



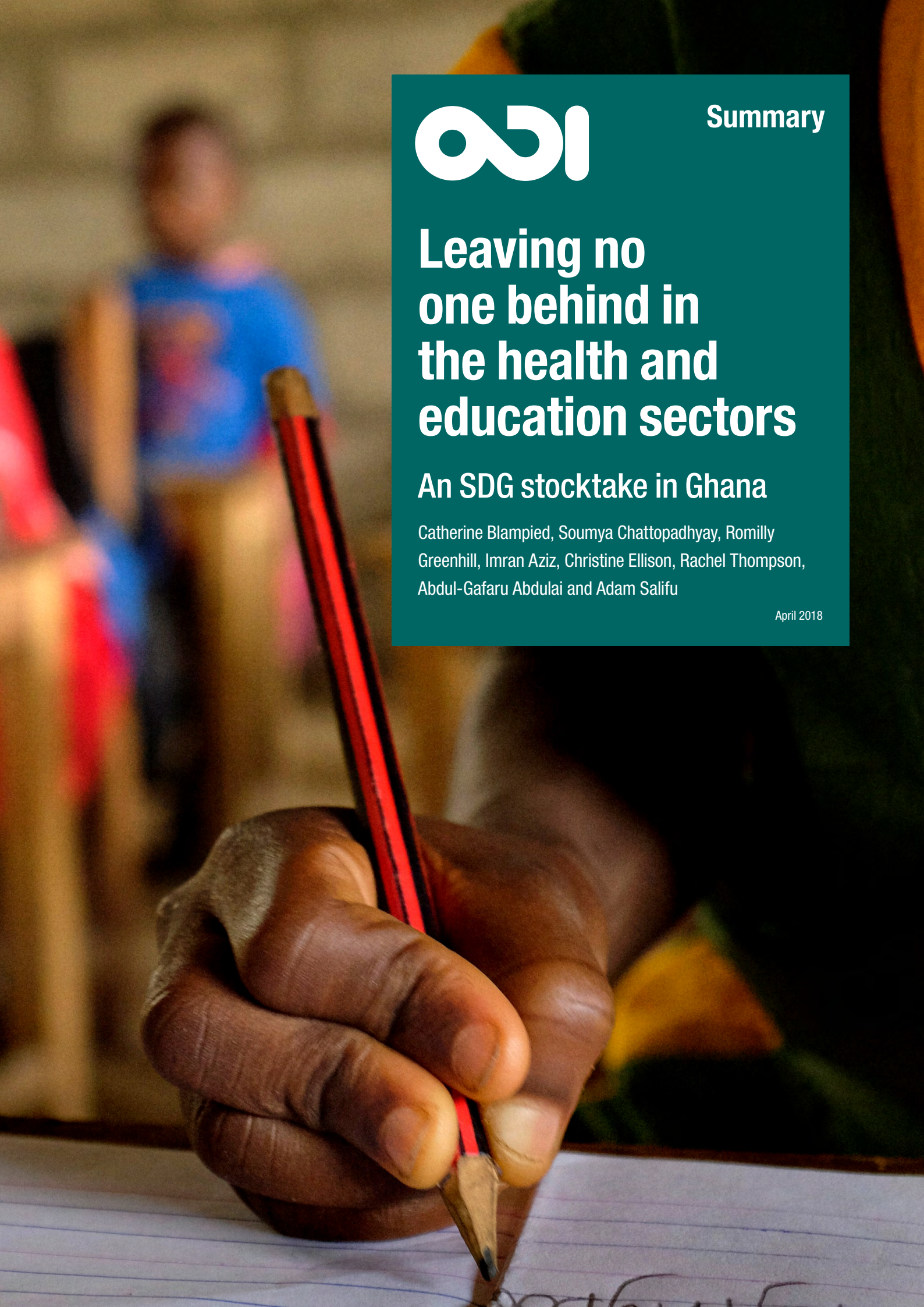
Summary

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.
Credit: Nyani Quarmyne/Panos.

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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 report¹ 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 – leading them, for example, to 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 Amporfu, 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 issue of 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 should now seize the

1 This publication is a summary of the full-length research report; see Blampied, C. et al. (2018) 'Leaving no one behind in the health and education sectors: an SDG stocktake in Ghana'. London: Overseas Development Institute.

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 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 government 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 government 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, this 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 should ensure that their aid transition planning addresses risks of reversing past gains and adverse impacts to vulnerable and marginalised groups. They should prioritise support for strengthening components of health and education systems that are currently hampering progress towards equity and inclusion, for example initiatives to train and retain local health workers and teachers, or to improve local accountability mechanisms, in the regions and districts where service coverage is lowest.
- Finally, in terms of **service delivery**, our overall finding was 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.

Leaving no one behind in health and education

Introduction

A fundamental tenet of the Sustainable Development Goals (SDGs) is the concept of ‘leaving no one behind’. This commitment 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).

There is a real risk that this commitment 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.

This report presents the main findings of our third stocktake, analysing access to key health and education services in Ghana.² These findings are based on quantitative data analysis using official datasets and other sources, key informant interviews at national and local levels and focus group discussions with poor and marginalised communities in the districts of Banda (Brong Ahafo region) and Zabzugu (Northern region), as well as a literature review.

First, we examine whether or not there is reliable, comprehensive, timely and detailed *data* available about who is being left behind and where they are living. We combine analysis of official datasets with findings from focus group discussions with marginalised communities and the literature to highlight which groups are furthest behind on key indicators of health and education access. We then assess whether government *policies* prioritise the needs of the poorest and most vulnerable groups in education and health care. Next, we consider whether the allocation of public *financing* (government and donor) for health and

education is aligned with the goal of leaving no one behind. Finally, we examine how well these elements are translating into effective *service delivery*, drawing on two local case studies of Banda and Zabzugu. Our conceptual framework (Figure 1) recognises that there are both technical and political requirements for each of these components.

Who is being left behind?

Ghana has been widely acknowledged as one of sub-Saharan Africa’s ‘rising stars’ across many of the Millennium Development Goals (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. However, 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 the commitment to leave no one behind is to be met.

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. Northern region’s Composite Coverage Index (CCI) score, measuring the coverage of key maternal and child health services,³ is 49.5% – that is, 16 percentage points behind the national average. Even demographic groups we posited as ‘non-marginalised’ (such as urban, or more highly educated) fare worse on the CCI in Northern region than most marginalised groups in other regions. In education, almost a fifth (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. The secondary school maths examination pass rate for girls is just 16% in Northern region, compared to 44% nationally.

2 Our analysis maps to SDG 3.8 on achieving universal health coverage; SDG 4.1 on ensuring all girls and boys complete free, equitable and quality primary and secondary education; and SDG 4.5 on eliminating gender disparities and equal access to education for vulnerable groups. For full details on our methodology and metrics used, see Chapter 1 of the main report. For ODI’s previous stocktakes in Kenya and Nepal, see ODI (2016).

3 The CCI is the best available proxy for the service provision aspect of universal health coverage that is currently available to the level of disaggregation needed for our analysis. Its benefits and limitations are discussed in Chapter 1 of the main report.

Figure 1. Conceptual framework

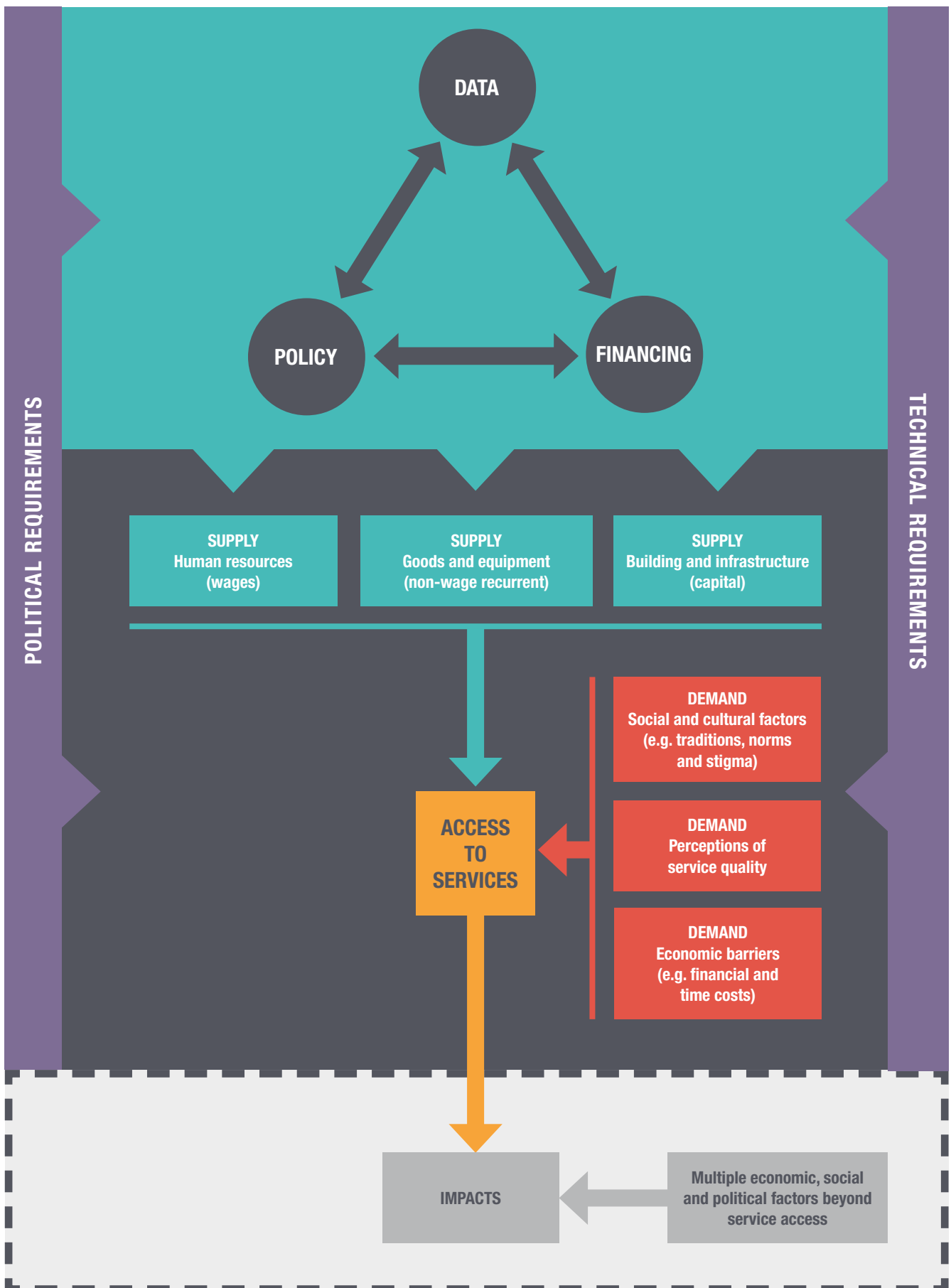
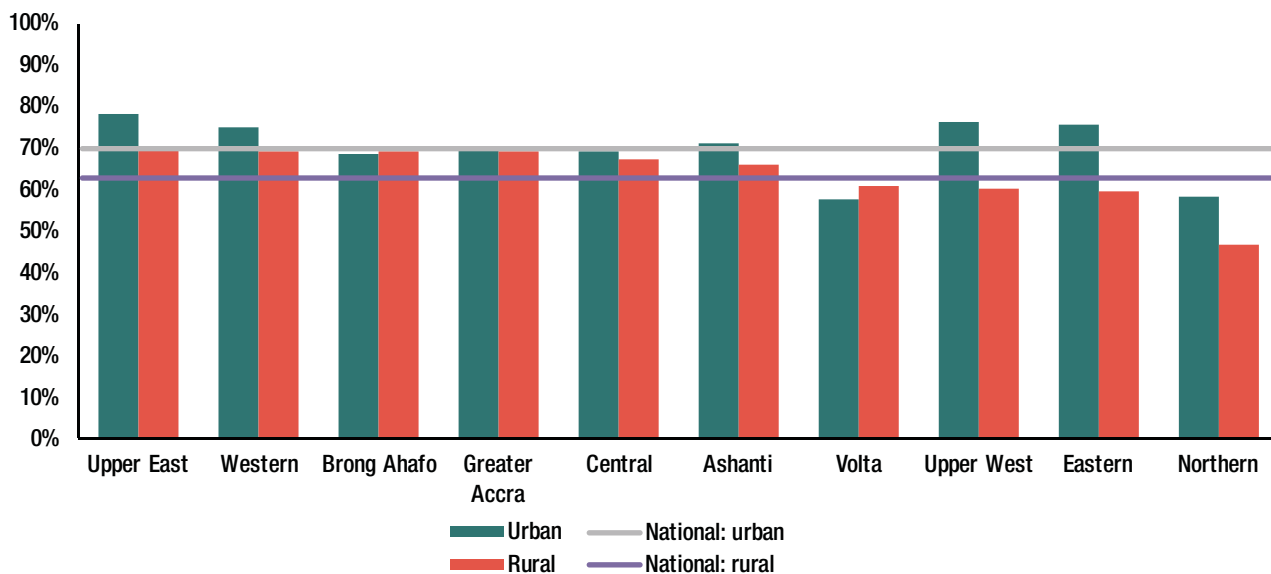
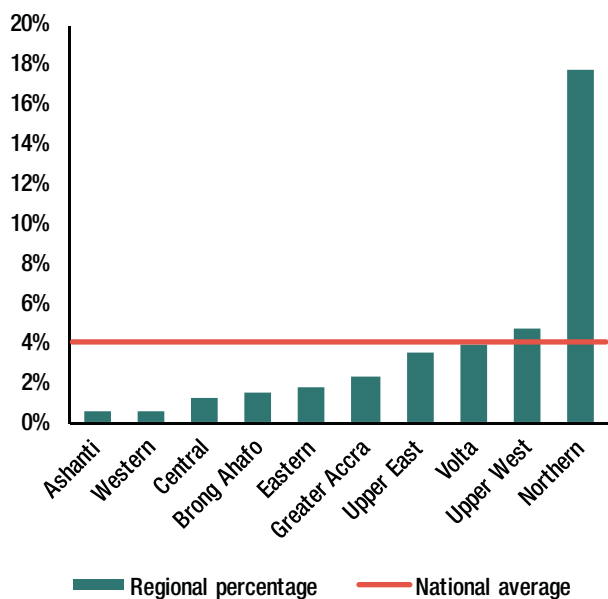


Figure 2. CCI by urban versus rural location in each region, 2014



Source: Authors' calculation using GDHS (2014)

Figure 3. Junior high school-age children (13-15 years old) with no formal education by region, by percentage of age group population



Source: Authors' calculations using GDHS (2014)

The poorest wealth quintile nationally are 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,⁴ ethnic minority status⁵ and, to a much lesser extent, gender⁶ – 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 two out of ten regions (Western and Central) saw overall progress in health coverage combined with a shrinking gap between marginalised groups and the rest of the population.

4 Examined for health only owing to data limitations.

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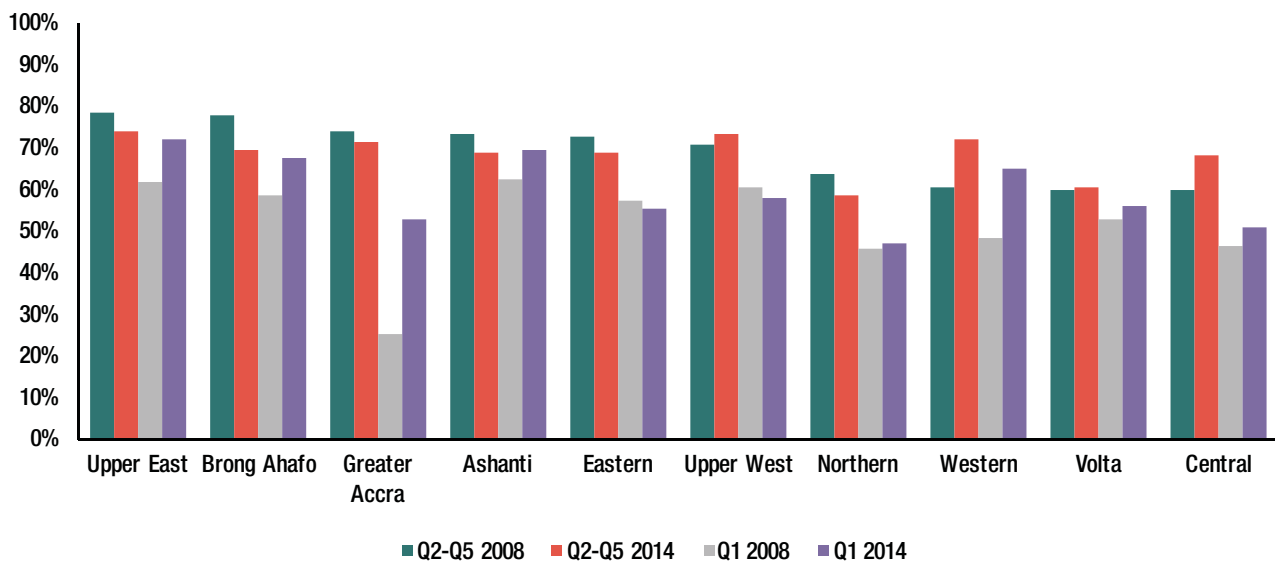
6 Examined for education only owing to the nature of the CCI, which does not cover male adults.

Figure 4. CCI by household wealth in each region, 2014



Source: Authors' calculation using GDHS (2014)

Figure 5. CCI by wealth quintile in each region, 2008 and 2014



Source: Authors' calculations using GDHS (2008 and 2014)

In terms of education, our interviews and focus groups with poor and marginalised communities suggested possible deterioration in the quality of public sector basic education, particularly in rural and more deprived areas of the country. Serious concerns were raised by communities we spoke to about the performance of teachers, the quality of learning resources and the safety of kindergartens and primary schools. Such concerns may be prompting a shift towards greater use of the private schools by families who can afford them.

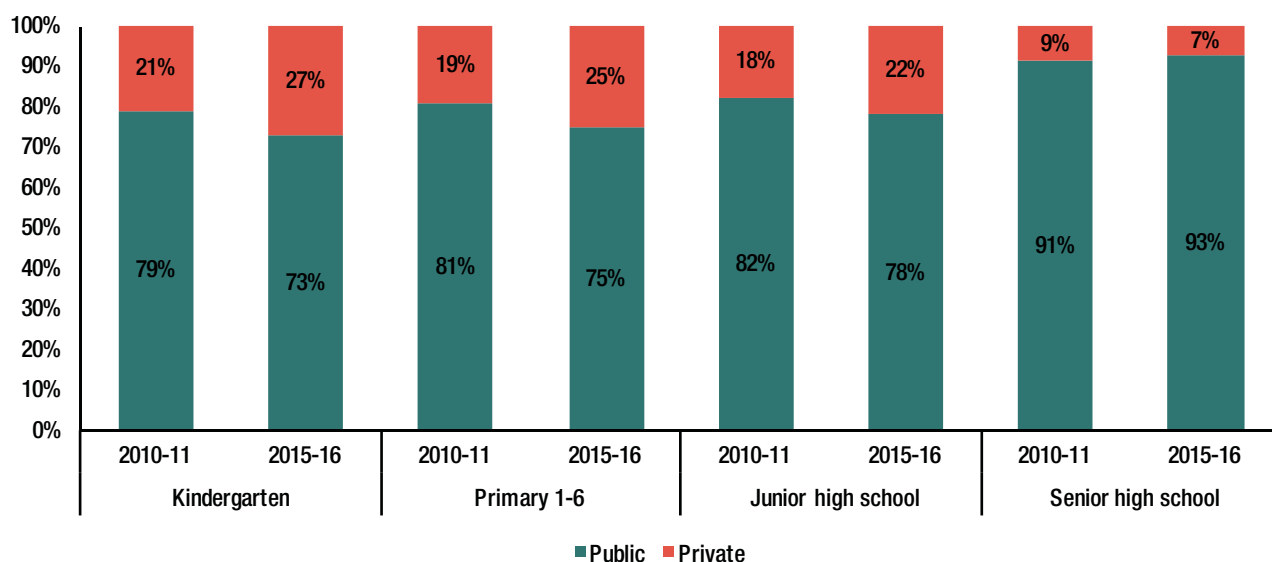
'Some of our schools, especially the kindergartens and lower primary classrooms... have cracked walls making them death traps and some don't even have walls around them ... In our school there is no water so the children have to run home during break crossing the lorry road which is risky.'

—Focus group discussion with women in Banda district, Brong Ahafo region

Finally, in the health sector, there appears to be a real risk that Ghana's *overall* achievements are reversing, moving the country further away 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 gross domestic product (GDP) per capita – than to

Kenya, a reasonable comparator (ODI, 2016). Also in line with this reversal away from universal health coverage is the trend in out-of-pocket (OOP) payments – the most regressive form of health financing. The share of OOP payments in Ghana's total health expenditure fell in every year between 2008 and 2011, but then rose markedly (also in absolute terms) between 2011 and 2014.

Figure 6. Share of total school enrolment in public versus private sectors, 2010-11 and 2015-16



Source: Authors' calculations using EMIS (2015-16) database

Figure 7. Out-of-pocket payments as a share of total health expenditure



Source: WHO Global Health Expenditure database

Why are vulnerable and marginalised groups being left behind?

First, to truly understand and address the needs of those being left behind, policy-making and planning processes need to incorporate sufficiently detailed information. Some limited data disaggregation (such as by gender and region) is used by policy-makers and planners at the central level, although this is much weaker at the regional and district levels, owing to constraints such as internet connectivity as well as the centralised nature of the health and education sectors.⁷ There persists, though, a blindspot concerning the generation of disaggregated data on certain markers of vulnerability such as disabilities. Furthermore, Ghana's national household surveys are representative only down to the regional level, not the district level, making administrative data (which by their nature are not representative) the only official, large-scale source beneath the regional level. Moreover, administrative data in the health sector are not made public, unlike in the education sector.

In terms of policies, we found that Ghana's policy framework is well aligned to the goal of leaving no one behind. Health and education policies demonstrate the intent to tackle many of the most salient patterns of inequality. This includes a commitment to implementing universal health coverage through the National Health Insurance Scheme (NHIS), which provides premium exemptions for the poorest and other vulnerable groups. The Community-Based Health Planning and Services (CHPS) policy is designed to bridge geographical inequities, by expanding the reach of basic health services into rural communities. Education sector plans address issues such as geographic, wealth and gender-based inequities, as well as special educational needs.

Yet, in spite of the inclusive policy agenda, 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 delays, averaging eight to ten months in reimbursing health facilities (Atim and Amporfu, 2016). Partly as a result, there is widespread and regressive 'informal' charging for health services and drugs that are supposed to be free, and NHIS coverage has stagnated below 40% of the population for years. Similarly, the roll-out in 2017 of an election campaign promise to launch free senior high school nationwide is laudable, but raises strong concerns about equity in a context in which it is estimated that almost half a million children will never even enter primary

school, and in which more than half of all girls who can already access secondary school are failing their maths and science exams.

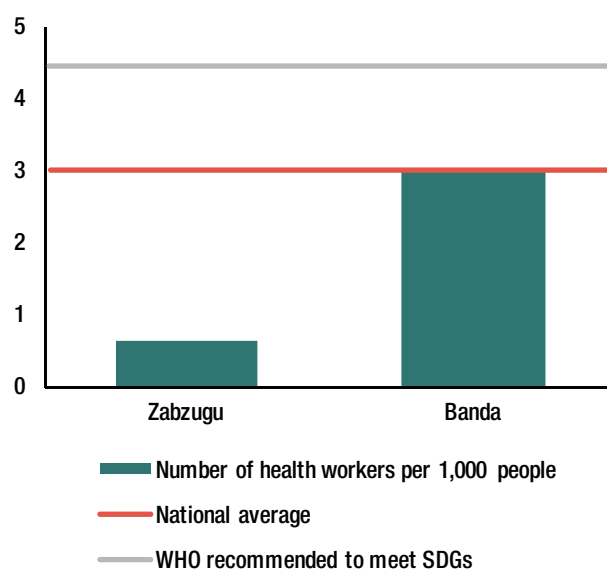
A progressive universalist approach would imply actively prioritising the furthest-behind groups within a universal framework, for example by sequencing reforms, rationing some resources (for example, the most expensive secondary and tertiary health services) and targeting resources to the areas of greatest need, such as the most deprived districts, especially in Northern region. This is even more important when there is not an expanding pot of government resources available, as has been the case in Ghana given the recent requirements of fiscal tightening.

In terms of financing, we identified four key ways in which resource allocation is misaligned with policies promoting equity and inclusion:

1. Failure to enforce existing rules for the deployment of health workers and teachers around the country is harming equity and efficiency.

The distribution of health workers and teachers is highly skewed away from poor, rural areas, which are regarded as 'punishment districts', where it often comes down to 'begging them to stay', according to local officials we interviewed in two different regions. Absenteeism, moonlighting and lobbying for new postings are pervasive, disproportionately impacting remote and deprived communities. Given that salaries absorb 90% and 98% of the discretionary budgets of the Ministries of Health

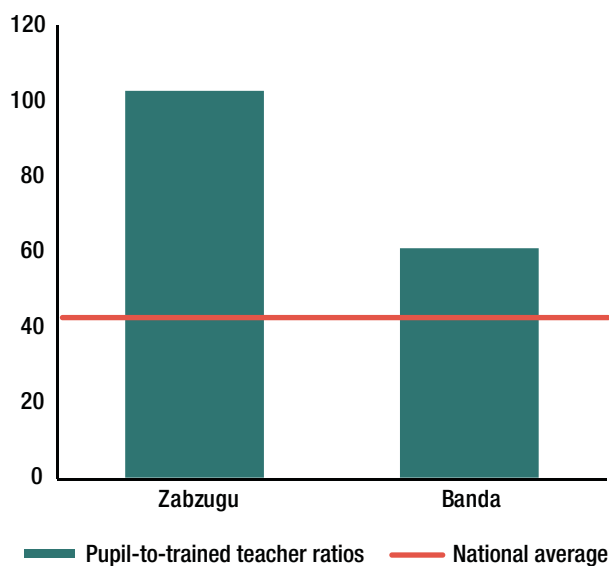
Figure 8. Health worker ratios in Banda and Zabzugu and national average



Source: Banda and Zabzugu District Annual Reports; WHO (2016)

⁷ For example, administrative data are fed up the chain from districts to regions to the centre, where they are collated and analysed, but there is relatively close control of these data by officials at the centre. Local officials have only partial access to the District Health Information Management System (DHIMS) and the Education Management Information System (EMIS), making it difficult for them to be able to compare against other regions and districts.

Figure 9. Pupil-to-trained teacher ratios in Banda and Zabzugu and national average



Source: EMIS (2015-16)

and Education, respectively, and actual spending on salaries runs significantly over budget every year, these inequities and inefficiencies in human resource distribution have a large effect on the overall distribution of financial resources in these sectors.⁸

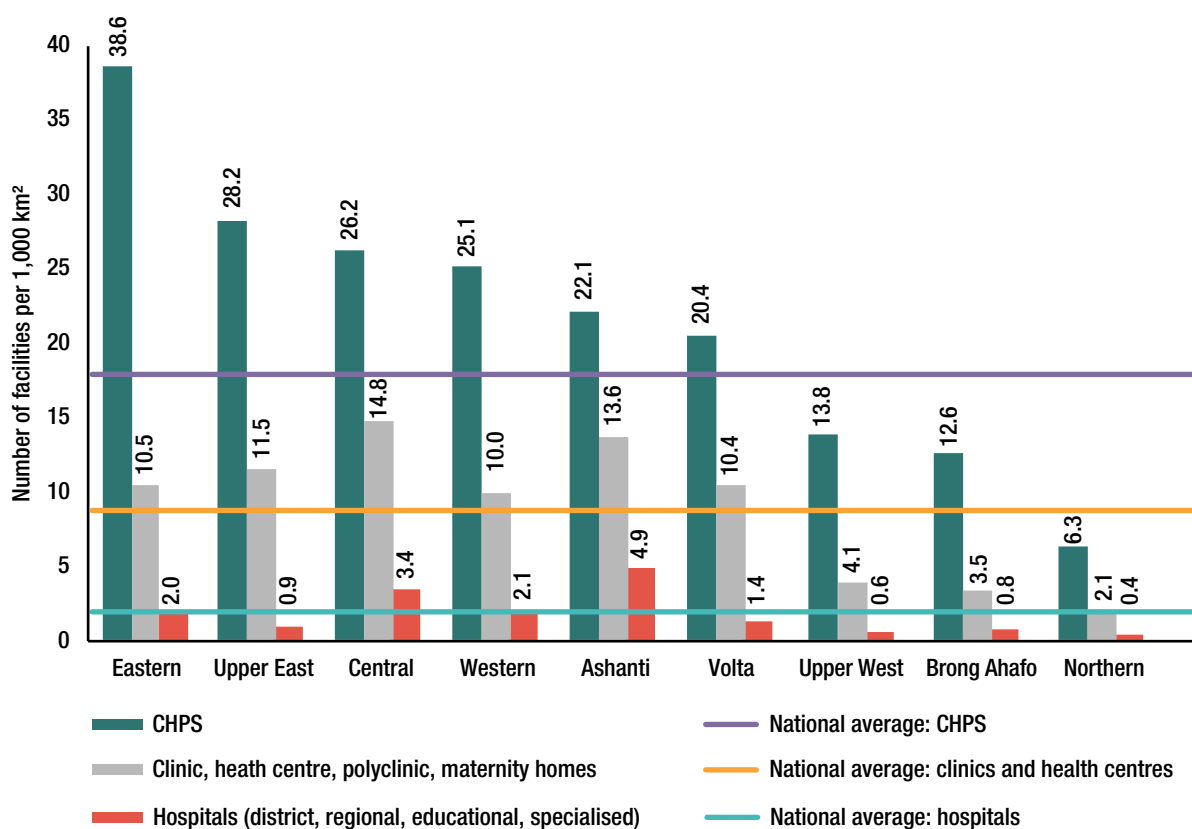
‘Anyone who knows a chief or a politician lifts the phone and they will not be sent here.’
—Local government employee in deprived district

‘Health workers and teachers do not want to go to deprived areas. Financial incentives won’t cut it if you don’t have basic amenities or have to wade through a river to get to the school.’
—Policy researcher, Accra

2. Components of the health and education systems that are most important for equity and inclusion have not been prioritised.

District and sub-district health services – which include CHPS facilities, health centres and district hospitals – are critical for reaching those left behind. Yet the share of the total health budget allocated to these district health

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

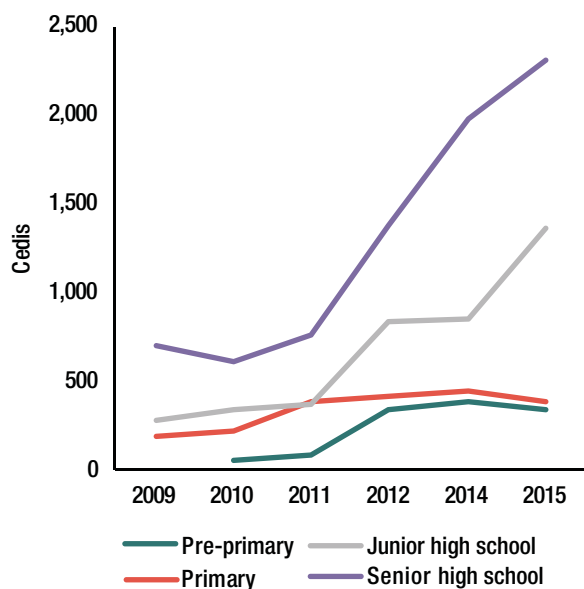


Note: Greater Accra not shown as an outlier – 82.9 CHPS, 137.5 health centres and clinics and 26.5 hospitals per 1,000 km².
 Source: Authors’ calculations based on DHIMS2 database summary (2016) and Census (2010)

⁸ For example, actual spending on employee compensation by the Ministry of Health was 22% over budget in 2014, rising to 34% over budget in 2016.

services declined from 42% in 2011 to 32% in 2015, while the share going to the central headquarters of the Ministry of Health and the Ghana Health Service more than doubled to 36% over the same period. Basic health facilities such as CHPS compounds and health centres are

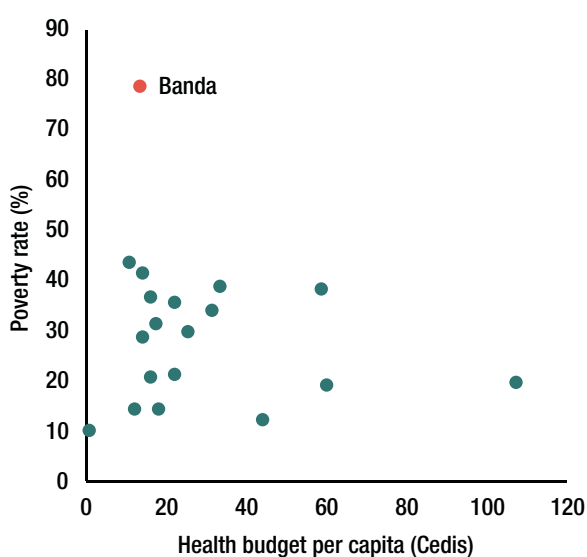
Figure 11. Government education spending per enrolled student by level



Note: In academic year 2017-18, the government's free education policy expanded to include senior high school.

Source: MoE (2013, 2015 and 2016)

Figure 12. Government health budget per capita versus poverty by district, Brong Ahafo region, 2015



Source: MoF (2015); GSS (2015, 2010); Banda District Assembly (2015)

Note: Some districts are excluded owing to data unavailability

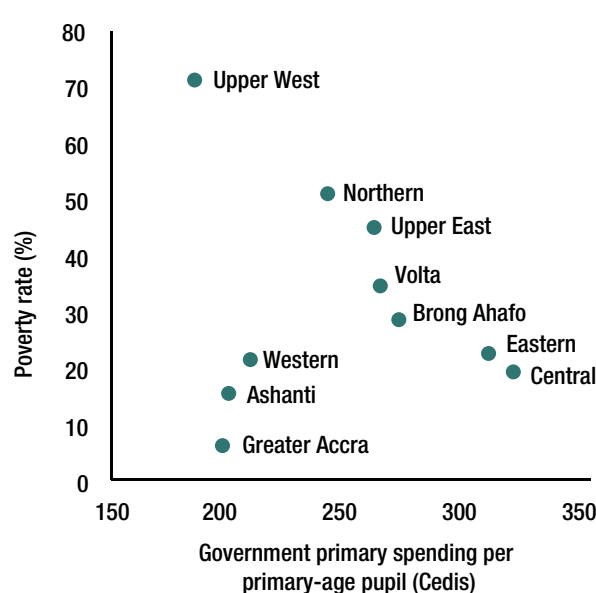
receiving insufficient capital investment (World Bank, 2017). In Northern region, for example, there are still only 6.3 CHPS compounds and 2.1 health centres per 1,000 km², despite the purpose of CHPS being to bridge geographical disparities in health service access. At the same time, non-wage recurrent funding to health facilities has also been extremely limited, meaning that, even where new CHPS compounds and health centres have been built, many are poorly maintained and supplied.

In education, while Ghana continues to maintain impressive overall public education expenditure surpassing the international benchmark of 20% of the budget, it is increasingly shifting this towards the secondary and tertiary sectors. Funding per pupil at primary and kindergarten levels – the fundamental basis for equity across the system – has flatlined, while secondary school funding has risen rapidly. In 2015, senior high school pupils were funded at six times the level of primary pupils. We found a clear ‘public-private crossroads’, whereby families with the means to do so send their children to private school for their basic education and then shift to the better-quality public high school system, stymying political impetus for reform at the lower levels.

3. Large variations in health and education budget per capita allocations between regions and districts are not explained by poverty, need or performance.

The predominant practice of incremental budgeting, rather than implementing a redistributive mechanism such as a budget allocation formula, is likely entrenching existing disparities between regions and districts, since recurrent funding keeps flowing to existing infrastructure and areas with higher levels

Figure 13. Government primary school spending per pupil versus poverty by region, 2015



Source: MoE (2016); GSS (2014); EMIS 2014-15

of staffing. This is of particular concern given that we found the single factor associated with the largest disparities in health and education access to be geographic variation.

4. Funding for operating and maintaining schools and health facilities is squeezed out by the large and rigid wage bill.

Salaries dominate the budget in both the health and education sectors, with very little funding left for other recurrent expenditure or capital investment.⁹ One district health directorate we visited had received no core operational funding for seven years. In education, the flat ‘capitation grant’ designed to eliminate financial barriers for all children amounted to less than 1 Cedi (US\$0.20) per pupil in 2015-16 (MoE, 2016). This squeeze in funding impinges disproportionately on the poorest and marginalised groups because it forces health facilities and schools to routinely ‘informally’ charge users for goods and services, which is the most regressive form of financing. It also hampers supervision and monitoring, which are critical for equity and quality.

‘We are asked to provide detergents like Dettol, paracetamol, rubber sheets ... it costs approximately 60 Cedis [\$14] per each delivery [of a baby] ... 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.’¹⁰

—Focus group discussion with women, Banda

‘My colleagues who monitor schools in the hinterlands that are 60 km away from Zabzugu township are unable to do regular monitoring due to lack of funds for that purpose ... 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.’

—Focus group discussion with school circuit supervisors

The case of health care in the Upper East Region – a cause for optimism

There is real cause for optimism that determined and innovative policy initiatives, backed by sufficient financial resources, can make a big difference in even a relatively short space of time. The story of health care in Ghana’s Upper East region illustrates this point. 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 donors and government. Among other initiatives, each district was given annual quotas to sponsor the training of community health nurses and midwives under a three-year ‘bond’. In collaboration with the Ghana Health Service headquarters, the regional health director ensured that those who left without serving their bond periods had their salaries blocked. The region also instituted coaching and mentoring of staff, as well as the awarding of certificates and letters of recognition, to incentivise improved performance. A focus was placed on combining ‘vertical’ or top-down accountability with ‘horizontal’ accountability whereby staff from different facilities and districts, as well as local communities, interacted and observed each other’s performance. Another innovation was the deployment of the ‘Motor King Ambulance system’ to overcome emergency referral challenges. 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.

⁹ In the health sector, this is exacerbated by the extreme delays in reimbursements to health facilities for patients covered under the NHIS, averaging eight to ten months (Atim and Amporfu, 2016).

¹⁰ As of 2008, Ghana’s health policy states that maternal and child health services should be free.

Recommendations

Data to leave no one behind

- **The government should strengthen transparency and open data in the health and education sectors, including financial 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 District Health Information Management System (DHMIS2) are not made publicly available, in contrast to the Education Management Information System (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.
- **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 2009-16 has been geo-coded, 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.**¹¹ Over time, the government should move to mainstreaming data disaggregated for people with disabilities into its routine data processes.
- **Government agencies – including the Ghana Statistical Service – 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.** UNICEF Ghana and the Ghana Centre for Democratic Development (CDD Ghana), in collaboration with the Ministry of Local Government and Rural Development, have created a District Scorecard. This 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), is then used to compile a District League Table. 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.

Policies to leave no one behind

- **Re-galvanise political commitment to universal health coverage with the launch of a reformed NHIS.** 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. 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 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

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

closer collaboration between local government and the regional and district offices of the Ghana Health Service. Importantly, the Ministry of Health 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.

- **Ghana should make a high-profile commitment to progressive universalism in education.** 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’.** 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.
- **To improve human resource recruitment and retention in deprived areas, a key element of success 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. There has been similar success nationally with the Untrained Teachers Diploma in Basic Education, supported by the Global Partnership for Education (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). The GPE grant ended in 2016, but the programme should be continued with domestic funding. Local authorities such as district assemblies can play a role in mobilising local revenues for sponsoring new nurses and teachers. However, resources in many of the poorest districts are extremely tight – thus the central government should 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 initial investment, the efficiency gains will be considerable given that the government is currently paying salaries for a large number of absent workers.

- **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 the Ghana Health Service (GHS) headquarters. Such intervention is currently difficult owing to the centrally controlled payroll and slow transmission of 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.
- **The third element involved creative ways to motivate and retain staff, including 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.¹² Such an initiative has significant cost implications, however, and in the short term maintaining wage growth discipline is a critical priority. 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 Christian Health Association – present in rural

12 A deprived areas allowance has been tried (not very successfully) in Ghana before, however; any new scheme would be need to establish clear and consistent delineation from the outset of which workers would benefit.

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).

Financing to leave no one behind

- **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 Ministry of Health should investigate and publish information about what is driving the decline in the share of health spending allocated to district health services, while the share for central headquarters funding has more than doubled 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 Ministry of Health should prioritise developing, implementing and publicising a clear and fixed formula for allocating funding to regions and districts.** We were told that formulas do exist in theory, but 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 budget 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 in regions with below-average funding and poor health coverage, principally Northern region.
- **On the basis of agreed reforms to improve equity and efficiency, the Ministry of Health should work with the Ministry of Finance to implement a health financing strategy that anticipates and adjusts for a decline in donor funding and the need to gradually mobilise more tax revenues for health.** The outlook of declining donor engagement is indeed recognised in the Ministry of Health's 2015 Health Financing Strategy, but this strategy has not been implemented. This document also considers Ghana's overall weak fiscal capacity relative to other lower-middle-income countries 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 Social Security and National Insurance Tax. The government 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 – but excluding any payment of arrears for previous years' unpaid salaries – which is just below the international benchmark of 15%.
- **The Ministry of Education 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 (\$100) for pre-primary; 386 Cedis (\$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 and kindergarten per pupil funding is flatlining, despite being less than a fifth of the UNESCO-recommended amount needed by 2030 to ensure equitable and inclusive universal access.
- **The Ministry of Education 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 formulas based on student need are commonly used in Organisation for Economic Co-operation and Development 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.
- **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 donors still significantly engaged in pre-secondary education in Ghana. Donors committed to the leave no one behind ambition should target their own funding towards key neglected areas, 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 lower-middle-income countries, 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 as a result of its gross national income. 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.

Service delivery to leave no one behind

- **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. Previous equity modelling for Ghana suggests that the construction of new facilities targeted to the poorest villages of the northern areas of the country yield much larger results, at a fraction of the cost, compared to a blanket approach. 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 out-of-school children by 3 million and reduced gender disparities (UNESCO, 2008).

- **The government should implement previous commitments (for example in the 2010 Education Sector Plan) 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).
- **On the demand side, the Ghana Health Service 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 the 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 region) and Zabzugu (Northern region), 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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