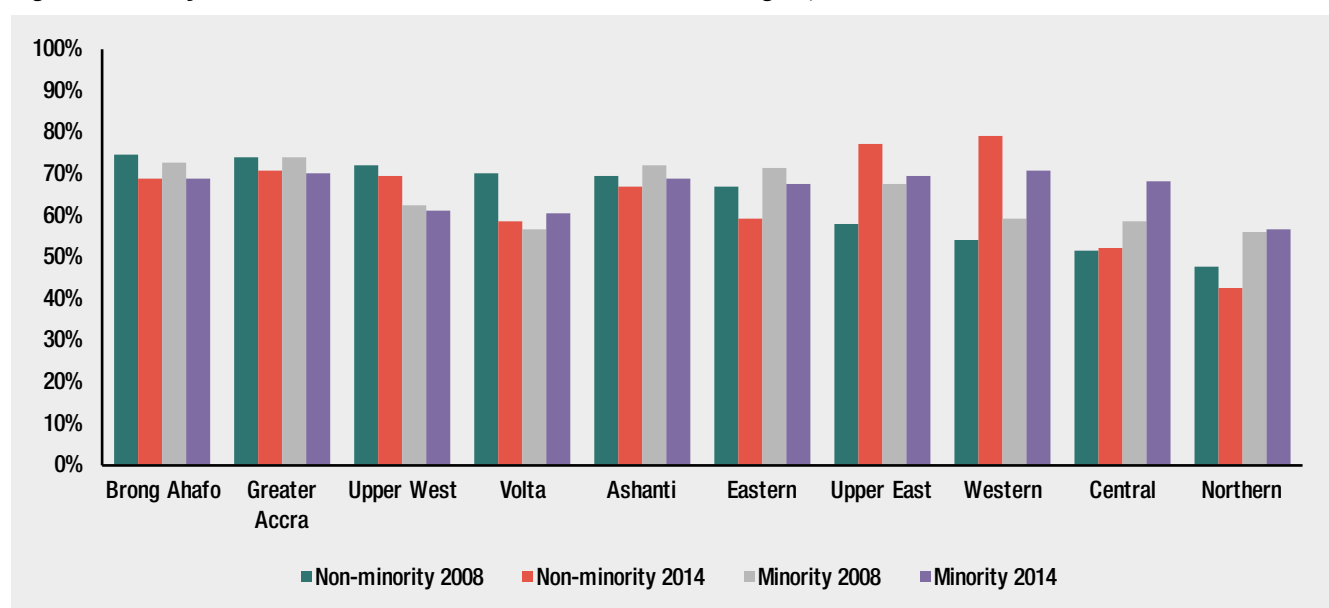
There was a variety of changes in health care access over the 2008-14 period. Among non-marginalised groups, CCI for urban households in Brong Ahafo declined by 12 percentage points; in Upper West, the more highly educated

Figure 22: CCI by wealth quintile in each region, 2008 and 2014



Source: Authors' calculations using GDHS 2008 and 2014

Figure 23: CCI by ethnic minorities versus non-minorities in each region, 2008 and 2014

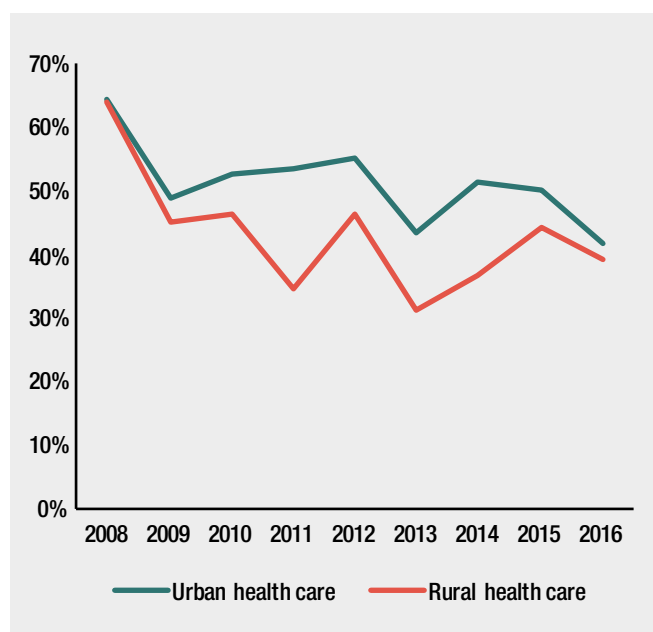


Source: Authors' calculations using GDHS 2008 and 2014

households saw their CCI decline by 10 percentage points. In contrast, in Upper East, both marginalised and non-marginalised groups tended to experience improvements in their CCI scores – although the latter more so, leading to gaps widening. Only Western and Central regions were unqualified successes in terms of the leave no one behind commitment. In these two regions, not only was there significant overall progress, but also the gap between the marginalised groups and the non-marginalised groups declined.

Gallup World Poll data tracking perceptions show that a persistently lower proportion of people living in rural areas are satisfied with the quality of health care, compared to urban areas, with the gap averaging 8 percentage points over the period 2008-16. Interestingly, there was barely any gap in 2007 and 2008, but this widened markedly during the period 2009-14, before beginning to narrow over 2015-16. However, this recent narrowing has been owed largely to a greater decline of satisfaction with quality in urban areas, rather than improvements in rural areas. Indeed, the trend in both urban and rural areas has been downward over this period.

Figure 24: Percentage of respondents 'satisfied' with the quality of health care, rural and urban



Source: Chattopadhyay and Graham (2017) using Gallup World Poll data

3.3. Who is using education services and who is left behind?

Our analysis of who has access to education and who is left behind combines data from the GDHS (2014 and 2008) and the sector's administrative database, EMIS (2015-2016). This provides annual data for the period 2012-16 on enrolled students from kindergarten through senior high school, as well as TVET institutions.

We assess enrolment levels (noting that enrolment does not equate to actual attendance or completion), and the total years and highest level of education attended among 7-12 year olds (primary age) and 13-15 year olds (junior high school age). We isolated these groups within the GDHS data in order to highlight the effects of recent and current policies, rather than those of previous decades that would have affected today's adults. We also examine average distance to school and time taken to travel to school in order to see if this sheds light on differences in enrolment and attainment between regions and groups. As a measure of educational quality and students' learning, we look at examination pass rates (noting that they do not provide a full picture of school quality, as they do not account for different starting points). Other aspects of the quality of education (for example prevalence of teacher absenteeism) that are difficult to capture in available quantitative data were also gauged through our qualitative fieldwork, highlighted in later chapters.

3.3.1. Enrolment and travel time to school

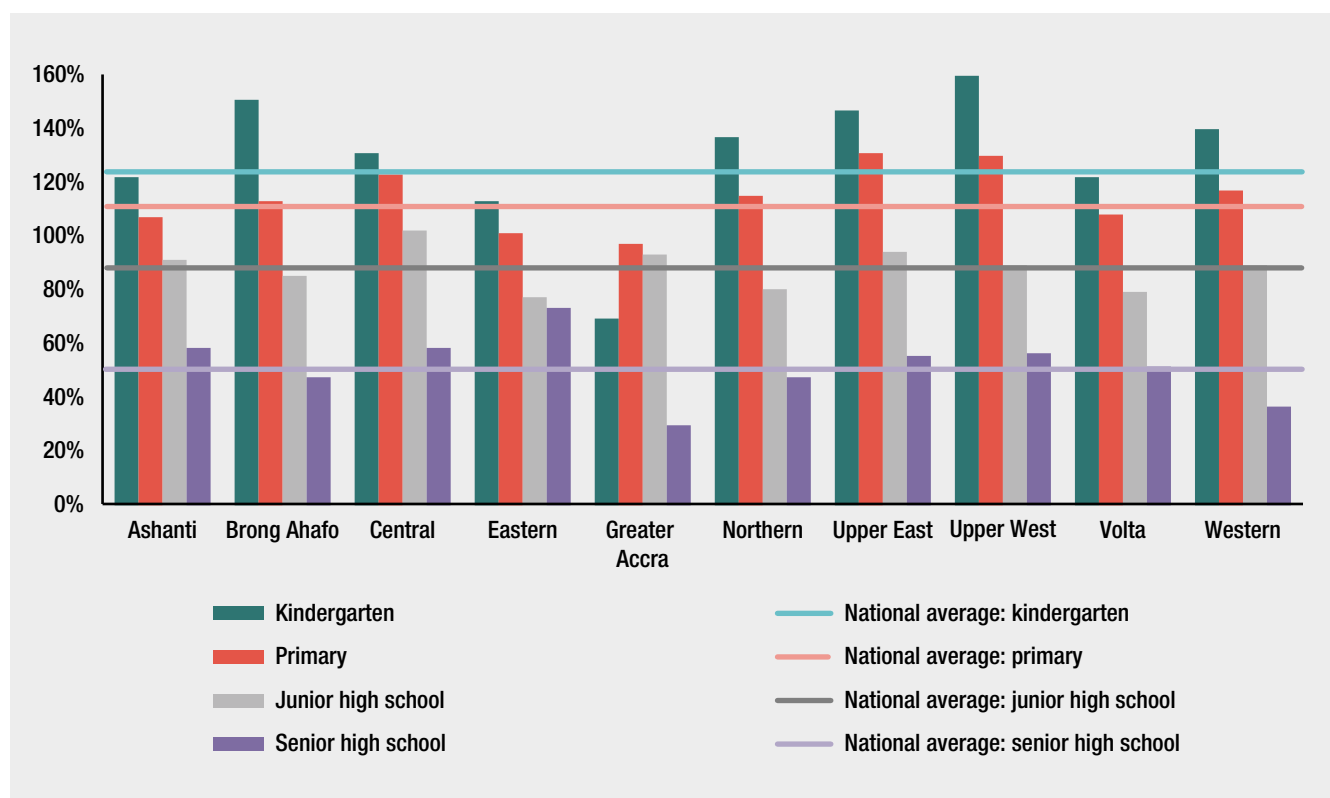
Comparing enrolment figures at each school level to the estimated population in the relevant age group to estimated gross enrolment rates reveals a trend of bulging at the kindergarten and primary levels and tapering off at the junior and senior secondary levels. Nationally, the gross enrolment ratio appears to be more than 124% at kindergarten and more than 111% at primary, but around 88% at junior high, and 51% at senior high.⁵⁰

Brong Ahafo has a similar pattern to the national average but with even more extreme differences between 'over-enrolment' at the basic levels and 'under-enrolment' at the higher levels. In Northern region, the pattern is similar to the national picture, but with lower secondary school enrolment rates. Greater Accra is the notable exception. Its enrolment rate does not exceed 100% at any level, although it falls after junior high school more precipitously than in any other region.

There are several possible reasons behind this pattern of 'over-enrolment' at pre-primary and primary and 'under-enrolment' at secondary. One explanation is that students are joining schooling later than they should for their age. Another is that students who ought to graduate up through the different levels of education are repeating grades. Since

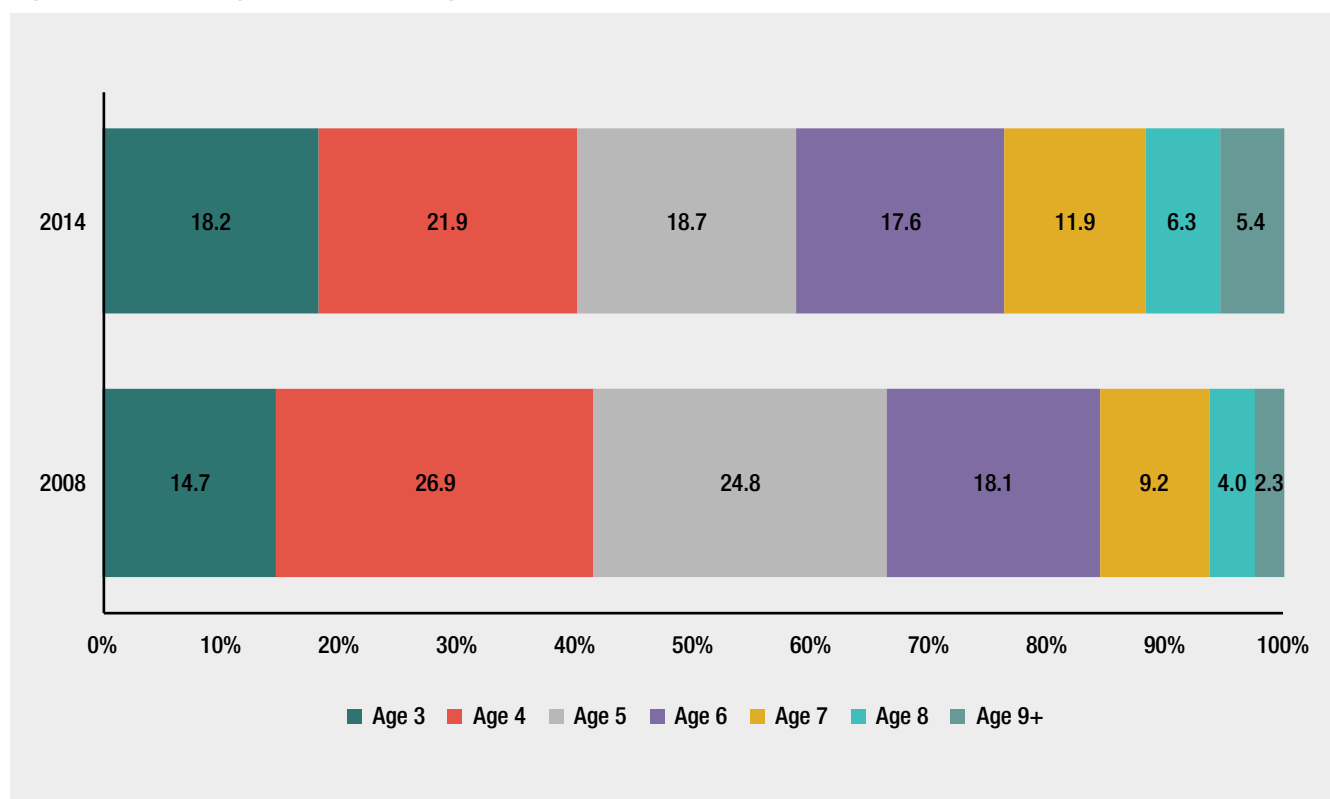
⁵⁰ Gross enrolment rates are computed as the ratio of the number of children who are actually enrolled in school at a particular level (from enrolment levels) and the number of children in that level-appropriate age category (from Census data). Some probable explanations for this ratio exceeding 100% at lower levels are discussed below.

Figure 25: Gross enrolment rate by region, 2016



Source: Authors' calculations using EMIS 2015-2016

Figure 26: Student age profile of kindergarten enrollees, 2014 and 2008



Source: Marshall et al. (2016) using GDHS and EMIS

EMIS does not record the actual age of students enrolled in each level, we are unable to verify these explanations directly from the database. However, our district fieldwork did indeed provide evidence for the former, particularly in Northern region, where parents complained that their kindergarten-aged children could not walk so far alone to reach the nearest school, and so families were delaying their school start (see Chapter 6).

Data from Marshall et al. (2016) indeed show that, nationally, almost a quarter of kindergarten enrollees are aged seven or above (the official age to begin primary school in Ghana is six years). This is a greater proportion than in 2008 (15.5%), suggesting this issue of delaying the start of education is worsening.

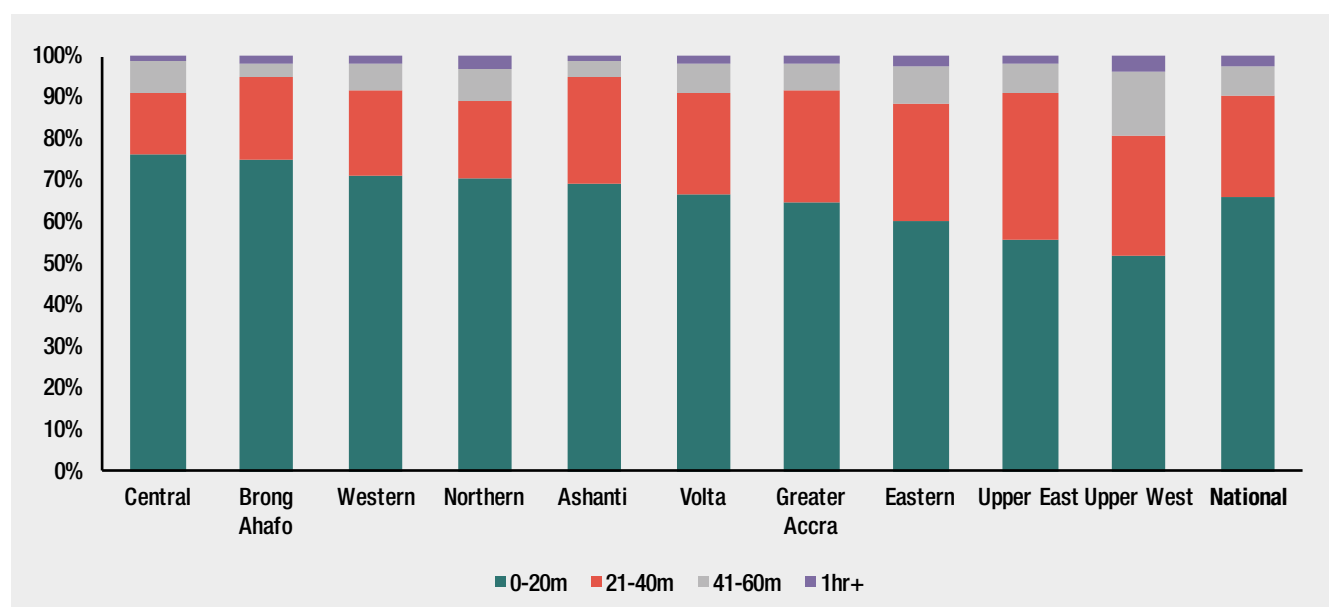
According to the results of regression analysis by Marshall et al. (2016), the factors most strongly associated with school enrolment are the level of the father's education, household wealth and the time needed to travel to school, even after controlling for geographic location.

Parents' education does correlate positively with the likelihood of their children being enrolled in school. But surprisingly, and in contrast to some of the literature (Akyeampong et al., 2007; Hashim, 2005), the strongest influence appears to be that of the father's rather than the mother's education, according to Marshall et al. (2016). Families where the father had seven or more years of education are at least seven times more likely to enrol their children in school than households where the father had no education. The impact of the mother's education, while positive, appears statistically negligible.

Marshall et al.'s (2016) analysis indicates that household wealth is also associated with enrolment: those in the richest wealth quintile are more than 22 times more likely to enrol their children in school than those in the poorest quintile. The biggest distinction is seen between the bottom 40% and the rest – from the middle quintile, each incremental wealth quintile increases the likelihood of children being enrolled by between 1.5 times to 3 times. As father's education and household wealth patterns tend to have long-term inertia, this suggests that – at least in terms of average enrolment across all levels of schooling – there is quite a large swathe of children at risk of being left behind, combined with deeper pockets of persistent (and possibly intergenerational) marginalisation among those children who do not even gain a primary school education.

A third finding of Marshall et al. (2016) is that the time needed to travel to school⁵¹ is another major factor associated with enrolment. In households situated less than 20 minutes from school, the likelihood of enrolment is more than 13 times higher than households situated further away than 20 minutes. This particularly disadvantages those areas of the country with a lower density of schools per square kilometre, poorer road quality and limited transport options – which was especially borne out in our fieldwork in Northern region. For example, we were told by women in Zabzugu district that 'the most pressing issue for us is that our children walk a very long distance' (FGDZWEA).⁵² This chimes with many previous studies that have demonstrated a close link between the distance to schools and the likelihood of never enrolling, or

Figure 27: Proportion of school attendees by time taken to reach school in minutes, 2014

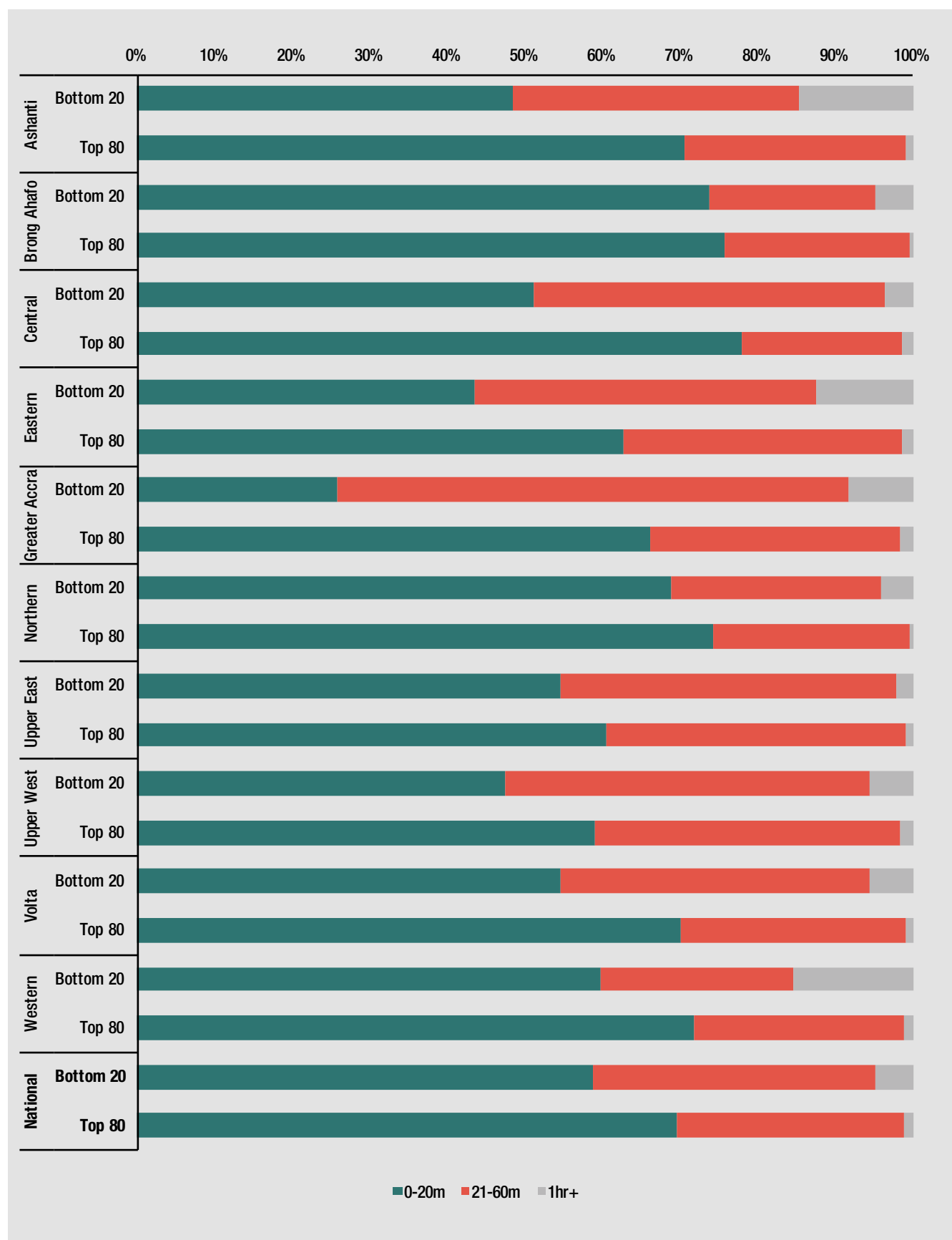


Source: Authors' calculations using GDHS 2014

51 The GDHS contains a question specifically on the time taken to reach school, rather than distance. However, we assume that a greater time implies a proportionately greater distance on average, all else (i.e. mode of transport) held equal. According to the GDHS data, the large majority of children in Ghana walk to school in all regions.

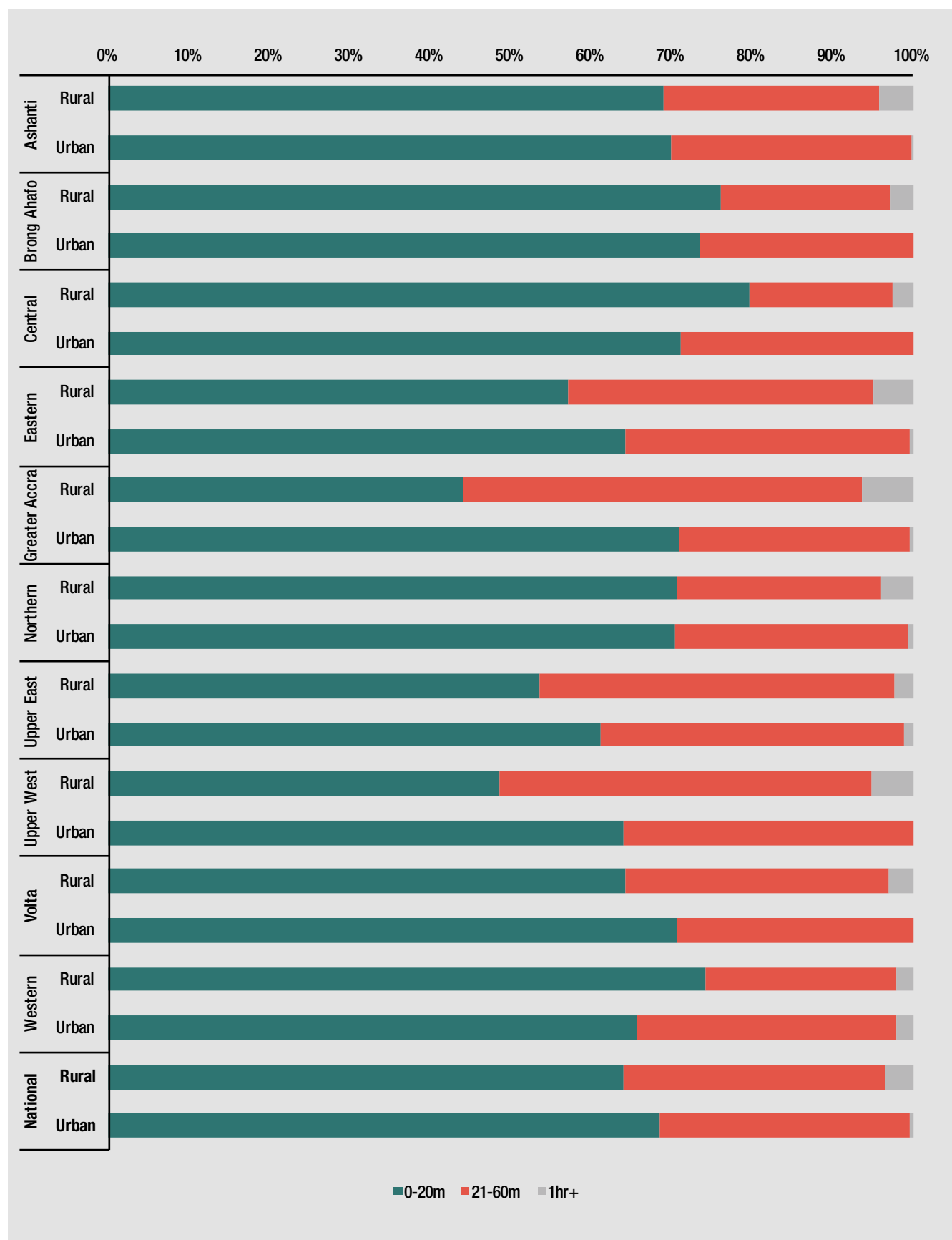
52 For FGD reference codes, please see Chapter 1.

Figure 28: Proportion of school attendees by time taken to reach school in minutes – bottom income quintile versus the rest, 2014



Source: Authors' calculations using GDHS 2014

Figure 29: Proportion of school attendees by time taken to reach school in minutes – rural versus urban households, 2014



Source: Authors' calculations using GDHS 2014

enrolling too late in comparison to the normal age of entry into primary school, or of dropping out (Wodon, 2016).

Our own analysis of the GDHS data indicates that most children who are attending school do have a relatively short journey to make (less than 20 minutes), even in Northern region. More than 70% of those who go to school in Northern and Brong Ahafo regions spend less than 20 minutes travelling there. However, an important caveat is that this metric, by definition, only captures children who are attending school and not those who have dropped out. Dropping out may be partly or wholly caused by distance. In other words, in regions with more highly geographically dispersed schools, it may be that a much larger share of children do not live within 20 minutes of a school, may have discontinued their education and therefore do not show up in these statistics.⁵³ This would tally with the much lower gross enrolment estimates at secondary level seen in more remote regions such as Northern.

Looking at other nationwide differences, on average there is a slightly longer travel time to school for children

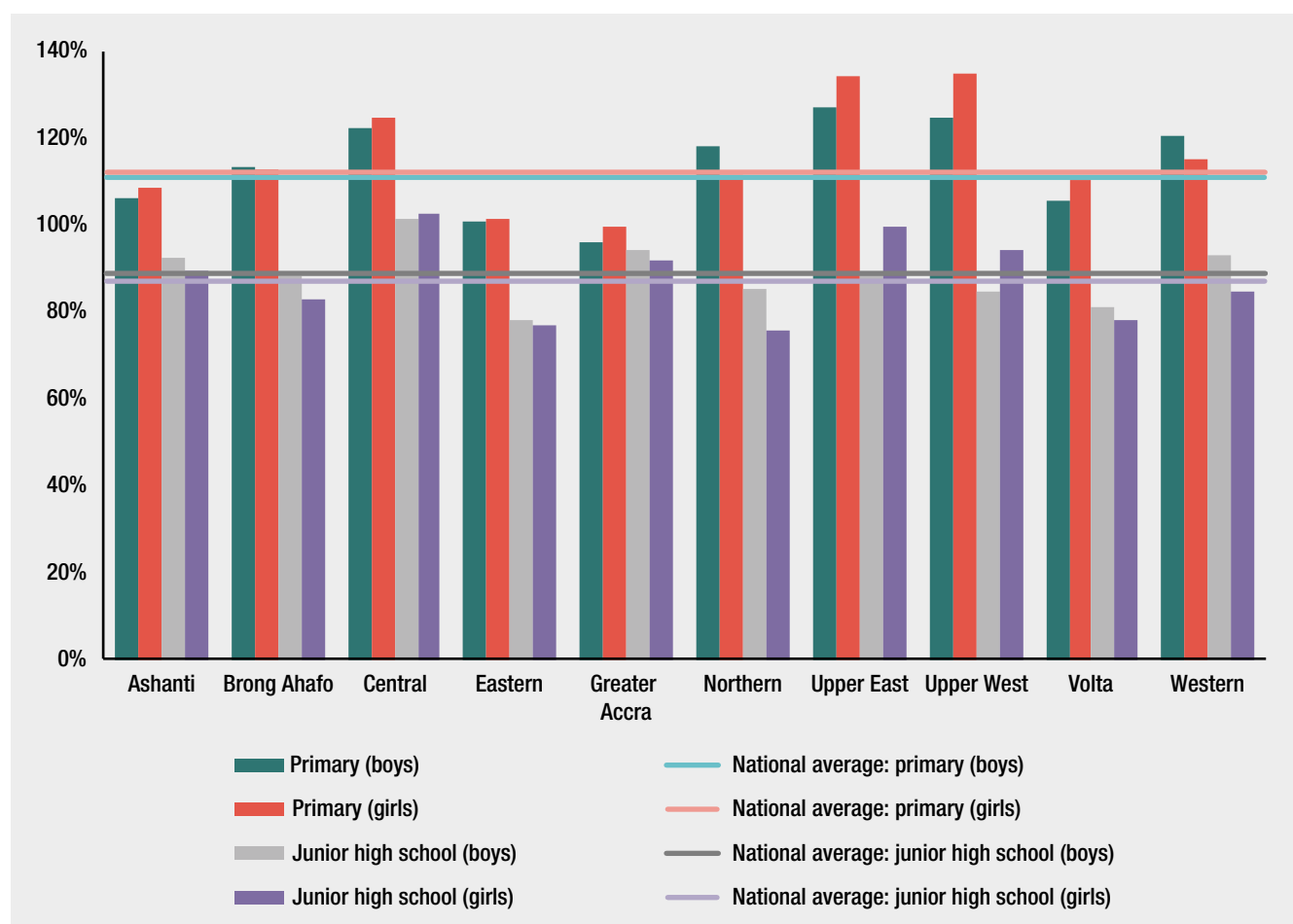
from households in the bottom wealth quintile versus the rest, and for children in rural versus urban households.

One positive finding is that gender does not appear to be a major driver of disparity in enrolment, at least at the national level. Across Ghana as a whole, the gross enrolment rate at primary level is 111% for boys and 112% for girls; at junior high school level it is 89% for boys and 87% for girls.

In eight of the ten regions, the gross enrolment rate at primary school level is at least as high for girls as for boys. However, as attested in some of our focus groups, Ghana faces the challenge of girls dropping out of school more frequently than boys when transitioning from primary to junior or during the high school years (Camfed Ghana, 2014). At junior high school level, the enrolment rate for girls is lower in several regions, including both Brong Ahafo and Northern. In Northern region, particularly, we see the largest gender disparities, with more boys than girls enrolled in schools at all levels.

Private education is a growing phenomenon in Ghana, including the expansion of the low-fee sector, to which

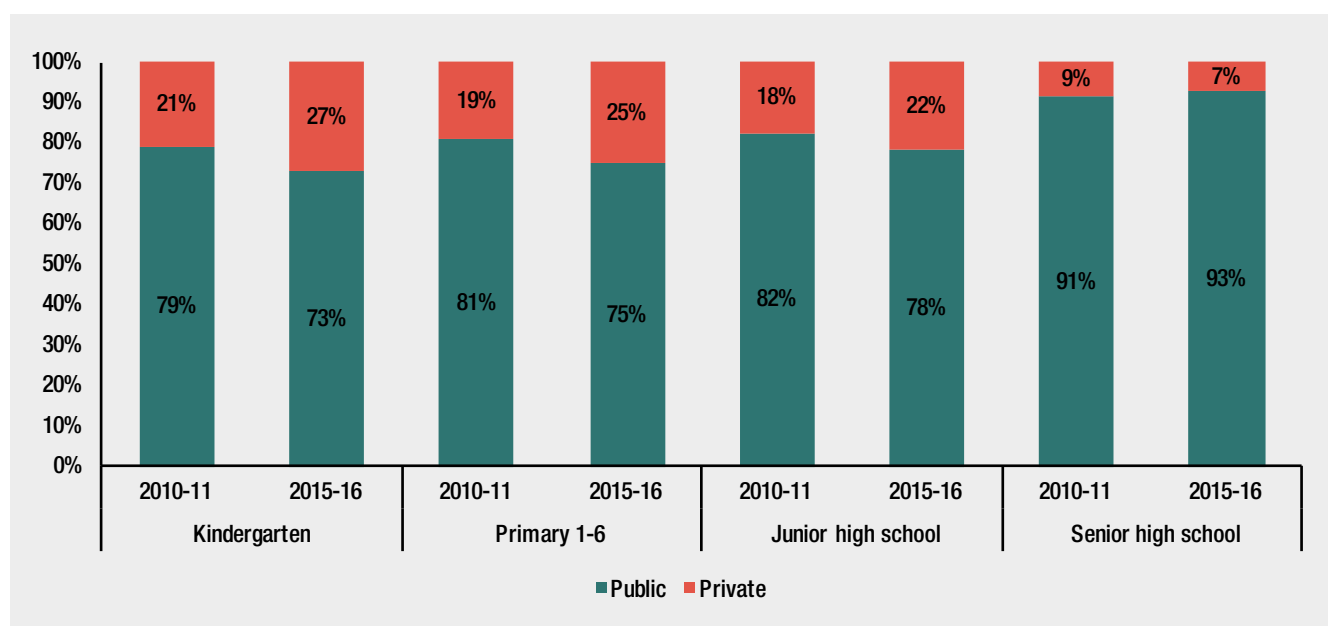
Figure 30: Gross enrolment rates by gender in each region, 2015-16



Source: Authors' calculation using EMIS database 2015-16

53 This is not possible to determine directly from the GDHS data as these do not contain information about out-of-school children.

Figure 31: Share of total school enrolment in public vs private sectors, 2010-11 and 2015-16



Source: Authors' calculations using EMIS 2015-16

even relatively poor families may choose to send their children – see Chapters 4 and 6. Private schools overall account for almost a quarter (23%) of total enrolment levels in Ghana. The highest proportion of this is at the kindergarten level, where 27.3% of total enrolment is private, reducing to 25.3% at primary and 22% at junior high school, and markedly dropping away to 7.5% by senior high school. Private school enrolments have grown steadily from 2010-2011 to 2015-2016 at all levels except senior high school (Figure 31).

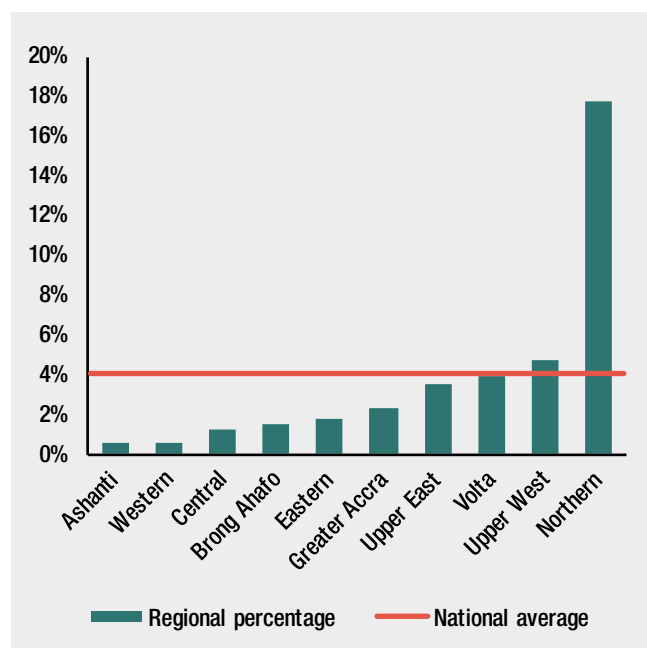
3.3.2. Levels and length of education

As of 2014, 4% of children aged 13-15 (corresponding to junior high school level) in Ghana have not received any formal education at all. In Central and Western regions, this figure drops to 1%, and our case study region of Brong Ahafo is also below the national average at just 2%. In Northern region, however, 18% of 13-15 year olds have never attended any education. As shown in Figure 32, Northern region is a striking outlier – nearly 13 percentage points behind the next region, Upper West.

However, comparing these figures against GDHS 2008 data suggests that the gap is closing. Between 2008 and 2014, there was a 17 percentage point decrease in the share of 13-15 year olds with no education in Northern region, compared to a 4 percentage point decrease nationally. Given the substantial disparity that remains, however, these results pose an urgent question of what more can be done to maintain this progress among the hardest to reach.

In terms of the number of years of education attended, on average in the 7-12 year age range (primary school age in Ghana), children in the Northern and Upper West regions are falling roughly one year behind their peers in Ashanti

Figure 32: Junior high school-age children with no formal education by region, by percentage of age group population



Source: Authors' calculations using GDHS 2014

and Greater Accra. Children aged 7-12 in the former two regions have around 1.5 years of schooling, on average, versus around 2.5 years in the latter two regions, with the national average at around two years (Figure 33). Brong Ahafo is close to the national average. This gap is likely owing to some children starting school later than their peers, as well as non-attendance among some children, reducing the average for their age group.

By the age when children should be in junior high (13-15 years), this gap between years of schooling among the best-performing and worst-performing regions roughly doubles (Figure 34). Within this age range, the youngest children should have undertaken at least six years of education (primary school) and the oldest ones at least eight years (primary plus two at junior high). The national average for the 13-15-year-old cohort is 5.3 years. By junior high school age, children in Ashanti and Greater Accra have received 6.3 years of education. Northern region ranks the lowest in the country, at just 4.1 years of schooling for 13-15 year olds, on average, with Upper West next at 4.5 years. Brong Ahafo, at 5.2 years, again falls close to the national average.

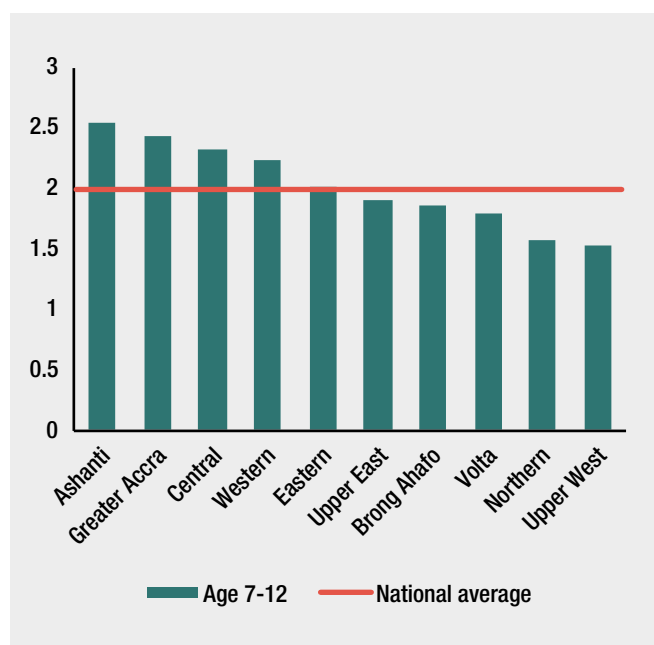
Though Northern and Upper West regions are faring consistently worse, there is evidence that some of these regional gaps in education are closing over time – at least in terms of years of schooling (although acknowledging that this does not indicate quality or learning). This echoes the above finding regarding the share of children without any education. First, comparing corresponding data from the 2008 GDHS, we find that, nationally, the length of education for children in Ghana has extended slightly, by 0.06 years for 7-12 year olds and by 0.25 years for 13-15 year olds. The rate of improvement in Northern region between 2008 and 2014 was more than twice as fast: 0.15 years of additional schooling for 7-12 year olds, and 0.63 years of additional schooling for 13-15 year olds. In Upper West, the story is

more complicated – the average length of schooling for 7-12 year olds actually declined by 0.27 years between 2008 and 2014; whereas it increased for 13-15 year olds by 0.48 years.

Beyond regional disparities, we also examined national differences between selected marginalised and non-marginalised groups.⁵⁴

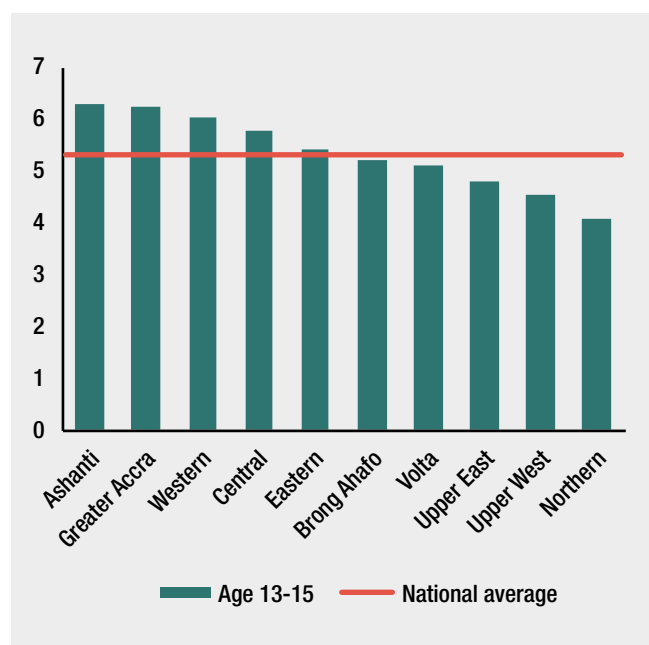
There is a persistent, but narrowing, gap in years of education between the poorest wealth quintile and the rest of the population. Among the bottom wealth quintile, 7-12 year olds have, on average, 1.5 years of education, whereas their peers in the rest of the population have 2.3 years. This gap narrowed between 2008 and 2014, but only by 2%. By the age of 13-15 years, children in the poorest quintile have 4.2 years of education, whereas the rest of their age cohort has 5.8 years. There has been a marked improvement towards closing this gap, however; the difference between the poorest and the rest in the 13-15 age range decreased by 21% between 2008 and 2014. Our finding that, nationally across Ghana, household wealth is a greater driver of disparity than gender or urban/rural location chimes with the literature, which identifies extreme poverty as one of the most important variables in educational attainment (Wodon, 2016). The wealth gap associated with length of education is most marked in Greater Accra (which is home to some of the greatest absolute disparities in wealth between its poorest and richest residents), but is also large in Northern and Upper West regions, indicating the importance of an interaction of poverty and geographic location.

Figure 33: Average number of years of education for primary school-age children, by region



Source: Authors' calculations using GDHS 2014

Figure 34: Average number of years of education for junior high school-age children, by region



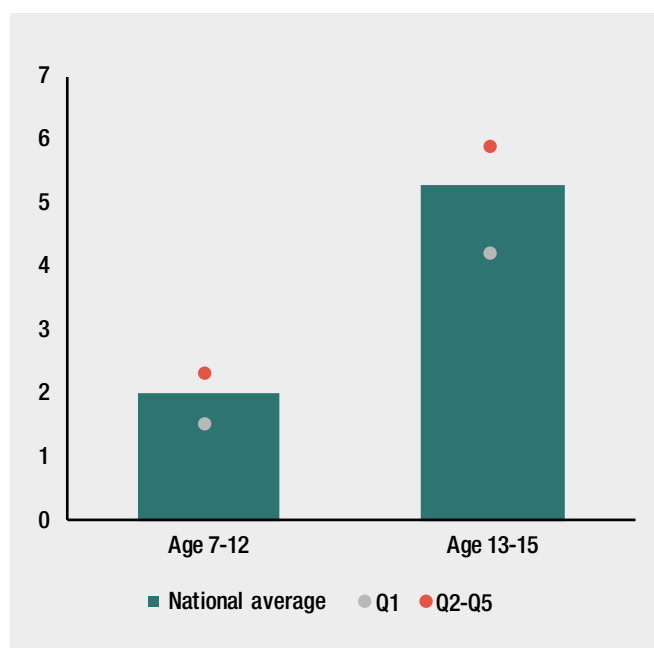
Source: Authors' calculations using GDHS 2014

⁵⁴ We do not present gender differences, since at a national level we do not find gender to be correlated with significant disparities in education. It was not possible to examine differences in education access indicators along ethnicity dimensions (minorities versus non-minorities) owing to lack of data disaggregation in the relevant module of the GDHS.

Finally there are gaps between rural and urban households (Figure 36), but these are slightly smaller than those between wealth quintiles: a difference of 0.7 years (7-12 years) and 1.3 years (13-15 years) respectively. However, one concerning finding is that the size of the

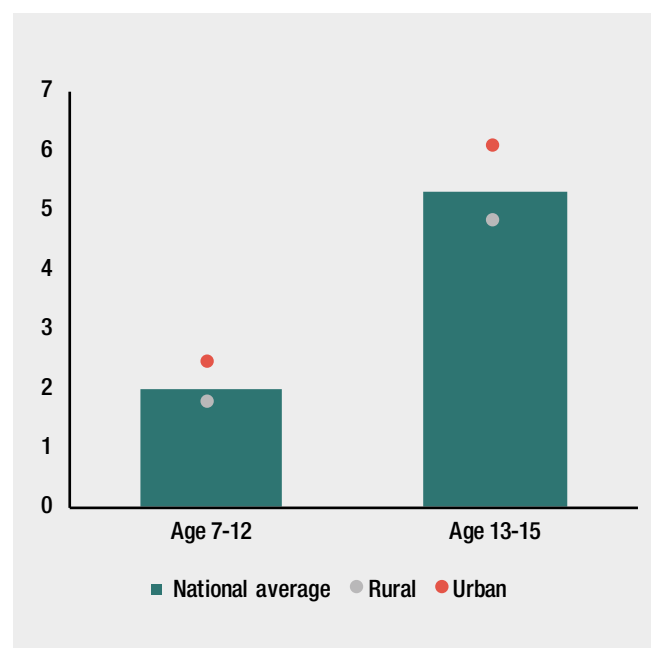
rural–urban gap at primary-age level has remained the same since 2008. At junior high age, the gap narrowed by 8% between 2008 and 2014. In Northern and Upper West regions, we see some of the largest absolute gaps in years of education between rural and urban children.

Figure 35: Average number of years of education, national average, bottom wealth quintile and the top four quintiles, 2014



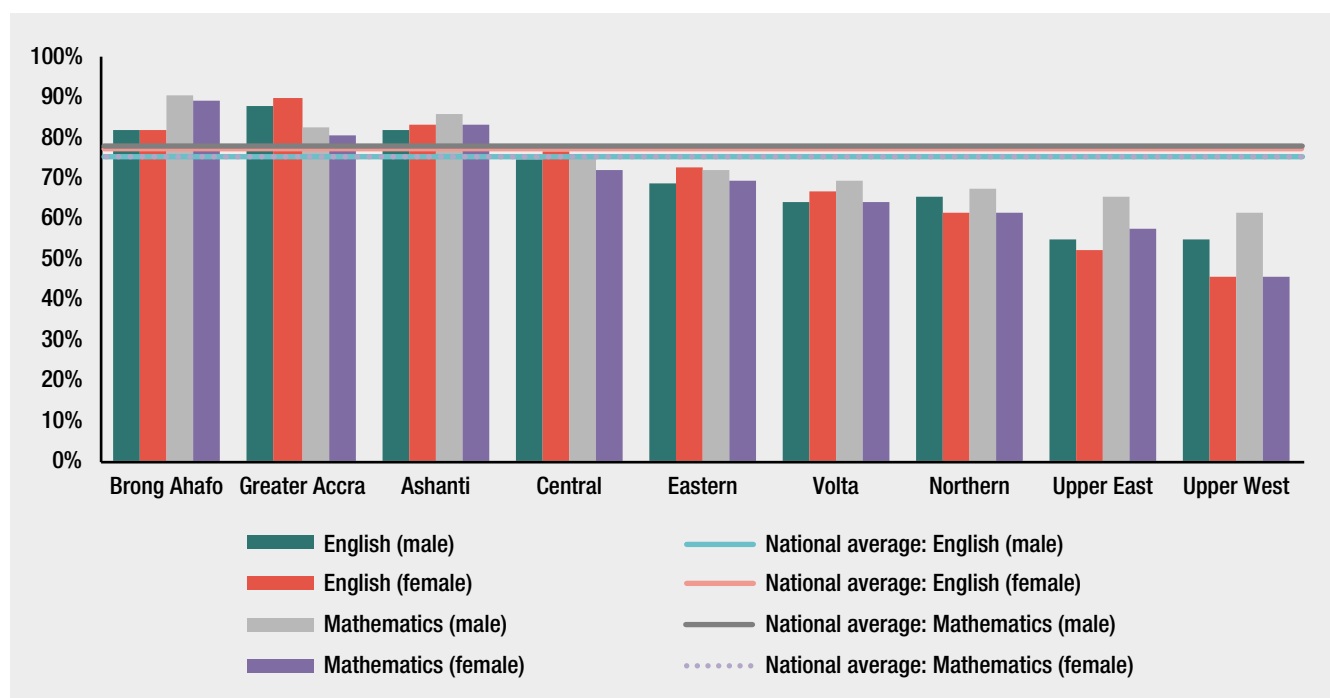
Source: Authors' calculations using GDHS 2014

Figure 36: Average number of years of education, national average, rural and urban, 2014



Source: Authors' calculations using GDHS 2014

Figure 37: Pass rates for key subjects at primary school level, 2014-15



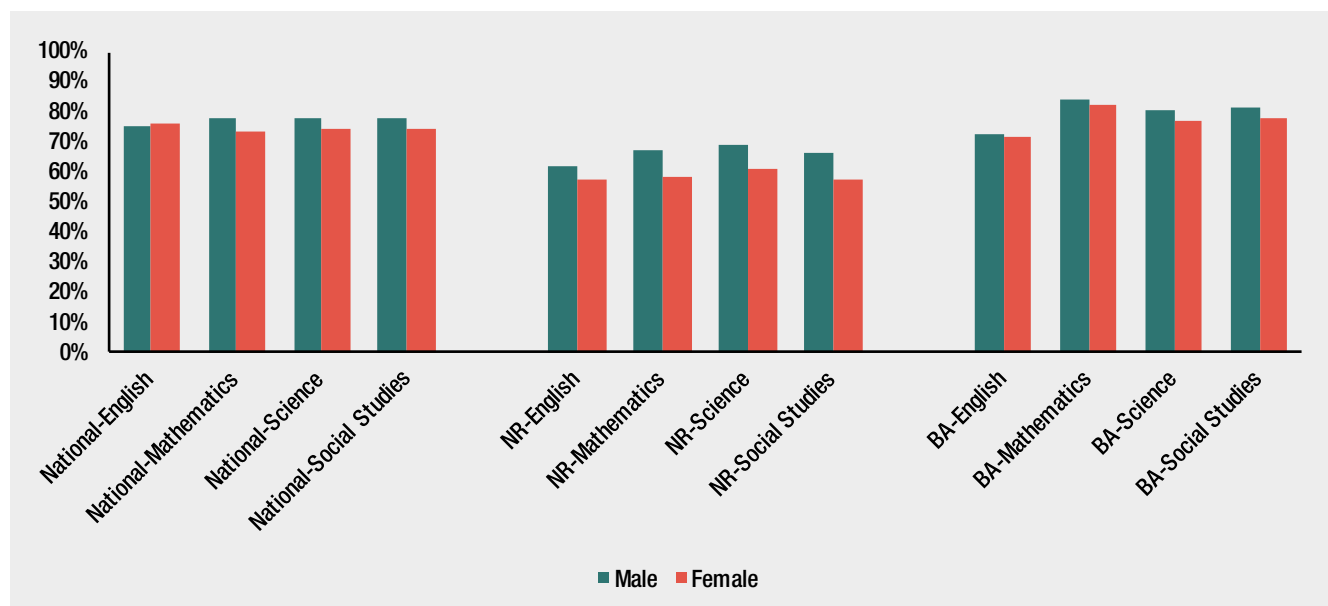
Source: Authors' calculations using EMIS database 2015-16

In terms of learning outcomes,⁵⁵ data on pass rates are available from EMIS, but disaggregated only by gender and region.⁵⁶

Pass rates at primary level are relatively good for both boys and girls across all regions, above 75% for both

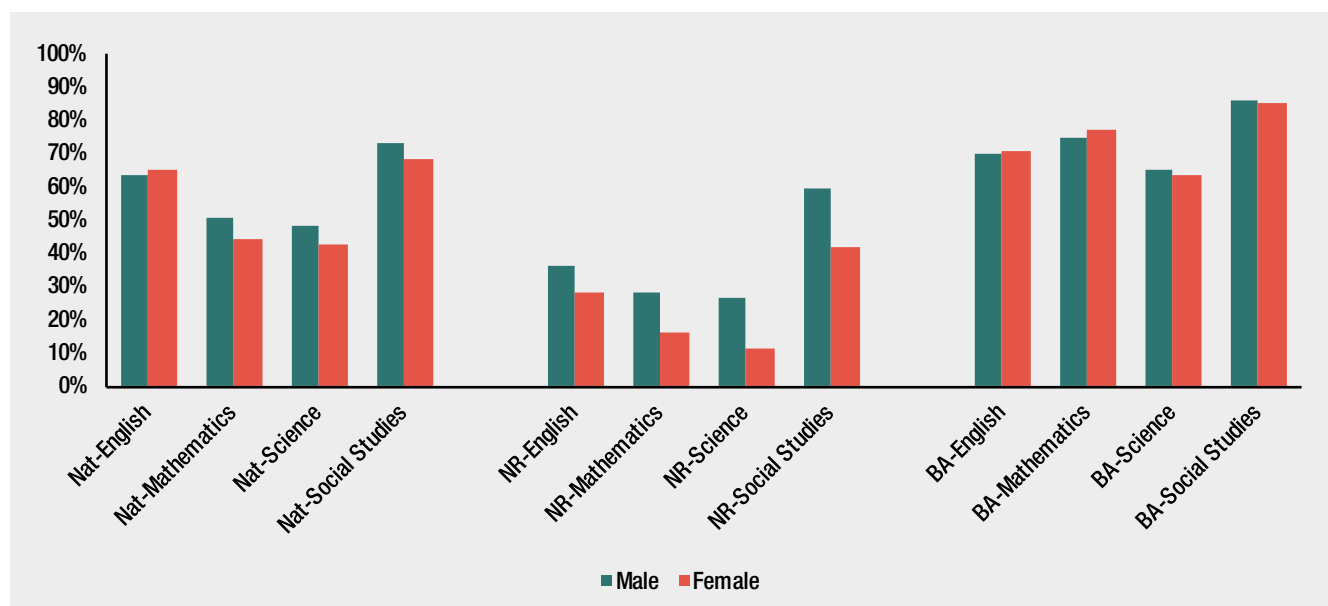
genders across all subjects. However, performance in some regions, particularly Northern, Upper East and Upper West, as well as Volta, is notably lower. It is in the three northern regions – Northern, Upper East and Upper West – where gender differences are more marked, even at primary level.

Figure 38: Pass rates for key subjects at primary school level – national, Northern (NR) and Brong Ahafo (BA), 2014-15



Source: Authors' calculations using EMIS database 2015-16

Figure 39: Pass rates for key subjects at secondary school level – national, Northern (NR) and Brong Ahafo (BA), 2014-15



Source: Authors' calculations using EMIS database 2015-16

⁵⁵ It should be noted that pass rates in national exams offer only a partial assessment of student learning. In addition, it is recognised that Ghana has experienced malpractice in the Basic Education Certificate Exams (BECE) including collusion involving teachers, invigilators and school proprietors. In 2011, more than 1,000 candidates were sanctioned for their involvement in such activities, for example (Folson and Awuah, 2014).

⁵⁶ Here we use EMIS data for 2014-15, since the 2015-16 data are not complete.

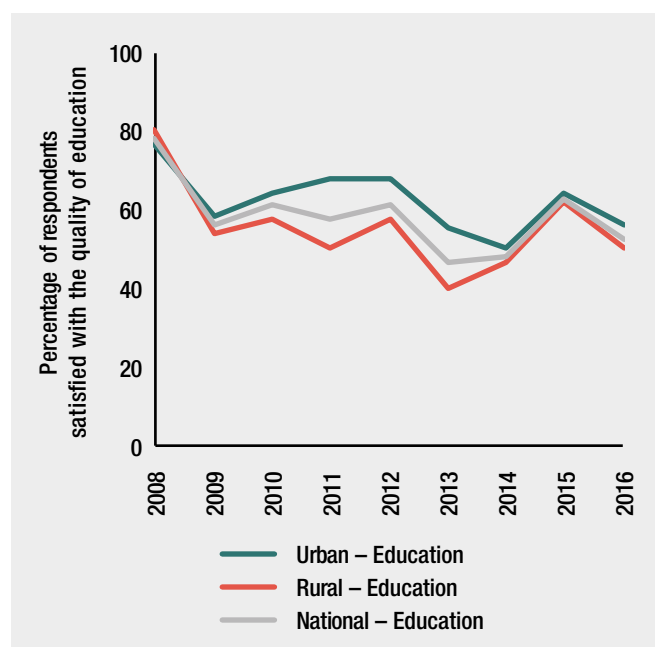
The gaps start to widen further with secondary school exams. In particular, children in Northern, Upper East and Upper West are falling significantly behind, with a more striking disparity between boys and girls. For instance, in mathematics, the secondary school pass rate is 86% for boys in Greater Accra, but only 16% for girls in Northern region. The regions with lower overall pass rates have the highest levels of gender inequality.

Opinion poll data from the Gallup World Poll provide complementary evidence about people's perceptions of the quality of the education system in Ghana (Figures 39 and 40). This shows a substantial decline in the proportion of people who consider themselves satisfied with the quality of education, from 78% in 2008 to 53% in 2016. This overall downward trend is common to both rural and urban areas,

although rural areas have seen sharper declines, with a marked urban–rural gap of on average 10 percentage points opening up between 2009 and 2014. In 2016, only half of rural respondents felt satisfied with the quality of education. In addition, fewer respondents from the poorest quintile are satisfied – just 44% in 2016, down from 50% in 2009, and 10 percentage points lower than the rest of the population.

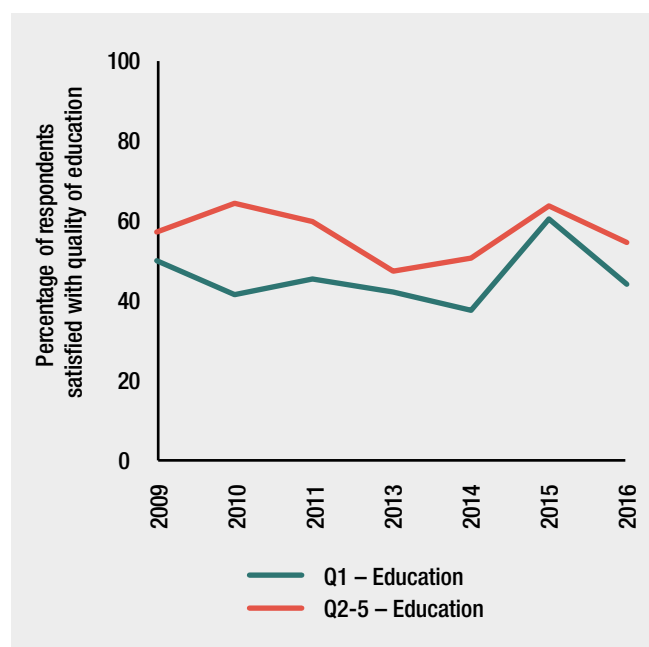
This suggests that, despite significant gains in the 'quantity' metrics of education (such as enrolment rate and average years of schooling) across most of the country over the past decade, there are serious – and possibly growing – concerns about quality. It reinforces this report's finding that there are widespread concerns in the population about the quality of Ghana's education system, and that issues of low quality are most prevalent in rural and deprived communities.

Figure 40: Percentage of respondents satisfied with the quality of education, urban, rural and national



Source: Authors' analysis using Gallup World Poll data

Figure 41: Percentage of respondents satisfied with the quality of education, poorest income quintile versus the rest



Note: Gallup World Poll uses income quintiles rather than wealth quintiles as per the GDHS used in the rest of this report.

Source: Authors' analysis using Gallup World Poll data

4. How fit for purpose are Ghana's health and education policies to leave no one behind?

4.1. The policy framework in health

Ghana's health policies are commensurate with the leave no one behind commitment, but they are not adequately resourced and implemented. Overly upbeat performance assessments are failing to highlight these issues sufficiently.

The main policy framework within the health sector is the Health Sector Medium Term Development Plan (HSMTDP) 2014-17,⁵⁷ which is prepared every four years:

The Health Sector Medium Term Development Plan (HSMTDP), 2014–2017, is the health sector's response to the National Medium Term Development Policy Framework (2014-2017). It also provides the basis for planning within the health sector in Ghana and defines the sector's contribution to the achievement of national medium term development goals and objectives. The HSMTDP builds on the general principles of providing quality primary health care to all people living in Ghana and it is underpinned by the desire to attain Universal Health Coverage. (MoH, 2014)

Recognising that the health situation in Ghana has been characterised by significant inequalities, the plan aimed 'to improve access to quality, efficient and seamless health services that is gender and youth friendly and responsive to the needs of people of all ages in all parts of the country'. This aim will be achieved by, for example, 'reducing geographical disparities in the distribution of national

resources'; and 'creating a new social order of social justice and equity, premised on the inclusion of all hitherto excluded and marginalized people, particularly the poor, the underprivileged and persons with disabilities.' This language clearly aligns with the commitment to leave no one behind.

Overall, the health sector in Ghana has numerous policies that seek to prioritise the needs of vulnerable and marginalised groups. Key health sector policies that seek to reduce inequities include:

- The Adolescent Reproductive Health Policy – however, the teenage pregnancy rate remains high, around 14%⁵⁸
- The MDG5 Acceleration Framework – however, MDG5 was missed (NDPC and UNDP, 2015)
- The Health Sector Gender Policy – however, pregnant women still face many access challenges, as discussed in this report
- The National HIV/AIDS and Sexually Transmitted Infections (STI) Policy – however, more than one in 100 Ghanaians are HIV positive.⁵⁹

Moreover, in line with our findings in Chapter 3 that regional variation is the most strongly associated with CCI variation, the first policy objective for the MoH plan is to 'bridge the equity gaps in geographical access to health services'. Progress (or lack thereof) in 2016, according to the MoH assessment using its administrative data, is shown in Table 8.

From this table we can see that the overall number of functional CHPS zones has increased over time, and so the

⁵⁷ This analysis refers to the 2014-17 plan, rather than the new 2018 plan

⁵⁸ 2014 GDHS data

⁵⁹ HIV prevalence among 15-49 year olds is 1.6% according to UNAIDS data, <http://www.unaids.org/en/regionscountries/countries/ghana>

MoH considers this an area that is ‘highly performing’. However, the evidence from our fieldwork and the wider literature highlights that many CHPS compounds are still poorly resourced and staffed, meaning that the rural and remote areas that CHPS compounds are intended to serve are likely receiving a poor quality of care. Given this reality, it is problematic that the official sector progress assessment is so sanguine in its rating of ‘highly performing’. The doctor-to-population ratio is also considered ‘highly performing’ despite the evidence that many rural facilities are without doctors, including the whole of Banda (Brong Ahafo region) and Zabzugu (Northern region) districts where we conducted our fieldwork. Indeed, none of the official equity indicators are considered to be under-performing – meaning that the MoH lacks an urgent impetus for action. Furthermore, this table highlights problems with data in the Ghana health sector. These are inherently aggregate indicators that are incapable of indicating inequities within communities or even between them. Moreover, the methodology used to calculate these indicators is not clear, reflected in the inconsistencies around, for example, proportions and absolute values. This is concerning given that this report is a key tool for policy-makers in Ghana.

The HSMTDP 2014-17 is highly ambitious. It acknowledges that challenges remain in terms of improving equitable access to services, particularly for essential services and in deprived areas, where progress in improving maternal and child mortality has been slow. It recognises that this is owing to limited attention to human resources and infrastructure management. However, policies in the health sector have not been resourced adequately, as we

illustrate in Chapter 5. There has been a disconnect between the ambitions of health policies to leave no one behind and actual financing patterns to implement them. Our research suggests that the challenges highlighted in the HSMTDP 2014-17 have yet to be tackled, and the plan for the next period will likely document a similar list. Indeed, many of these challenges – for instance health worker distribution and ratios in deprived areas – are longstanding and can be found in annual MoH reviews dating back decades.

Ghana’s flagship NHIS, which should be the main vehicle for providing UHC to vulnerable and marginalised groups, is under significant pressure and is not delivering on its potential.

The NHIS is the flagship policy in Ghana’s health sector. It was established in 2003 with the aim of removing financial barriers to accessing health services, particularly for the poor and vulnerable. The benefits package is broad, covering outpatient, inpatient, maternity care and emergency health services, as well as some aspects of oral health and eye care, but with several notable exceptions, such as family planning.⁶⁰

The programme’s ultimate goal is to provide universal insurance coverage to all Ghanaians. At the end of 2016, the number of active NHIS members stood at 11 million, representing 38% of the national population.

The scheme is financed through a combination of individual premiums, a 2.5% levy added to the value-added tax on goods and services and an earmarked 2.5 percentage point portion of social security contributions from formal sector workers. Individual premiums are charged based on income or wealth. The scheme is currently designed to cover about 95% of the disease burden in Ghana (Scheiber et

Table 8: Progress towards equity objectives in the HSMTDP, as assessed by the MoH in 2016

No.	Indicator	2014	2015	2016	Performance
Objective 1: Bridge the equity gaps in geographical access to health services					
1.1	Proportion of functional ambulance service centres	128	127	133	
1.2	Proportion of functional CHPS zones	2,948	3,951	4,034	
1.3	Per capita outpatient department attendance	1.14	1.08	1.06	
1.4	Equity poverty: Under-five mortality rate	1.4	N/A	N/A	N/A
1.5	Equity geography: Supervised deliveries	1.38	1.7	1.7	
1.6	Equity geography: Doctor to population	13.1	9.6	7.1	
1.7	Equity geography: Nurse to population	1.88	2.1	2.1	
1.8	Equity gender: Female/male NHIS active membership	1.38	1.37	1.43	

Note: The MoH classifies progress on the indicators marked in green as ‘good’, in yellow as ‘stagnant’ and in red as ‘poor’. These are the measures as reported in the MoH report, but it is worth noting that some seem inconsistent with their reporting – e.g., instead of proportions, absolute numbers are reported. Furthermore, despite the objective being to bridge equity gaps in geographical access, progress that may be differential geographically is not adequately captured in the reported measures in this table, which refer to national data on the (presumed) assumption that overall increases in resources translate into improved equity.

Source: MoH (2016)

60 The full benefits package can be found at <http://www.nhis.gov.gh/benefits.aspx>

al., 2012). The scope of the basic benefits package is broad and includes outpatient and inpatient services ranging from surgeries to maternity care services.

To ensure that all Ghanaians can access services, at least in theory, premium payments are waived for a number of vulnerable groups, including people over the age of 70; children under 18 years; ‘indigents’ (which should cover the poorest people, see Box 2); pregnant women; persons with mental disorders; and other categories of disabled persons. More than 2 million Ghanaians have been identified as extremely poor, living on less than 2.17 Cedis (\$0.50) per day (GSS, 2014b). However, the majority of Ghanaians living in poverty are not enrolled in the scheme. According to Fenny et al. (2018) less than 2% of the poor are covered. The view that the NHIS is not pro-poor was raised by one interviewee: ‘Under NHIS, UHC is an illusion ... the users of NHIS are not the poorest. Even if the poor pay less, they don’t use it as much as others’ (DP1). However, we also heard an alternative view that the NHIS is perceived as being so associated with the poor that it is not attractive to the wealthier populations who would be needed to balance the risk pool and provide funding: ‘it has turned away those who can pay ... NHIS marketing focuses on it being “pro-poor” so it is a status symbol not to be insured’ (CG22).

Several respondents described how the scheme is in ‘crisis’ or ‘emergency’. A major reason given for this was the situation created by the policy of premium exemptions, where the number of ‘healthy and wealthy’ members is

not enough to sustain the number of exempt members. Under-18s, who comprise 45% of the scheme members, pay nothing – a situation which one respondent (CG22) described as a ‘particular drain’. The broader issue, as discussed further in Chapter 5, is that revenue for the NHIS is de-coupled from its (growing) membership. This, combined with the fact that the package of benefits included is notably broad (with limited incentives within the system for efficiency and cost control), has resulted in NHIS expenditure outpacing revenue, producing a financial crisis.

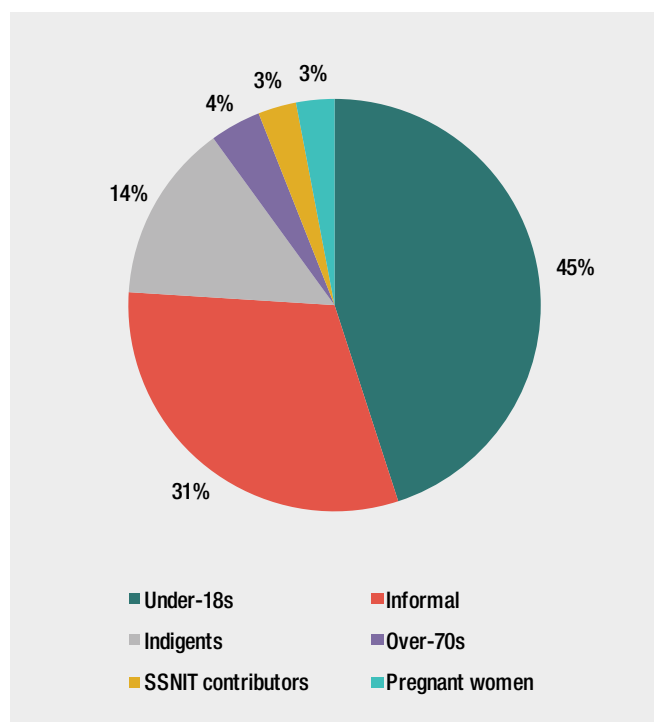
The unsustainable financial situation of the NHIS has also, in part, been caused by the dynamics of party politics in Ghana. Indeed, the story of the NHIS illustrates the way in which electoral cycles in Ghana have influenced health policy. Before 2000, health care in Ghana operated on a widely unpopular ‘cash and carry’ system. The NPP built its 2000 election campaign around this issue, promising to institute a more equitable insurance scheme. However, the NPP knew that a single national health insurance scheme was not feasible, owing mainly to the low percentage of people employed in the formal sector. The manifesto therefore pledged to encourage segments of society (workers, employers, private health companies) to establish their own insurance schemes, with government retaining only a regulatory and monitoring role. When the NPP won the 2000 election, it was under pressure to take visible action and get the national health insurance bill passed before the next election cycle began. To speed up the process, political nominees were given a decisive role and the role of technocrats at the MoH was diminished; and the government rushed the bill through Parliament with very limited time for debate (Carbone, 2012, 2011; Rajkotia, 2007). The bill passed in 2003, but a number of health donors raised serious concerns and opposed the NHIS on multiple grounds including its lack of fiscal soundness, an over-ambitious timeframe for rolling out, lack of technical capacity, and inadequate governance and institutional arrangements to ensure successful implementation – all concerns that have since proved valid.

Five years later, during the run-up to the 2008 election, the then President John Kufuor announced an additional free maternal health care initiative to be implemented through the NHIS, despite the financial implications of scaling up an already struggling scheme.

The focus on the political, rather the technical, has continued as the current government has focused on increasing enrolment onto the NHIS, against technical advice that it should be restricted to the most vulnerable. As a result, the financial sustainability of NHIS is now in crisis. (Abdulai, 2017)

The current NHIS ‘crisis’ is thus a result of political, financial and technical factors. Its major consequence from the perspective of our study is an increasing reliance on out-of-pocket (OOP) payments in recent years. Between 2008 and 2011, OOP payments declined as a share of total health

Figure 42: Percentage of NHIS enrolment by population group, 2014



Note: SSNIT – Social Security and National Insurance Trust.
Source: World Bank (2017b), based on NHIA annual reports

expenditure every year, but since 2011 their share has risen significantly (from 16.1% in 2011 to 26.8% in 2014).⁶¹ The rise in OOP payments is occurring because facilities are waiting lengthy periods for NHIS claims to be reimbursed, are becoming burdened with debt and are no longer able to provide many drugs and services for free. The financial situation of the NHIS and its effects on service delivery are discussed in more detail in Chapters 5 and 6, respectively. The implication from a policy perspective, however, is that, in its current form, the NHIS cannot feasibly provide the right framework to leave no one behind.

From the perspective of health sector bureaucrats, one way of sustaining the NHIS within the context of currently limited resources is to restrict its benefits to the poorest sections of society. However, the political benefits associated with universal coverage make such reforms an unappealing option to ruling political elites, particularly in an environment of highly competitive democracy. Rather, a more promising way forward would be to maintain the universal aspect of membership, but restricting or rationing

the benefits package with a heavy emphasis on preventive and primary health care. This would de facto skew services towards being more pro-poor (and cost-effective, given the relative public health impacts per dollar of primary services compared to secondary and tertiary services). It is also in line with the recommendations of the NHIS Committee (Atim and Amporfu, 2016).

Ghana's Community-Based Health Planning and Services (CHPS) could be an important policy to leave no one behind, but implementation is lagging. 'CHPS is the major policy for vulnerable and marginalised groups, tackling the problem of accessibility' (CG3).

CHPS is the second major national policy that has the potential to help Ghana achieve universal health coverage and leave no one behind. It has the ambitious goal of reaching every community with a basic package of essential health services and bridging equity gaps by 2030. In theory, CHPS should address the geographical, cultural, socioeconomic and other factors that limit access to care, by making health services *available* through close

Box 2: Reaching the poor

The category of 'indigent' used in the NHIS exemptions is defined as an individual who is unemployed, has no identifiable source of income and has no abode. One of the biggest challenges the NHIS has faced in terms of the leave no one behind commitment is identifying indigents who should qualify for free services.

One solution has been to link the NHIS with Ghana's main national social protection scheme: the Livelihood Empowerment Against Poverty (LEAP) programme. LEAP is a social intervention targeting the extreme poor in Ghana. There are currently 213,000 households in LEAP, and 90% of these are in the NHIS (CG10). LEAP provides bi-monthly cash transfers to households living below the national extreme poverty line, specifically targeting households that have at least one member who is aged, disabled, orphaned, pregnant or a child under one year of age. The whole household becomes exempt under the NHIS if one member is eligible for LEAP grants. In addition, many LEAP pay points are strategically positioned inside health facilities where health workers conduct health promotion activities on days when beneficiaries are receiving payments (CG10). Since 2012, the Ministry of Women, Children and Social Protection has increasingly taken on the role of helping the NHIS to identify indigents through its proxy means testing and community validation.

This linking of social protection schemes has been successful in increasing health access for LEAP households; however, registration with the NHIS is no guarantee that health care will be used (Roelen et al., 2017). First, while LEAP registration triggers a

notification to the NHIS administrators, individuals still have to get to their nearest NHIS registration centre and go through the enrolment process (CG10). Many poor households find the cost of transport to NHIS offices prohibitive. Second, even if households are enrolled in both LEAP and the NHIS, there may be other supply- and demand-side barriers that (disproportionately) affect access for LEAP beneficiaries, such as the financial and time costs of visiting health facilities or 'informal' charges for drugs and services (see Chapter 6). Although indigents have grown as a proportion of the overall active members from 1.7% in 2005 to just under 14% in 2016, renewal rates are low – reported as 50% among LEAP beneficiaries, for example (Witter et al., 2017).

A recent evaluation of LEAP (Witter et al., forthcoming) reported that 52% of LEAP households were covered by the NHIS in 2016. Reported health conditions did not change much for adults with valid NHIS cards, although their care-seeking improved considerably. The evaluation found that increased coverage did not translate into improved health outcomes or reduced health expenditure for children. In addition, the coverage of the LEAP programme itself remains low, estimated at 25% of the extreme poor. Even with the assistance of this programme, coverage of NHIS membership remains below the national average in the lowest quintile (31%) (Witter et al., forthcoming). While LEAP is being expanded gradually, many of Ghana's 2 million people living in poverty are still not able to benefit from linking social protection to health insurance.

61 2014 is the most recent data point available in WHO's Global Health Expenditure Database, based on National Health Accounts data.

proximity to rural families, socially *accessible* through wide community participation and *affordable* through a free delivery system (Sakeah et al., 2014).

The core strategy of CHPS entails deploying nurses, known as community health officers (CHOs), to village locations where they provide primary care and promotional health services, either in homes or in community clinics known as ‘compounds’. The original concept of CHPS was rooted more in door-to-door services, focused especially on preventive health, community outreach and education, but it has over time put greater emphasis on the presence of physical facilities in compounds and providing curative health care. It has been argued that this is a result of the establishment and growth of the NHIS (Simon et al., 2017), through which eligible CHPS services are funded, as long as the compound facility is accredited with the NHIA.

CHOs are supported by lower skilled cadres of community health workers (CHWs) and enrolled nurses. The services provided should include immunisation, family planning, supervising delivery (if trained staff are available), antenatal and postnatal care and treatment of common diseases such as malaria, diarrhoea and acute respiratory infections. The target for CHPS coverage is that one zone should cover a geographical area of 4 km in radius and between 4,500 and 5,000 persons (roughly corresponding to an electoral area).

According to MoH (2016) data, 67.4% of demarcated CHPS zones are functional. However, what ‘functional’ means in practice is called into question by both literature and our research. The World Bank Health Sector Assessment in 2013 found that 77% of CHPS compounds in the Western and Central regions were in a ‘state of disrepair’; 60% of compounds were partially equipped and without accommodation (Saleh, 2013). The World Bank report also found that the poor did not participate in the decision-making of community programmes and were often unaware of what was going on, and many believed needs had been predefined by service providers (Ibid.). Similar findings from our fieldwork that the CHPS policy is not functional in terms of reaching marginalised groups are discussed in Chapter 6.

Although CHPS has the capacity to contribute to improved health care access, its implementation has focused on the construction of compounds at the expense of equipping these compounds to perform basic functions. As discussed in Chapter 5, there is very little discretionary funding left in the health budget, after salaries are paid; therefore, capital spending is very low. However, what relatively little discretionary non-salary resources are available tend to get prioritised for the construction of new facilities – and not necessarily to a high standard – rather than the maintenance of existing facilities and their operating costs. This failure is explained by the dynamics of Ghana’s political settlement, as described in Chapter 2 – a form of ‘competitive clientelism’ that incentivises ruling politicians to

focus investments on the quantitative provisioning of visible infrastructure, while paying limited attention to quality outcomes (Abdulai, 2017).

Furthermore, key elements of the original CHPS conception have been lost. The focus on physical compound construction is not consistent with the original emphasis on the door-to-door provision of services. Door-to-door services are essential for removing the recipients’ costs of accessing services that many rural communities in Ghana face. The original concept also emphasised the importance of the community’s role in the planning and prioritising of services.

Ghana’s policy implementation fails to address the significant challenge of health worker distribution, which particularly impacts deprived and remote areas, including in the north of the country.

By African standards, Ghana has a relatively good supply overall of trained health workers, at roughly 3 per 1,000, compared to two per 1,000 across the Africa region as a whole (WHO, 2016b). Many respondents noted that the problem is not quantity, but distribution. Incentivising health workers to live and serve in deprived or remote communities is not a unique challenge to Ghana, but one that is pertinent considering the size of the MoH payroll and its large share in the total health budget. ‘The barrier in health has always been access to health facilities and infrastructure, which led to the CHPS policy. Now the main challenge is the availability of health workers’ (RP3).

As a result of the CHPS focus on building compounds, in many areas communities have a compound⁶² but no clinical staff or supplies. In addition, geographic variation in the availability of medical doctors has actually increased over time, despite the official policy rhetoric of bridging the gaps (Abdulai, 2017).

A preference hierarchy exists, in which postings to the north of the country (Northern, Upper East and Upper West regions) are generally regarded by health workers as the least desirable, followed by more rural or remote locations in the south (such as our case study district of Banda in Brong Ahafo region), followed by urban locations in the south. Indeed, we were told that rural areas are seen as ‘punishment districts’ (LG4).

Health workers and teachers do not want to go to deprived areas. Financial incentives won’t cut it. A salary bump is no good to you if you don’t have basic amenities or have to wade through a river to get to the school. The key is instead to develop the infrastructure and amenities in those areas, so people will not mind being posted there. (RP3)

This problem of distributing health workers to the north of the country is very likely a critical one underlying Northern region’s poor CCI performance of just 49.5% – 16 percentage points behind the national average. However, it is also notable that the best-performing region

62 Funding sources for building CHPS compounds vary by district but may include the District Common Fund, the MP Common Fund and direct contributions from the last President and his appointees. These are not the same funds that pay health worker salaries.

in terms of CCI score is Upper East, also a region of the north. Indeed, the Upper East has been a success story of rapidly improving health outcomes, and much of its success has been bound up with innovative implementation of rules, incentives and accountability for health workers, backed by strong leadership (see Box 3).

Meanwhile, nationally there has been a history of various policies drafted to encourage staff to work in deprived and rural areas. A 'deprived area allowance' was tried in 2004;

however, all (non-clinical) staff involved in the health services demanded the allowance and it soon became unsustainable. A human resources policy was developed in 2007 which included the objective to 'strengthen incentive schemes' in rural areas (MoH, 2007). Yet the issue is one of implementation. Currently, if a doctor is posted to Northern region, there is no penalty if he/she does not report for duty there.

The problem of a lack of enforcement and accountability is stymied by the political economy

Box 3: Successful innovations in health resourcing in the Upper East region

Upper East is one of the three regions making up the north. It has similar levels of poverty and deprivation as Upper West and Northern regions. However, Upper East has consistently recorded surprising and impressive progress in key health indicators in recent years. The region recorded the highest number of average antenatal visits, and the highest number of skilled deliveries in Ghana between 2011 and 2013. In 2013, skilled delivery coverage in the region was 70% compared to a national average of 55%. The question is then: *How has the Upper East region emerged as a 'pocket of effectiveness' in health service delivery in Ghana?* The following factors were important for success:

- 1. Leadership:** Regional health directors can be influential, if motivated to drive change. Between 2008 and 2015, a dynamic Regional Health Director, Dr Koku Awoonor-Williams, was able to inspire health workers and drive real progress. Under his leadership, the Upper East region was able to mobilise greater financial resources (for instance from donors) to put towards innovative health planning and programming ideas.
- 2. Human resources:** To increase the production and retention of health workers, each district was given annual quotas to sponsor the training of community health nurses and midwives who were then required (under bonds) to serve the district for a minimum of three years before they could move out of the region. In collaboration with the GHS headquarters, those who left without serving their three-year bond periods had their salaries blocked. Dr Awoonor-Williams also initiated coaching and mentoring of staff to incentivise and improve performance (CG2). In Upper East they have also focused on career development for CHWs to motivate them (CG2).
- 3. Incentives and supervision:** The provision of incentives such as television sets in remote CHPS compounds, as well as the practice of recognising hardworking staff through awarding certificates and letters of recognition, successfully improved the performance of health workers. Incentives were funded from a combination of locally raised resources and the vigorous pursuit of donor funding.

- 4. Innovation:** Despite challenging economic and social circumstances, CHPS was successfully scaled up through a number of innovations, including: nurse recruitment from home districts to improve worker morale and cultural grounding; community engagement and advocacy to local politicians to mobilise resources for financing start-up costs; and knowledge exchange visits between new and advanced CHPS implementers to facilitate learning and scale-up within and between districts. In addition, emergency referral challenges were overcome through the deployment of the 'Motor King Ambulance system': this initiative introduced a customised module of a three-wheeled vehicle ubiquitous in Ghana, alongside a mobile communication plan for community volunteers (who serve as drivers) and health workers in underserved communities.
- 5. Accountability:** Incentives for health worker performance are underpinned by a hybrid form of accountability that combines 'vertical' or top-down pressures from the regional directorate with 'horizontal' forms of accountability whereby staff from different facilities and districts, as well as local communities, are interacting and observing each other's performance. This has been referred to as 'diagonal' accountability (see Goetz and Jenkins, 2001; Fox, 2015): 'hybrid combinations of vertical and horizontal oversight, involving direct citizen engagement within state institutions' (Fox, 2015).

Lessons learned: The progress made in Upper East can be explained by the ability of a regional health director to create a highly motivated workforce and nurture multi-stakeholder alliances. In turn, this helped to mobilise additional funds, which were put to good use in resourcing the innovative ideas described above. The successes in Upper East demonstrate that other regions in Ghana could, and should, be achieving better health inputs and outcomes. But such progress is fragile and must not be taken for granted. Since the regional director was relocated to Accra, many of the systems he put in place have been neglected and the gains made could soon be lost. Systemising and scaling up successful 'pilots' and innovations like these, and sharing the lessons of what worked and what did not, are therefore crucial for sustaining and spreading progress.

dynamics around this issue. There is often local political pressure around allocation of staff, as one respondent summed up: ‘go and see a big man and she [the health worker] is posted elsewhere’ (INGO2). Medical personnel payroll is centralised in Ghana and there is a standardised salary spine, regardless of location. Trained health workers do not have financial or other incentives to work in areas that may offer less in terms of quality of life and training opportunities. The Ghana Medical Association is powerful and resists decentralisation of salaries that could potentially enable enforcement of more equitable distribution. However, according to one respondent, ‘even under a centralised system, the government could know whether health workers were in places they are supposed to be – it is more of a question of political will’ (DP1). Absenteeism and moonlighting are also commonplace (Lievens et al., 2011).

Health worker issues in the GHS contrast with the situation in CHAG facilities. CHAG is a quasi-public, quasi-private network of faith-based providers operating throughout the Christian south of the country, predominantly in remote and deprived areas (although not present everywhere – for example, none were operating in rural Banda, our case study district in Brong Ahafo). Their quality was described as good by multiple respondents (CG3, GNGO1, GNGO2, INGO2) and in previous literature (Saleh, 2013). CHAG health workers in rural areas are provided with good quality, free accommodation, as well as up to 40% additional salary incentives (GNGO1). While the majority of staff in CHAG facilities are government workers, CHAG providers are not subject to the same salary centralisation issues and are able to discipline and sack poor performing staff. This suggests that decentralising GHS salaries could help improve quality.

However, a few points of caution should be added: CHAG facilities are better resourced than GHS because they are linked with churches and missions, which provide some (albeit waning) funding for non-wage recurrent costs. CHAG facilities are not equally dispersed around the country but focused in the Christian south, leaving a notable gap in the three northern regions. Furthermore, CHAG’s policy of incentivising health workers is currently being challenged by the delays facing all facilities in receiving NHIS reimbursements – around 90% of CHAG patients are in NHIS-exempted categories. They are particularly affected by the delays and can no longer pay incentives.

4.2. The policy framework in education

Policy frameworks address many of the marginalised groups identified in the data but pay less attention to harder-to-see groups.

The key policy on education is documented in the Education Strategic Plan (ESP). The current ESP (2010-20) (MoE, 2012) addresses many of the key groups that our analysis and the wider literature demonstrate as being particularly vulnerable to exclusion from education. In particular, it details that no child should be disadvantaged by ‘location (remote, rural, inner city), sex, special educational needs (SEN) or poverty’. The ESP’s third policy goal focuses specifically on gender, calling for gender parity in basic education enrolment, attendance and completion. Other factors such as relevance of curriculum and supply of female teachers are addressed throughout the plan. The fourth policy goal specifically addresses education for people with disability including plans to mainstream all children with non-severe SEN in basic education.

Key challenges related to equity identified in the strategy include:

- continued impact of cost as a barrier to education
- geographical disparities in access to education infrastructure and facilities
- high proportion of untrained teachers especially in rural communities
- unwillingness of teachers to take up appointments in deprived communities
- gender disparities in access to senior high school education
- low completion rate at senior high school especially among girls

Overall, the ESP addresses many of the key characteristics associated with marginalisation in education in Ghana that are ‘visible’ in the main datasets such as the GDHS and GLSS, and highlighted by our own analysis in Chapter 3, namely location, gender and household wealth. In addition, while information on students with SEN is less well represented in current methods of data collection, it is an issue that has gained some degree of traction, with new Education Sector Analysis guidelines on Inclusive Education being piloted in Ghana.⁶³ Both the GSGDA (GoG, 2014) and the ESP highlight the issue of students with SEN as a key policy area.

However, Ghana’s education policy fails to fully address the needs of those ‘harder to see’ in the conventional datasets. For example, education data in relation to religious affiliation are less readily available. One significant gap is out-of-school children (OOSC), which is only briefly mentioned in the ESP. One recent analysis (Marshall et al., 2016) brings together a number of

⁶³ The Inclusive Education Policy is an ambitious document that sets out plans for a harmonised approach among the health and education ministries, as well as non-state organisations, to enable the mainstreaming of students with mild to moderate special educational needs. Important policy dialogue has sought to identify needs in terms of data collection, identification of students in need of support, training and support for teachers and learning materials. However, its implementation since its launch in 2016 has been limited because of a lack of finance.

datasets⁶⁴ to give the best estimate of the scope of the OOSC problem in Ghana. This research concludes that, although there has been a substantial reduction in the number of OOSC since 2003, it is estimated that almost half a million children in Ghana will never enter school, 28.6% of whom are in Northern region alone (Ibid.). The authors argue that reaching these final few per cent of children will require targeted interventions, which are flexible on a case-by-case basis (Ibid.). This implies that ‘standard’ or universal policies such as a capitation grant may not be enough. One example of this arose in our research in Banda district, where a small fishing community had recently relocated to the other side of a major river (with no bridge and very few safe river transports available). This community was cut off from access to health and education services, and potentially was employing child labour. These children would not necessarily have been identifiable from standard datasets as part of one of the key left-behind cohorts, but rather constitute a highly context-specific vulnerable group that may need tailored and targeted interventions.

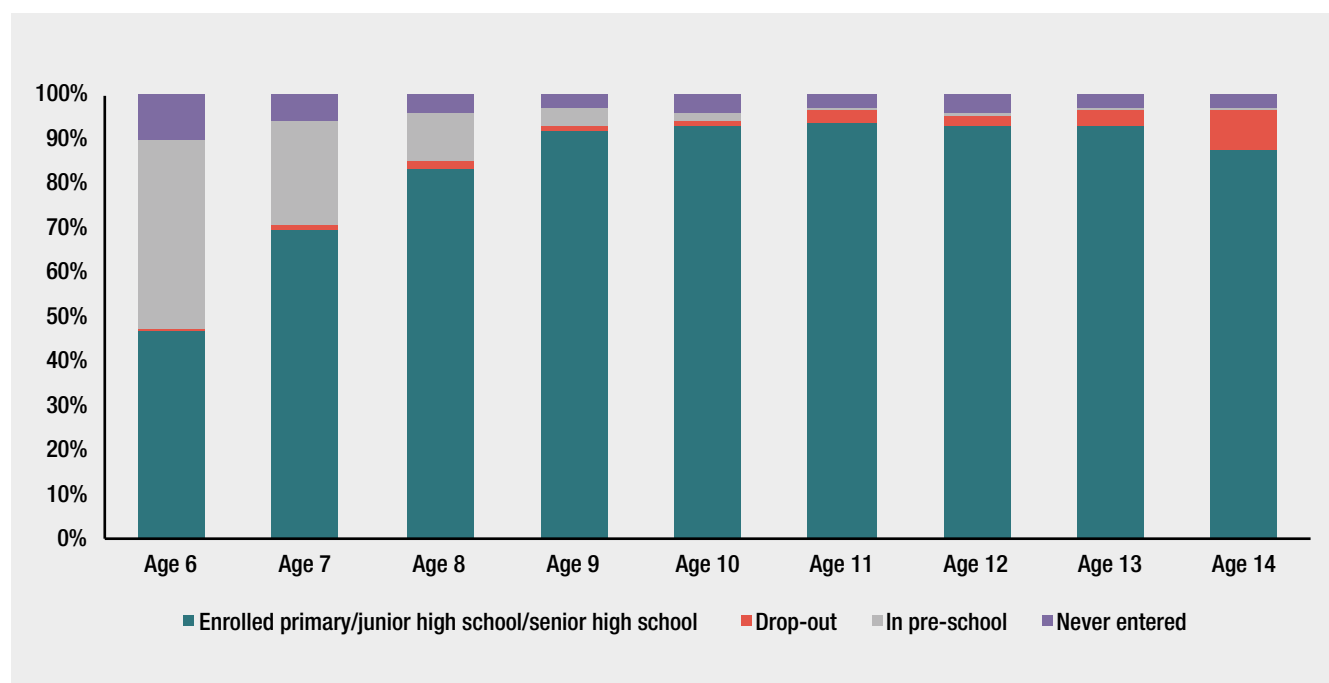
Marshall et al. (2016) also highlight the issue of over-age enrolment in Ghana, which is especially apparent at pre-school level. Although access to quality pre-school education is important for laying the foundations for learning (Rose and Alcott, 2015), the 2014 GDHS identifies 723,000 children who are of primary school

age, but who are enrolled in pre-school. This can be problematic because students may not fully benefit from the education offered when they are significantly older than the target age, and also because over-age enrolment can effectively shorten the total number of years that children are able to spend in school if the end-point is essentially an age threshold (e.g. other demands such as work or family life are placed on their time at a certain age).

A final major limitation of Ghana’s education policies is their lack of attention to the experience of multiple, intersecting forms of disadvantage. One notable exception is girls’ education in the north, an area in which development partners have focused their attention through high profile programmes such as Complementary Basic Education (CBE) – a partnership between the Ministry of Education, the UK Department for International Development (DFID); USAID and several NGOs; Girls’ Participatory Approach to Student Success (G-PASS) supported by DFID; and the MasterCard Foundation Scholars Program at Camfed Ghana.

The MoE is currently updating and finalising its ESP for 2018-30 and the associated Medium-Term Implementation Plan 2018-21.⁶⁵ This is a prime opportunity to ensure that comprehensive equity analyses – in terms of education inputs (including the distribution of resources through the system), access and outcomes – are conducted and their assessment incorporated in the new policy framework.

Figure 43: School attendance history by age, 2014



Source: Marshall et al. (2016), using GDHS and MICS

64 These include GDHS for 2003, 2008 and 2014; MICS for 2006 and 2011; GLSS for 2005-06 and 2012-13; PHC for 2010; and official government administrative data, mainly EMIS for the period 2003-14.

65 This work is being supported by an ESP Development Grant from the Global Partnership for Education (GPE).

Fiercely competitive elections have pushed education up the agenda, but there has been a shift away from basic education and targeted equity measures towards politically favourable policies for universal secondary education.

As seen in Chapter 2, electoral competition in Ghana has become increasingly intense, with very narrow margins separating the two main parties (Abdulai and Hickey, 2016). In this politicised context, education has become a key electoral issue over which the two main parties have sought to differentiate themselves. This has resulted in some very significant achievements, notably the ongoing removal of fees at different levels of schooling, and greatly improved enrolment rates and average years of schooling. It has also led to the emergence of a broad and ambitious package of free education, which covers two years of kindergarten, six years of primary and three years of junior high school. Recent electoral campaigns have been dominated by discussions of free senior secondary education. The NDC won the 2012 election with a pledge to ‘increase subsidies currently paid to existing secondary schools with a view to reducing the burden on parents’ (NDC, 2012). In the 2016 election, the NPP argued that the previous policy had not gone far enough and pledged to institute free education for all Ghanaians attending public senior high schools (SHS).⁶⁶ The NDC responded with a promise to ‘expand the progressively free SHS programme to cover boarding students with emphasis on needy students’ (NDC, 2016). The NPP won the election and the free SHS programme was launched in September 2017.⁶⁷

Another example is school construction. During the 2012 election campaign, the NPP promised to construct 350 secondary schools as part of universally free SHS, while the NDC – reportedly in reaction – pledged to build 200 new senior secondary schools ‘with emphasis on districts where there are no such schools’ (NDC, 2012). The MoE secured funding from the World Bank for the construction of 23 SHS through the \$156 million Secondary Education Improvement Project, 80% of which have been completed (World Bank, 2017c). By the time of the 2016 elections, the NDC faced heavy criticism for failing to deliver on its promise. The media and civil society organisations highlighted that only 10 of these 200 promised schools had been built, and they criticised their location and lack of disabled access (GNECC, 2016). Interestingly, however, similar campaign pledges to build kindergartens⁶⁸ did not receive the same level of attention. The number of government crèches and kindergartens actually reduced by 38% from 2012-13 to 2014-15;

during the same period the number of private crèches and kindergartens increased by 22% to 5,900 (Ibid.).

The overall result has been a shift of attention and transfer of resources away from basic education towards the secondary level. While universal secondary education completion is a key target within the SDGs and crucial for countries to advance their development, it is concerning that the policy focus on secondary-level education is coming at the expense of basic schooling – particularly since evidence demonstrates the importance of prioritising early years and primary-level education for equity. Children from disadvantaged groups are more likely to access education at earlier grades than at more advanced grades. It is also in the early years where learning inequalities already emerge and need to be tackled before they become entrenched and compounded (Martinez et al., 2017; Rose et al., 2017, 2016; Rose and Alcott, 2015; Heckman, 2008). A lack of attention to pre-primary and primary education also contradicts international recommendations. In 2016, the International Commission on Financing Global Education Opportunity, reflecting the objective of leaving no child behind in SDG4, called for ‘progressive universalism’ (Education Commission, 2016). At its core, progressive universalism is about ensuring that universal education systems balance scarce public resources in order to ‘prioritise the poor and early years where social returns are highest, and minimise household spending on basic education by the poor’ (Ibid.). Analysis of early years interventions including pre-school has shown that it has high returns (Wodon, 2016).

Furthermore, the implementation of the free SHS policy was a concern to many of our respondents, who believed that, in reality, it would not be ‘free’. One district official commented that:

It is the same as basic education. Because of the free education policy, parents expect that they will have to pay nothing at all. But there will always be some costs. We still have exam fees, money for school lunch. They will think the same with this SHS. They think it will be free but it won't. Those that can afford these things will go to school, but [other] people will still struggle. (LG12)

The policy is recognised as distracting attention from fixing the problems in basic education. As one interviewee argued, ‘you need to start to fix the problems at the beginning. Kindergarten and primary – this is the foundation’ (LG12). Another said, ‘focus on kindergarten – you must first get everyone to enter’ (LG16). Another aspect where

66 The final NPP commitment pledge read: ‘Redefine basic education to include Senior High Schools (SHS), covering Vocational, agricultural and technical schools, and make it available for free on a universal basis to all Ghanaians’ (NPP, 2016).

67 According to President Akufo-Addo, ‘By free SHS we mean that in addition to tuition which is already free, there will be no admission fee, no library fee, no science centre fee, no computer lab fee, no examination fee, and no utility fee; there will be free text books, free boarding and free meals, and day students will get a meal at school for free’. (<http://www.ghana.gov.gh/index.php/media-center/news/3436-free-shs-to-commence-september-2017-president-akufo-addo>).

68 In 2012, the NDC manifesto included a promise to allocate more resources for kindergarten facilities (NDC, 2012).

government and donor attention has been focused is retention and achievement at junior high school level, especially among girls, and especially in the north of the country. High-profile programmes such as G-PASS, Camfed and CBE have sought specifically to address this issue. Since students must pass the BECE exam at the end of junior high school in order to be admitted to the senior level, this is a key juncture of the system where disadvantaged children are more likely to miss out. In this vein, donors expressed the view that junior high might become the level of schooling where they could add the most value to the free SHS policy (DP2).

Chronic under-investment in pre-primary and primary education and poor human resource management have resulted in a ‘public–private crossroads’ in Ghana’s education system. The lack of any influential stakeholders with an interest in changing this has stymied reform in the public primary system.

A key trend in Ghana’s education system is increasing privatisation, particularly at the basic levels. During fieldwork it was commonly stated that anyone with the means to do so uses the private system for their basic education (kindergarten, primary and junior high school) and then shifts to the public system for senior high school (CG13, CG17, DP1, DP2, NGO4, TU1, TU2). Conversely, children who do not achieve the necessary grades at the Basic Education Certificate Exam (BECE) to gain a place at a quality public secondary school cross over to (poorer quality) private secondary schools or choose another route such as an apprenticeship.

Parents choose private (even low-fee) basic education because of a perception of better quality (TU1, LG21, NGO4). However, education authorities highlight that, although these emerging schools may give the impression

of quality, their methods may not necessarily be in the best interests of the students in the long term. According to regional education staff, it is common practice to use inappropriately high-level curriculum to give the impression that pupils are advancing quickly:

Their aim is to attract more students in order to make money so they often use a higher curriculum. In P1 you find they are doing what they should do in P2 so that you have children that can rhyme off things from the year above. But not everyone can keep up and it has problems in the long term. (LG21)

It is also widely acknowledged that the private sector relies on untrained teachers because it is unable to compete with salaries in the public sector (TU1, TU2, CG17). This is borne out in the EMIS data, which show significantly lower proportions of trained teachers in the private sector at all levels of the education system, with the biggest differentials at kindergarten and primary levels. For parents, it comes down to the fact that, in the private sector there is *school-level* supervision of teachers, which essentially means that parents are assured that a teacher will always be present, whereas teacher absenteeism is rife in public schools (CG17, LG20, LG21, TU1).

Hossain et al. (2012) identify two approaches to improving education governance: devolve control through school-based management or increase choice through private schooling. Despite international optimism regarding school management committees (SMCs), they argue that the initial endowments of community capabilities for school management are likely to be considerably lower in poorer areas and the mechanism does not typically address the imbalance of power that limits

Figure 44: The public–private crossroads in Ghana’s education system

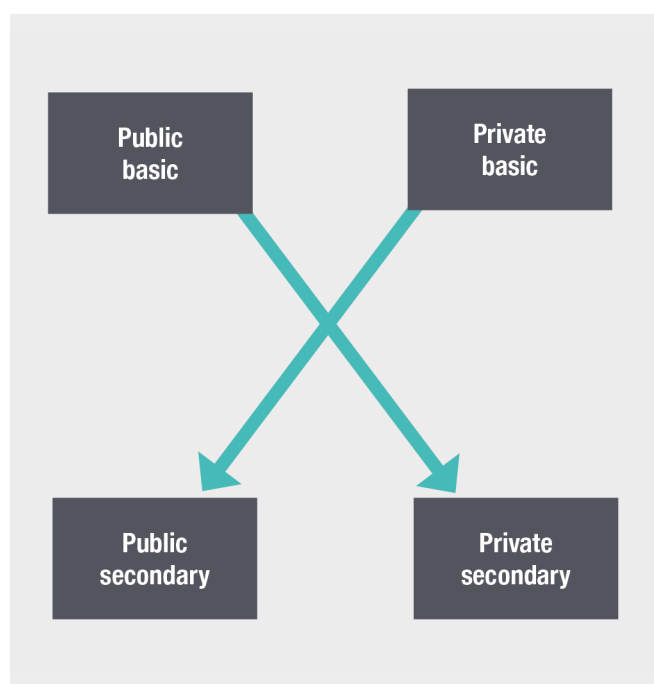
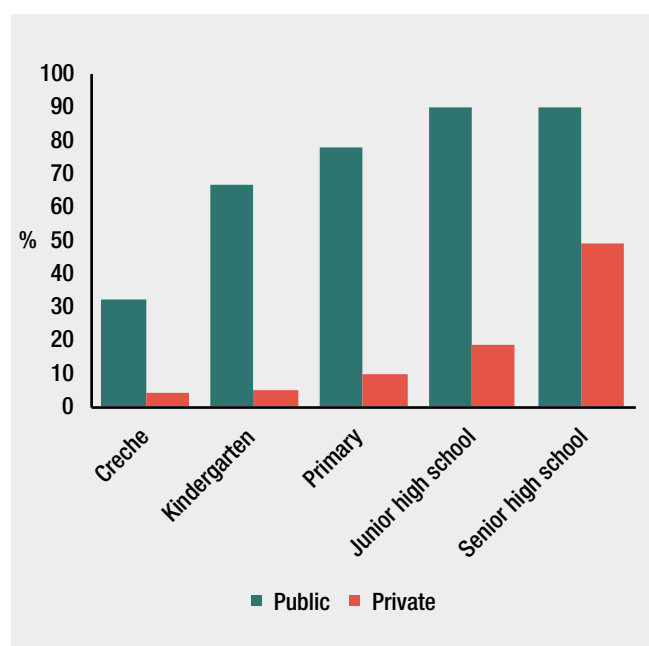


Figure 45: Percentage of trained teachers in the public and private education sectors, 2015-16



Source: EMIS 2015-16

the ability to enforce sanctions (Ibid.). In Ghana, every school is required to have such a committee, but their effectiveness varies in the absence of objective performance parameters or benchmarks. Particularly in rural areas, committee members feel that they should simply be happy that the teacher has accepted the posting (TU1, FGDZT). In the absence of effective school governance, parents with the means to do so are choosing to opt out of the public system.

The use of the private sector for basic education is also driven by a mistrust of government to invest sufficient resources in basic level infrastructure. An incident in which a kindergarten building in the Central region collapsed in January 2017, killing six children, received a lot of media attention and seemed to confirm people's fears that kindergarten classrooms are not fit for purpose (Ghanaweb.com (2016)). Lack of investment in infrastructure at the basic level was highlighted as a key challenge by almost all stakeholders interviewed, including regional and district education officials, headmasters, teachers and parents:

Some of our schools also have poor infrastructure, especially the KGs and lower primary classrooms. Some of these structures have cracked walls making them death traps and some don't even have walls around them. (FGDBWHA)

There are schools without facilities. In our school there is no water so the children have to run home during break crossing the lorry road which is risky. (FGDBWHA)

In Ghana we have this problem where we build, but we don't maintain. The state of the KGs [kindergarten] in particular is not good at all. It is dangerous. (GNGO4)

The 'public-private crossroads' has led to a lack of momentum for reform of basic education. Interviewees suggested that parents who traditionally would be best placed to push for reform are less interested in the public primary sector as their children largely attend private schools.

When we have meetings, the parents come and ... the comments they gave – I feel like they have more attention on the older children who are at JHS [junior high school] onwards than the KG children. When I was an Assemblywoman, we sat the contractor down so that he should help us get a KG block ... So when the money came into hand, we moulded the block seeking to build the KG. All of a sudden, one of the teachers raised a concern that we need a JHS at the community so they built the JHS instead of the KG. So we [are still] under trees, even now. The parents, they don't actually feel [the need] to help the younger ones. (FGDBT)

In Ghana we have this situation where parents send their children to private basic schools and then they move to secondary school. So they don't care about the public primary. Their children are not there. (TU1)

A second pressure group that might be expected to challenge the shift from primary to secondary education are GES staff at regional and district levels. They were keen to highlight that secondary is not where they would like to see resources channelled. However, they are not in a position to directly challenge the political campaign promises:

We are not policy-makers; we are implementers, so if we want to influence policy we must do it indirectly ... we may send papers [to feed into Parliamentary consideration of bills], but not in the name of GES. It must be done in a personal capacity. Or we can do it through NGOs. For example, we call a regional forum on a certain issue and then send a petition in the name of the people. But with this free SHS, it is not education policy; it is government policy. This party has its policy and it will deliver. (LG16)

This situation is further complicated by the fact that many education officials have ties to either the NPP or the NDC. If they were to challenge a party policy, they may be viewed as doing so in their political capacity rather than in their technical role (LG20).

A third group of stakeholders that could potentially challenge the shift in focus is the teacher unions. The National Association of Graduate Teachers, representing 31,000 members, is widely thought to have the strongest influence on policy matters.⁶⁹ As university qualification is a condition of membership, the majority of its members work in the secondary sector. It is not necessarily in their favour to challenge a shift towards the secondary sector and, indeed, the strength of their influence may even be a contributory factor.

There is a clear ambiguity around rising privatisation of basic education in Ghana. Public-private partnerships are encouraged in the current ESP and it is commonly argued that private investment is filling an important gap in provision (DP2, TU2).

As one organiser explained, 'people see that privatisation is helping education; it is improving the quality. And what is the alternative? Public education? But we see that it is not good' (TU2).

At the same time, it is recognised that this is at odds with the principle of progressive universalism and is contributing to inequity (TU1, CG17).

Somewhat in recognition of this, the government has recently announced plans for 82 public 'elite schools' to reserve 30% of free SHS places for students who have attended public junior high schools. In practice, however, it is likely that this will only impact a small number of

⁶⁹ The Ghana National Association of Teachers is the largest union with 172,500 members as of 2014. It has seen membership numbers as a proportion of the teaching workforce fall (99.6% in 1995 reduced to 78.7% in 2014), owing to a failure to understand the changing profile of its membership and a high level of dissatisfaction with the union's performance in wage negotiations (Boh, 2014).

students rather than fundamentally redressing the current inequity in the system.

The lack of policies and measures to incentivise and enforce the distribution of teachers across deprived areas has a large impact on the functioning and quality of education among marginalised communities, especially in the north of Ghana.

Given the large increases in pupil enrolment that Ghana has experienced, it is impressive that the pupil to teacher ratio has remained steady at around 34:1 over the past decade, very close to the average for LMICs (Lenhardt et al., 2015). However, this was achieved in large part by employing more untrained teachers. Recently, the supply of trained teachers has gradually improved, but it is still below the target outlined in the ESP to reduce the proportion of untrained teachers to 5% by 2020. As of 2016, the level of untrained teachers nationally stood at 22% (EMIS). This is a concern given that the quality of teaching (skills and knowledge of both the curriculum and pedagogy) has been demonstrated as one of the most important determinants of pupil achievement (Bold et al., 2017). Studies show that several consecutive years of outstanding teaching can offset the learning deficits of disadvantaged students (Wodon, 2016).

Previous studies have also established that there is a problem with the regional distribution of trained teachers in Ghana as many are unwilling to serve in rural, deprived districts (Associates for Change, 2016) especially in the

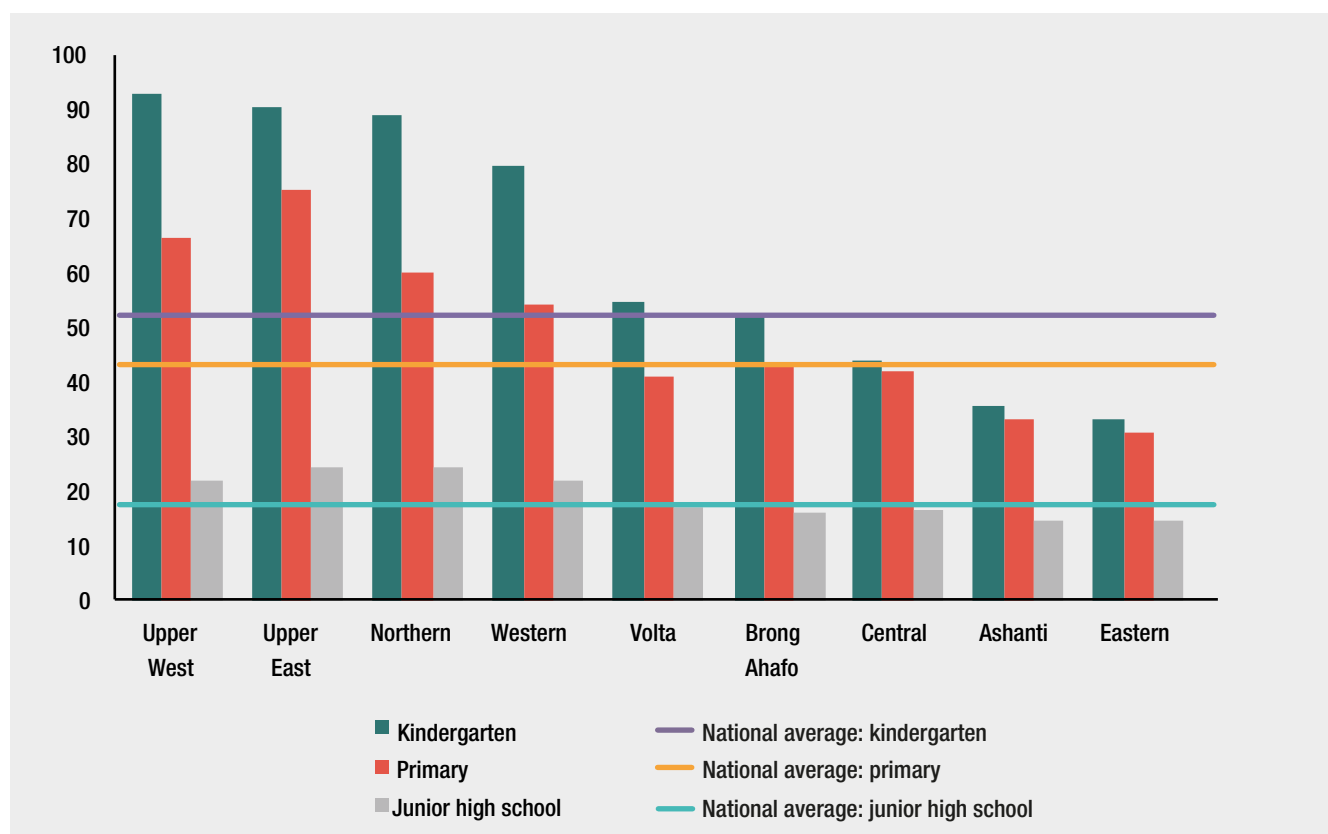
north of the country. In 2016, the pupil-per-trained teacher ratio (PTTR) in the three regions making up the north of Ghana – Northern (58:1), Upper East (63:1) and Upper West (60:1) – was triple that of some regions in the south – Greater Accra (29:1) and Eastern (26:1) (EMIS).

From an equity perspective there is a good rationale for placing the most qualified teachers at lower levels of education where the poor and marginalised are most likely to benefit and where the educational foundation is laid. However, the early grades of basic education are the most neglected in terms of trained teacher supply. This has led to PTTRs as high as 89:1 (Northern), 93:1 (Upper East) and 90:1 (Upper West), and is in stark contrast to the targets approved by the MoE in its ESP for ratios of 25:1 for kindergarten, 35:1 for primary and 25:1 for junior high school.

Within regions, there is also a ‘hierarchy’ of more and less desirable locations, since trained teachers are often reluctant to travel far from the regional capital or other urban centres. For instance, within Northern region, the capital Tamale is preferable to more remote districts such as Zabzugu, as indicated in Table 9. In Zabzugu, we were told by parents that,

The teachers usually miss school for about a week and the children have no other option than to return home. At most times, Fridays automatically become holidays because the teachers do not come to school. (FGDZWEA)

Figure 46: Pupil-to-trained teacher ratios by region, 2015-16



Source: EMIS 2015-16

Table 9: PTTR in case study districts

	Banda district	Brong Ahafo regional average	Zabzugu district	Northern regional average
Kindergarten	71	52	198	89
Primary	61	43	103	60
Junior high	22	16	33	24

Source: EMIS 2015-16

The community we spoke with identified one priority for improvement as having more teachers available in the few schools existing in the area.

While this pattern of skewed human resource distribution is common, the pervasive practice of intense lobbying in Ghana's teacher deployment means that, for many of those posted to less desirable locations, there is an alternative: 'anyone who knows a chief or a politician lifts the phone and they will not be sent here' (LG12).

Even once a teacher has accepted a posting, this does not mean that that teacher then settles there. In Ghana it is the teacher's right to request to be moved to another posting after three years. In deprived districts this period has been reduced to two years as an incentive to encourage people to accept postings in such areas. The process of finding a new posting is a political and time-intensive one:

You have to find somewhere else, a better district, where you know people. You start to lobby people there. You go to the schools. You talk to everyone there, the headmasters, the chief ... until they accept you. (FGDZT)

This means that, even when a teacher has accepted a post in a deprived area, they may still spend a substantial amount of time visiting another district to lobby for a new position (FGDZT).

In an attempt to address high levels of untrained teachers, especially in deprived, rural areas, the MoE secured funding of \$15.06 million from the Global Partnership for Education (GPE) to support the Untrained Teachers Diploma in Basic Education (UTDBE) programme. The UTDBE programme is a four-year teacher training programme provided through a combination of distance learning and residential courses in the Colleges of Education. By 2016, 6,480 trainees had completed their full training (Ibid.). An assessment of the programme found that UTDBE trainees were more willing to stay in remote and rural areas than those on the traditional pre-service training programme (Ibid.). It is likely that this is because a high proportion of UTDBE trainees (72%) originate from the communities in which they teach – the assessment found that they experienced fewer challenges related to accommodation and community integration. It also notes the important role played by education authorities, parents and chiefs in providing incentives and ensuring the retention of teachers within the communities (Associates for Change, 2016).

The final issue that cuts across both health and education is that vulnerable and marginalised groups are left out of the policy-making process, despite Ghana's democratic political system.

Previous ODI research has documented challenges for political participation in Ghana and how those who are poorer, more vulnerable or in geographically hard-to-reach regions do not have the same influence on the policy process (Lenhardt et al., 2015). Increased political voice for all does not necessarily translate to greater accountability; elections, lobbying and decision-making processes leave out the voices of the poor and the acutely marginalised, at both national and local levels (Ibid.). Our research yielded similar findings:

Some marginalised people do have a seat at the table but it is a big challenge whether their voices are really heard. They do not get much mainstream policy attention. Marginalised people will have to find their feet under a decentralised system, and hope that things will improve for them. (RP3)

Despite the promise of decentralisation, informants indicated that policies and sector priorities are set at a national level, with little input from regions, districts and communities: 'the policy-making process is very top-down' (RP3). Women, especially, tend to be excluded from district decision-making (FGDBWHA).⁷⁰ Civil society organisations (CSOs) are helping to create platforms for advocacy, and community meetings, known as durbars, are another forum with potential. However, both have financial costs that the most deprived communities find difficult to meet. Local planning officials acknowledged that they do not (and are not required to) meet minority or marginalised groups as part of the district planning process, but rather simply meet one overall representative of each area (LG3). They also complained that it is difficult to generate the will to participate among community members: 'They only come if you provide lunch or snacks; they don't see the benefit of attending' (LG3).

In theory, limited decentralisation (though not in the health or education sectors) means that metropolitan, municipal and district assemblies have more power to allocate spending and prioritise the issues of equity and marginalisation in their districts. However, the reality of severe financial constraints – combined with a lack of genuinely participatory local planning and accountability mechanisms – means that this potential is not being realised.

⁷⁰ However, it is interesting to note that men from the same community stated that women should be more involved, and appeared supportive of women's political participation.

5. How well is public financing allocated and delivered in line with the commitment to leave no one behind?

5.1. Financing of health

Ghana's health sector is financed through a combination of budgetary expenditures, donor support and household spending. Government revenue flows to the MoH and health facilities through budgetary transfers, a dedicated levy and deductions from the Social Security and National Insurance Trust (SSNIT) to finance the NHIS, which is managed by the NHIA. Development partners provide grant support, technical assistance and both concessional and commercial loans to the MoF, the MoH, the NHIA and individual health facilities. Households contribute through premium payments to the NHIA and OOP payments at health facilities (World Bank, 2017b). The main structure and sources of public health financing in Ghana are described for reference in Figure 47 and Table 10.

In our analysis of financing, we have concentrated primarily on district-level health services.⁷¹ Given the structure and limited extent of disaggregation of Ghana's budget, we maintain that district health services are the best yardstick for basic services that are critical for reaching those left behind and are most relevant to the CCI measure.

The squeeze in overall public health resources and a simultaneous increased reliance OOP payments creates a context in which leaving no one behind becomes all the more challenging, especially as vulnerable groups are typically those most reliant on public health care and least able to afford OOP payments.

According to government financial statements, health spending⁷² as a share of total government expenditure in Ghana declined from 14.5% in 2011 to 12.2% in 2014. In 2015, it partially recovered to 13.8% – however, it is likely that a significant proportion of this increase was used for clearing past arrears, rather than new investments.⁷³ In any case, government health spending still remains below the minimum recommended level needed to achieve decent health care for all, including the 2001 Abuja commitment to allocate 15% of government expenditure towards health and the Chatham House Expert Group benchmark of 5% of GDP in MICs (WHO, 2011; Centre on Global Health Security Working Group on Health Financing, 2014).

In real terms, government health spending per capita in Ghana roughly doubled between 2011 and 2015.⁷⁴ However, in 2015, it stood at only 195 Cedis (c. \$50) per capita – much less than the \$86 per capita that is estimated

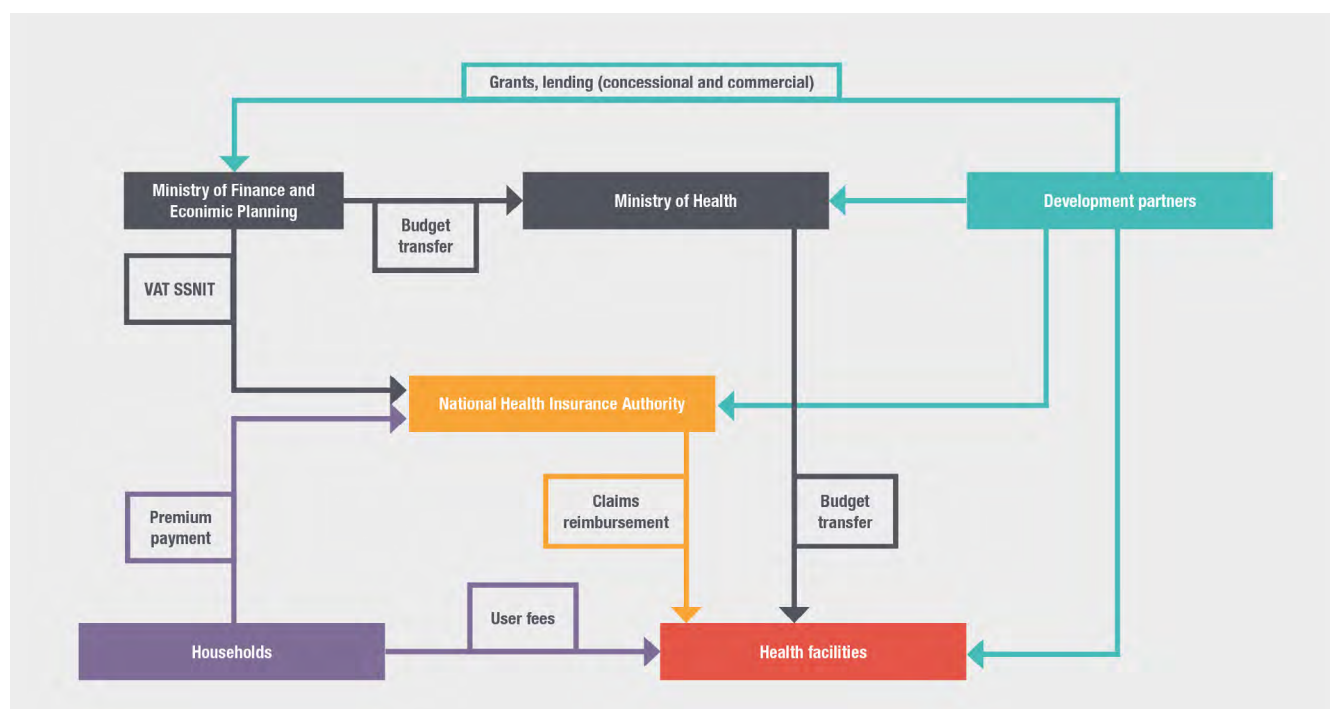
71 See Chapter 2 for a description of how the health sector is organised.

72 Health spending here includes the extra-budgetary National Health Insurance Fund (NHIF), as well as the MoH budget.

73 This is not possible to identify from the budget document itself, owing to a lack of transparency, but was the explanation given to us by government officials.

74 The nominal increase was around 1.4 times between 2011 and 2015, but there have been high levels of inflation during this period, averaging 12% per year (World Bank, World Development Indicators database). These figures include the extra-budgetary NHIF.

Figure 47: The flow of funds in Ghana's health sector



Note: Grey lines signify the flow of GoG revenues; yellow lines signify NHIS funds; turquoise lines signify resources from external development partners; and purple lines signify household expenditure. The MoH includes funding for the GHS, which transfers resources to regional and district health facilities, while other departments are responsible for central and tertiary functions. Some resources for health also flow from local government (not shown here). Source: World Bank (2017a)

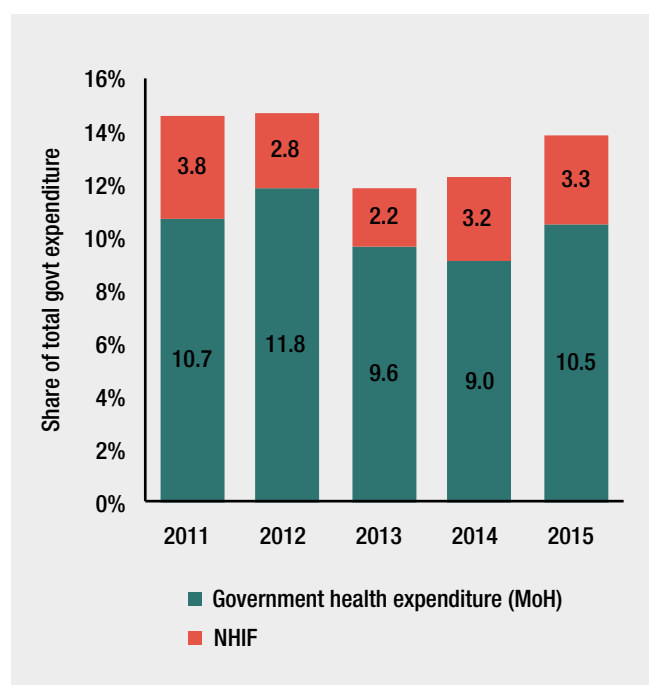
to be needed to achieve UHC even in LICs (Centre on Global Health Security Working Group on Health Financing, 2014).

According to WHO's cross-country health financing dataset, Ghana ranks fourth from bottom in terms of both the proportion of government spending devoted to health and total (public plus private) health spending, when looking across other LMICs in sub-Saharan Africa.⁷⁵

Since 2011, OOP payments have risen both in absolute terms and as a share of Ghana's total health expenditure (from 16.1% in 2011 to 26.8% in 2014). In a ranking of all countries worldwide, where those at the top pay the smallest share of health expenditure in the form of OOP payments, Ghana plummeted from 59th in 2010 to 118th by 2013 (World Bank, 2017a). OOP payments include self-treatment costs, co-payments 'informally' charged to NHIS members and payments for services by non-NHIS members. According to the World Bank (2017a), data suggest that the majority of OOP payments in Ghana are for prescription drug purchases.

Indeed, the government has run up sizeable arrears in drug procurement. Extreme delays in the NHIS reimbursement process have meant that facilities are increasingly getting into debt and are not always able to supply drugs that should be free to insured patients. To the extent that vulnerable and marginalised groups,

Figure 48: Government health expenditure



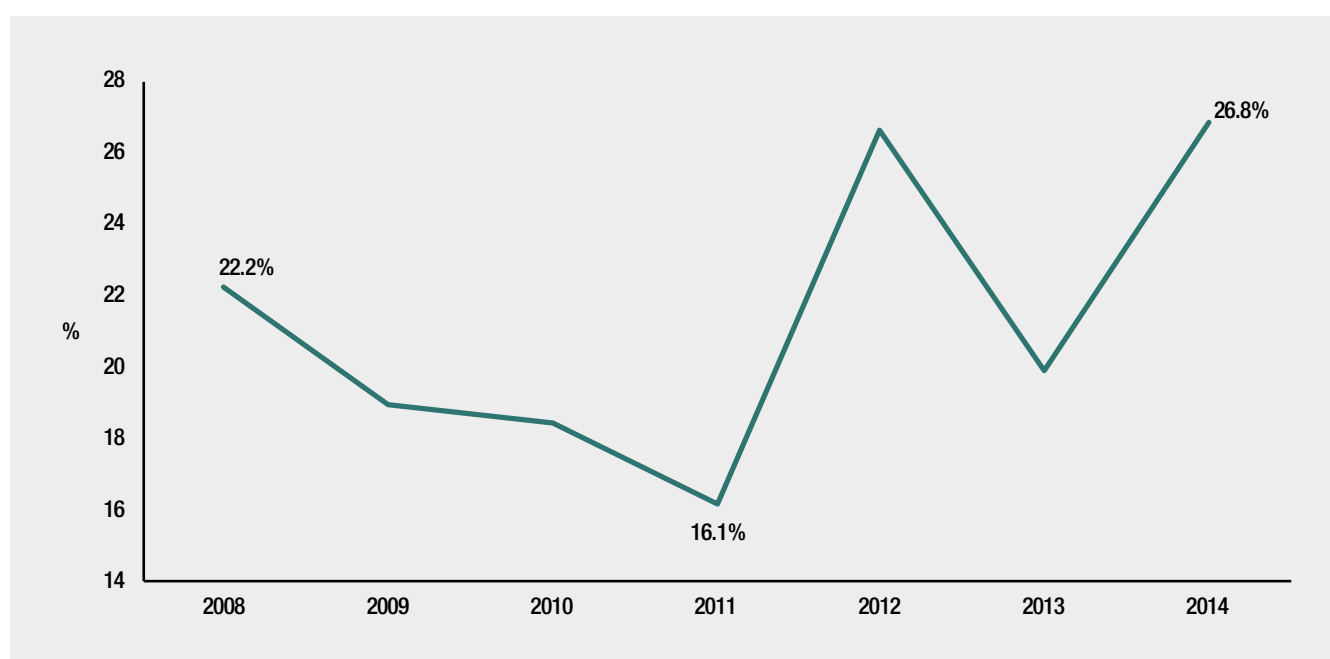
Note: The NHIS in Ghana is funded via a separate mechanism, the National Insurance Fund, which is separate to the MoH budget. Source: Budget Statements annexes (various years)

⁷⁵ This information is available only up until 2014. It should be noted that Ghana's figures in this database do not match GoG budget data, possibly because of difficulties in capturing the extra-budgetary NHIF, although the overall trends over time do correspond quite well between the two datasets.

Table 10: Institutional arrangements and spending criteria of key health funds

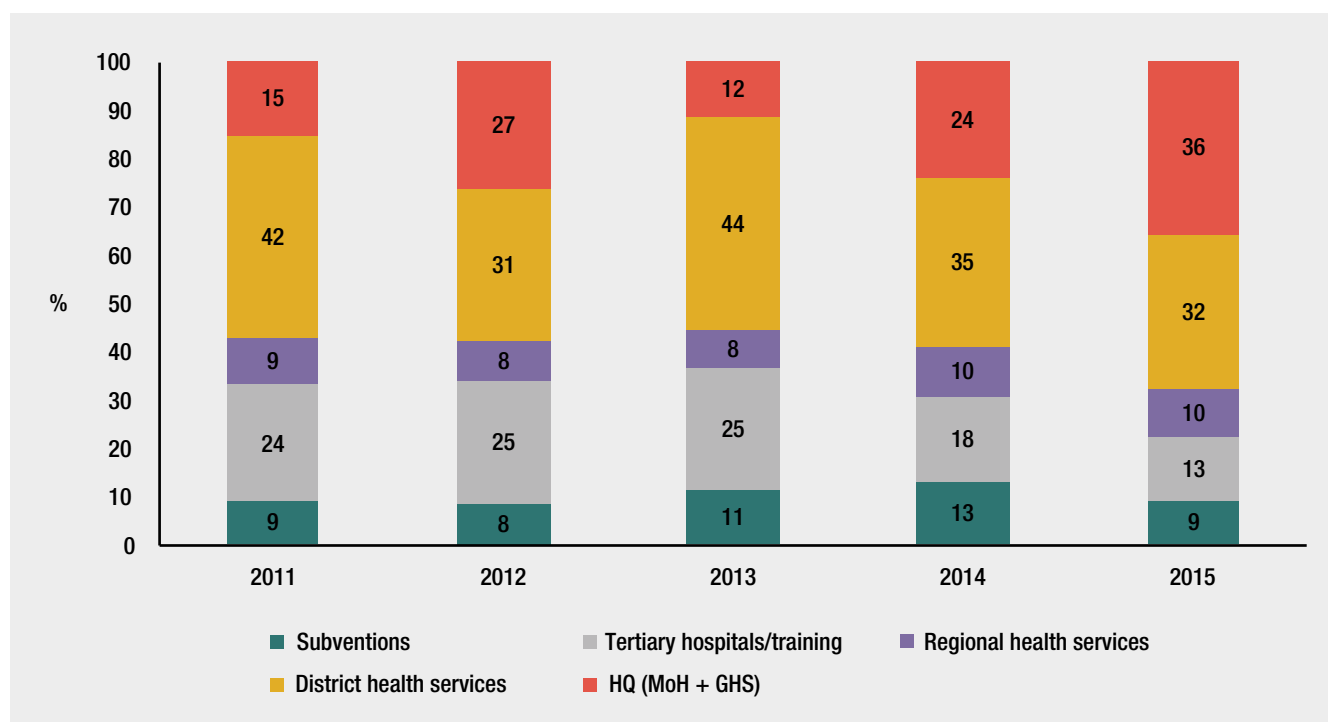
Type of fund	Institutional arrangements	Spending criteria
GoG discretionary	Non-earmarked funds that can be used at the discretion of the MoH (in practice, 90% is spent on salaries).	No predefined spending criteria
Annual Budget Funding Amount (ABFA)	Receipts from oil revenues. The ABFA Secretariat and senior management within the MoF earmark resources and spend on predefined specific policy priorities once approved by Parliament.	Depends on decision of the board; typically, investment and capacity-building
Sector budget support	Earmarked funds from donors historically either as part of the Heavily Indebted Poor Country (HIPC) debt relief process or through pooled arrangements via the health fund. Allocative and spending decisions determined through a joint dialogue between sector representatives and development partners.	Intended to address regional inequalities and support lower levels of service delivery
Foreign loans	Loans to fill the asset gap created by reduction in HIPC support and budget support reductions. The GoG has greater discretion on the allocation and spending of non-concessional loans, whereas concessional loans are linked to targeted development partner priorities.	Earmarked for specific districts and types of health care facility
Earmarked donor programmes	Public and preventive health programmes such as HIV/AIDS, malaria and vaccinations, under the budget line of 'MoH programmes'. Gavi and the Global Fund are the main funders, but this also includes GoG contributions (e.g. counterpart or co-financing obligations). Allocation and spending decisions are jointly coordinated.	Will depend on the agreement with the donor
Internally generated funds (IGFs) – NHIS repayments and user fees	Health facilities (budget management centres (BMCs) or cost centres) collect reimbursements from the NHIA and fees paid directly by patients. Allocative and spending decisions are at the discretion of the BMCs, but they have very limited control over NHIA reimbursements.	Spending is discretionary, but is used to cover shortfalls from other government transfers
District Assemblies Common Fund (DACF)	A block transfer of no less than 5% of total revenue (currently pegged at 7.5%), transferred directly to DAs. Allocation and release decisions made by the DACF Secretariat (an independent body) and approved by Parliament.	70% to be used for economic ventures, social services and the environment
Donor projects and NGOs transferring funds to districts directly or through the Ministry	Depends on the project memorandum of understanding, but can serve as a direct district transfer to a BMC or can be channelled through the district authority or directly to an NGO. One such example is DFID's 'Adolescent Reproductive Health Programme', which aims to mainstream adolescent reproductive and sexual health into implementation activities by supporting a range of actors at regional and local level, including District Assemblies, civil society organisations, and various government agencies such as GHS and GES.	Depends on the project

*Health has never yet been one of the selected priorities of ABFA – see Witter et al. (2017).

Figure 49: Out-of-pocket payments as a share of total health expenditure

Source: WHO Global Health Expenditure database

Figure 50: Share of government health spending by level



Note: Subventions refers to transfers to the following entities (based on the 2015 detailed budget): Centre for Scientific Research into Plant Medicine; College of Nurses and Midwives; College of Pharmacists; Ghana College of Physicians and Surgeons; Ghana Institute of Clinical Genetics; Ghana Red Cross Society; Mental Health Authority; National Ambulance Service; St. John's Ambulance Brigade; West Africa Health Community; World Health Organization.
Source: MoH Audited Financial Statements (various years)

particularly the income-poor, are the least able to afford OOP payments, this trend is antithetical to leaving no one behind. In Banda, the accumulation of debt via both formal and informal channels to meet everyday needs such as health appeared to be a pervasive practice. Chapter 6 discusses further the negative impacts of OOP payments on vulnerable groups' demand for services.

Public health spending does not appear to be as pro-poor in its allocation as it could be, partly because of a combination of technical inefficiencies, but also because of matters of political choice. District health services overall are receiving a diminishing direct share of the budget, and are receiving virtually nothing for non-wage recurrent costs, while allocations via the centre are growing.

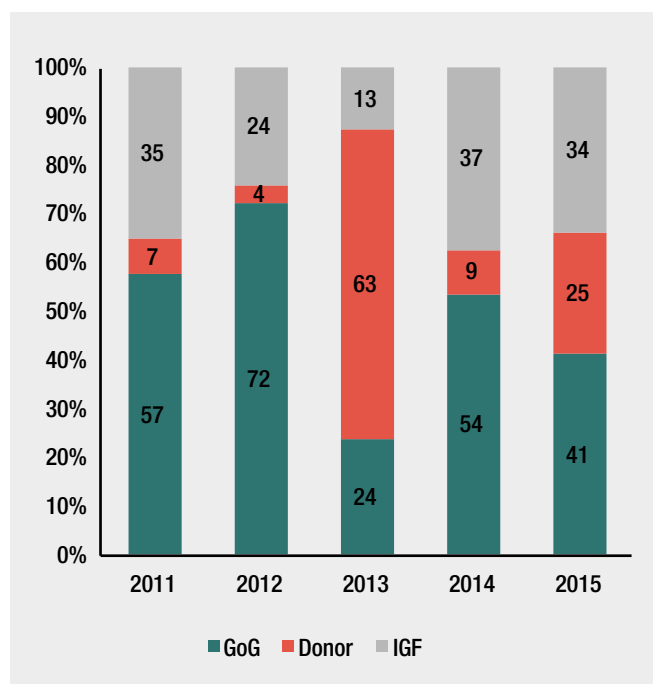
With the exception of 2013, the share of government health funds allocated to district health services has been on a generally downward trend, from 42% in 2011 to 32% in 2015 (MoF, 2015). In contrast, allocations to the centre (MoH and GHS headquarters) grew four times faster than all other levels. These central functions are now responsible for 36% of total spending, up from just 15% in 2011. A relatively small share (13%) of this growth is accounted for by 'MoH programmes', a budget line that includes the major vertical funds such as the Global Fund and Gavi, which do deliver services via the district health infrastructure. However, the vast majority (82% or more than 1 billion Cedis) of the rise in central spending since 2011 has been driven by a sharp increase in government discretionary funding. Based on the 2015 detailed budget

(MoF, 2015), this growth in central discretionary spending was not budgeted for. No further details about what this expenditure funded are available in government documents, and the trend could not be accounted for during field visit interviews with MoH officials.

In proportional terms, there has been an increasing reliance on donor resources to fund service delivery at district level (Figure 51).

As discussed further below, wages absorb 90% of the discretionary government budget, with virtually nothing left for non-wage recurrent expenditure, after a small number of capital projects are also budgeted for. As seen in the previous chapter, the expansion of CHPS compounds is a key plank of public health policy, and yet the government is not putting in the financial resources required to implement it. Basic operating costs such as fuel, vehicles and bicycles, and administrative costs including data for information and communication technology use and office supplies, are not being provided (LG15). In one district, the health directorate had not seen any core administrative releases for seven years; the only non-wage funding released during this time was for specific projects. They argued that this 'affects us very heavily'; for instance, halving the regularity with which they can monitor the quality of health services compared to what should be the case, and forcing them to undertake 'innovative accounting' (LG4). In one FGD, participants explained how CHWs no longer visited their hard-to-reach sub-district and that the nearest CHPS was not adequately stocked, meaning they would have to travel

Figure 51: Share of funding for district health services by source



Note: IGF comprise reimbursements by the NHIA to facilities plus OOP payments by patients.

Source: MoH Audited Financial Statements (various years)

longer distances (at cost) or pay out of pocket over the counter (FGDZWENA).

District and sub-district service delivery functions such as CHPS have historically relied heavily on donor funding. The nature of this funding has evolved over time. During the early to mid-2000s, Ghana benefited from more than \$1 billion in debt relief under the Heavily Indebted Poor Country (HIPC) initiative. As per the terms of the scheme, it channelled much of this funding towards priorities in its 2003 Poverty Reduction Strategy, notably health and education, aiming to reduce regional disparities (GoG, 2003). Ghana's CHPS provision has its roots in these HIPC arrangements. From the mid-2000s to 2012, donors were providing quite a large annual volume of general and health sector budget support to Ghana in the form of grants, which was also drawn on to resource the district health system.

However, HIPC has now come to an end, and bilateral donors are no longer providing budget support, preferring instead earmarked programmes and projects. Nevertheless, some of the most notable current donor programmes are still fulfilling a similar function of plugging critical gaps in district health services, for instance the World Bank through its Ghana Maternal, Child Health and Nutrition Improvement Project (GMCHNIP).⁷⁶

Yet, as acknowledged in the most recent holistic assessment report of the health sector, 'Funds from these sources [development partners] are dwindling and [this] may have a negative impact on service delivery' (MoH, 2016). Indeed, in one district we were told that, if the GMCHNIP funding stopped coming, it would 'push us into a corner' (LG4).

As shown in Figure 52, official development assistance (ODA) figures reveal a broadly upward trend in aid for basic health care up to 2012, and thereafter an overall stagnation, at least up until 2015 (at the time of writing, the most recent available data).⁷⁷ There was a slight decrease in both absolute terms and proportional terms between 2012 and 2015. However, a number of donors have stated that they are in the process of phasing out their support or intend to in the near future. With Ghana's transition from LIC to MIC status in 2011, a number of donors with significant country programmes active in the social sectors, such as Denmark and the Netherlands, have announced that they are phasing out their development assistance towards an imminent exit (Dutch MoFA, 2016; Danida, 2014). The UK – Ghana's second-largest bilateral donor after the US – also substantially reduced its overall aid to the country in 2014 and 2015, with the revised Operational Plan for 2011-16 confirming plans 'to reduce the level of general and sector budget support reflecting Ghana's lower middle income status and greater ability to raise domestic revenues' (DFID, 2014 rev.). The British High Commissioner has said that, 'Budgetary support to Ghana is no longer on the cards because the government of Ghana is supposed to provide its own basic services' (Joy Online, 2016).

Ghana was set to graduate completely from new Gavi assistance in 2018 owing to its income status, although that has now been reversed because its three-year average gross national income (GNI) has dipped back below Gavi's threshold (see Box 4).

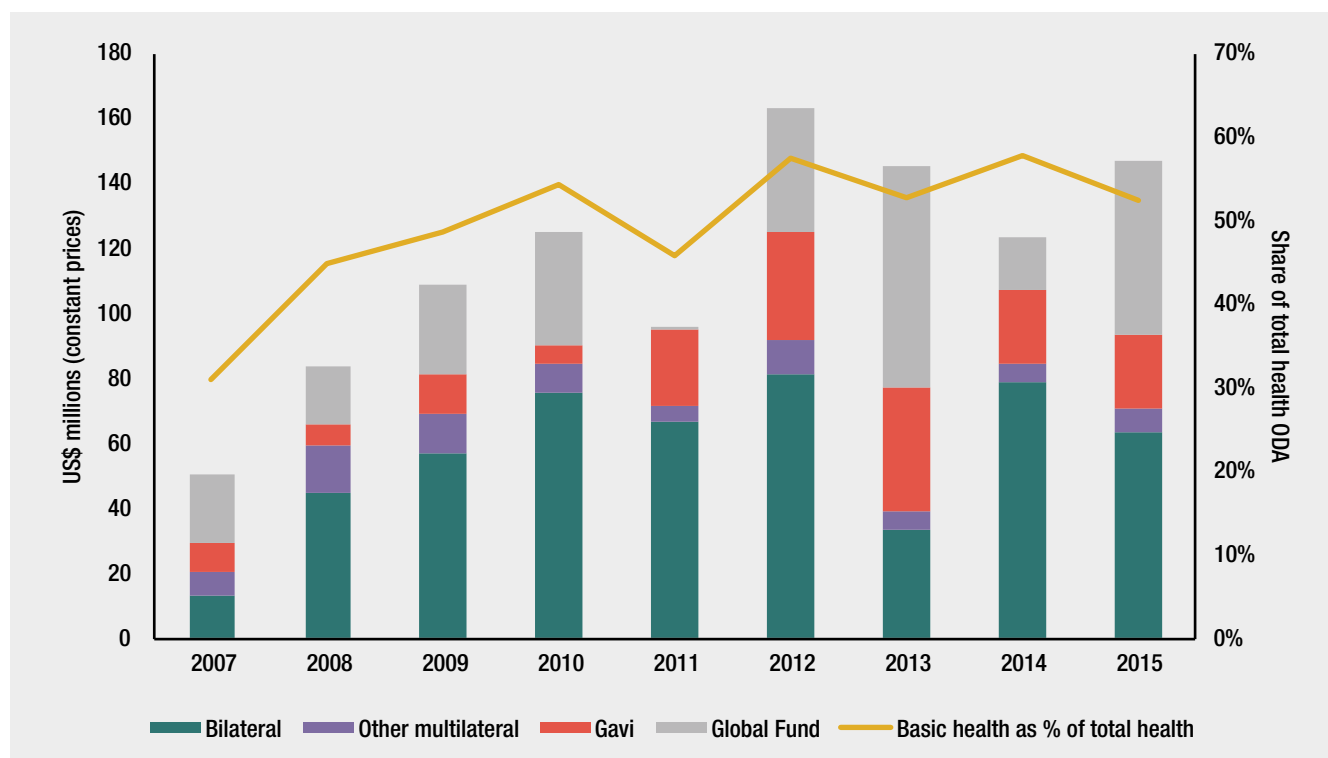
In any case, it is clear that Ghana's relationship with development partners, including the types, terms and conditions of assistance, is in transition, and donors do not seem likely to increase their funding. Rather, a process of reduction looks very likely over the coming years (and, given the data lag for 2016 and 2017, is possibly underway already). If government resources do not compensate, it could severely jeopardise the continuation of effective service delivery that can reach those left behind through policies such as the CHPS expansion.

While district health services are seeing a diminishing share of the government's health budget, tertiary and specialist services are absorbing the lion's share of what little capital investment there is (MoF, 2015). As argued by some commentators, capital investment should be rebalanced towards primary care facilities, such as health centres and CHPS compounds, which tend to deliver much more

⁷⁶ See <http://projects.worldbank.org/P145792/?lang=en&tab=overview>

⁷⁷ The Creditor Reporting System (CRS) of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), available at <http://stats.oecd.org/Index.aspx?DataSetCode=CRS1>

Figure 52: ODA to basic health in Ghana



Note: Bilateral includes DAC member countries. Multilateral includes all multilateral organisations that have reported their ODA disbursements to the DAC. Basic health is defined in the CRS reporting under code 122.1.2.b as basic health care (primary care, and associated drugs and nursing); basic health infrastructure; basic nutrition; infectious disease control; health education; malaria control; tuberculosis control; and training for basic health care staff. Total health ODA denominator combines codes 120: Health Total and 130: Population Policies/Programmes and Reproductive Health.
Source: OECD DAC CRS

cost-effective services, but do not receive sufficient resources for capital investment (World Bank, 2017a). The vast majority of health infrastructure is financed through loans and credits (MoH, 2016). In 2015, there were 374 million Cedis (around \$90 million) of financial credits (donor loans) recorded on the health budget. It appears that the trend towards loans rather than grant financing in health is helping to precipitate a shift in focus towards tertiary and specialist facilities, since these hold the potential to generate revenues that can be used to help pay back the loans (for example through health tourism). According to one official, the government sees revenue potential in developing Ghana as a regional hub for health tourism, and it must now focus beyond primary services:

It should not be business as usual – Ghana is growing; aid is shrinking; we can’t wait for grants. We need certain equipment and infrastructure ... We cannot only look at primary health care, so that we need to fly people out to other countries for anything more advanced. (CG4)

Yet a heavy reliance on external borrowing for health infrastructure brings its own challenges, given the serious

public debt burden currently faced by the government and the fact that Ghana’s rising income status has triggered a shift to less concessional finance (see Chapter 2).

At a sub-national level, health budgets are allocated to regions and districts largely on an incremental basis. The MoH does not implement any redistributive mechanism such as an allocation formula, and the variation in per capita budgets does not seem to be explained particularly well by poverty or need.

Spending on primary health services – the allocation of which is determined by the MoH centrally – is largely done on an incremental basis. The MoH does not implement an allocation formula or other such tool to skew spending to be pro-poor, needs-based or performance-based. This means that the budget is not well placed to address entrenched supply- or demand-side disparities in health service access, such as additional programmes or incentives needed in areas with historically worse health access, or the typically more expensive cost of providing services to remote, low population-density areas.⁷⁸ The two regions selected for our case studies – Brong Ahafo and Northern – both have similar and below-average per capita budgets. It is interesting to note that Upper East and Upper West

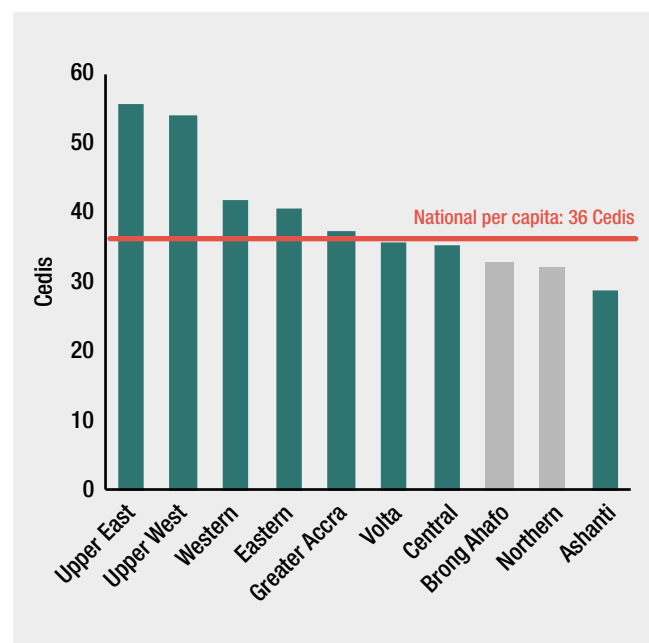
⁷⁸ For example, no correlation was found between budget per capita and population density across regions, though it might be expected that low-density areas would be more expensive to serve to provide similar levels of services per person. As an illustration, the Northern and Upper West regions have very similar population densities (35 and 38, respectively), but widely diverging per capita budgets (\$32 and \$54, respectively).

both receive high per capita health budgets; by contrast, Northern (the third region making up the historically marginalised north of the country, with the second highest rate of poverty and the country's lowest CCI score) receives less than two-thirds of the financing per person budgeted for Upper East and Upper West.⁷⁹ One factor is the very unequal distribution of health workers. Given that the majority of the health budget funds salaries, budgets are skewed towards those areas with higher densities of health workers. Indeed, as seen in Box 3, the Upper East region has used several initiatives to successfully recruit and retain health workers.⁸⁰

Within regions, district health budgets vary widely on a per capita basis – again, there is no correlation with rates of poverty.⁸¹

A selection of districts for Northern region is shown in Figure 58. Zabzugu, our case study district, has a below-average health budget and number of public facilities per capita compared to the regional average. As well as a large variation between districts, there does not appear to be any consistent relationship between budget and the number of health facilities per capita. This may owe in part the differing types and sizes of facilities. For example,

Figure 53: Health budget per capita by region, 2015



Source: MoH Budget; GSS (2010)

Box 4: Ghana and the vertical health funds

The two main vertical funds – the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, the global alliance for vaccines and immunisation – have grown more dominant in Ghana's health donor landscape. The GoG has been responsible for incrementally increasing co-payments towards these programmes owing to the rise in its GNI per capita. This is visible in the allocation of resources within the government's health budget, with less going directly into the district health system that provides the vast majority of basic health care through health centres and CHPS compounds. Instead, since 2011, a growing share of the budget has been allocated to the central HQ level for these vertical programmes, which are under the control of the MoH, growing from 54 million Cedis to 202 million Cedis (MoF, 2015). These programmes fund health interventions (largely preventive), many of which do take place at the district level and directly benefit vulnerable and marginalised groups, such as immunisation programmes rolled out through district health facilities and CHPS compounds. Nevertheless, they are designed and earmarked centrally for specific purposes rather than used at the discretion of the local facilities.

Taking the example of Gavi, in 2017, Ghana was in the 'accelerated transition' phase of the programme,

having crossed the GNI per capita threshold of \$1,580 on average over three years, which forms the basis of Gavi's transition policy (Gavi, 2015). This means that it would become fully self-financing within five years. The share of co-financing obligations borne by the government has steadily increased from 13% in 2012 to 24% in 2015. However, the government defaulted on its Gavi obligations for the first time in 2016 (it paid these arrears in 2017).

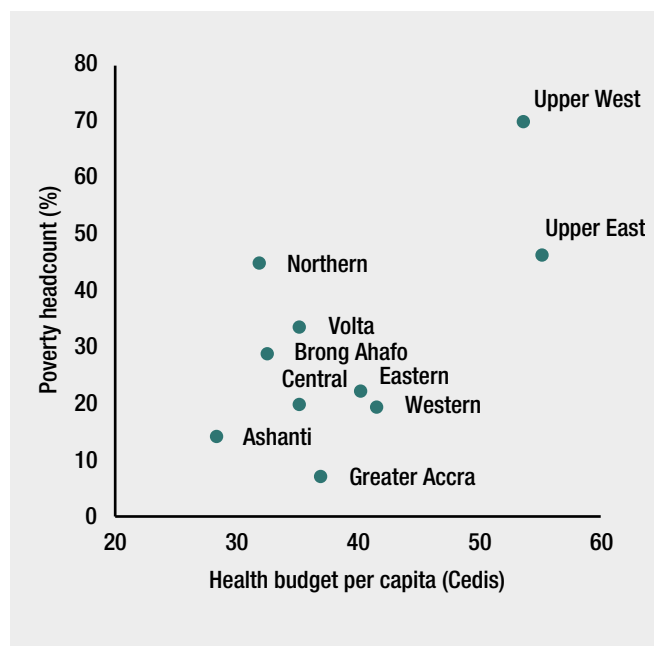
However, according to its 2017 GNI, Ghana has now dropped back below Gavi's threshold and will reverse out of the accelerated transition phase back to 'preparatory transition' and hence become eligible again for funding. This example points to larger issues – principally, how to ensure consistency and predictability for countries near the income threshold or facing severe fiscal challenges in planning their spending in the social sectors, and how to safeguard progress already made in reaching people previously left out of access to health services, as in Ghana. There is a real risk that, as development partners disengage or harden the terms of their engagement, precious gains made during the MDG era could be reversed, and fulfilling the promise to leave no one behind may grow more difficult.

79 Owing to data unavailability, it is not possible to examine trends over time for regional and district-level health budgets.

80 It is not possible to break down salaries and other categories of expenditure in regional budgets since these data in Ghana's budget documents are not disaggregated by economic classification.

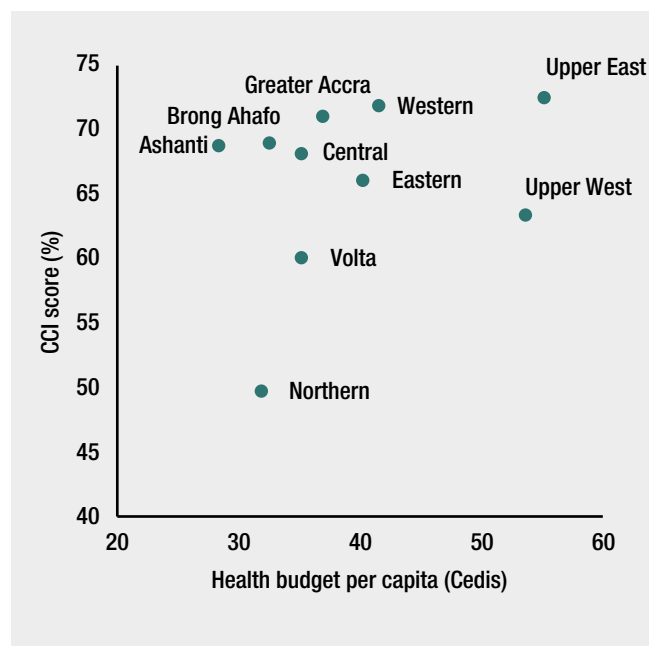
81 It should be noted that poverty rates at district level are not based on a nationally representative sample.

Figure 54: Health budget per capita vs poverty rate by region, 2015



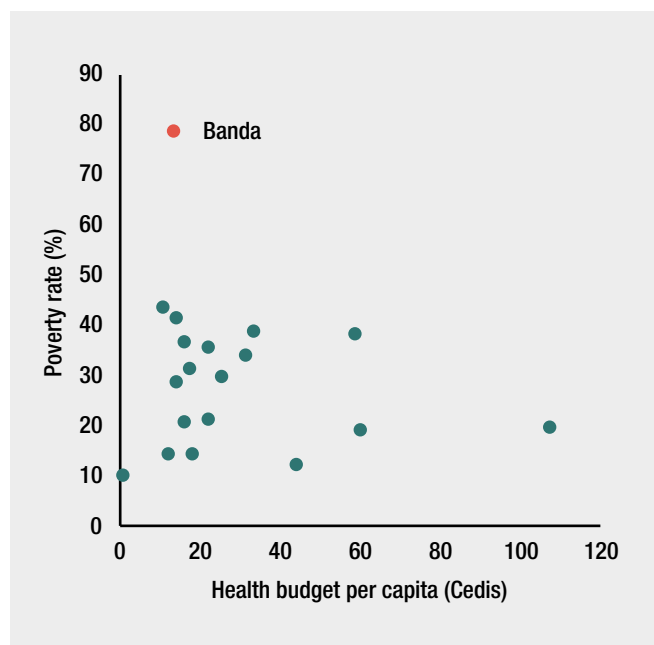
Source: MoH Budget; GSS (2014b)

Figure 55: Health budget per capita vs CCI by region, 2015



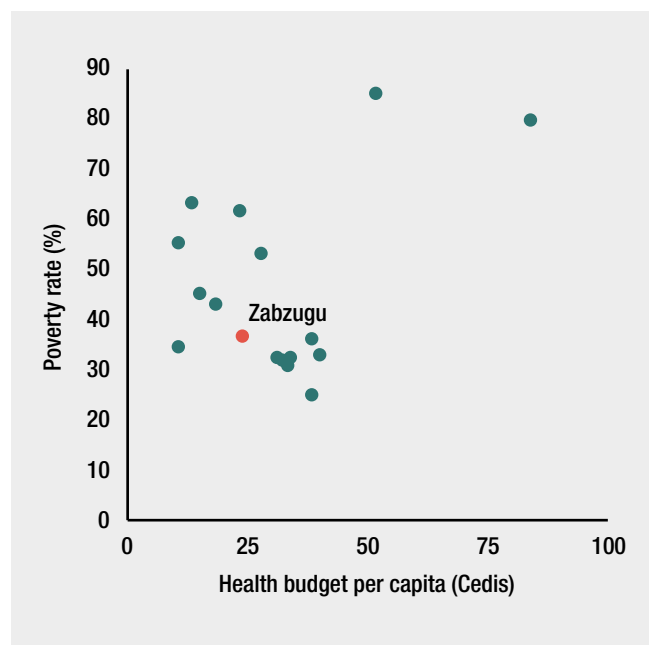
Source: MoH Budget; CCI score created from data from GDHS 2014 and DHIMS

Figure 56: Health budget per capita vs poverty by district, Brong Ahafo region, 2015



Note: Some districts are excluded owing to data unavailability.
Source: MoF (2015); GSS (2015, 2010); Banda DA(2015)

Figure 57: Health budget per capita vs poverty by district, Northern region, 2015



Note: Some districts are excluded owing to data unavailability.
Source: MoH Budget; GSS (2015)

Tamale (the regional capital) has a below-average number of facilities per capita, but the highest concentration of more expensive services (such as hospitals and doctors, as opposed to CHPS and CHWs), thus likely explaining its above-average per capita budget.

In terms of donor funding, many of the major health programmes are explicitly targeted towards marginalised communities, such as the rural areas that are the focus of the CHPS programme, or specific vulnerable groups such as women, children and adolescents. However, it is difficult to estimate how overall health aid is allocated geographically across the country – and how well this aligns with the challenge of leaving no one behind, both between and within regions and districts – because this data are not captured in any systematic way. Ghana has only recently instituted an Aid Information Management System; this system is for internal government use only and it does not intend to make the data public (CG4). The only other source of geo-coded information is the International Aid Transparency Initiative (IATI) data repository. However, many major donors are still not fully reporting to IATI, and most are not using the optional geo-coding function. Currently, just 29% of data on aid to Ghana’s basic health sector for the period 2006-16 has been geo-coded. This shows a clear concentration of

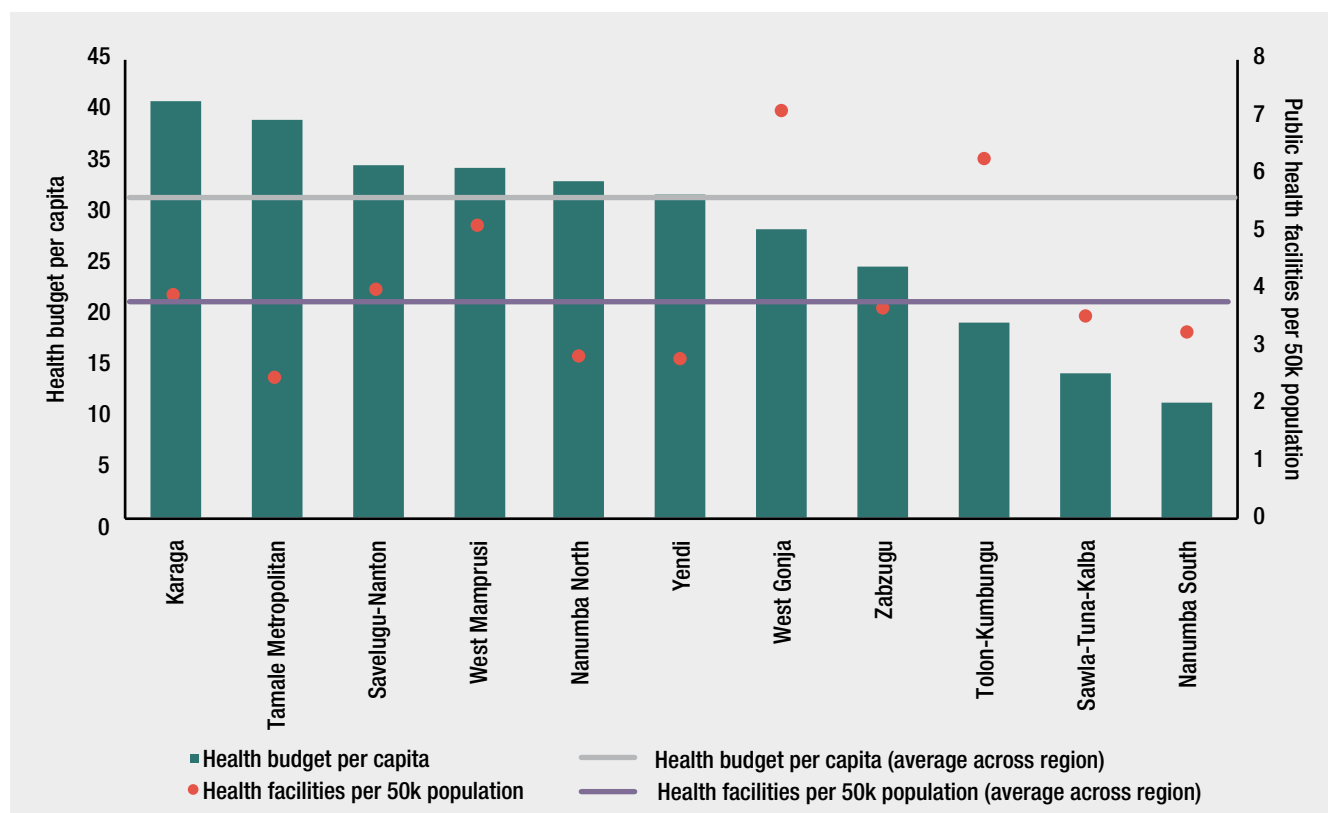
resources in Accra (but this may also be a categorisation/reporting issue).⁸²

The health sector’s large and chronically over-spent budget for wages leaves little room for any other recurrent funding, exacerbating inequality between districts and facilities, which must rely on other income streams. This overspend on wages forces districts and local health facilities to become heavily reliant on IGFs and donor resources to cover their basic operating costs. This introduces unpredictability into the system, and, more importantly for our focus, exacerbates inequality between districts and facilities – disadvantaging those with less access to other resources.

As shown in Figure 59, employee compensation in the health sector goes well over budget each year. Spending on assets, goods and services is then reduced to only small fractions of the budgeted amount.

Health facilities are heavily dependent on NHIS reimbursements and user fees to cover their costs, while DAs are increasingly being asked to mobilise more local revenue to plug the gaps. An undue reliance on these IGFs is a regressive form of financing, since it is typically poorer districts such as Banda and Zabzugu that are least able to mobilise funding. Such districts have low levels of

Figure 58: Health budget and provision of facilities among selected districts in Northern region

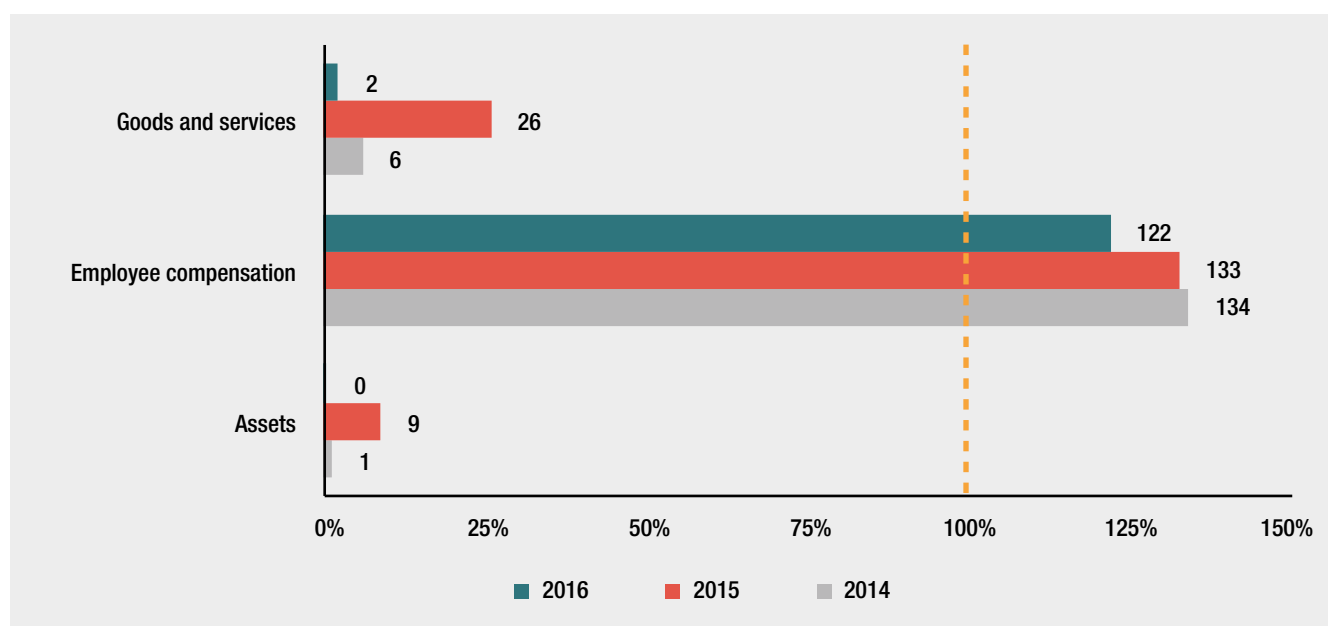


Note: Horizontal lines represent average across region (unweighted). Districts excluded from the analysis have extremely low populations, not part of the aggregate national Census in 2010, or do not have available information on facilities.

Source: MoH Budget; Ghana Open Data Initiative, data sourced from MoH (2016)

82 IATI d-portal: <http://www.d-portal.org/ctrack.html#view=search>

Figure 59: Percentage of MoH budget actually spent, by economic classification



Source: Report of the Auditor General of the Public Accounts of Ghana (various years)

local economic activity, fewer insured residents and fewer patients able to pay for services and drugs out of pocket. While donor resources may well be targeted in a pro-poor way, they are inevitably patchy in their distribution and cannot make up the shortfall nationwide, particularly in the context of Ghana's ongoing aid transition and donor withdrawal. The restricted nature of central discretionary resources, and the increased reliance on these other sources to cover running costs, is therefore likely to exacerbate – rather than reduce – inequalities between districts. Furthermore, it has regressive effects at household level. In Banda, women delivering their babies in health facilities told us that they are expected to bring basic supplies such as disinfectant with them (FGDBWHA).

The final major set of issues in financing Ghana's health system is the raft of challenges concerning the NHIS, which are disproportionately affecting the poorest and most vulnerable. While these extend far beyond the specific focus of this study and have been well covered in other literature, the current crisis facing the NHIS not only overwhelms debate about health policy in Ghana, but also disproportionately affects the poorest and most vulnerable people who rely on functioning, free, public health care and, in many cases, NHIS exemptions.

The National Health Insurance Fund (NHIF)⁸³ constitutes 3% of Ghana's total government spending (World Bank, 2017b). As outlined in Chapter 4, the NHIS was established as the key tool to bring the country towards UHC, with

certain categories of vulnerable people exempted from paying premiums so as to subsidise their health care demand. These exempted groups now account for two-thirds of enrolments.⁸⁴ However, only 38% of the total population is enrolled, and many of these people are not actually receiving the benefits they should (Atim and Amporfu, 2016).

Two recent reviews of the NHIS – one by the World Bank focused on efficiency and financial sustainability, and another commissioned by the government to look at the whole NHIS system – have concluded that there are multiple sources of inefficiency (World Bank, 2017b; Atim and Amporfu, 2016). One important finding of these reviews is that, while the NHIS offers an (overly) broad and generous package of services, it excludes many cost-effective preventive services and does not adequately focus on quality of care, thus the NHIS is 'essentially paying for the consequences of under-performance of public health programmes' (Atim and Amporfu, 2016). There is a real risk that a well-meaning and progressive policy is producing regressive effects owing to problems in its financing and implementation.

The financial sustainability of the NHIS has long been an issue, which in recent years has worsened to the point of crisis. Growth in expenditures has outpaced growth in income, most of which is constrained by its link to VAT through the National Health Insurance Levy (NHIL). This growth in expenditures has been owed to an expanding pool of exempt members – the driving factor from 2008

⁸³ The NHIS is financed from the central NHIF, which is sourced from the National Health Insurance Levy (NHIL) of 2.5% tax on selected goods and services; 2.5% of SSNIT contributions, largely by formal sector workers; payment of premiums; and donor funds.

⁸⁴ Exemptions include SSNIT contributors, children (under 18) and older people (over 70), 'indigent' (extremely poor) people, those living in institutions and some beneficiaries of social protection programmes such as LEAP.

Box 5: Financing human resources in the health sector

In recent years, 90% of the MoH's discretionary budget has been absorbed by salaries. As a proportion of the overall health budget, salaries constitute around 54%. While this is not a particularly high proportion in a human resource-intensive sector, it creates a high degree of budgetary rigidity, given that the vast majority of the rest of the budget cannot be allocated at the MoH's discretion. Moreover, health workers are unevenly distributed across the country and not given adequate incentives to take up postings in remote and deprived communities (see Chapter 4). These two facts combined mean that the majority of financial and human resources are skewed towards more prosperous and urban areas, and not towards those left behind.

What lies beneath these financing patterns?

First, Ghana has a relatively good quantity of trained health workers nationally, although they are not equitably distributed around the country. The government made a determined effort to stem the 'brain drain' of doctors and nurses to other countries by increasing training placements and salaries. Brain drain still occurs, but has eased off in recent years (MoH, 2011; Darko, 2015). Between 2011 and 2012 alone, public employment in the health sector expanded by 25%. The MoH has stated that there is now an 'over-subscription' to recruitment in the public health system (citifmonline, 2016). As of 2016, there are 104,652 health workers registered on the MoH's payroll, of which 85% are medical professionals (the majority of whom are nurses) – yielding an overall national ratio of roughly 3 health workers per 1,000 people; in the majority of regions across Ghana, the ratio is between 2.5 and 2.9 (World Bank, 2017a). These ratios are still some way short of WHO's recommended benchmark of health worker density required to meet the SDGs (4.45 per 1,000), but they are good compared with many countries in the region (WHO, 2016b).*

Until recently, the MoH has effectively guaranteed jobs for 'bonded' nurses who had received training in publicly funded institutes, meaning that they were being automatically absorbed into the public health care system and onto the MoH payroll. Under the restrictions of the IMF ECF package, the government was compelled to institute a freeze on net public sector recruitment (CG12). In 2016, it was announced that the practice of bonding would be ended, although the MoH argued that all nurses would still be employed because the government had greatly expanded the stock of health facilities via CHPS compounds and new district hospitals, and it would be expected that nurses would take up postings in these new facilities across the country (citifmonline, 2016).

Second, while there is no comprehensive, cross-country dataset on health worker pay, it would appear that health

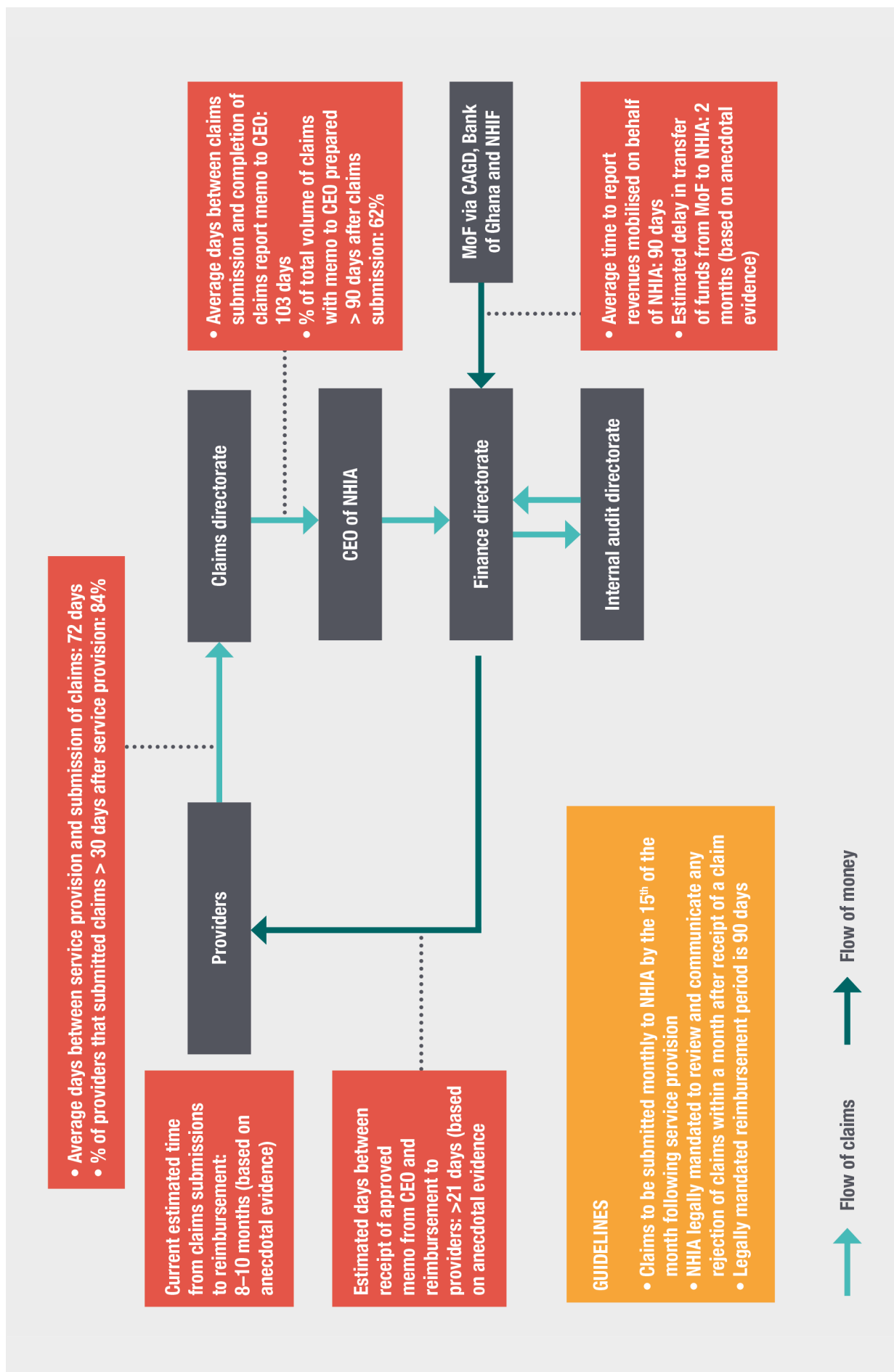
workers in Ghana are relatively well paid compared to those in similar countries in the region (WHO GWAH Task Force, n.d.). McCoy et al. (2008) found that midwives and nurses in Ghana earn 12.4 times and 10.9 times the GNI per capita, respectively, whereas in Nigeria the equivalent ratios are 11.1 and 9.8 times, respectively, and in Zambia, 9.6 times. The GoG sharply increased health worker pay in 2006 as part of its bid to stem the medical brain drain. The Single Spine Salary Structure subsequently resulted in significant further pay increases across the whole public sector, including the health system. This policy was introduced in 2010, but initially was not fully funded – leading to another large hike in the wage bill from 2012 onwards, as salary arrears began to be cleared.

A third compounding issue is the significant inefficiency with which human resources are managed. Health workers are very unevenly distributed and there is no policy provision for financial or other incentives for health workers taking up postings in rural or poor communities. Around a decade ago, Ghana did briefly introduce a Deprived Area Incentive Scheme, which offered an additional allowance of 20% to 35% of basic salary, but this was discontinued. According to Lievens et al. (2011), the scheme was criticised because it was paid irregularly, and not consistently applied to relevant health workers. Furthermore, because the 'deprived' areas were not well defined, many health workers regarded the scheme as a political tool (Ibid.). There have also been a Health Staff Vehicle Hire Purchase Scheme and various housing schemes, but none has proved particularly successful (ACCA, 2013).

At the same time, recruitment and payroll are managed centrally. This greatly limits the discretion of regional and district authorities and facilities themselves to be flexible and responsive to local needs. For example, in Northern region, casual staff had been brought in to help plug gaps, but they have not been given payroll clearance, and therefore the regional directorate had to find a way to pay them (LG18). District authorities are meant to verify actual numbers and locations of staff on the ground, and report these up through the chain to regional and ultimately central authorities, but this process is slow and inefficient. It also makes it more difficult to detect and sanction absent or under-performing staff, as the facilities and local government do not themselves have the authority to do so. These two issues combined – the lack of policies and financial incentives to motivate staff to work in deprived areas, and the inability to adequately monitor and sanction absenteeism – lead to chronic inefficiency in the deployment of resources, which disproportionately affects poor and marginalised communities.

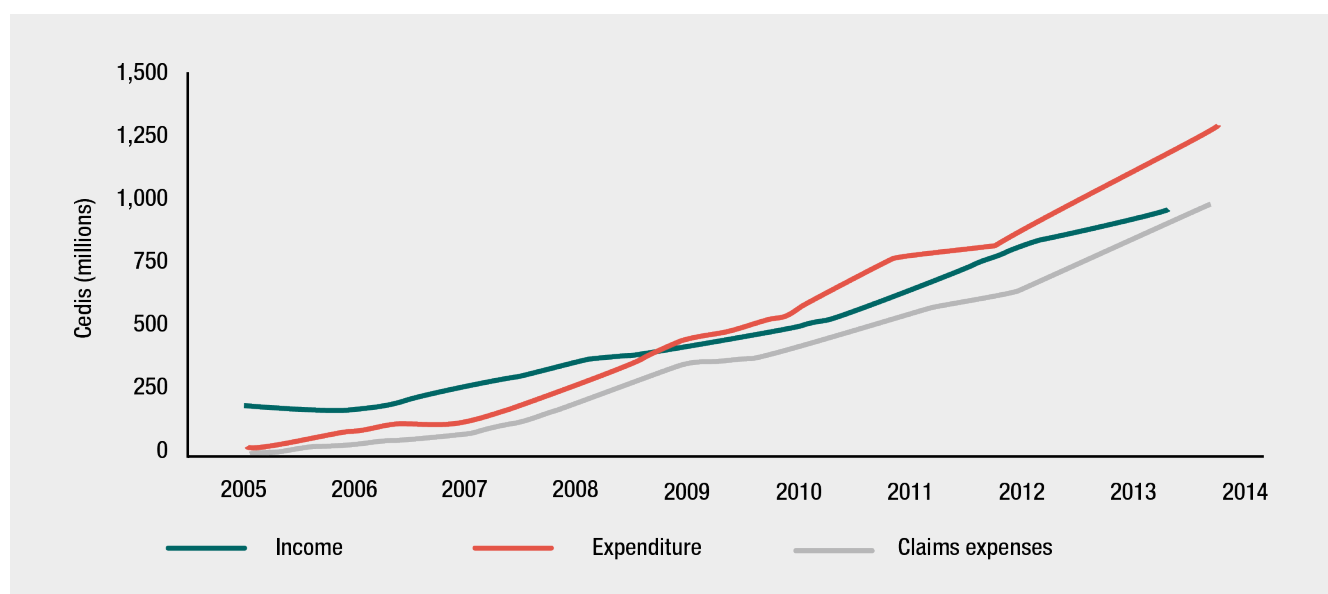
*The average health worker ratio across the Africa region is 2 workers per 1,000 people.

Figure 60: Delays in NHIS claims submission, processing and reimbursement system



Note: CAGD - The Controller and Accountant General's Department, Ghana.
Source: Atim and Amporfu (2016)

Figure 61: NHIS income and expenditures, 2005-14



Note: Claims expenses refer to the cost of reimbursements for health facilities. Total expenses include other operational and running costs of the NHIA.
Source: World Bank (2017b) (based on NHIS financial statements)

to 2011 – combined with increasing utilisation rates and rising unit costs – the primary factor since 2011 (World Bank, 2017b). Consequently, the NHIS has run a deficit each year since 2009, and has been financing this by drawing down its investment fund to finance its deficit, and more recently contracting loans with interest payments reaching almost 40 million Cedis (c. \$9 million) in 2013 (Ibid.).

As discussed above, facilities are receiving virtually no funding for operational costs from the MoH budget. The government has directed district health facilities to use IGFs collected from NHIS reimbursement to fund their operating costs, and payment of NHIS claims now finance around 80% of health facilities’ operational expenses, with the other 20% coming largely from OOP payments (World Bank, 2017b). However, this funding stream is hampered by extreme delays and deficiencies in the process (see Figure 60). The lack of timely reimbursements is the main factor behind the financial strain that facilities are facing and the rise in ‘informal charging’ and OOP payments, which disproportionately affect the poorest people.

Key informant interviews substantiated several of the bottlenecks highlighted in Figure 60. In one district, an interviewee noted ‘the last time we received payment [from the NHIS] was March 2016’ (LG15), i.e. a 16-month lag. This was in part because of errors on the claims form by the service provider, but also because of to scarcity of resources within the fund itself. Zabzugu has an NHIS enrolment rate of just 31%, which is below the national figure of 38%, and may be at least partly explained by these acute problems experienced by service providers in the provision of drugs and widespread use of OOP payments (LG15).

5.2. Financing of education

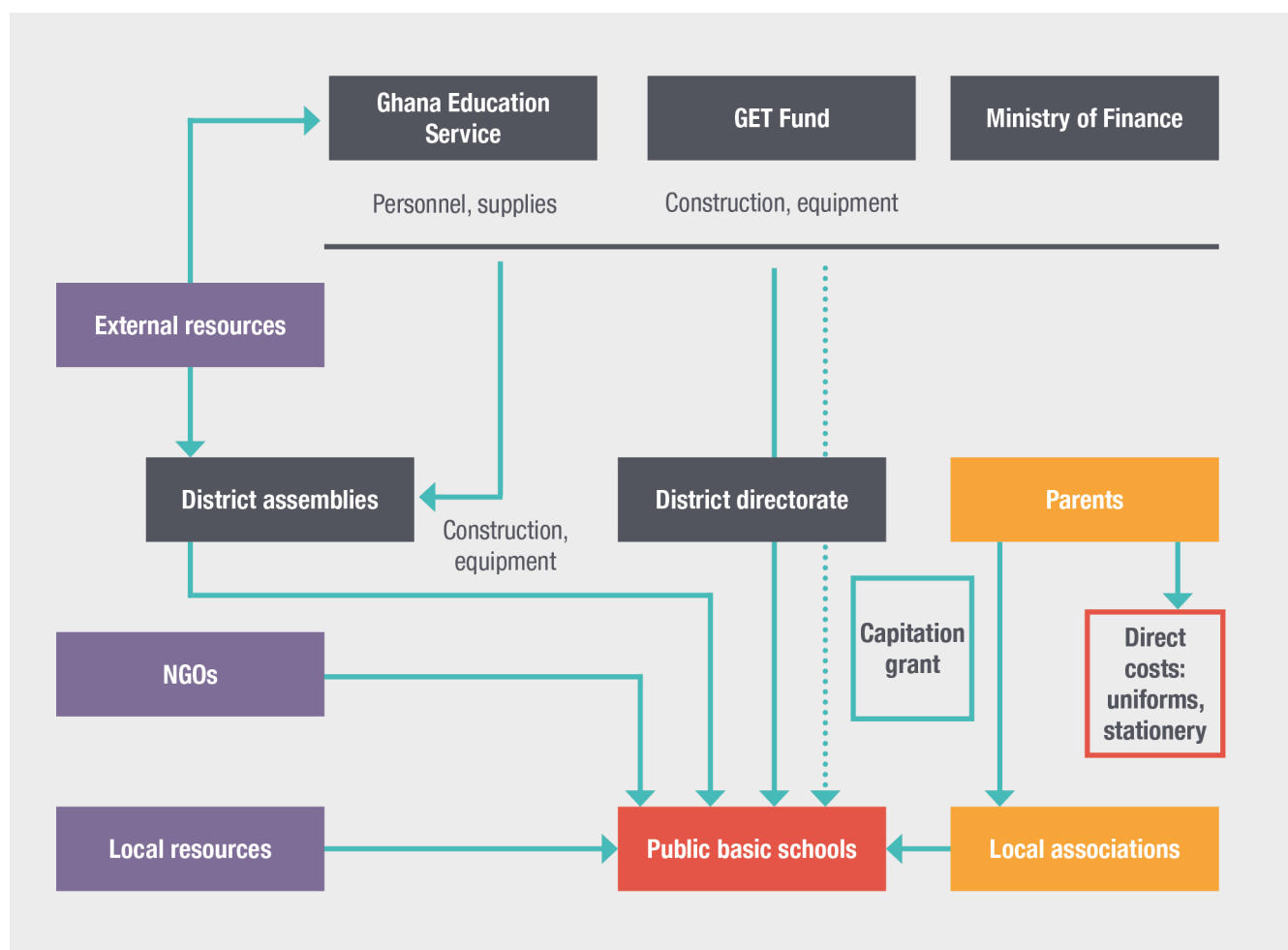
Figure 62 depicts the flow of funds in the education sector. The main sources of and arrangements for financing the public education system are described in Table 11.

In our analysis, we take as our definition of being ‘left behind’ those children who do not receive an adequate (or any) level of primary education, despite the country’s stated aim to provide free universal primary education. Without this basis those children are unable to move through future years of education, and miss out on crucial cognitive development and a huge range of life opportunities. Evidence has repeatedly demonstrated the importance of prioritising early years and primary education for advancing equity (Rose and Alcott, 2015). The analysis in this chapter, while recognising the importance of universal secondary education and its place in the SDGs, therefore largely concentrates on the financing of the primary education system in Ghana.

While Ghana continues to maintain impressive overall public education expenditure, it is increasingly shifting this towards the secondary and tertiary sectors, with primary education – the fundamental basis for equity across the system – starting to experience a decline in per capita funding in recent years.

In contrast to health, Ghana devotes a high share of public expenditure to education (Figure 63). It is one of the relatively few countries to exceed the Dakar Education for All commitments to allocate 4% to 6% of GDP and 15% to 20% of the national budget to the sector, and spends substantially more than the average among LMICs, which was 15.6% in 2014 (UNESCO, 2016).

Figure 62: Flow of funds in Ghana's public basic education system



Source: World Bank (2017a)

However, in the context of the fiscal consolidation effort described above, the government's education expenditure has declined since 2012, relative to both GDP and the total budget.

Moreover, the share of the government's education expenditure devoted to primary education has shrunk significantly, from 34.6% in 2011 to just 14.6% in 2015 (MoE, 2016, 2015). In fact, the government's figures show that funding in per capita terms for pupils at primary level has levelled off and indeed slightly declined in 2015 to 392 Cedis (roughly \$90) per pupil annually. UNESCO analysis has suggested that LMICs should be incrementally aiming towards a benchmark of \$510 per pupil by 2030 in order to provide good quality universal primary education (UNESCO, 2015).⁸⁵ While this is obviously not a realistic target for the medium term, the very fact that Ghana is

far short of this benchmark makes it difficult to justify movement in the opposite direction.

These pre-secondary funding trends are in stark contrast to the secondary budget, which has grown rapidly even in per capita terms. In 2015, senior high school pupils were being funded at nearly six times the level of primary school pupils (the average ratio across OECD countries is roughly 1.4 times). Junior high school is included in the government's ambitious free basic education package, unlike in most comparable countries, which would cover only up to grade Primary-6 (age 11-12).⁸⁶

The government's much-debated policy to further expand the free education package to include senior high school from academic year 2017-18 will be extremely costly. One analysis by the Ghanaian think-tank IMANI estimated that around 2.7 billion Cedis (c. \$600 million)

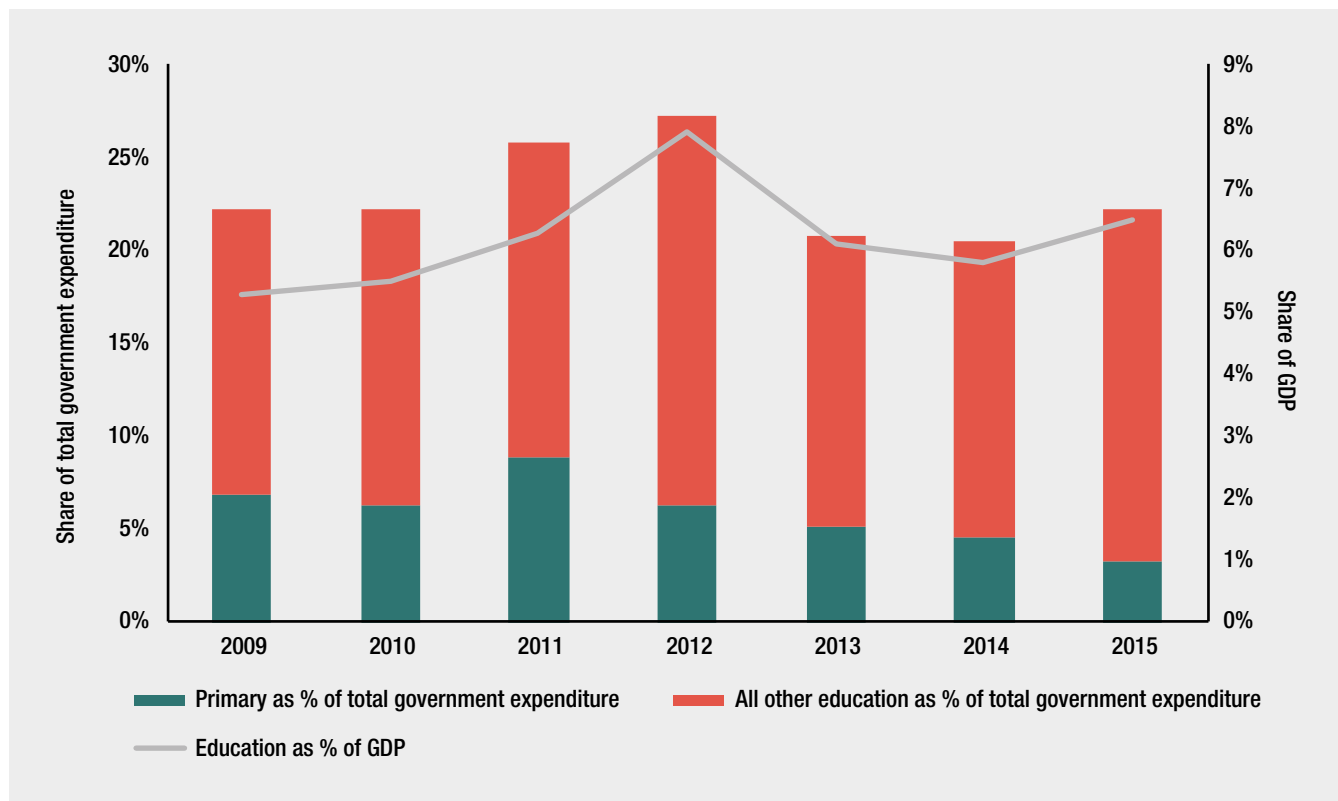
⁸⁵ The figure of \$510 (2012 prices) is based on UNESCO's projection taking into account the need to increase enrolment to universal levels, and to uplift expenditure per pupil to improve quality (e.g. pupil-teacher ratios) and equity to acceptable levels.

⁸⁶ Government funding for tertiary and technical and vocational education (not shown on the chart in order to preserve scale) has also increased significantly – respectively to 7,439 Cedis and 5,707 Cedis per student.

Table 11: Institutional arrangements and spending criteria of key education funds

Funding source	Institutional arrangements	Spending criteria
GoG discretionary	<p>The MoF establishes the overall budget and defines remuneration for teachers and other employees.</p> <p>The MoE is responsible for proposing the annual budget through the budget hearing process. Non-earmarked funds can be used at its discretion.</p> <p>The GES manages recurrent expenditures and determines the appropriate number of primary and secondary school teachers.</p> <p>The National Council on Tertiary Education is responsible for formulating the tertiary education budget.</p>	There are no criteria as such, but the first call is salaries, which account for 98%.
ABFA	Receipts from oil revenues, earmarked for specific spending priorities derived by Fund board and approved by Parliament.	Finances education infrastructure, including the construction of primary and secondary schools and the upgrading of scientific resource centres.
GET Fund	Decided by the GET Fund Secretariat.	Predominantly used for capital spending.
IGF	Currently charged from SHS levels and above (this will change since SHS is brought under the free basic education package from academic year 2017-18).	Not applicable – generally used to fill gaps where other funding sources prove inadequate.
DACF	A block transfer of no less than 5% of total revenue, transferred directly to districts. Allocation and release decisions made by the DACF Secretariat (independent body) and approved by Parliament.	<p>2% to sustain the district education fund, to help needy students with scholarships, bursaries or repayment of loans with good academic record.</p> <p>70% to be used for economic ventures, social services and the environment.</p>
Donor projects and NGOs transferring funds to districts directly or through the ministry	<p>Donors are increasingly reverting to earmarking for specific programmes and projects, and have a growing focus on supporting marginal groups.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • DFID's G-PASS, which specifically targets disadvantaged girls among the 75 designated 'deprived' districts with scholarship packages via the GES and an international NGO, Camfed. • The World Bank-funded Secondary Education Improvement Programme, which aims at improving equity relating to geography, gender and poverty, and is targeted towards the 75 deprived districts. 	Depends on the project, but general trend has been for support to most deprived districts and other marginalised groups (such as girls).
Parent teacher associations (PTAs) and school management committees (SMCs)	Parents and community members may sometimes chip in small amounts for basic costs such as the printing of exam papers, when other funding streams are insufficient.	Discretionary and needs-based for relatively minor expenses.

Figure 63: Ghana's government education spending



Note: Horizontal purple line indicates upper recommended EFA benchmarks of 6% of GDP and 20% of total budget.

Source: Data from MoE (2016, 2015 and 2013)

will be required annually to fund the policy, equivalent to almost a third of the government's entire expenditure on education in 2015 and more than twice its primary education spending.⁸⁷ *Business and Financial Times* (2017) put the annual cost of free senior high school even higher, at 3.6 billion Cedis (c. \$810 million). Despite the roll-out of the policy, it remains unclear how it will be financed, and whether this will necessitate a redirection of resources away from basic education. IGFs (school fees) have been the second biggest funding source to senior high schools and have grown four-fold since 2011 (MoE, 2016, 2015 and 2013). Without being able to generate their own funds through school fees, secondary schools will need to rely heavily on government funding.

A benefit incidence analysis of current education expenditure in Ghana indicates that it is pro-rich at all levels of provision, and particularly so at the higher levels. Ilie and Rose (2017) find that the richest decile benefit from 20% more resources than the poorest decile at the

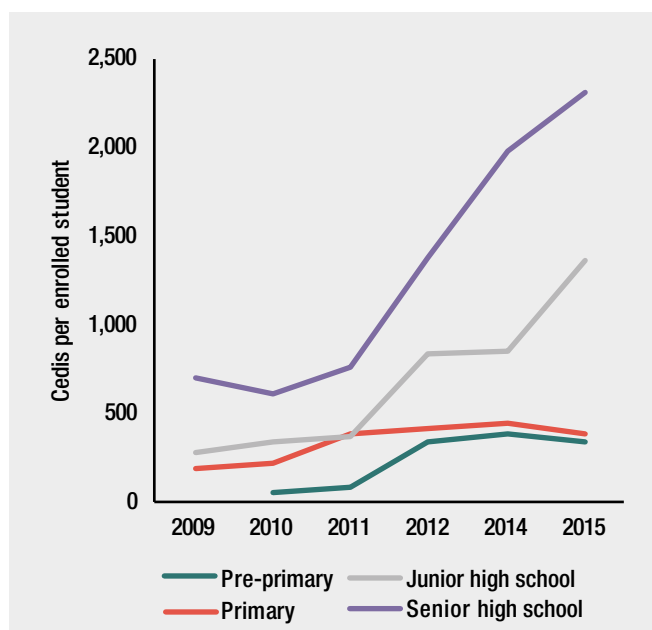
primary level, widening to almost five times more at the secondary level, and 135 times more in higher education. There remain pockets of marginalised children who do not even participate consistently in or complete primary education, and there are grave quality issues across the public primary sector that tend to be more acute in poorer and more marginalised communities. Given this, the marked under-funding of the public primary system is at odds with the MoE's policy to enhance the distributional equity and systemic quality of education provision – and is worrying if Ghana is truly aiming to leave no child behind.

As shown in Figure 65, development partners are also pivoting to secondary education, in line with the government's own policy preferences, reinforcing rather than compensating for these trends. With one notable exception (the GPE – see Box 6),⁸⁸ multilateral partners are not funding primary education. As of 2015, there are only three DAC-reporting bilateral partners of any financial significance remaining: the US (\$36 million), the UK

⁸⁷ Pulse (2017)

⁸⁸ Note that the GPE – a significant provider of primary-level grants to Ghana over the past few years – does not yet report as a multilateral organisation to the OECD DAC database. GPE flows are currently included in the CRS as 'bilateral' (i.e. earmarked/non-core multilateral) flows. However, this is disaggregated by regions only (America, Asia, sub-Saharan Africa, etc.) and not country recipients. Thus, GPE funding to Ghana is not represented in the dataset we have used here, but rather in the overall regional data for sub-Saharan Africa, from which individual country recipients cannot be distinguished. GPE is in the process of preparing its systems for future reporting to IATI and the CRS, which should improve the accuracy and specificity of the data.

Figure 64: Government education spending per enrolled student by level



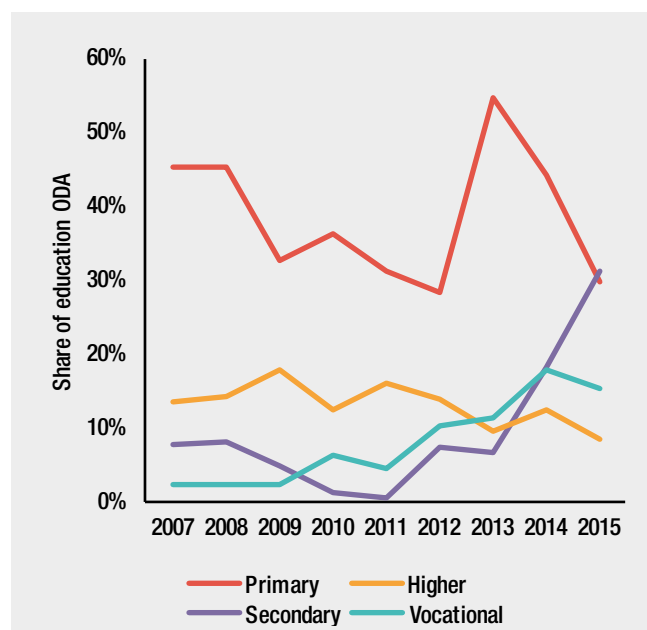
Note: Data for 2013 not available. In academic year 2017-18, the government's free education policy expanded to include SHS.
Source: MoE (2016, 2015 and 2013)

(\$8 million) and Japan (\$1.2 million).⁸⁹ The share of education ODA allocated to primary level fell from 55% in 2013 to 30% in 2015, overtaken by secondary for the first time. Official ODA data beyond 2015 were not yet available at the time of writing, but, according to the government's budget documents, there was zero on-budget donor funding planned for primary education in 2016 and 2017.

In terms of the leave no one behind commitment beyond the primary level, it is the case that donors are strongly focused on equity and inclusion in the programmes they are supporting at the secondary level and above. One key example is the World Bank's Secondary Education Improvement Project, which operates only in deprived and under-served districts to build new schools and improve quality in the 125 schools with the lowest test scores.⁹⁰ DFID's G-PASS project (2012-18) is providing secondary school scholarships to 81,000 girls via the Ministry of Education and the NGO Camfed in order to improve gender parity.⁹¹

The modalities of donor financing are also changing, in line with the trend of Ghana's changing income and aid

Figure 65: Education ODA in Ghana by sub-sector



Note: Total does not equal 100% since other sub-sectors are not shown here, including education policy and administrative management, basic life skills training for youths and adults and advanced technical and managerial training, as well as flows with no sub-sector specified. These figures do not include the GPE, since its funding is currently only counted in the OECD's official aid statistics under regionally aggregated figures, not broken down by individual country.

Source: OECD DAC CRS

status. The share of education ODA in the form of grants dropped from 90% in 2013 to 54% in 2015, with the large majority of non-grant financing in the form of World Bank International Development Association (IDA) credits.⁹²

The second key issue identified is an inequitable geographical pattern of public primary education financing, whereby per pupil allocations to regions and districts vary widely. These variations do not appear to be well correlated with poverty, access or performance indicators.

In terms of how the government's primary education funding is distributed between regions, this varies widely from 187 Cedis (c. \$42) per primary-age pupil in Upper West to 320 Cedis (c. \$73)⁹³ in Central region. However, such variations do not appear to be driven by poverty, access or performance. Resources tend to follow their historical distribution, with a continual adoption of incremental

89 OECD DAC CRS: <http://stats.oecd.org/Index.aspx?DataSetCode=CRS1>

90 See <http://projects.worldbank.org/P145741?lang=en>

91 See <https://devtracker.dfid.gov.uk/projects/GB-1-202493>

92 This dataset does not include Ghana's GPE grant, which averaged \$20 million to \$25 million per year during 2012-15 – see Box 6.

93 These figures are lower than the overall national primary budget divided by primary-age population because that budget also includes all central-level spending not allocated out to regions for headquarter operations and national and regulatory bodies. The per-pupil financing analysis in this chapter draws on primary-age population estimates from EMIS 2014-15, for alignment with the period with available budget data.

budgets meaning that entrenched disparities between regions are harder to address. In our analysis of selected indicators, we did not observe any clear correlations (Figures 67-69). Indeed, per pupil spending seems, if anything, *inversely* correlated with regions' poverty levels – the higher the rate of poverty, the lower the per pupil spending. Spending in itself does not seem to have a bearing on school attendance rates (Figure 68); for example, Western region achieved the same attendance rate as Central and Eastern regions, despite spending only two-thirds of the amount per child.

As in the health sector, the substantial wage bill absorbs the vast majority of the ministry's discretionary resources (see more below). For non-wage recurrent spending, we were informed that there is an allocation formula. However, we were not able to find any further information about this, including from our interviews with the MoE. In practice, there is little a formula could meaningfully

achieve in a context where the total resource envelope for non-wage recurrent spending is extremely limited.

Variation between districts within the same region appears even more varied. Taking Brong Ahafo region as an illustrative example, per primary-age pupil funding in 2015 ranged from 153 Cedis (c. \$35) to 528 Cedis (c. \$120) (Figure 70). Banda, at 300 Cedis (c. \$68), is slightly above the median for the region.

As discussed below, the majority of the budget pays for salaries. However, the distribution of trained teachers is highly unequal. Districts in Brong Ahafo range enormously from 34 children per trained primary teacher (in Sunyani, the region's capital city) to 98.

On a per capita basis, there appears to be a slight correlation between trained teachers and spending patterns among districts in Brong Ahafo, and a stronger correlation in Northern region.

Box 6: The Global Partnership for Education in Ghana

The importance of continued donor support to primary education among poor communities is underscored by the emphasis that our key informants at regional and district levels placed on the most recent GPE grant. This \$75.5 million grant has for more than four years (2012-16) provided resources in the 75 'deprived districts', both to district authorities to support the delivery of their annual programmes of work to improve access, equity, quality and management of education, and directly to schools as supplements to the government's capitation grant.

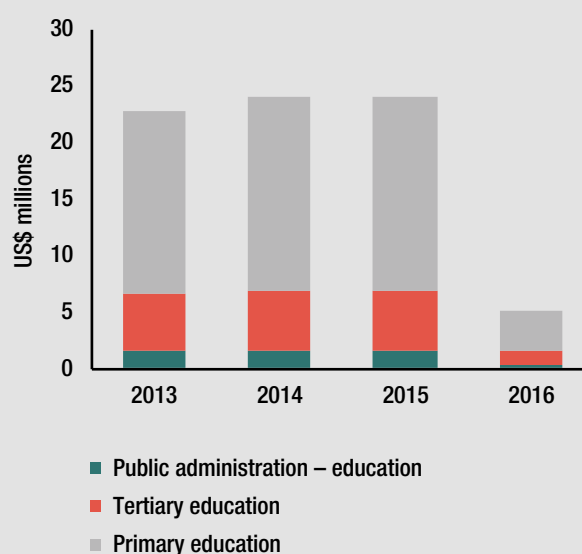
The GPE grant was designed to fund the non-salary recurrent expenditure that is otherwise lacking, such as the training and upgrading of teachers (particularly local, unqualified teachers who predominate in rural and deprived areas), materials and operating costs. The most popular activities carried out included buying essential supplies such as chalkboards, desks, chairs and teaching and learning materials; monitoring and planning activities, including regular school inspection; providing gender-friendly toilet and sanitary facilities in schools; training teachers and district officers; and organising school appraisal meetings within the districts (World Bank, 2017c).

Multiple stakeholders in one district (LG8, FGDBT) discussed, unprompted, the importance of the GPE grant for ensuring that basic operations that should happen did indeed take place, such as circuit supervisors carrying out mandated regular school inspections in order to monitor teachers' performance, using GPE-funded fuel and vehicles. While the government's capitation grant should cover schools' non-salary recurrent expenditure, it is only a very small amount per pupil (less than 1 Cedi (c. \$0.20) per pupil in 2015-16; MoE, 2016) and, as we were informed, has not always been reliable or timely

in its disbursement. The last tranche of Ghana's GPE grant was disbursed in mid-2016, with the vast majority already disbursed by 2015. As of mid-2017, in the districts we visited the ending of this funding had been felt very noticeably.

The future of GPE-like social sector grant funding in Ghana is uncertain. On paper, Ghana no longer meets the eligibility criteria for the GPE's ESP Implementation Grants, since it is not an LIC, a small island or small landlocked developing state or an LMIC with a primary completion rate of below 85%.

Figure 66: GPE grant to Ghana, 2012-16



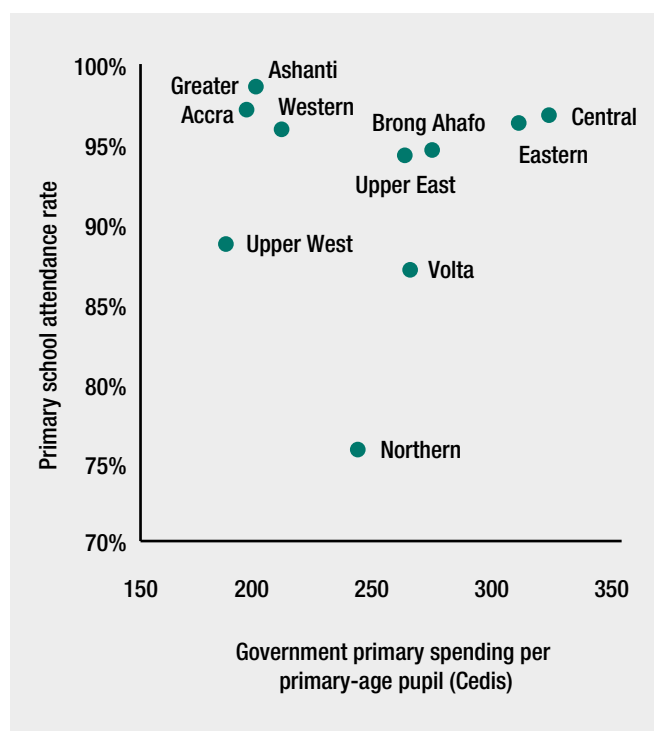
Source: World Bank (2017c)

Primary education spending does not appear to be well targeted towards districts with higher poverty levels – we could not find any such correlation.⁹⁴

There does appear to be a slight degree of correlation between gross enrolment rates and spending. It may be the case that historical patterns of higher spending have contributed to higher enrolment rates.

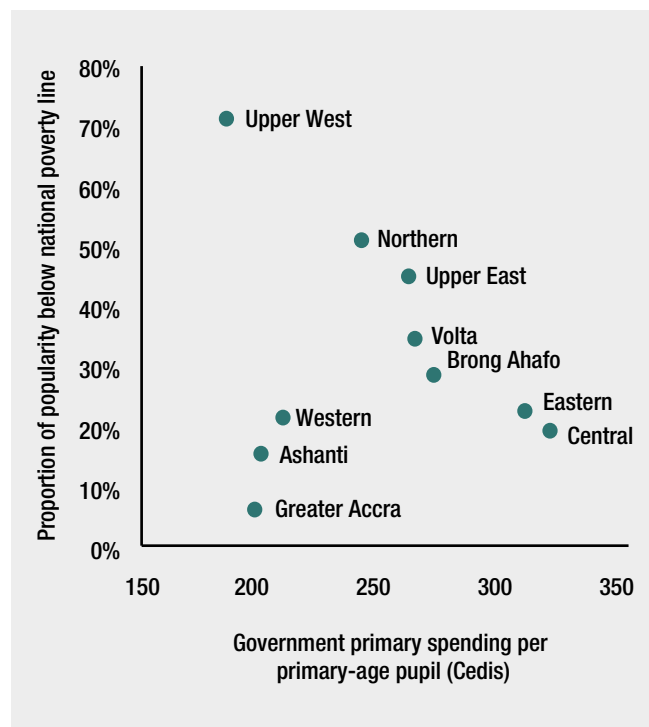
This lack of prioritised and targeted spending is likely to be hampering the overall efficiency and impact of the MoE's expenditure because it is often the case that the largest and most cost-effective gains can be made in areas currently faring the worst. For example, results for Ghana from the Simulations for Equity in Education model developed by UNICEF and the World Bank show that the construction of new kindergartens can have a greater overall impact if they are targeted to poor, marginalised children. This analysis compared the cost-effectiveness and impact of building 500 new kindergartens evenly across all districts in the country without kindergartens, or only in the northern areas of the country, or only in the poorest villages in the northern areas. According to this model, the gains in the number of children subsequently completing primary school were highest in the last of these three and lowest in the first. Conversely, the cost per additional child completing primary school was lowest (just a quarter of the cost) when the intervention was targeted towards the poorest villages in the north, rather than nationwide (UNICEF and World Bank, 2013).

Figure 68: Government per capita primary spending vs school attendance by region, 2015



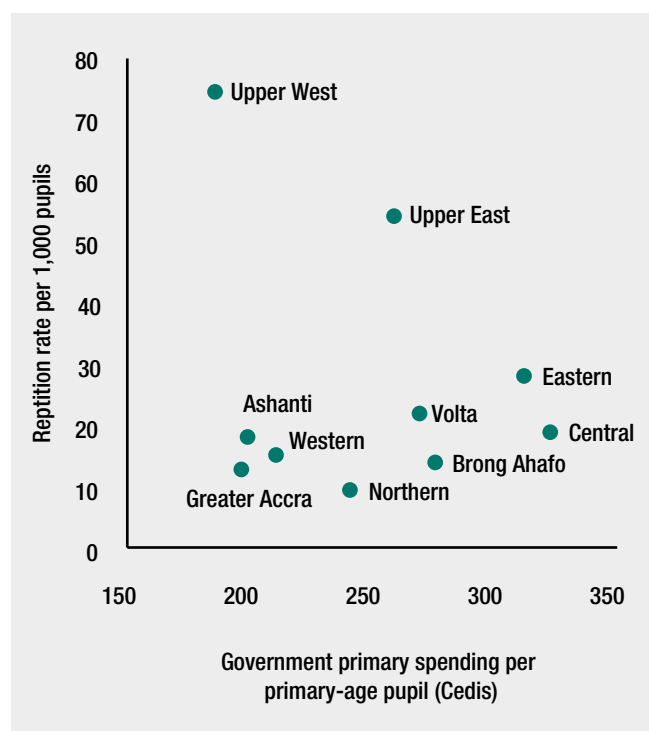
Source: MoE (2016); GSS (2014a)

Figure 67: Government per capita primary spending vs poverty by region, 2015



Source: MoE (2016); GSS (2014b)

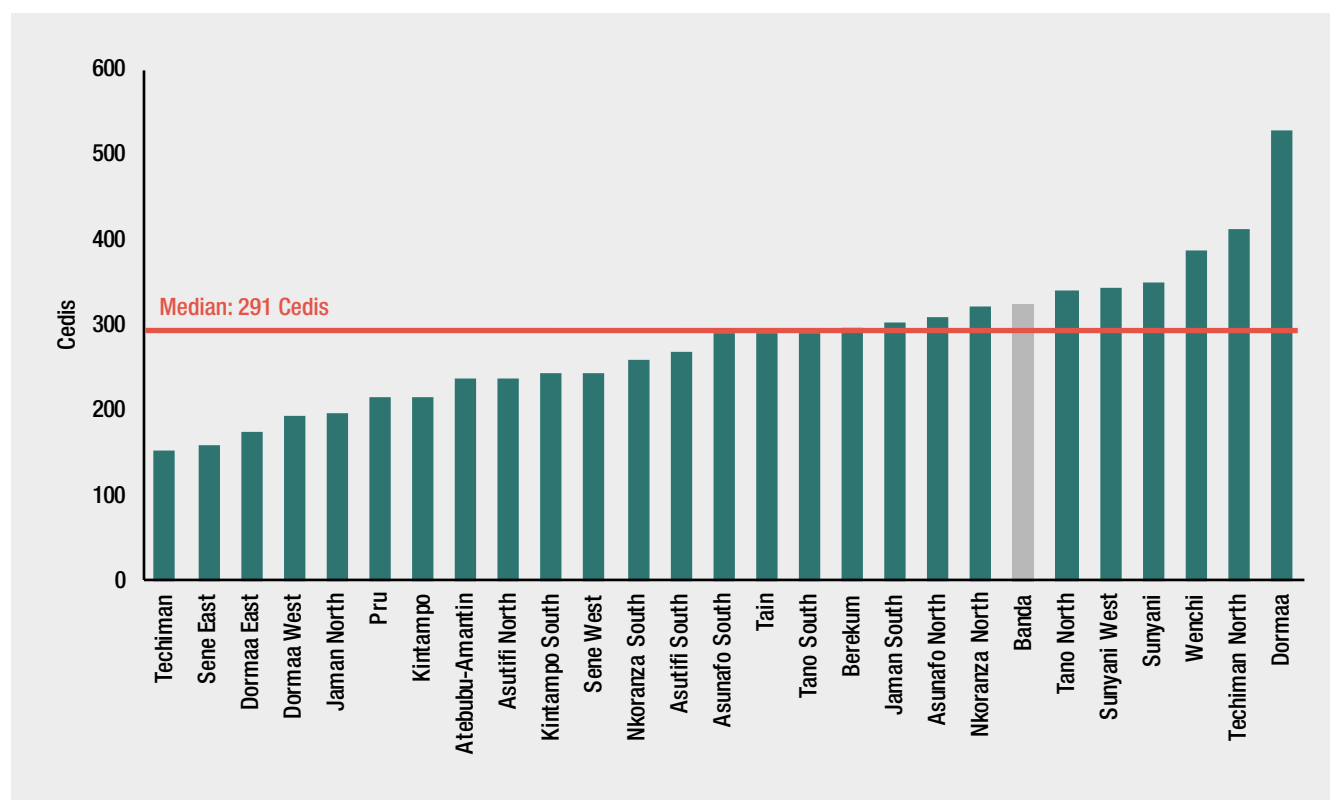
Figure 69: Government per capita primary spending vs Grades 1-6 repeat rate, 2015



Source: MoE (2016); EMIS

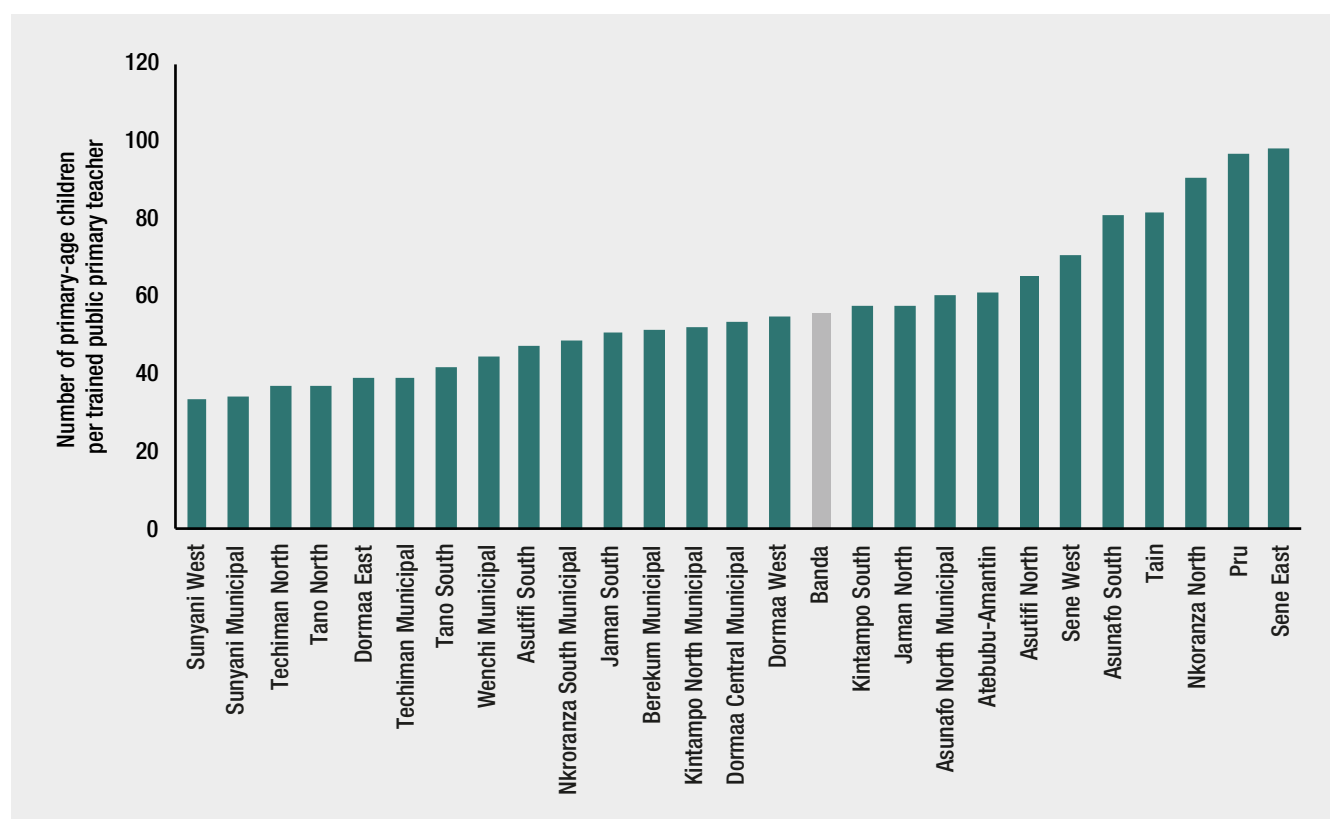
94 There are no nationally representative data on district poverty levels. The data we have used are from the GSS's 2015 poverty mapping exercise, which are Ordinary Least Squares estimates based on GLSS6 data, which are representative at a regional level.

Figure 70: Government primary spending per primary-age pupil by district, Brong Ahafo region, 2015



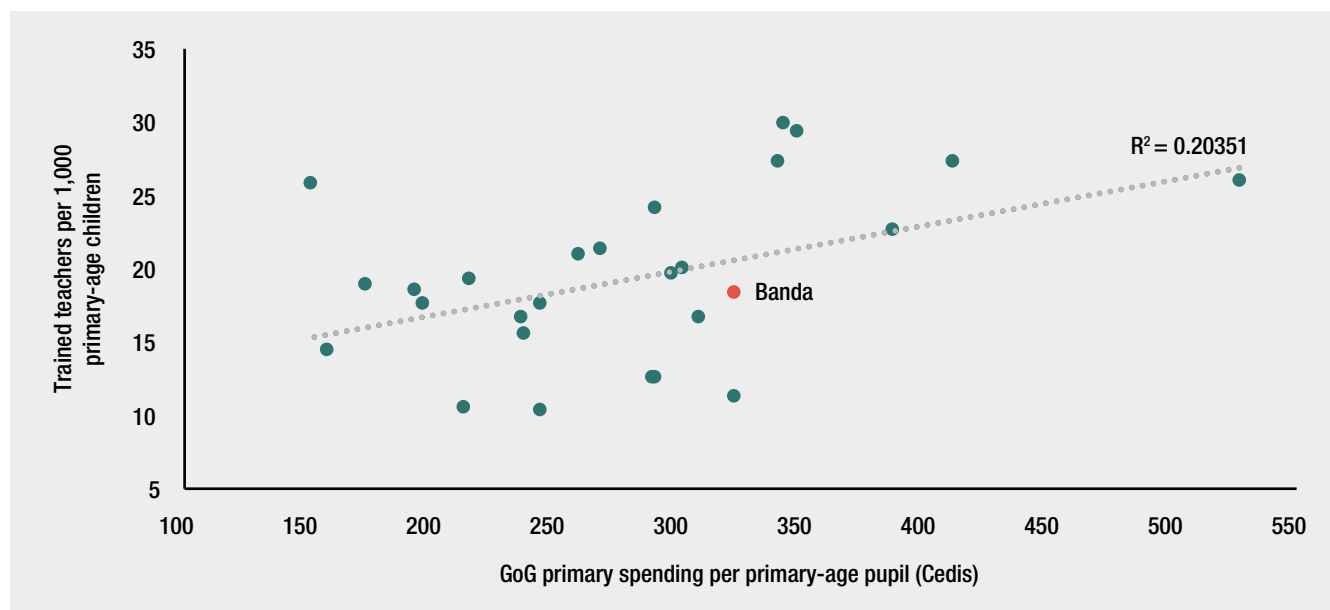
Source: Budget Estimates (2015)

Figure 71: Ratio of primary-age children to trained public primary teachers by district, Brong Ahafo region, 2015



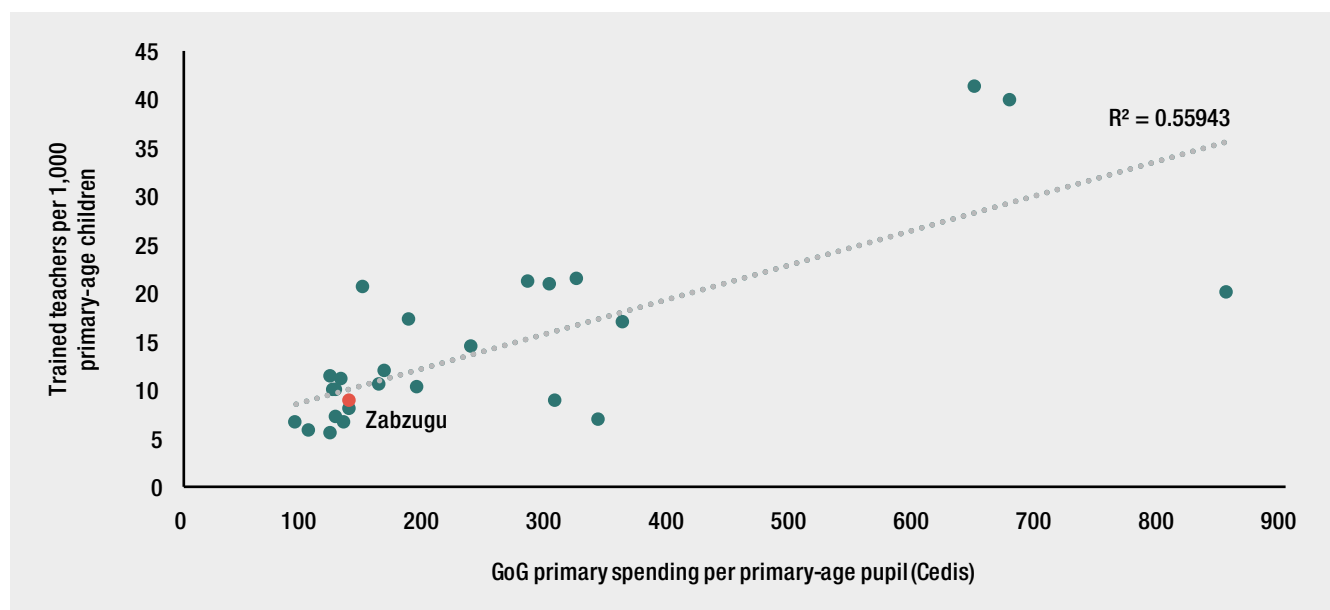
Source: Budget Estimates (2015)

Figure 72: Government primary spending vs trained teachers by district, Brong Ahafo region, 2015



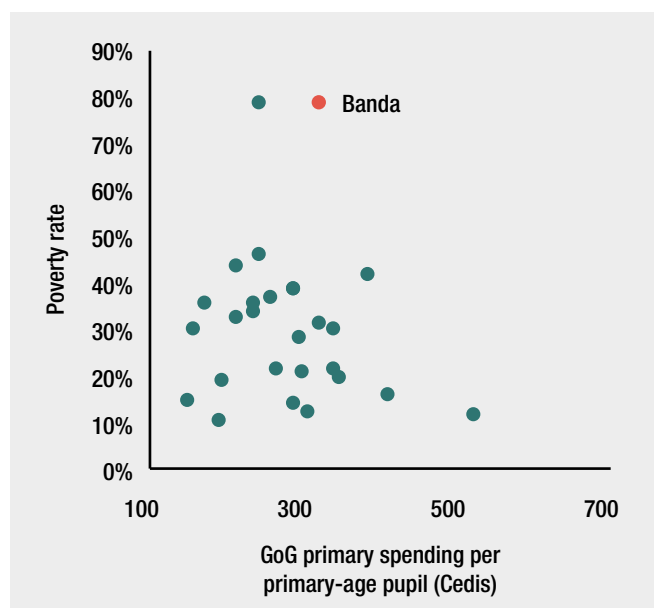
Source: Budget Estimates (2015); EMIS

Figure 73: Government primary spending vs trained teachers by district, Northern region, 2015



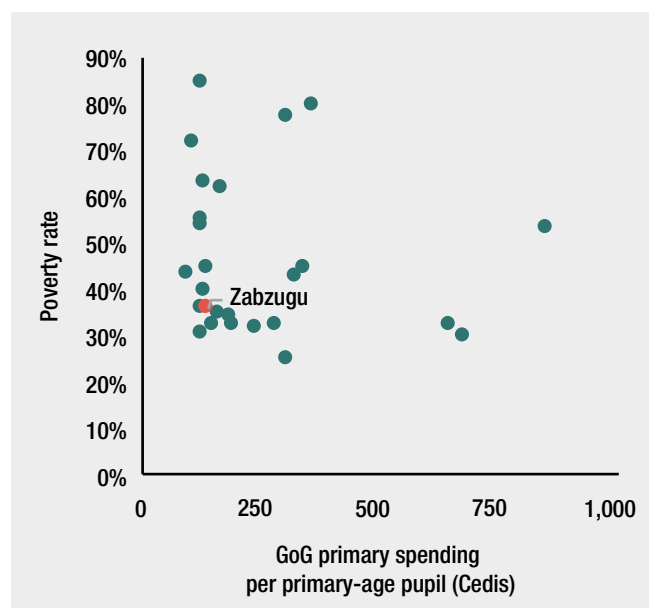
Source: Budget Estimates (2015); EMIS

Figure 74: Government per capita primary spending vs poverty by district, Brong Ahafo region, 2015



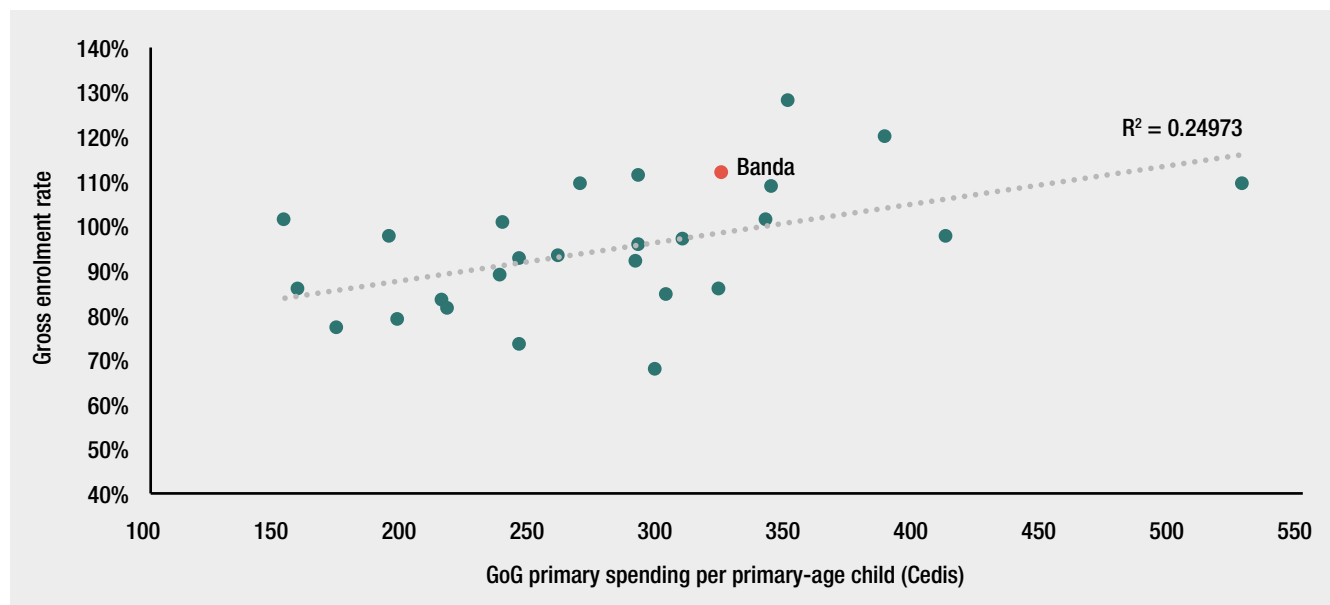
Source: Budget Estimates (2015); GSS (2014b)

Figure 75: Government per capita primary spending vs poverty by district, Northern region, 2015



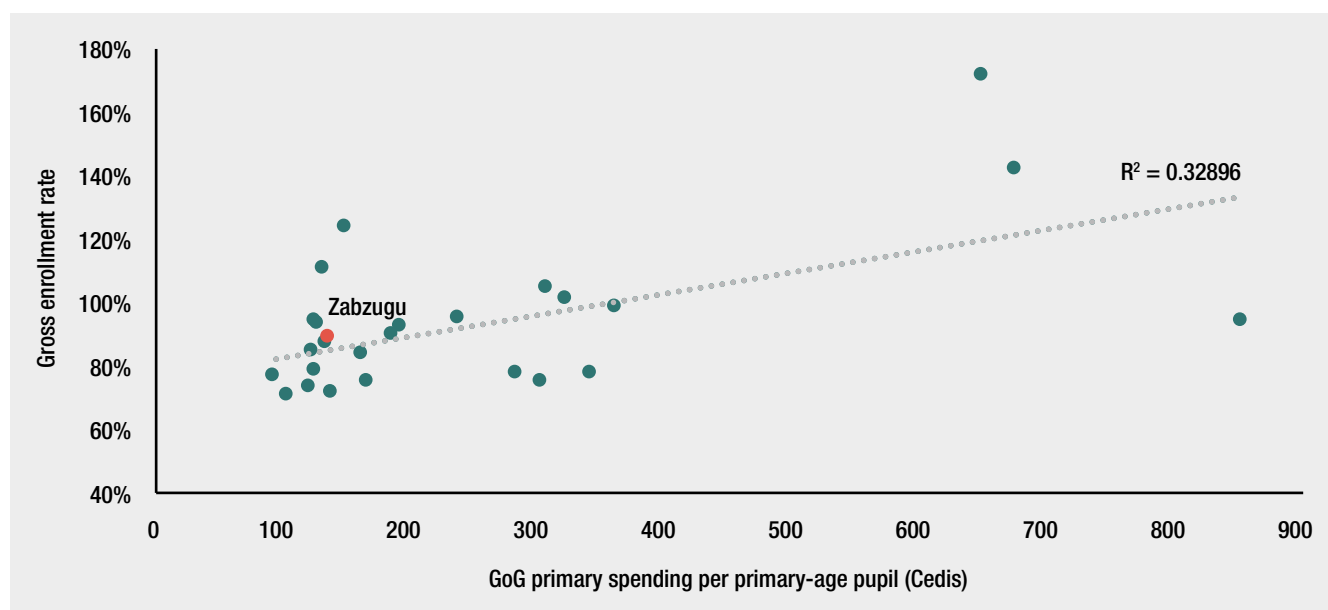
Source: Budget Estimates (2015); Ghana Statistical Service (2014b)

Figure 76: Government primary spending vs gross enrolment rate by district, Brong Ahafo region, 2015



Source: Budget Estimates (2015); EMIS

Figure 77: Government primary spending vs gross enrolment rate by district, Northern region, 2015



Source: Budget Estimates (2015); EMIS

As with health, there has been enormous growth in the wage bill in recent years, squeezing other resources in the education sector, and making it very difficult for schools to maintain basic operations without significant reliance on donors, parents and local communities. This squeeze is having detrimental effects on education access for poor and vulnerable groups.

Wages in the education sector have grown continuously, rising 136% between 2011 and 2015. In 2015, they constituted 75% of the total sector budget (and around 98% of discretionary MoE funds). Wage commitments do not seem to have been constrained by MoF ceilings, and indeed are far above the average for the sub-Saharan African region.

Similarly to health, the introduction of the Single Spine Salary Structure and inefficiencies of the centralised payroll structure have driven over-spending. Pay rises initiated in 2010 were delayed until 2012, leading to subsequent spikes to clear these arrears. A second factor is inaccurate information flowing from the districts up through the regions into the central budget planning process, resulting in unpaid salaries to clear.

Since 2009, all non-wage recurrent spending and capital investment have been allocated from IGFs, donor resources or statutory funds (ABFA and the GET Fund), all of which have been declining and/or are likely to decline in volume in coming years.⁹⁵

Because wages are over-executed (i.e. more is actually spent than initially budgeted), other expenditures are

necessarily under-executed (Figure 81). In 2016, no MoE spending on assets, goods and services was actually recorded, because employee compensation was 28% over budget.

This situation has also put pressure on the capitation grant – government funding allocated on a flat per pupil basis that is supposed to ensure that ‘free’ education really is free, by taking care of associated costs such as exam fees. The capitation grant has been squeezed to a tiny amount – in 2015-16, nationwide it amounted to less than 1 Cedi (c. \$0.20) per pupil (MoE, 2016). Recently, the release of the capitation grant has been subject to considerable delays and uncertainty. In 2015, funding had to be sourced from the DACF (which is supposed to be used by districts, primarily for capital investment), thereby reducing the funding available to construct new facilities (CG13). Furthermore, capitation grant funding is being absorbed for general purposes, to plug the gaps in schools’ basic operating costs. It is therefore not necessarily directed towards its intended objective of promoting equity and inclusion by ensuring that all children can access education without any associated financial barriers.

A final challenge in public education financing is the fragmentation of the budget from the central level down to the district level, which undermines the coherence and transparency of planning and decision-making processes.⁹⁶

Centrally, there are multiple statutory funds, each with their own management and allocative protocols. While

⁹⁵ IGFs will decline with the introduction of the free SHS policy. Ghana’s LMIC status is likely to signal further reductions in donor funding. According to the 2017 Budget Statement, education is no longer an ABFA priority (these priorities change over time). Despite fluctuating erratically in recent years, the GET Fund’s total share of the sector budget has declined from 16% to 8%.

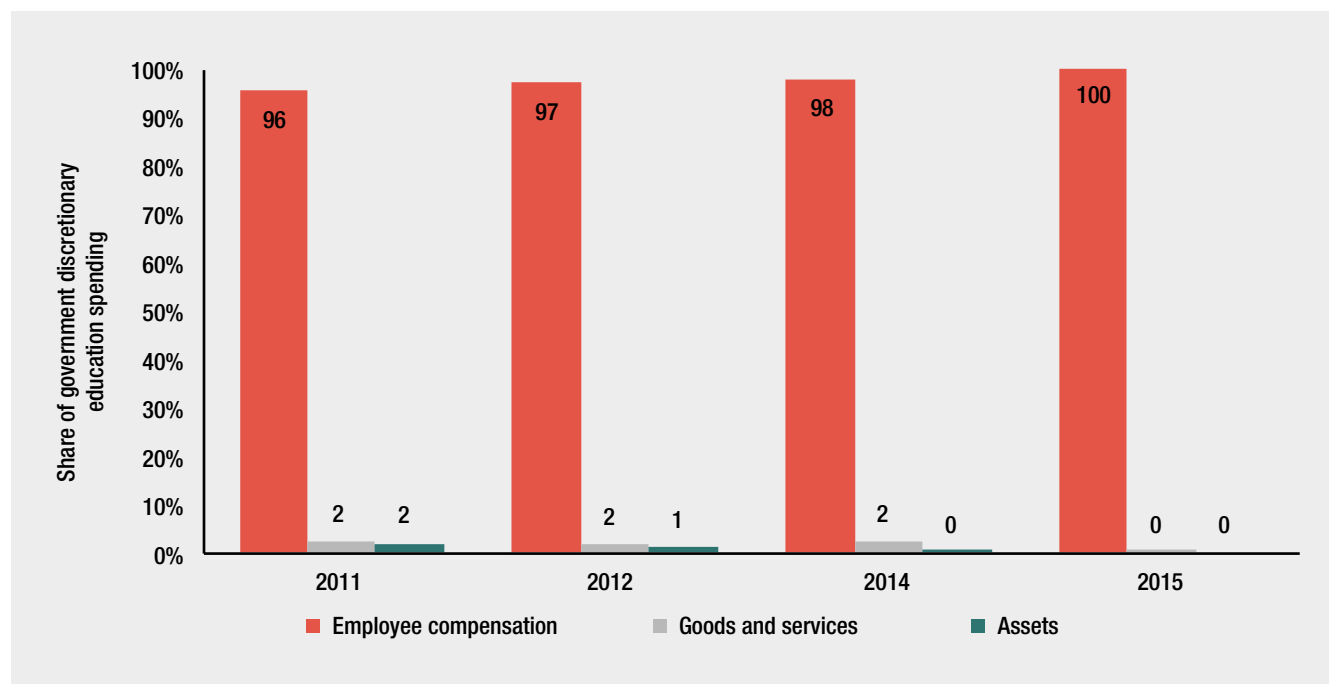
⁹⁶ Donor programmes such as GPE have been supplementing the capitation grant in deprived areas.

the DACF, GET Fund and ABFA all have stated guidelines on what they should be used for, recently these have been circumvented, and they have been used to make interest payments and clear outstanding arrears (CG7). These funds also operate outside the standard budget and accounting practices (CG6), which raises transparency concerns. There

is no way for observers to monitor if they are actually serving their intended developmental purposes.

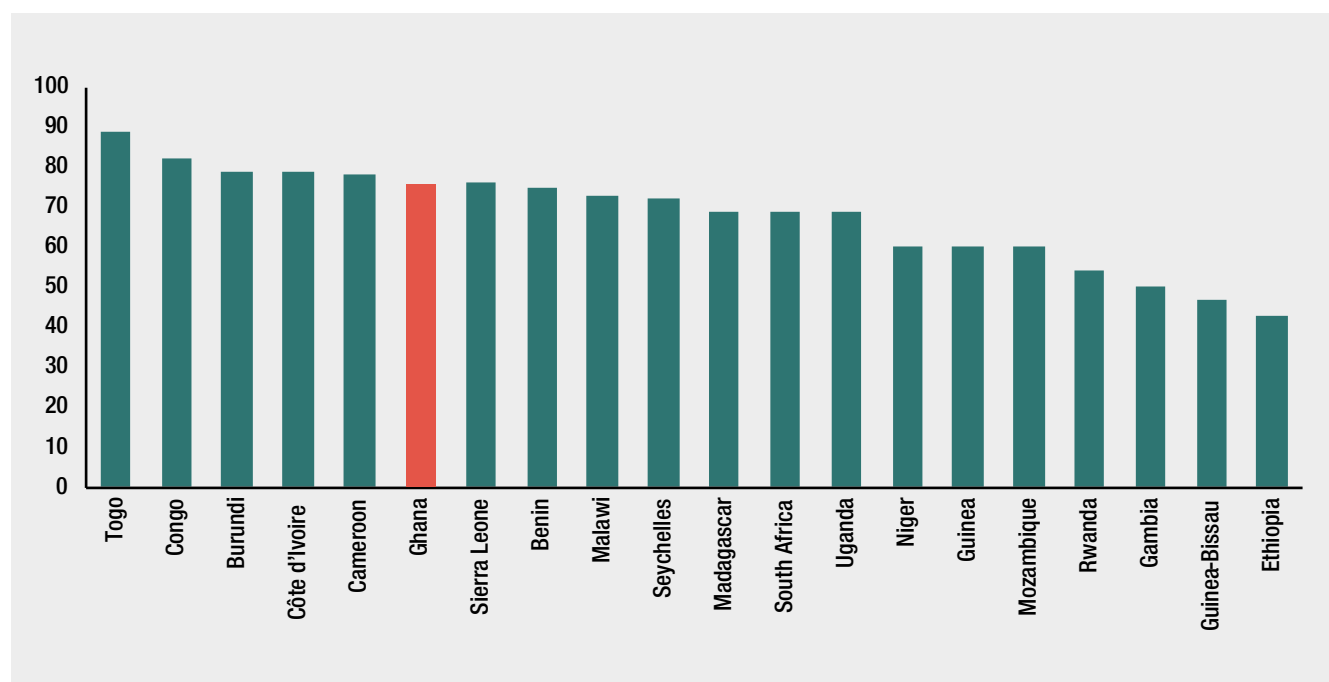
At the district level, there is a dual system operating, given the incomplete nature of Ghana's decentralisation (see Chapter 2). Some central government officials took the view that DAs can play a positive, complementary

Figure 78: Government discretionary education spending by economic classification



Source: MoE (2016, 2015 and 2013)

Figure 79: Wage bill as share of total education spending, 2015 or latest available year

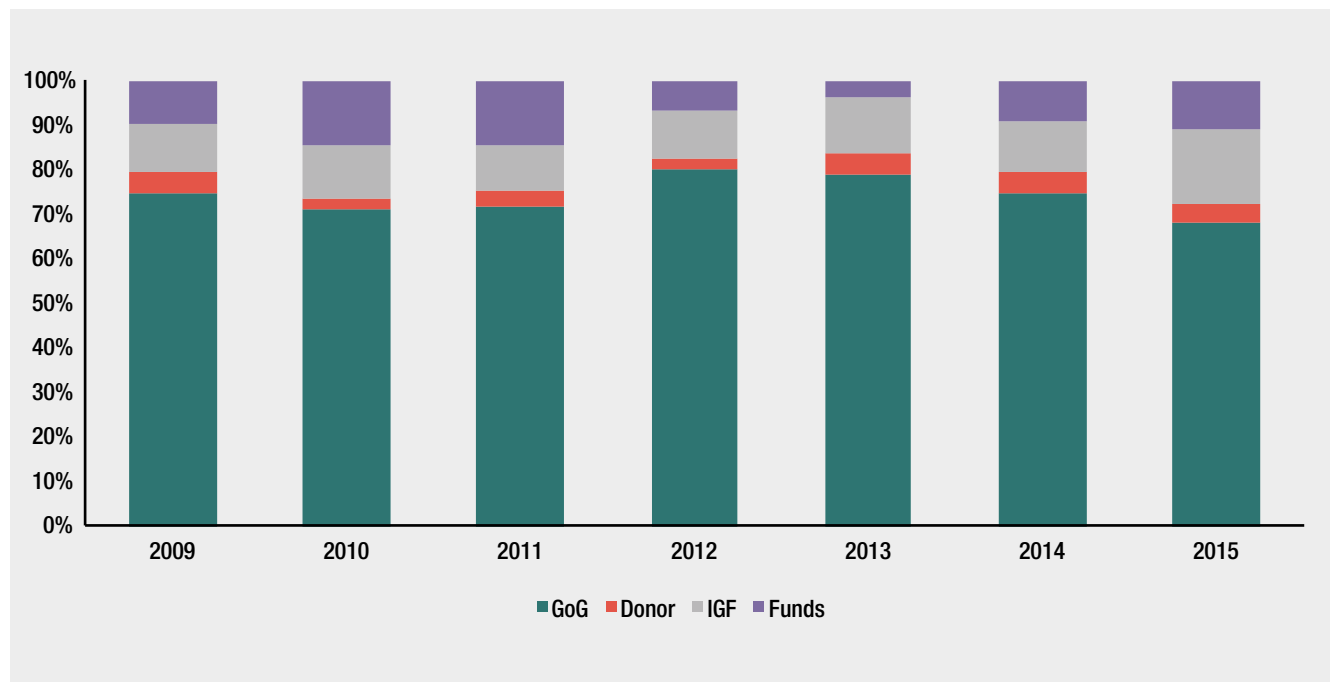


Source: MoE (2016, 2015 and 2013)

role in using their DACF allocations to support school construction, for example (CG15). However, there is no legal mandate for the sharing of information between DAs (the political, decentralised entities) and the DEOs (deconcentrated representatives of the centralised GES) during planning and budgeting processes (CG21). This

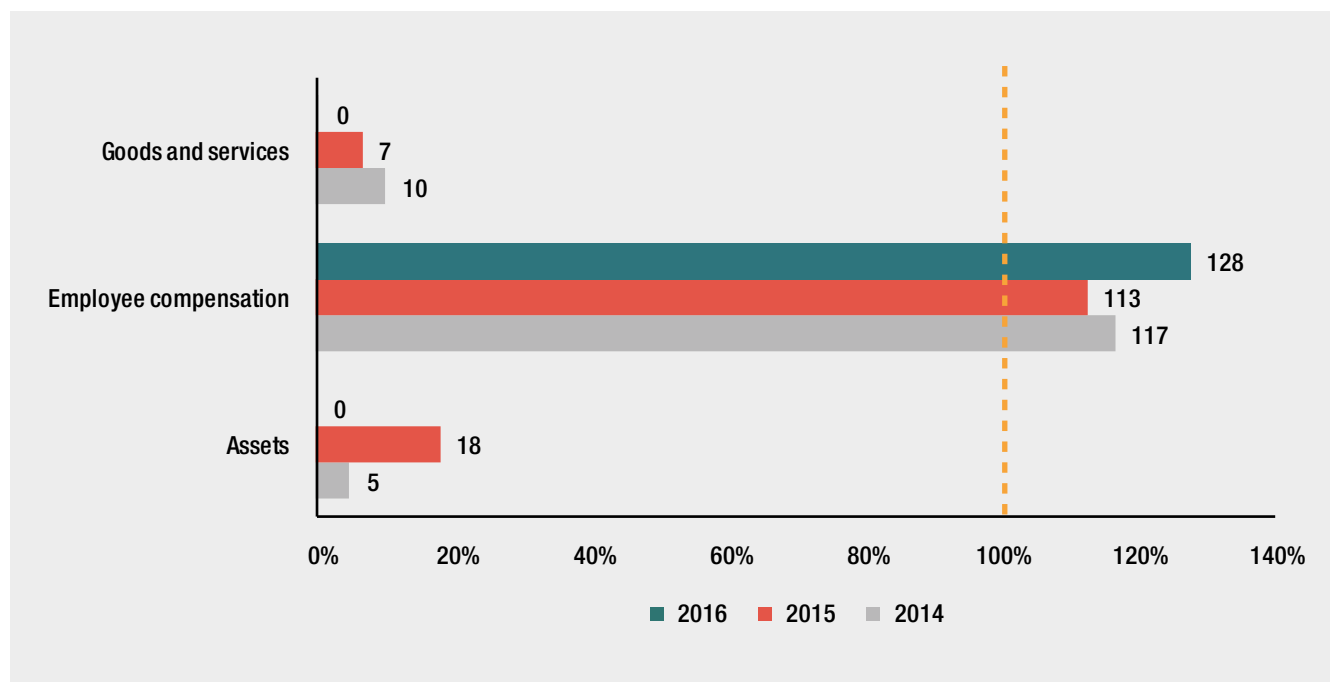
means that, in any given district, it is up to the discretion of these two respective authorities how coordinated and coherent their allocative decision-making will be. There is often a strained or simply uncoordinated relationship between the two entities. The DEOC, which is supposed to play the bridging role, often does not function properly.

Figure 80: Composition of funding sources to the education sector



Source: Report of the Auditor General of the Public Accounts of Ghana (various years)

Figure 81: Percentage of MoE budget actually spent, by economic classification



Source: Report of the Auditor General of the Public Accounts of Ghana (various years)

6. How are policy and financing translating into service delivery for left-behind groups?

In this chapter, we explore the extent to which policy and financing are translating into effective service delivery for vulnerable and marginalised groups. We further investigate the differences between the two regions and districts selected as case studies, Northern region (Zabzugu district) and Brong Ahafo region (Banda district), and explore in more detail the views of key stakeholders and community members at local level. This chapter draws particularly on material from our FGDs conducted in Zabzugu and Banda, and the key informant interviews conducted in the two districts and in the regional health and education directorates of Brong Ahafo and Northern.

The case studies are intended to illustrate and augment findings from our national-level fieldwork, quantitative analysis and literature review. As noted in Chapter 1, we purposefully selected districts that – broadly speaking – were representative of their region. However, we are aware of the limitations of focusing only on two districts. The analysis should therefore be interpreted with appropriate caution and is not necessarily generalisable.

We structure the analysis according to our conceptual framework (Figure 82), looking first at supply-side and then demand-side factors that are found to be either promoting or hindering effective service delivery to vulnerable and marginalised groups. Overall, we found that problems with the supply side, rather than the demand side, are the main barrier to service delivery in both health and education. In particular, respondents noted critical bottlenecks relating to human resource distribution (inadequate incentives and accountability) and severely insufficient (non-wage) recurrent funding. On the demand side, it was the ‘hidden costs’ associated with services that should be provided for free that are hindering access, particularly for the poorest.

6.1. Service delivery in the health sector

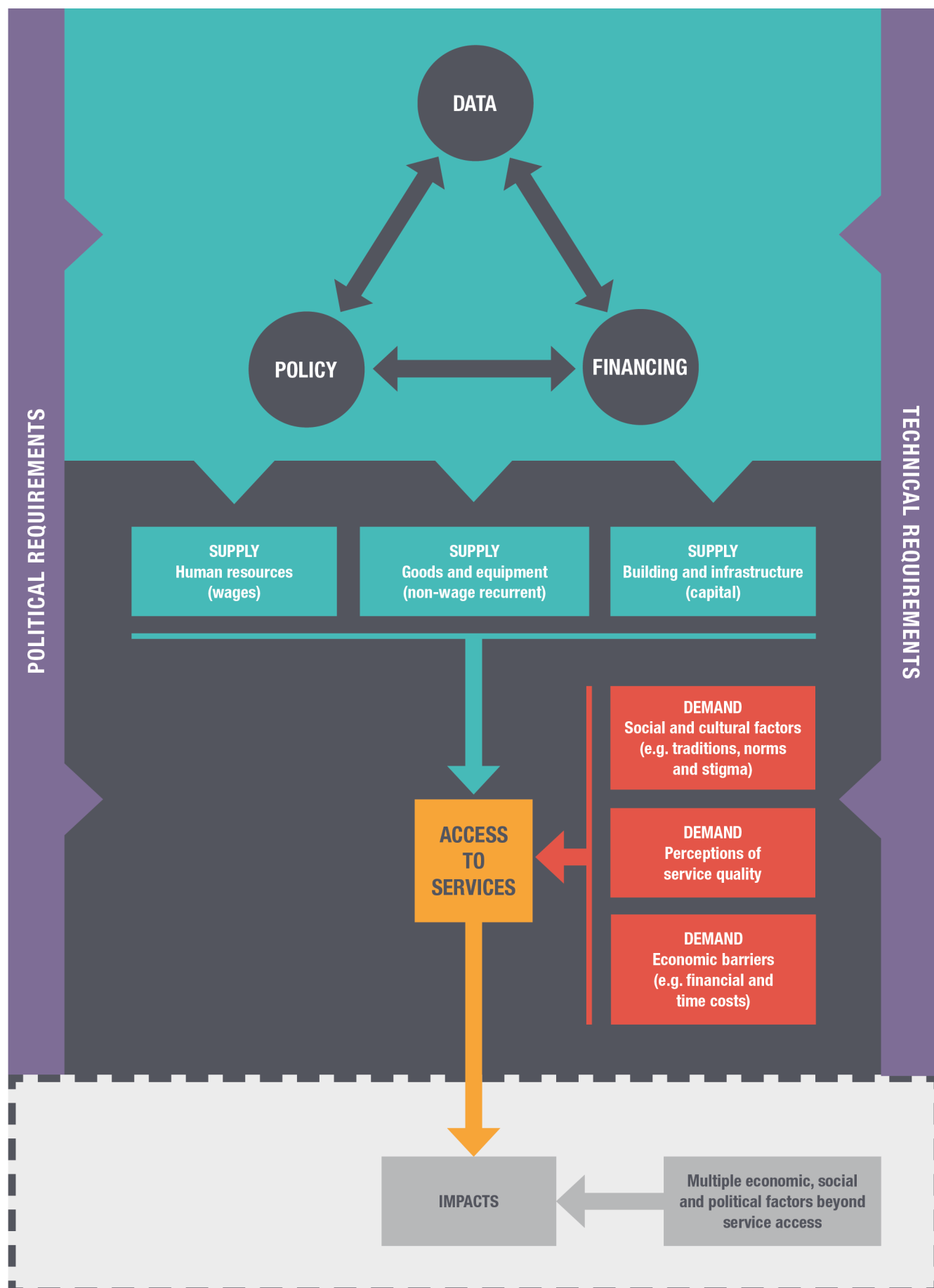
According to one key informant (CG2), the supply side is the more important driver than the demand side, and it appears to be the supply side that explains the different performance across regions.

6.1.1. Supply-side barrier: human resources

Our research found that the lack of health workers (especially doctors and midwives) in rural districts is a major challenge. In Banda district, Brong Ahafo, there is no doctor and only one medical assistant, and only four out of the eight facilities have midwives. Community members observed that more trained midwives and nurses would improve health services, especially in childbirth (FGDBWHA). Nevertheless, Banda’s health worker levels correspond to Ghana’s national average of roughly 3 per 1,000 people. In addition, the Health Directorate successfully lobbied the district planning process to build extra compounds. These compounds are not fully supplied but they are managing: ‘Ideally we would like all compounds to have midwives, but in the meantime we have trained up community health nurses with a short course, and they are doing quite well’ (LG4).

In Northern region, however, the situation is more acute. Zabzugu district has no doctor and just five midwives and two medical assistants covering a population of 63,800 people. In total, the health worker ratio is tiny: 0.67 per 1,000 – far short of WHO’s recommended minimum ratio to achieve universal health coverage (4.5 per 1,000). The District Annual Report (Zabzugu DA, 2015) cites ‘inadequate critical staff (midwives and physician assistant)’ as a key challenge, linked to the lack of accommodation for staff. In contrast to Banda, community health nurses are not well

Figure 82: Conceptual framework



supported (FGDBCHW). Furthermore, among the staff who do work in Northern region, ‘most of those around are not really employed by the government... the DHA [district health authority] takes care of them [pays their salaries] and they are casual workers’ (FGDZCHW). As noted in Chapter 4, this is an issue primarily of distribution across the country, not the overall quantity nationwide. In other words, it is an issue of enforcement and accountability.

Without adequate numbers of health workers in rural areas, services for these communities are not functioning to meet the needs of the populations they serve. The lack of doctors at district level means that patients presenting with complex and/or life-threatening symptoms will need to be referred to higher facilities. But referral systems in rural areas are not working: ambulances are not maintained and the cost of private transport may be prohibitive. The lack of doctors also increases the demand for and reliance on traditional healers, who are available in the community and are trusted. Meanwhile, the lack of midwives means staff are over-worked and over-stretched, which causes stress and may impact on their attitude to women in delivery. The negative attitude of some health workers was captured in our FGDs in both districts:

Sometimes, she [the nurse] will come when you have already delivered on the ground and she will insult you because you have delivered on the ground, while it is not your fault, because there was no help. (FGDBWHA)

The nurses are helping us a lot but sometimes they don't treat us well, they are very harsh. (FGDZWH)

6.1.2. Supply-side barrier: funding for administration, drugs and equipment

As discussed in Chapter 5, the virtual absence of any non-wage recurrent funding has a major impact on service delivery. Banda health authorities have not had any funding for core operating costs for seven years (LG4). In both districts we heard about increased reliance on IGFs and donor projects, with immediate negative implications for equity between regions and districts.

The fact that there is no regular funding for non-wage recurrent costs means that resources for monitoring and supervision are also limited. Respondents confirmed that the lack of money for vehicles and fuel is preventing the supervision needed to enforce quality and motivate performance. In addition, as discussed previously, the centralised recruitment and payroll structure of the health sector means that it is hard for district authorities and facilities themselves to discipline, sanction or dismiss absent or under-performing staff (LG11).

Lengthy delays in reimbursements from the NHIA to facilities mean that the latter are getting into debt and experience regular drug stock-outs. Health workers in Banda confirmed this, noting the lack of drugs is the ‘main

problem’ (LG5) and there are often stock-outs. In such cases, health workers are forced to write out prescriptions for patients to buy elsewhere, knowing all too well that most people cannot afford the costs. If patients cannot afford the drugs prescribed they will either have to borrow money (and get into debt themselves) or rely on ‘herbs’. The centralised drug procurement process is also affecting supply:

Sometimes drugs are supposed to be included in the NHIS package but they are not available to people. This happens when the Regional Medical Store has a stock-out but does not issue a non-availability certificate, meaning the district facility cannot then go out and buy these on the private market. (LG4)

Lack of equipment is also a major problem; for example, there is only one bed in Banda’s health clinic, and it is broken (LG5). Without adequate supplies, health workers of all cadres are challenged to perform their roles. On the front line, CHWs feel the shortages acutely:

There are some materials they should have given us before starting the programme but such materials are not there, so it is making our work very difficult ... We were supposed to be given registers and other materials but for now we have to buy exercise books instead ... A month will pass without pay; what will you use to buy all these? (FGDBCHW)

Without adequate supplies of human and other resources in rural areas, services that are notionally ‘accessible’ for vulnerable and marginalised groups may not be available, affordable or acceptable. If a critically ill patient presents at a CHPS compound, even if there are medical staff present, without appropriate equipment and/or drugs the patient may die, and communities’ trust in services will be eroded. Although we did not hear first-hand accounts of such fatalities, our findings do nevertheless call into question the government’s policy of increasing access universally, without having adequate systems and resources to ensure services are delivered. As one respondent described: ‘Access is not bad... [but] access to what?’ (CG22). Another said: ‘Our hospitals here are not up to standard and are unable to give the required health care’ (FGDBMHE).

6.1.3. Supply and demand-side barriers: infrastructure, distance and transport costs

Although the CHPS policy has gone some way to overcome access issues, distance to facilities and the cost of transport are still major barriers, especially in the north where the distances that need to be covered are far larger, on much poorer roads. Northern region has only 2.9 public health facilities and 3.3 total health facilities (including private) per 1,000 km², compared to a nationwide average of 7.8 and 11.8 respectively (Ghana Open Data Initiative, 2016; GSS, 2010).

The ambulance here has broken down, making transportation of patients very difficult. The distance of the health facility is one major hindrance leading to poor patronage of antenatal services. Majority of women in the community still deliver at home. (FGDZWH)

In Zabzugu, the district health authorities do not seem to have the power to influence the DA, which ‘just builds the compounds between communities’ (FGDZCHW), rather than based on need. Despite reported demand in Zabzugu – ‘the hospital is the most preferred option by community members as compared to traditional medicine’ (FGDZWH) – the ability to act on this demand was very clearly affected by distance and transport issues: ‘Because we have no health centre over here we spend a lot [of money] before accessing health care ... All that we need is a health centre’ (FGDZWH).

In Banda, we were told that there has been a flurry of CHPS construction over the past three years, which has indeed facilitated access. All community members we spoke to in each of the four focus groups live within a reasonable walking distance of a health facility. However, distance and the associated cost of transport remain an issue for people if they need to be referred to hospital, as there is no functioning ambulance. Instead, the district health director has established a deal with the local transport union whereby they facilitate urgent referrals of serious cases to the local hospital, with the agreement that patients’ carers or families can negotiate afterwards (LG4). While unwillingness to travel or inability to pay transport costs can be considered a demand-side issue, clearly the provision of more health facilities closer to communities, and/or the provision of free or subsidised transport (such as ambulances, which were not functioning in either district) are key supply-side solutions to this barrier.

6.1.4. Demand-side issue: out-of-pocket expenses

Those without health insurance are expected to pay for drugs and health services themselves. While key vulnerable groups are exempt from paying NHIS premiums, anyone wishing to be covered under the scheme must register and re-enrol annually, a process that takes place in dedicated NHIS offices. Many respondents reported the costs associated with registering for and renewing NHIS membership, particularly the time and financial cost of transport to the nearest NHIS office, as a challenge that prevented them from gaining access to the scheme. Some districts – including Banda – do not even have an NHIS office, and residents must travel to the next district. We heard that, in previous years, health workers could assist poor and vulnerable patients in this process by taking batches of membership cards to the office on their behalf, but now the cards are biometric, so this is no longer possible:

Economic barriers cut across – some households cannot afford 20 Cedis [c. \$5] for NHIS per person per year. Even those exempt might not be able to afford to travel to the NHIS registration office. (LG4)

This situation is confirmed by the District Annual Report (Banda DA, 2015):

The difficulties in renewing the insurance registrations in 2016 with the biometric system have caused many of the clients to go to chemical shops for drugs when there is a need. The few who come to the facility with expired cards have to pay as non-insured clients.

On top of the challenges of non-insured populations, we found much evidence of pervasive ‘informal charging’ and other financial barriers even for people who are supposed to be covered under the NHIS.

What will you do when you are sick and you have no money? There are so many instances, and when this happens, what we do first of all is to go for herbal medicines. It happened to me recently. I fell sick and felt that my health insurance was not working, not knowing it hasn’t expired yet. So I went to the bush for some herbal leaves. (FGDBMHE)

Financial constraints is also a sickness for us, because when we go to the clinic and they prescribe drugs for us to buy, we sometimes cannot (surely) afford such monies. (FGDZWH)

The NHIS covers most of the health care services in this community. When community members go for NHIS, they are told that everything at the hospital is free so far as one is registered but that is not the reality, making it a problem. (FGDZCHW)

One repeated example was women having to bring basic supplies such as disinfectant with them when delivering in a facility, a phenomenon acknowledged by the MoH (2017):

A recent [MoH] monitoring visit to the regions and facilities in the districts confirmed the practice of staff preparing a list of supplies that a pregnant woman would need to bring along as part of preparation for delivery at the public health facilities ... The practice itself makes nonsense of the free maternal delivery policy.

Indeed, contrary to the 2008 policy that maternal and child health services should be free, women reported many examples of charging. For example, during antenatal care women may be charged:

When they check the health of the baby in the womb, a fee of 1 Cedi [c. \$0.20] is charged ... [and at the time of delivery,] we are asked to provide detergents like Dettol, paracetamol, rubber sheets ... it costs approximately 60 Cedis [c. \$14] per each delivery.

Although all children are meant to receive free services, women report: ‘We pay for some of the injections. If the child is detained and given water infusion they pay about 60 Cedis’ (FGDBWHA).

For many women the cost of delivering at a facility is too great a barrier, and they deliver at home instead (FGDBWHNA, FGDZW). This barrier may be exacerbated by intra-household gender dynamics. Women described how:

*The men are always not ready to help us ...
Sometimes we are forced to deliver at home because
we know our husbands cannot foot the bill or cost
of delivery at the health facility* (FGDBWHA)

Another potential impact of OOP payments is pervasive indebtedness to cover everyday health costs. Although we did not hear reports of catastrophic expenditure in our fieldwork, there are numerous examples in the literature. Catastrophic expenditure on drugs not covered under the NHIS is stated as a barrier to maternity health-seeking by women in Ghana (Ayanore et al., 2017). If money cannot be raised, the consequences may be fatal:

Usually when one is sick, he will try to manage it at home, going to the drugstores and using herbal medicine until the sickness become serious to the point of death. Then relatives will come in to support. Most often, relatives will go round to look for money to borrow, which may take some days while the sick person’s health gets worse. Sometimes, relatives find it difficult to get this loan, meaning the sick person is likely to die. (FGDBMHE)

Having said this, it is worth noting that overall demand in Banda – especially for our key indicator of skilled birth attendance – was high. OOP payments did not seem to affect access particularly for our respondents, although we did hear anecdotally of extremely poor groups that cannot afford the charges. Women who delivered at home in Banda only did so because of their ‘quick labour’ (for example they had already delivered on the way to the facility) and reported ‘not having a prolonged labour’ as a key reason why they did not go to the facility (FGDs). This aligns with literature that documents how ‘social norms appear to be shifting in favour of facility delivery’ (Moyer et al., 2013).

6.1.5. Demand-side issue: traditional medicine and socio-cultural beliefs

There is a mixed and complex picture of health-seeking behaviours as individuals navigate public, private and traditional health providers. According to some participants in our focus groups, it is usually only if traditional health services fail that they choose to access biomedical health services (FGDBCHW). This means that many cases present late, when it may be harder or too late to treat symptoms; this experience may have a negatively reinforcing effect on demand.

Interestingly, cost may not be such a barrier to access for herbalists as for other health services. Multiple respondents reported that consulting a herbalist can be more expensive

than using health services: ‘When it comes to the cost, the clinic is the cheapest as compared to traditional or local medicine’ (FGDZW). The decision to pay out of pocket for herbal medicines, rather than access (supposedly) free health care at facilities, highlights the complex choices that individuals make about their well-being when faced with uncertainty, and points to issues of inadequate reliability and quality in the public health system.

When it comes to maternal health, the role of traditional beliefs and practices in influencing individual decisions remains a factor. A recent study emphasises how ‘cultural prestige for home births was expressed by women as desirable’ (Ayanore et al., 2017). Moyer et al. (2013) describe how ‘some households still consider it “taboo” to deliver in a facility ... If the local soothsayer was adamant about avoiding the hospital, families feared repercussions from the ancestors if they disobeyed the advice’. Our research suggested that such social and cultural factors can indeed negatively influence demand. In Zabzugu, for example, traditional birth attendants may spread rumours about health facilities such as: ‘they will lose their child or both of them will die if she decides to visit a particular clinic’ (FGDZCHW).

This mix of biomedical and traditional approaches reflects the literature, such as Wilkinson and Callister (2010), who found that child-bearing women in Ghana do not rely solely on either. Furthermore, CHWs have been deployed effectively to help overcome socio-cultural demand-side barriers, including in the Upper East region, where strongly held belief systems had prevented women’s access to health care (CG2; Awoonor-Williams et al., 2013; also see Box 3 on Upper East region, Chapter 4).

6.1.6. Local political factors influencing service delivery

Local political dynamics in Banda seem to be having a (relatively) positive effect on health access: the district health directorate (DHD) and DA do not seem to be in conflict. According to the District Annual Report, CHPS compounds in the district have ‘worked to bridge the access to health gap and hard-to-reach communities’. It was also noted that the MP has ‘done well’ in providing some of his DCF money for CHPS (LG4). In addition, the DHD successfully lobbied in the district planning process to build extra compounds.

According to some reports, the opposite appears to be true in Zabzugu, where some respondents said that the DA’s role is perceived to be one of representing and advancing the interests of the ruling party at the local level. In some districts, DAs may ignore decisions by DHAs that would require them to locate development projects in a way that is unlikely to advance the interest of the ruling party.

These different situations reflect the incomplete and inconsistent nature of decentralisation in Ghana, where lines of authority between DAs and DHAs are unclear. The relationship between these institutions at local level thus depends primarily on the governance style of the actors

involved (Horowitz and Palaniswamy, 2010). In general, the relationship between the DAs and the deconcentrated units of the education and health sectors vary by district, and some recent studies suggest that this relationship can lead to variations in the quality of service delivery at the sub-national units.

6.2. Service delivery in the education sector

6.2.1. Supply-side barrier: teacher deployment and retention

As described in Chapter 4, Ghana has a centralised teacher recruitment process and lacks policies and measures to incentivise staff to take up and maintain positions in deprived and rural areas. There is also a fierce culture of lobbying for ‘good’ (i.e. urban, southern) postings. The result of this is not simply that the ‘less desirable’ districts have an insufficient number of teachers, but also that the teachers who do go there are largely inexperienced and unprepared to deal with the challenges. As one interviewee explained,

When the teachers arrive and we see a young girl just finished college we think ... she will not last. It is not that they do not have the skill. They are not prepared. The communities here, many are hostile. They do not really want education. And it is a clash of cultures. The local people think they (the teachers) are looking down on them. It is very demoralising for the teacher. (LG13)

In this context the district education staff engage in their own form of ‘counter lobbying’ to convince the trained teachers to remain. One key strategy is to try to find funds for teacher accommodation.

We know why they do not want to come. The schools are far away. There is no accommodation there ... In these places a man builds a house for himself and his family, there are no places to rent. So the teacher lives in the town and travels a very long time every day and it is expensive. Or they sleep on the floor of the classroom.’ (LG12)

Another strategy is to lobby for utilities such as water and electricity so that teachers will be happier to live in the communities. However, these expensive strategies depend on the ability of the district to raise IGF or lobbying the DA for the use of earmarked funds for these purposes. Given financial constraints in Zabugu, a district official explains, ‘often it just comes down to begging them to stay. But after the two years is up, it is their right to go’ (LG13).

6.2.2. Supply-side barrier: teacher supervision

Another key barrier to quality education in Ghana is a lack of teacher supervision. Analysis of EMIS data from 2008

indicated that only 77% of schools were visited on more than one occasion a year (Darvas and Balwanz, 2014). Our FGDs with teachers and GES staff (including circuit supervisors – whose job it is to visit schools, monitor teachers’ attendance and assess quality within a given geographical area), and those with community members, revealed inadequate levels of monitoring and supervision to be a real issue felt on the ground.

You see, before you move [travel to schools] you need fuel, and the directorate doesn’t have it: what do you do? You have to improvise or you have to sacrifice, so you become fed up because you use your own money and nothing will come [from the government] ... The support is not there ... and [yet] we have to supervise. (FGDBT)

As discussed in Chapter 5, Ghana received a GPE grant of \$75.5 million between 2012 and 2016 to support planning, monitoring and delivery of basic education. This included funds for the training and support of circuit supervisors, as well as head teachers in the use of school report cards in order to inform a school performance improvement plan. Over the course of the GPE programme there was a steady increase in the number of school visits by circuit supervisors rising to an average of 7.8 visits per school in 2015-16 (World Bank, 2017c). In addition, head teachers were satisfied that the feedback from circuit supervisors, was contributing to school planning decisions (Ibid.). Since the end of the GPE grant in 2015-16, the improvement in supervision and inspection has not been maintained, particularly because of recurrent costs such as fuel – this was evident from our fieldwork in both districts. This has led to an inequitable approach to school supervision whereby schools located more remotely are disproportionately suffering from lack of supervision, in some cases for up to two years at a time.

We have been given motorbikes for monitoring but no money to buy fuel to enable us to monitor the schools. [It] is making the work difficult for us. (FGDZT)

Because my circuit is closer to town, I am able to do regular and routine monitoring but my colleagues who monitor schools in the hinterlands that are 60 km away from Zabugu township are unable to do regular monitoring due to lack of funds for that purpose. (FGDZT)

There was an organisation here called GPEG [the Global Partnership for Education Ghana] ... they left here more than a year or two ago. Since then our work has come to a standstill. I feel bad, very embarrassed because the work is not going on, just because the money is not there for the work. (FGDBT)

School supervision is considered to receive low political attention because it is not a vote-winner, as one circuit supervisor explained to us in the FGD:

A politician's priority is where he or she will get more votes in the next election. Four years ago, the government embarked on massive eradication of 'schools under trees' to the neglect of monitoring. So much funds went into the construction of these schools – to end the 'schools under trees' system. Supervision does not feature prominently in the preparation of the budget just because it does not add anything in terms of votes for the political party in power. (FGDZT)

The most immediate result of a lack of supervision is high teacher absenteeism. According to one circuit supervisor,

Teachers know that the circuit supervisor does not have money to fuel his bike and travel to monitor their work and so they would opt to stay at home instead of going to school to teach. (FGDZT)

The teachers usually miss school for about a week and the children have no other option than to return home. At most times, Fridays automatically becomes holidays because the teachers do not come to school. (FGDZWEA)

This is particularly important as teacher absenteeism is one key reason why parents shift to the private sector for their children's basic education, but this option is not available to all, or in all districts – exacerbating inequality. Furthermore, in less densely populated areas such as Northern region, the absence of just one teacher can have outsized effects:

It's not cost effective to set up schools in every community; there might be five children in each one. So what we do is we cluster the communities so there are maybe 15 or 20 pupils in the school. It is multi-grade teaching so one teacher looks after P1-P3 and so on. So there are maybe three teachers in the school. It only takes one teacher to not turn up and there are only two teachers looking after the whole school. It doesn't take long for people to get disillusioned. (LG13)

6.2.3. Supply and demand-side barriers: infrastructure and distance to school

The most cited barrier to education in Northern region was distance. Women in Zabzugu whose children do attend school told us that, '[There is] no school in our area, the school around is very far. They go to school mostly by walking; only a few ride bicycle to school' (FGDZWEA). This is in contrast to the situation in Banda where we were told 'distance is not an issue' (FGDBWHA). In some respects this distinction is unsurprising. Northern region is the largest in Ghana with a land mass of 70,384 km² and a population density of just 35 people per square kilometre, compared to

Brong Ahafo which is 39,557 km² with a population density of 58 people per square kilometre (GSS, 2010).

As discussed in Chapter 3, GDHS data on the time taken to reach school suggests that there are relatively good levels of school supply, with more than 70% of those attending school in Northern and Brong Ahafo regions living less than 20 minutes from their school. Given the relatively high levels of enrolment overall, for the majority of students the issue is not that they will never attend school. Rather, fieldwork indicates that distance to school has a different impact at different stages of the education system. One key finding is that at the early ages distance to school delays enrolment. As one parent stated, 'You have to wait until the child is strong enough to manage the journey to school' (FGDZWHA); another told us, 'Some start [their schooling] at the age of seven or eight. And more to the point the distance discourages some of them' (FGDZME). Interestingly, it seems that, typically, these pupils who delay schooling until they are seven or eight years old are still placed in kindergarten rather than enrolling directly in primary school. This may be related to the fact that kindergarten is considered part of the basic education policy, making it free and compulsory. Stakeholders also argued that as capitation grants are paid on a per-pupil basis it makes financial sense for head teachers to extend the length of time a pupil spends in their establishment.

Once students have entered the school system, distance was seen to be related to absenteeism and school drop-out. As one parent in Northern region stated, 'The journey to school is long, the children are ok when they are eight or nine but then they get older they get distracted and bored and they wander off.' (FGDZW1)

Once a student reaches the end of primary school, the distance to junior high school may also affect their decision to transition. At this level Northern students travel a much greater distance to school than those in other regions. Of particular concern are the 33.7% of children in Northern region who live 6 km or more away from a junior high school (Marshall et al., 2016). This is compared to 7.2% in Brong Ahafo.

6.2.4. Demand-side barrier: hidden costs of schooling

Respondents in both Brong Ahafo and Northern region highlighted the persistence of extra costs associated with sending their children to school, particularly exam fees and school lunch.

In theory, exam fees should be covered through the capitation grant. However, according to school teachers and exam officers, where other government support is lacking, the capitation grant is used to pay for essential school maintenance and to repair items such as broken school chairs and tables (FGDBT). Delays in schools receiving capitation grants also mean that funds are not there at the time of year when exams take place (FGDBT, FGDZT). For a head teacher who has not received timely funds, the first step is to

approach the PTA. For example, with regard to the printing costs associated with exams, one head teacher explained,

We go to the PTA and we negotiate. Last year we decided we would take it in turns. For one exam they pay to print the papers, for the next one we write the questions up on the board in chalk, and so on. (FGDZT)

Much of the ability to cover these extra costs therefore comes down to the efficacy of the PTA. However, there are many instances where there is a lack of parental participation, particularly on the part of fathers:

You will organise [a] PTA meeting and it's only women. So I asked, 'No men in this community? You only gave birth to the children? You don't have husbands?' and they were all laughing. At the end of the meeting you have a very nice document but no implementation. Because the men who pay these monies are not there so at the end of the day it ends up on rocks. (FGDBT)

A second key barrier relates to feeding children while they are at school. Since 2005, the government has been implementing the Ghana School Feeding Programme (GSFP), which aims to provide children in public primary schools with one meal per day. However, the programme is not yet universally implemented.

I am unable to feed my children regularly because of lack of food and money. Sometimes my children will go to school without food, and there is no money for them to buy food at the canteen when they are on break. Some will come home and will not go back to school because they are hungry. The children need money to buy food in school because not all schools have access to the government free feeding programme. (FGDBWHA)

At the district level parents and teachers complained of a lack of transparency around the choice of schools that benefit from the programme. In particular, mothers feel isolated from these decision-making processes. Unlike school-level decisions taken at PTA meetings (that ultimately depend on male financing), men dominate the district-level meetings on infrastructure or school feeding projects.

When men are discussing an issue and you are not called, you cannot go and join them in their meeting. When there is a project to be put up, the men will meet and discuss what to do without calling us and before we realise the project is going on. It is only where there is work for women to do like carrying water or sand then they inform us by beating the gongon. When we respond to their call and after carrying out our duty, we just take

our pans and go home without anyone telling us anything. (FGDBWHA)

There is, however, a strong feeling that it is a process driven by politics: 'It is the political leaders that decide' (FGDBT). This reflects previous research that indicates that the way in which the school feeding programme has been implemented is a highly political process (Abdulai and Hickey, 2016). The GSFP was designed to target 'the most deprived districts/communities and the poor' and the selection of GSFP beneficiary districts was to be guided by a set of needs-based criteria, including the levels of poverty and school enrolment rates in the various regions and districts. There was a shift towards a more universal approach, justified on the grounds of national unity, whereby one primary school would be drawn from each of the 10 administrative regions, before being scaled up to two and then five schools per district by the end of 2005-06 (Abdulai and Hickey, 2016).

However, when it came to actually disbursing expenditures, this more benign and potentially more inclusive form of patronage politics was trumped by a more exclusive form, with resources captured by dominant factions within the ruling coalition. The pattern of this capture directly reflected both the regional distribution of holding power within the ruling coalition at multiple levels, and the highly personalised functioning of the public service. (Abdulai and Hickey, 2016)

The analysis indicates the way in which this compounded existing regional inequalities. Ashanti, a key voting block for the then ruling NPP, received the highest proportion of GSFP spending (28%) over the period 2005-08. In comparison, Northern region, an NDC stronghold, received just 3%, despite being a much more deprived area. The analysis also demonstrates that Brong Ahafo, a swing region, received high levels of school feeding resources because of a key parliamentary by-election at the time (Abdulai and Hickey, 2016).

6.2.5. Political factors: incomplete decentralisation and poor coordination at a district level

As described in Chapter 2, there are parallel lines of authority and responsibility in Ghana's education governance structure – with the technocratic, deconcentrated GES representative (the DEO) on one side and the political local government body (DA) on the other. There are pressures of national-level demands and, in this context, coordination at the district level is challenging.

Directives on education at the district level come from national or regional headquarters with strict compliance and they come with deadlines. All other activities pertinent to the teachers' performance and classroom work in the district are then relegated to

the background in favour of the national demand. (ESID, 2016)

This was confirmed in our fieldwork, for example:

One of the key challenges really is ‘parachute projects’ coming from the centre. There will be pressure to get it done. (LG14)

Sometimes they do things at the last minute and sometimes we do things without really involving them. (LG14)

We don’t work much together ... only collaborate on certain big projects. (LG6)

The DEOC is designed to be the coordination body between the DAs and the DEOs. However, a key challenge highlighted by respondents is that the district coordinating chair is supposed to chair the meetings and, as it is not a priority, the DEOC remains largely dormant. Contact between the DA and DEO therefore happens as part of the wider district planning process. The DEO attends quarterly meetings of the DA’s district coordination planning unit. Alongside representatives from agriculture, health, fiscal planning and social and community welfare, these meetings provide an opportunity to report on the district’s progress and challenges in the sector. In practice, most discussions centre on infrastructure given the nature of funding available to the DA (for example the DACF and DDF, which are to be used for capital spending) and the de facto ‘division of labour’ that has emerged as a result, whereby the MoE provides very little for capital investment. According to one respondent, ‘if we need more schools or to maintain buildings ... the DA... those are the people who will help us with that’ (LG6).

It is also widely reported that the DAs tend to prioritise visible infrastructure as it brings political favour with voters. The result is that, when asked about the priorities

for education in their district, representatives from the DA highlight the need for school buildings or teachers’ accommodation. This is in contrast to representatives from the DEOs, who highlight the need for community sensitisation efforts, experienced and motivated teachers and intensive education courses for those students needing extra support (LG12, LG13).

There is also, at times, a lack of collaboration on projects that are decided as a result of the planning meetings. For example, a decision may be taken by the DA to start construction work on a school without the knowledge of the DEO.

It is the politician that builds it. And the politician will not consult the [education] directorate. (FGDBT)

We should have been consulted. It was just one of the officers who noticed it when he was out doing his rounds. But the way they built the school was not good. The toilets were too close to the classrooms. The headmaster’s office should be at the end of the block so that he can see when pupils are leaving when they should not. There was a double veranda, which obscures his view. We could have told them these things. Show us the plans. We are not architects but we know about education and schools. (LG12)

Overall, it is clear that the DEOCs are not operating as they should be. While the district coordination planning Unit provides some form of participation from education sector representatives in the district planning process, it skews information-sharing towards areas that are most likely to attract capital, such as the construction of school buildings, thereby relegating other vital issues that would require recurrent investment. Furthermore, these planning unit meetings do not create the consistent collaboration needed to ensure that projects respond to a community’s education needs.

7. Conclusions and recommendations

Ghana has been widely acknowledged as one of sub-Saharan Africa's 'rising stars' across many of the MDGs (Lenhardt et al., 2015). Successive governments have made laudable progress on improving provision of basic health and education services, spurred by strong aspirations for inclusive national development. Under the SDGs, Ghana has committed not only to expand these achievements but also to 'leave no one behind' in doing so. However, as this report shows, there are several twists to this tale of progress, suggesting that urgent reforms are needed in the design and resourcing of some key health and education policies if this commitment is to be met.

First, an underlying pattern of inequity in service coverage and access persists, most obviously on a regional basis, with the remote and culturally distinct Northern and Upper West regions experiencing the most acute marginalisation by most of our indicators. For example, Northern region's CCI score, measuring the coverage of key maternal and child health services, is 49.5% – that is, 16 percentage points behind the national average. Even demographic groups we posited as 'non-marginalised' (such as urban, and more highly educated) fare worse on the CCI in Northern region than most marginalised groups in other regions. In education, 18% of children aged 13-15 years in Northern region have not received any education, compared with just 5% in the next-worst region (Upper West) and just 4% nationally. This reinforces a well-established literature emphasising the historical marginalisation of Ghana's north.

We also identified the poorest wealth quintile nationally to be consistently vulnerable to exclusion from health care and education. In the poorest quintile of households, the average CCI was 58%, compared to 68% for the rest of the population. Children aged 13-15 years whose households fall in the poorest quintile have, on average, 4.2 years of education, whereas the rest of their age cohort have 5.8 years. Other drivers of exclusion we investigated – rural location, lower education levels,⁹⁷ ethnic minority status⁹⁸ and, to a much lesser extent, gender⁹⁹ – appeared

important for certain indicators or certain regions, but were not as consistently marked as regional and household wealth differences.

Some of these gaps have narrowed over time, especially in education. For example, the improvement in the average length of schooling for children in Northern region between 2008 and 2014 was more than double the national rate of improvement, and the share of Northern region's population aged 13-15 without any education fell by 17 percentage points over this period, compared to 4 percentage points nationally.

However, in many cases we found that those who were already the most excluded were being left further behind. The CCI score of Northern region – which was already the lowest performing in 2008 – declined further by 2014. Only 2 out of 10 regions saw overall progress in health coverage combined with a shrinking gap between marginalised groups and the rest of the population. In education, the quantitative data paint a more positive picture, but are mostly limited to metrics of 'quantity' rather than 'quality'. Our interviews and focus groups with communities suggest that greater policy attention is needed to the quality of pre-primary and primary education, particularly in more deprived areas of the country, where serious concerns were raised about the quality of teachers and learning resources. In some cases – in education, as in health – narrowing gaps were a result of worsening access for non-marginalised groups, rather than improvements for marginalised groups.

In addition, at least in the health sector, there appears to be a real risk that Ghana's overall achievements have gone into reverse, moving the country further from its stated goal of universal health coverage. The national CCI declined slightly from 67.2% (2008) to 65.9% (2014). This puts Ghana closer to Nepal – a least developed country with roughly half its GDP per capita – than to Kenya, a reasonable comparator (ODI, 2016). Over the same period, OOP payments – the most regressive form of health financing – have risen both as a share of total spending and in absolute terms.

97 Examined for health only owing to data limitations.

98 Examined for health only owing to data limitations.

99 Examined for education only owing to the nature of the CCI, which does not cover male adults.

If there is strong political will in Ghana behind the aspiration to inclusive development, how can these mixed outcomes be explained?

Overall, we found that Ghana's policies in health and education are ambitiously universal, but that the allocation of financial and human resources to implement these policies is not in line with the principle of progressive universalism. Ghana's highly competitive electoral dynamics have resulted in a clear, cross-party preference for universal policies that are ambitious to the point of fiscal implausibility – as seen in the broad benefits package of the NHIS and the recent roll-out of the NPP's election campaign promise to launch free senior high school nationwide. This has come at the cost of sustaining a focus on achieving, and maintaining, the basics: good quality preventive and primary health care, and early years and primary education, with adequate recurrent budget and an adequate distribution of teachers and health workers in all regions. A progressive universalist approach implies making overt changes to resource allocation and actively prioritising the furthest-behind groups, for example, by sequencing reforms and targeting resources to the areas of greatest need. This is even more important when there is not an expanding pot of government resources available; indeed, Ghana's recent context has been one of macroeconomic slowdown and fiscal tightening.

Our analysis suggests that this mismatch of policy ambition to the realities of resource allocation is having a detrimental effect on health care and education access for vulnerable and marginalised groups for two reasons. First, historically deprived areas with significantly lower baseline levels of infrastructure/facilities and staff will be left further behind under a 'business as usual' system of incremental budgeting, and where the majority of the budget is allocated to salaries, as is the case in both sectors. Second, it is the poorest households and most remote communities that are least able to access private sector alternatives, and are thus disproportionately impacted when the availability and quality of (free) public services are weak.

There must be renewed and urgent action to reach the most marginalised – but there is real cause for optimism that determined policy initiatives, backed by sufficient financial resources, can make a profound difference in even a relatively short space of time. The story of Ghana's Upper East region illustrates this point; its lessons could be drawn upon to guide similar progress in other regions. In 2008, the Upper East had one of the lowest CCI scores (66.2%) in the country, very similar to that of its neighbouring region, Upper West (65.8%). By 2014, it had recorded the highest CCI performance (72.3%) in the entire country, opening up a 9.2 percentage point gap with Upper West, and bucking the country's overall trend of decline. During this period, regional health authorities in Upper East energetically drove through a series of initiatives to train, retain and incentivise health workers, underpinned by new structures of 'diagonal' (combining vertical and horizontal) accountability, and backed by additional funding from both donors and government.

In Ghana's heavily centralised health and education sectors, broad and sustainable reform will need to be led by central government. But the contributions of local government, donors, civil society organisations and other actors will also be critical. Below, we conclude with a series of policy options covering data, policies, financing and service delivery that could be considered as priorities for ensuring inclusive access to health care and education.

7.1. Data to leave no one behind

One major impediment to leaving no one behind is the lack of data that are available over time and are systematically and routinely disaggregated by district, region, urban/rural location, income or wealth, gender, ethnicity and other demographic characteristics, as governments committed to in signing up to Agenda 2030. While Ghana has high-level political support and a promising environment for open data, our analysis nevertheless faced constraints in the availability of and access to data.

One issue that affected our quantitative analysis of who is being left behind was the availability of disaggregated data on vulnerable groups that are currently 'invisible' in the data, such as people with disabilities. Second, data on health access collected via the DHMIS2 are not made publicly available, in contrast to the EMIS for education. The EMIS database itself is also a work in progress: we (and other data users) could not find the codebook and other documentation that are necessary for analysing the data correctly. A third issue that constrained our financing analysis is the lack of comprehensive budgetary datasets in historical time series, with respect to actually executed financing (as opposed to planned budgets), and in a machine-readable format rather than large PDFs, especially down to district levels.

Two promising recent initiatives are the District League Table, and the announcement of district-level statistical offices. The District League Table, compiled by UNICEF Ghana and the Ghana Centre for Democratic Development (CDD Ghana) in collaboration with the MoLGRD, creates a composite metric for household well-being in each district, based on nationally verified data on education, health, rural water, sanitation, security and governance (UNICEF and CDD Ghana, 2016).

Recommendations

- The government should strengthen transparency and reporting on financing for and access to data in the health and education sectors, including by making DHMIS2 and integrated budget and actual spending data publicly available in an open data format. To build up a sufficiently detailed picture of who is being left behind, and how financing is being allocated geographically, these data must be disaggregated to regional and district levels.

- **Donors and the government should work together to improve transparency of reporting on development assistance flows**, including on the distribution of aid around the country. Only 29% of data on aid to Ghana's basic health sector for the period 2009-2016 has been geo-coded, for example, making it difficult to identify how well it is targeted to areas left behind.
- **As part of the next nationwide household survey in Ghana, the Washington Group questions on disability should be implemented.**¹⁰⁰ Over time, the government should move to mainstreaming data disaggregated for people with disabilities into its routine data processes.
- **Government agencies – including GSS – should work with civil society to broaden the scale and scope of disaggregated, data-driven monitoring systems such as the District Scorecard initiative, and integrate this tool into policy-making and planning.** In just three annual iterations of this exercise thus far, it has spurred closer tracking of outcomes by the authorities and is being discussed in mainstream media, which in turn has created greater awareness among stakeholders of specific, real-time trends in inequalities. The plan to institute district-level statistical offices is an excellent first step towards much more systematically and routinely gathering high-quality, timely and disaggregated official data to feed into decision-making.

7.2. Policies to leave no one behind

Ghana's policy framework for the health sector has many potentially progressive components, including both the NHIS and CHPS policy. However, the apparent recent trend away from UHC, the rise of OOP payments and the fact that the NHIS still covers only 38% of the population are deeply concerning.

Health recommendations

- **Re-galvanise political commitment to UHC with the launch of a reformed NHIS**, in line with Ghana's support for the SDGs and the 2012 UN General Assembly Resolution.¹⁰¹ The current government, led by the party that first established the NHIS, now has an opportunity to re-launch it with some important reforms to its design to make it fit for leaving no one behind, particularly in the current fiscally constrained environment. This re-launch should involve a commitment to full population coverage, with core health services provided for free at all public

health facilities. However, in line with the principle of progressive universalism, there should be a much stronger focus on preventive health, family planning (which is not currently included) and basic curative services. These are the most crucial components of a health system for both equity and cost-effectiveness, delivering large health benefits for relatively low costs. The broad benefits package of NHIS services – currently covering 95% of the population's health conditions (Atim and Amporfufu, 2016) – should be re-designed realistically. While the package needs to remain attractive to the non-poor, and hence some secondary and tertiary services should be included, these must be limited and rationed, for example through waiting lists. Chile and Thailand are good examples where highly successful and pro-poor national health insurance programmes began with an explicit primary health care focus and a limitation on hospital services, and were then scaled up to a broader benefits package when fiscal space allowed. If the system of membership cards is retained, it will be important to ensure that the registration and any re-enrolment processes are minimal and not burdensome for those in remote areas and vulnerable groups, for example by making these services available via registered health facilities.

- **Ghana should continue to roll out the CHPS policy, which has significant potential for bridging health gaps in remote and rural areas.** However, the building of any new CHPS compounds must not take place in isolation, but in tandem with planning for how these will be equipped, staffed and maintained. This will likely require closer collaboration between local government and the regional and district offices of the GHS. Importantly, the MoH should not rely solely on district authorities to mobilise funds for building and equipping new compounds, which disadvantages the most deprived areas. But, for any new construction, the government should prioritise only the most deprived areas where CHPS provision is currently very sparse – especially in Northern region (which has the lowest number of CHPS compounds per square kilometre in the entire country). The main focus should be on allocating greater funding towards existing CHPS' recurrent budgets, to ensure a minimum quality of services.

In the education sector, there is a need to raise greater political attention to serious quality issues in the pre-primary and primary levels, and the resulting problem of the 'public-private crossroads' (whereby better-off children attend private primary schools, then go on to public secondary schools), which is undermining equity.

¹⁰⁰ Examples of the implementation of the Washington Group questions on disability in other developing countries can be found here: <http://www.washingtongroup-disability.com/methodology-and-research/censuses-and-surveys/>

¹⁰¹ Resolution A/67/L.36 'Global health and foreign policy', http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36

Education recommendations

- **Ghana should make a high-profile commitment to progressive universalism in education**, in line with the recommendations of the International Commission on Financing Global Education Opportunity. Progressive universalism in education promotes balancing scarce public resources in order to prioritise the poor and early years where social returns are highest. This would entail careful phasing in of the commitment to free senior high school. For example, the policy could be rolled out in deprived districts first, or implemented using means testing such that wealthier households continue to pay some portion of the fees (which would presumably still remain an attractive option, given the perception of status and quality afforded to public secondary schools). It would also thereby cross-subsidise poorer households. In any case, developing a costed and realistic proposal is critical to ensure that the initiative does not cut into already diminishing basic education funding.
- **Introduce age-appropriate catch-up programmes for children starting school late.** The data indicate that ‘over-age’ enrolment is a significant problem, which may limit the quality of education received and total length of time spent in school. Catch-up programmes should aim to transfer children into their appropriate year group within a limited timeframe. Evidence shows that smoothing children’s transition into primary school can improve learning outcomes, school attendance, pass rates and grade promotions while reducing drop-out and repetition rates (Wodon, 2016).
- **Engage equity groups on the ‘public–private crossroads’.** We did not find much evidence of concerted political or civil society attention to the phenomenon where those who can afford to are increasingly enrolling their children in private kindergartens and primary schools, before re-joining the public system at secondary level, while the most marginalised children are facing lower-quality primary education, and are less likely to make it to secondary school at all. Ghana’s education debate appears squarely focused on secondary school policy, in line with the interlocking interests of wealthier households, political elites and the powerful graduate teachers’ unions. Yet a multitude of evidence shows that early years is the most important stage for improving equity. Civil society groups and others with an interest in equity issues could play a valuable role in igniting a debate and building political pressure for a greater policy focus on the state of pre-primary and primary education in Ghana.

One of the greatest inequities that cuts across both the health and education sectors is the failure of policies to redistribute human resources, which are drastically skewed towards urban centres and the southern regions. As an illustration, Zabzugu district in Northern region has only 43 health workers (and no doctors) serving a population of more than 63,800 people – a ratio of 0.67 health workers per 1,000 people, compared

to the national ratio of around three per 1,000. While various central government policy initiatives have tried to redress the problems of absenteeism and moonlighting, none has been particularly successful owing to weak enforcement and accountability, although the government’s recent efforts with IMF support to remove thousands of ‘ghost workers’ from the GHS and GES payrolls have been promising. From a financial efficiency perspective alone, there is a very strong case for the government to find solutions to the problem of health and education worker distribution as a priority, particularly given the substantial increases in the health and education wage bill seen since 2012. While the powerful medical and teachers’ unions have an obvious interest in maintaining the status quo, this need not be an insurmountable challenge. Upper East region, which rapidly increased and retained its health worker force, provides a good example of a successful ‘carrot and stick’ approach, underpinned by a combination of vertical and horizontal lines of accountability.

Cross-cutting recommendations

- **A key element in Upper East was establishing annual district quotas for training local people, who are more likely to want to continue living in the area, as community health workers and nurses.** In education, there has been similar success nationally with the Untrained Teachers Diploma in Basic Education, supported by the GPE, which has trained 6,480 teachers from deprived districts. These teachers were found to be more willing than non-locals to stay in their home areas. Local hiring of teachers has more generally been found to be a ‘proven’ strategy for improving the effectiveness of learning (Wodon, 2016). Though the GPE’s specific funding ended in 2016, the programme was effective and should be maintained. Local authorities such as DAs can play a role in prioritising the mobilisation of locally raised revenues for sponsoring new nurses and teachers, where possible. However, as emphasised to us in Banda district, local resources in many of the poorest districts are extremely tight – the central government should therefore provide some financial assistance for a defined quota of sponsorships in a prioritised list of the most deprived and under-staffed districts. While this does require some initial investment, the efficiency gains will be considerable given that the government is currently paying salaries for a large number of absent workers. It is also likely to be a cost-effective strategy. According to results for Ghana from an equity costing model developed by UNICEF and the World Bank (2013), implementing a pro-equity strategy for teachers focused in the northern regions and with a focus on providing remedial teachers for the poorest learners, while providing in-service training to the existing uncertified teachers, would lead to more children reaching the National Education Assessment mathematics standards by 2020, and cost about 20% less than replacing a much larger number of untrained teachers nationwide.

- **A second element in Upper East was sponsoring health workers under a bond and ceasing payment of salaries for those who broke the bond.** This, until recently, has also been standard government policy for nurses nationally. The key difference in Upper East, however, is that absent nurses actually had their salaries blocked by the regional health director in collaboration with GHS headquarters. Such intervention is currently difficult as a result of the centrally controlled payroll, which relies on the slow feeding of ‘ground’ information up the chain. One option would therefore be to deconcentrate the payroll to regional or district levels, where it is better aligned to both local information and local incentives to sanction absenteeism. However, the Upper East example demonstrates that the central payroll is not a binding constraint, if there is an active regional directorate motivated to intervene.
- **The third element, the ‘carrot’, involved creative ways to motivate and retain staff, including (improved) accommodation, training and some small material incentives.** A financial incentive, such as a salary percentage top-up, for workers to relocate to under-served areas may be a good option when this becomes financially and politically viable. In The Gambia, for instance, a 30% to 40% top-up introduced in 2006 resulted in 24% of teachers requesting a transfer to a hardship posting the following year. A deprived areas allowance has been tried (not very successfully) in Ghana before, however, so any new scheme would need to avoid the same issues, including a clear and consistent delineation from the outset of which workers would benefit. Such an initiative has significant cost implications, however, and in the short term, maintaining wage growth discipline is a critical priority in order to free up resources for other recurrent and capital expenditure. In Upper East, the regional health authorities boosted morale and retention through training, mentoring, certificates, letters of recommendation and relatively small material incentives such as TV sets in health workers’ accommodation, a strategy that was partly backed up by additional funds from donors and communities themselves. Ghana’s CHAG – present in rural areas across the south of the country – provides health workers with good quality, free accommodation. Similarly, countries such as Uganda allocate grants for teacher housing (Mulkeen and Chen, 2008).

7.3. Financing to leave no one behind

In some contrast to our previous stocktakes in Kenya and Nepal, in Ghana we found that financing is currently a binding constraint to achieving the commitment to leave no one behind.

In the health sector, while per capita government funding has risen over the past few years, it is likely that a large part of the increase is being used to pay salary

arrears rather than to make new investments in services. As a share of the total government budget, health spending has declined since 2011, and the share of this allocated to district health services (versus central functions) appears to have diminished significantly. Furthermore, the way this budget is allocated to regions and districts does not appear to be responsive to equity gaps in current provision.

Health recommendations

- **Community and district-level services are critical for improving health equity and can be highly cost-effective in delivering health outcomes; funding should be made more transparent and reallocated to these services from the centre.** The MoH should investigate and publish information about what is driving the decline in the share of health spending allocated to district health services, (which dropped from 42% in 2011 to 32% in 2015), while the share for central HQ funding grew by more than 20 percentage points over the same period. This could not be clearly explained either in the available budget information or in our interviews with government officials, implying a need for greater budget transparency. The ministry should take urgent action to curb any further growth of HQ functions and to reallocate funding to district and sub-district health facilities, particularly health centres and CHPS compounds, many of which have been under extreme strain with virtually no recurrent funding in the past several years. The government’s requirement that district facilities rely on ‘internally generated funds’ (NHIS reimbursements, which are slow and incomplete; and user fees, which are regressive) and donor funds (which are limited in amount and coverage) is an inequitable financing strategy that particularly harms the poorest districts.
- **The government should implement a health financing strategy that proactively addresses the withdrawal of donor funding (particularly in areas critical for leaving no one behind, such as preventive health, public health and family planning) and the need to gradually mobilise more tax revenues for health.** The outlook of declining donor engagement is indeed recognised in the 2015 Health Financing Strategy (MoH, 2015). This document also considers Ghana’s overall weak fiscal capacity relative to other similar LMICs in the region in terms of tax/GDP. It notes the need to gradually increase government revenues for health, for example through earmarked ‘sin taxes’ on cigarettes and alcohol, or an increased share from the SSNIT. However, this Health Financing Strategy has not yet been implemented.
- **The MoH should prioritise developing, implementing and publicising a clear and fixed formula for allocating funding to regions and districts.** While we were told that formulas do exist in theory, they were not obtainable in our research and, according to some of our interviewees, they are unclear and change regularly. In Kenya, for example, there is a clear and transparent formula for

allocating funds to counties, including a 20% share based on the poverty gap and an 8% share based on land area. Unlike in Ghana, our stocktake in Kenya found a positive correlation between county allocations and need (ODI, 2016). Given that such a process can take several years, an immediate priority in the meantime would be to increase the non-wage per capita allocations to a defined minimum (such as the current national average) in those regions with below-average funding and poor health coverage, principally Northern region. Meanwhile, the geographical distribution of wage spending would be shifted over time towards currently under-served regions and districts based on the policy recommendations above relating to human resource training and retention.

- **On the basis of agreed reforms to improve equity and efficiency such as those described above, the MoH should work with the MoF to implement a health financing strategy that anticipates and adjusts for a decline in donor funding.** This could set the medium-term goal of re-instating the overall envelope for health spending to its recent (2011-12) peak level of 14.5% of the total budget, which is just below the international benchmark of 15%. But this should take into account how the government will offset expected declines in external assistance, and also exclude from the target any payment of arrears for past years' salaries, which do not represent new investments in services for the budgeted year.

In the education sector, we found a dramatic decline in the share of the education budget devoted to pre-primary and primary funding, from 35% in 2011 to 15% in 2015. More worryingly, even in per pupil absolute terms, funding at these levels has flat-lined, and slightly decreased in 2015. Meanwhile, funding for secondary and tertiary education has risen rapidly. These trends are likely to be exacerbated by the commitment to roll out free senior high school nationwide. At the same time, families are increasingly turning to the private sector at the lower educational levels (not for senior high school). The private sector accounted for 25% of primary school enrolments in Ghana in 2015-16, up from 19% five years earlier. Our qualitative research uncovered real concerns about the quality of public kindergartens and primary school education.

Education recommendations

- **As a first step, the MoE must urgently commit to protect front-line pre-primary and primary funding per pupil – excluding central HQ functions – to at least its 2014 level (446 Cedis (c. \$100) for pre-primary; 386 Cedis (c. \$85) for primary), and then develop a plan with clear milestones for how these levels will be gradually increased over time in order to meet minimum quality standards in every district.** Currently, Ghana's primary funding is less than a fifth of the UNESCO-recommended amount needed by 2030 to ensure equitable and inclusive universal access.
- **The MoE should implement and publish a clear funding formula for regions and districts,** and in the meantime concentrate on narrowing the largest geographical gaps in per pupil non-wage funding levels. As noted in Vegas and Coffin (2013), funding formulae based on student need are commonly used in Organisation for Economic Co-operation and Development (OECD) countries to distribute resources intended to improve learning. Results for Ghana from the Simulations for Equity in Education model (UNICEF and World Bank, 2013) suggest that proactively targeting resources to the poorest areas in the north would create significantly larger gains (in terms of the number of children completing primary school and performing well on the National Education Assessment), and would cost significantly less than a nationwide, non-targeted strategy.

For donors, countries such as Ghana pose a conundrum: a recently turned MIC, with rapid rates of growth during the 2000s, is now facing severe macroeconomic challenges and burgeoning public debt repayments, and is subject to an IMF bailout, squeezing the public resources available for development, especially in social sectors. Several major donors (such as Denmark and the Netherlands) have recently announced that they are phasing out development assistance to Ghana, with others such as the UK considering transition plans. The first and foremost responsibility to leave no one behind lies with national governments. Yet donors have historically made large and effective investments in Ghana's health and education sectors and they should be concerned to protect these gains, particularly to mitigate any negative effects of their aid reduction or withdrawal on vulnerable and marginalised groups.

Cross-cutting recommendations

- **Donor support to Ghana should prioritise strengthening health and education systems at points where diagnosed weaknesses, such as those highlighted in this report, are most likely to undo past gains and disadvantage vulnerable and marginalised groups.** Donors should also proactively discuss with the Ghanaian government and other domestic actors from the outset how programmes will be transitioned fully to their ownership, identifying the political dynamics necessary to sustain initiatives that benefit the poorest and most marginalised groups. Large-scale financial grants are probably no longer realistic in the Ghanaian context. Given this, our research suggests certain options for donor support that could be highly valuable:
 - Sponsorship for quality training and mentoring of nurses, midwives and teachers from the most deprived and under-staffed districts, in support of the policy recommendation on human resources above.
 - Funding for certain core functions at regional and district level that are important for equity but

vulnerable to being cut when central government resources are not available, particularly data gathering and analysis, supervision and inspections, and monitoring and evaluation. Again, these activities should be prioritised in districts with the highest deprivation and lowest service coverage.

- Testing and piloting innovative accountability initiatives such as the District Scorecard.
- **While donors should respect country ownership of development priorities, they can play a valuable role in championing the leave no one behind agenda and evidencing its implications for government policies and resource allocation.** Aligning exclusively behind the government's own spending priorities may reinforce rather than redress gaps in the system. For example, there are now only two significant donors still engaged in pre-secondary education in Ghana. ODA for education in Ghana has declined rapidly since 2013, and was overtaken by ODA for secondary education for the first time in 2015. Donors committed to the leave no one behind ambition should target their own funding towards key neglected areas such as improving the quality of pre-primary and primary education, while encouraging the government to redress its own spending balance (for example through matched funds, results-based instruments and policy dialogue).
- **More broadly, Ghana's story is illustrative of the need for both bilateral and multilateral donors to think through carefully their aid graduation and transition approaches, particularly in LMICs, whether this involves withdrawal of assistance altogether or moving from concessional to non-concessional finance.** In the case of Gavi, Ghana repeatedly delayed on co-payments for 2016 and 2017, and has now fallen back below its income threshold, so will become eligible for new Gavi assistance in 2018. In the case of the GPE, Ghana is technically no longer eligible given its GNI. Rapid economic growth spurts, particularly when heavily premised on commodity prices (and complicated by the effects of GDP re-basing) as in Ghana, are not in themselves a sufficient basis to determine that a country no longer needs concessional aid. Donors should take account of countries' changing macroeconomic conditions, debt sustainability and socioeconomic indicators in their transition planning.

7.4. Service delivery to leave no one behind

Our research suggests that the most critical blockages to basic health care and education access in Ghana are on the supply side rather than the demand side, or relate to issues that cut across both, such as the distance required to travel to facilities. Our analysis indicates, for example, that the two key explanatory factors behind the divergent health and education coverage in Brong Ahafo and Northern regions relate to the large difference in baseline provision of

physical infrastructure such as schools, health centres and CHPS compounds per capita – and, even more strikingly, per square kilometre – combined with acutely uneven patterns of human resource distribution. In Northern region, community members most frequently cited distance to health facilities and schools as the main barrier to access. In Brong Ahafo, concerns were centred on 'hidden' costs associated with school lunches, drugs and medical services, as well as the quality and reliability of services.

Recommendations

- **The construction of new schools and health facilities must be carefully balanced with maintaining and improving the quality of existing ones. But where new construction does take place, the government should focus squarely on district and sub-district facilities (particularly CHPS compounds), kindergartens and primary schools in deprived and remote districts where their provision is currently furthest below the national average.** People living in Northern region, on average, have the furthest distances to travel to reach even basic health facilities – with just 6.3 CHPS compounds and 2.1 health centres per 1,000 km², for example. In Upper West region, less than half of rural-dwelling pupils can reach their school in less than 20 minutes, and for 5.6% of them, it takes more than an hour. These statistics do not even include children who do not attend school, possibly because for them it is too far away. Previous equity modelling for Ghana suggests that the construction of new facilities (500 new kindergartens as an example from UNICEF and World Bank, 2013) targeted to the poorest villages of the northern areas of the country could increase the number of children going on to complete primary school by five times more than simply building the same number of kindergartens evenly nationwide, and at a fraction (one quarter) of the cost per child. A list of targeted districts, based on objective data on current levels of provision, should be published and circulated within those districts to improve transparency and accountability – together with a political commitment not only to build facilities but also to equip, maintain and staff them. The example of Ethiopia shows how a concentrated programme of rural classroom construction can accelerate progress towards universal primary education; it decreased the number of OOSC by 3 million and reduced gender disparities (UNESCO, 2008).
- **The government should implement previous commitments (for example in the 2010 ESP) to provide suitable transport for children who live a certain distance away from the nearest kindergarten or primary school (3 km) and high school (5 km).** Given that it may not always be cost-effective to build new schools in lightly populated areas, providing public transportation is an important policy option to reduce travel time and increase enrolment, especially for girls (Wodon, 2016).

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- **On the demand side, the GHS could consider introducing specific material incentives to encourage women to deliver in health facilities.** This would help to overcome some of the demand-side barriers identified, such as fears about the risks of delivering in public health facilities. In Mozambique, for example, the government introduced specific cash incentives, and provision of baby equipment for women who delivered in health centres (Rodriguez-Pose et al., 2014). Conditional cash transfers contingent on antenatal visits could also be introduced. Likewise in education, conditional cash transfers have had success in some contexts, such as rural Ethiopia and the Indian state of Haryana, in keeping girls in school and preventing child marriage (Wodon, 2016).
 - **Ghana should re-focus its school feeding programme to the poorest districts nationally and make transparent the criteria by which beneficiary districts and schools are selected.** In our fieldwork in Banda (Brong Ahafo) and Zabzugu (Northern), one of the most frequently cited demand barriers to primary education was lack of money for school lunches, and it was not clear to community members why some schools were included in the feeding programme and not others. There is good evidence that school feeding can be effective for both increasing school participation and improving learning outcomes (Snilstveit et al., 2016).

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Annex 1: Methodological appendix

The list of interviewees who consented to be named in this report is as follows:

Charles	Abugre	Chief Executive Officer	Savannah Accelerated Development Authority
Charles	Acquah	Deputy Director	Policy, Planning, Monitoring & Evaluation Division, Ghana Health Service
Mustapha	Adam Hamed	Deputy Director	Finance Department, Ghana Health Service
Archibald	Adams	National Campaigns Coordinator – Universal Access to Healthcare Campaign	Oxfam Ghana
Christian	Addae Poku	President	National Association of Graduate Teachers
Seth	Afful	District Budget Officer	Zabzugu District Assembly
Manuel	Akilagpa Sawyer	Budget Officer, Health and Education	Real Sector Division, Ministry of Finance
Mary	Akonne	District Chief Executive	Banda District Assembly
Joseph	Amah	District Coordinating Director	Banda District Assembly
Effua	Amissah-Dawson Amuah	District Education Director	District Education Directorate, Banda, Ghana Education Service
Bright	Amissah-Nyarko	Vice Chairman of the Board	NGO Coalition on Health
Festus	Ankrah	Head of Social Policy	IMANI
Joseph	Antwi	Head of Fiscal Decentralisation	Fiscal Decentralisation Unit, Ministry of Finance
Jacqueline	Anum	Head of Data Services Unit	Ghana Statistical Service
Evelyn	Arthur	Chief Budget Analyst	Budget Division, Ministry of Finance
Osei	Asibey	Regional Education Director	Regional Education Directorate, Brong Ahafo Region, Ghana Education Service
Clara	Asigri	Finance Officer	Regional Health Directorate, Northern region, Ghana Health Service
Mohammed	Awal	Research Officer	Centre for Democratic Development
Koku	Awoonor Williams	Director	Policy, Planning, Monitoring & Evaluation Division, Ghana Health Service
Lydia	Baaba Dsane-Selby	Acting Deputy Chief Executive, Operations	National Health Insurance Authority
Kathleen	Beegle	Program Leader for Ghana, Liberia and Sierra Leone	World Bank
Gabriel	Benarkuu	Chairman of the Board	NGO Coalition on Health
Owusu	Boampong	Regional Deputy Health Director (Administration)	Regional Health Directorate, Brong Ahafo region, Ghana Health Service
Sam	Boateng	Chief Accountant	Financial Management Services, Ministry of Health
Anab	Chrys	Director, Social Development	Savannah Accelerated Development Authority
Janice	Dolan	Education Adviser	Department for International Development
James	Duah	Deputy Executive Director	Christian Health Association Ghana
Diane	Dufie Jefe-Appiah	Northern Brong Ahafo Regional Coordinator	Savannah Accelerated Development Authority

Sebastian	Duut	District Planning Officer	Banda District Assembly
Veronica	Dzeagu	National Coordinator	Ghana National Education Campaign Coalition
Emmanual	Ewuntoma	District Health Director	District Health Directorate, Zabzugu, Ghana Health Service
Andrew	Fosu	Educational Technical Programme Manager	World Vision
Atia	Francis	District Education Director	District Education Directorate, Zabzugu, Ghana Education Service
Daniel	Kanyage	District Coordinating Director	Zabzugu District Assembly
Christian	Koramoah	Financial Controller	Ghana Education Service
Samuel	Larbi	Regional Education Budget Officer	Regional Education Directorate, Brong Ahafo region, Ghana Education Service
Issac	Lartey	Regional Health Officer	Regional Health Directorate, Northern region, Ghana Health Service
Felix	Logah	Head of Operations & Case Management	Livelihood Empowerment Against Poverty Secretariat
Salawudeen	Mohammed	District Planning Officer	Zabzugu District Assembly
Alhaji	Mohammed Haruna	Regional Education Director	Regional Education Directorate, Northern region, Ghana Education Service
Alhaji	Mohammed Issah	Deputy Director Inspectorate	Regional Education Directorate, Northern region, Ghana Education Service
Amos	Nantamba	Acting District Medical Director	District Health Directorate, Banda, Ghana Health Service
Lemon	Nladobi	District Medical Assistant	Ahenkro Health Centre, Banda District, Ghana Health Service
Benard	Ntim	Head of Budget Unit	Ghana Education Service
Benjamin	Nyakutsey	Head of Policy Analysis Unit	Policy, Planning, Monitoring & Evaluation Directorate, Ministry of Health
Daniel	Oberko	Tax Justice Organiser	Public Services International
Reginald	Odai	Acting Director	Research, Statistical and Information Management Directorate, Ministry of Health
Anthony	Ofusu	Deputy Director, Information, Monitoring & Evaluation	Ghana Health Service
Enerst	Otoo	Planning Officer	Planning, Budget, Monitoring and Evaluation Directorate, Ministry of Education
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Peter	Peprah	Head, Field Operations and Logistics	Ghana Statistical Service
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Yvonne	Quansah	Director	External Resource Mobilisation (Bilateral Division), Ministry of Finance
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Leo	Shang Quartey	Essential Social Services Platform	Integrated Social Development Centre
Naa-Dei	Thompson	Chief Accountant	Ghana Education Service
Jeremaih	Tiimob	Deputy Director for Administration	Regional Health Directorate, Northern region, Ghana Health Service
Sara	Yeboah	Regional Education Planning Officer	Regional Education Directorate, Brong Ahafo region, Ghana Education Service

At every stage, efforts were made to triangulate information using different informants and data sources. However, on some topics we were able to get the opinions or experience of only one or two interviewees. This will be apparent to the reader from the references, and our findings in such cases are appropriately circumspect. In both countries we followed ethical protocols, informing potential interviewees of the purposes of the research, assuring them of confidentiality and seeking their consent.

Our interviews are coded as follows:

CG	Central government official
LG	Local government official – includes both local government and deconcentrated central government officials based in regional or district directorates
GNGO	Ghanaian NGO and civil society
INGO	International NGO
RP	Research and policy e.g. think tank or academic
TU	Trade union
DP	Development partner

Our focus groups are coded as follows:

Banda, Brong Ahafo	Code	Zabzugu, Northern	Code
Women – health (access – delivered at a facility)	FGDBWHA	Women – health	FGDZWH
Women – health (no access – did not deliver at a facility)	FGDBWHNA	Women – education (access for their children)	FGDZWEA
Women – education	FGDBWE	Women – education (no access for their children)	FGDZWENA
Men – health and education	FGDBMHE	Men – education	FGDZME
Community health workers	FGDBCHW	Community health workers	FGDZCHW
Teachers and GES staff	FGDBT	Teachers and GES staff	FGDZT

Annex 2: Sustainable Development Goals and targets for health and education

Goal 3: Ensure healthy lives and promote well-being for all at all ages

- 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents
- 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Means of implementation

- 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- 3.b: Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

- 4.1: By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes
- 4.2: By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education
- 4.3: By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university
- 4.4: By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship
- 4.5: By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations
- 4.6: By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy
- 4.7: By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

Means of implementation

- 4.a: Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all
- 4.b: By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing States and African countries, for enrolment in higher education, including vocational training and information and communications technology, technical, engineering and scientific programmes, in developed countries and other developing countries
- 4.c: By 2030, substantially increase the supply of qualified teachers, including through international cooperation for teacher training in developing countries, especially least developed countries and small island developing States

Source: UN Sustainable Development Knowledge Platform (<https://sustainabledevelopment.un.org/sdgs>)



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Cover photo: Primary school kids at recess during reading tests, Ghana.
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