FINAL REPORT

GAVI HSS/ISS/CSO SUPPORT EVALUATION

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Submitted By:

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LIST OF ACRONYMS

BCG	Bacillus Calmette-Guerin
CHNs	Community Health Nurses
CHPS	Community-Based Health Planning System
CMA	Common Management Arrangement
CMYP	Comprehensive Multi-year Plan
CMYP	Comprehensive Multi-Year Immunization Plan
CSO	Civil Society Organization
CWC	Child Welfare Clinic
D/MHMT	District/Municipal Health Management Team
DANIDA	Danish International Development Agency
DCOs	Disease Control Officers
DDHS	District Directorate of Health Services
DFID	Department for International Development
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DPT	Diptheria-Pertussis-Tetanus
EPI	Expanded Programme for Immunization
GAVI	Global Alliance for Vaccines & Immunization
GCNH	Ghana Coalition of NGOs in Health
GHS	Ghana Health Service
GoG	Government of Ghana
HPV	Human Papilloma Virus
HSS	Health Systems Strengthening
IALC	Inter-agency Leadership Committee
IGF	Internally Generated Fund
ISS	Immunization Systems Support
JICA	Japanese International Cooperation Agency
MDG	Millennium Development Goals
MMDA	Metropolitan Municipal and District Assembly
MOH	Ministry of Health

MR	Measles Rubella
NGO	Non-governmental Organization
NHIA	National Health Insurance Authority
NID	National Immunization Day
NIP	National Immunisation Programme
NITAG	National Immunization Advisory Group
PCV	Pneumococcal Conjugate Vaccine
PEI	Polio Eradication Initiative
PPME	Policy Planning Monitoring & Evaluation
PPMED	Policy Planning Monitoring & Evaluation Division
RDDHS	Regional Directorate of Health Services
RHMT	Regional Health Management Team
TT	Tetanus Toxoid
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

1. INTRODUCTION AND METHODOLOGY

This document presents the entire Evaluation Report on the Global Alliance for Vaccination and Immunization (GAVI) support to Ghana from 2007 to 2013. The overall thrust of the evaluation was to assess the extent to which planned objectives of GAVI HSS/ISS/CSO support have been achieved. The evaluation assessed the overall contribution of the supports to the achievement of the health sector objectives as defined within the Health Sector Five year Programme of Work (2007-2011) and Health Sector Medium Term Development Plan 2010-2013.

The Global Alliance for Vaccine and Immunization (GAVI) support was delineated into Health System Strengthening (HSS), Immunization Systems Support (ISS) and financial support to Civil Society Organizations (CSOs). The HSS was designed to support health system strengthening generally by equipping the health directorates and facilities at the various levels and to ensure that these various levels are well positioned in terms of human resources (both in quality and quantity) and specifically to support the child and maternal health delivery including immunization. This provides capacity building support in terms of training and on-the-job skills improvement. Since 2011, a manual for training of sub-district health facility management has been in production. However, from the evaluation it came to light that the manual has not been in frequent or regular use at the target level beyond the initial trainings in 2012. The ISS focused on cold chain equipment and related logistics including vehicles and the availability of vaccines for immunization across the country in a timely manner. The CSO support was aimed at supporting increasing immunization coverage in children under-five (5) years of age and to strengthen the capacity of indigenous/local organized groups and structures. This was highlighted in two regions (Central and Volta Regions).

The Results-based Evaluation/Assessment technique (also known as managing for results) was adopted in undertaking the evaluation exercise. Results here refer to the outputs, outcomes and impacts from the various interventions, which may be intended/unintended, expected/unexpected, positive/negative or direct/indirect. Under this evaluation assignment, the focus of results is more on outputs and outcomes rather than impacts. In general, the evaluation focused on the relevance and effectiveness of the design and implementation of

the GAVI support; the efficiency in the implementation; results achieved; and the sustainability of the innovation introduced.

A multi–stage sampling approach integrating both random and structured purposefully selected beneficiary and stakeholder units at the various levels of the system was adopted for the assessment. The country was divided into three zones (Northern, Middle and Southern) out which two regions were selected per each zone leading to a total of six regions out of ten in the country

Presently three key strategies are employed for the delivery of the immunization services in the country. These are; static immunization services at health facilities, outreach programmes in the communities; and Immunization campaigns reaching out to most of the unreached populations.

2. SUMMARY OF KEY FINDINGS

The findings show that the main sources of funding for operational activities in the public health care delivery system in Ghana are Government of Ghana (GoG), (budgetary allocation, Internally Generated Funds (IGF) which includes National Health Insurance Fund and direct payments by patients, private funding such as donations from corporate organizations and other philanthropists, and Development Partners (DPs) Support. The Government of Ghana is responsible for the total cost of the traditional vaccines and supplies for injections since the inception.

During the period of support under the current evaluation (2007 to 2013), GAVI provided funding in the procurement of vaccines, cold chain equipments and other related logistics. Fifty-three (53) Great Wall and 49 Ford pick-up trucks were also procured under the programme.

The vaccines currently in use in Ghana are BCG, Measles, Penta, Yellow Fever, Measles Rubella, PCV, Rota-virus, Tetanus for Women and Polio. For the period under review (2007 – 2013) there was no reported shortage of vaccines.

Staffing was generally adequate at the higher levels of the health care delivery system in terms of the numbers and skills for performance. However, towards the peripheral levels, it was noticed that there was a challenge with the numbers, skill-mix, quality and skill of staff

which was not adequate. This staffing challenge tends to place immunization and health delivery pressure on the limited staff available at these levels.

There were community volunteers in various aspects of the health service delivery system across the country. In communities where CSOs (funded by GAVI) worked, they are known as “the GAVI people”. Community volunteerism was noted to be effective and critical, especially for the Northern Zone because of sparsely populated communities scattered over a large area and poor transportation facilities coupled with numerous hard-to-reach areas.

Penta–3 coverage in general has been over 80% in all the regions except Greater Accra which persistently recorded below 80% and Volta which only recorded below 80% in 2013. Persistent over 100% coverage could be due to wrong population base data, population movement in relation to market centre and influx from neighbouring border towns during immunisation periods. Likewise, lower than expected coverage could be due to wrong population data among others.

Generally the design and approach adopted in implementing the EPI in Ghana has been effective. Under the GAVI HSS support, the existing systems have been strengthened in addition to putting up new systems to ensure that stewardship and governance for the immunization process are working effectively.

The disbursement of funds follows through the existing administrative systems of the GHS. Thus from the national level, funds are released to the regional health administrative system to the districts and sub-districts. Though funds are released without much of bureaucratic bottlenecks, on occasions there are hold-ups especially between the national to the regions.

3. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

The support from GAVI and other development partners has contributed immensely to improve EPI, health care service delivery and health status generally in Ghana. From the information so generated from the evaluation, the following conclusions are drawn and some recommendations made:

Summary of Key Findings

(1) There is a well-structured and coordinated system for the design, planning and implementation of the GAVI and other development partner support to the Ghana health service delivery system especially towards child and maternal immunization.

(2) Due to the effective monitoring system in place for reporting, even delayed reports from the districts on immunization are followed up and received at the regional and national levels. This has contributed to the rather favourable percentage of report submission.

(3) The liaison role of UNICEF (with its international or global presence, capacity and influence) in ensuring the effective and efficient procurement of the necessary appropriate vaccines for EPI cannot be over-emphasised.

(4) Immunisation as an essential health service is now well accepted throughout Ghana. The visibility of immunisation in Ghana could be ascribed to the collaboration from all stakeholders with leadership from the Ghana Health Service. Also Ghana Coalition for NGOs in Health has also been instrumental in community sensitization and mobilization for health service take up including immunisation.

(5) It is on record that since 2003, no child has died of measles in Ghana. No polio cases have also been recorded.

(6) Generally it is evident that all indices for the health sector relating to immunization have improved essentially. Though not perfected, the immunization coverage has contributed to improved general health especially child and maternal health status across the country.

(7) In the absence of the GAVI support, it is obvious that the Government of Ghana will have very severe challenges sustaining the gains made through immunization without adequate preparation.

(8) The breakdown and challenges associated with maintaining cold chain equipment for storage of vaccines threatens the sustainability of gains made so far by the EPI coverage.

(9) The absence of adequate vehicles and other logistics in parts of Ghana is posing considerable challenges to the outreach services.

(10) Remote rural communities and other hard-to-reach areas are often under threat of abandonment due to poor access by health personnel.

(11) The continued sustenance of the EPI hinges on a deeper and more active participation of local community stakeholders including MMDAs, traditional leaders, faith-based organizations as well as private sector businesses.

Recommendations

(1) Considering the imminent withdrawal of funding support from GAVI for Ghana's immunization programme in its current form, alternative funding arrangements should be commenced now to forestall the roll-back of gains made over the years.

(2) Considerations may be made for co-payments where parents of children to be immunized would be encouraged to pay token amount towards defraying the cost of immunization.

(3) Mechanisms can be put in place over the next five (5) years to ensure that by the exit of the GAVI support, immunization investments is absorbed by government through mechanisms like absorption into the National Health Insurance Scheme (NHIS).

(4) As much as possible cold-chain facilities should be established at all sub-district levels and CHPS compounds especially in regions with wide geographical area and hard-to-reach areas.

(5) The cold chain maintenance team needs to be further decentralized to the MMDA level and strengthened. Resources should be provided to ensure that cold chains are maintained at working levels at all times. Solar refrigerators could be preferred especially for CHPS and sub-district levels.

(6) In-service training and career development programmes should be intensified with adequate resources so as to ensure that skill levels are improved and updated at all levels.

(7) It was observed that there are a number of training manuals in the health delivery system at the various levels which are not being used for continuing professional development of staff at these levels. Efforts should be made at institutionalizing regular in-service training in identified areas.

(8) It has been indicated that the withdrawal of GAVI support has been noted and transition arrangements are being made to start from 2015 over the next seven years such that Ghana will be fully responsible for immunisation investments by 2022.

(9) The data management system should be improved with adequate training and office system infrastructure for the management of records in data collection, storage and retrieval.

(10) CSOs should be more closely monitored, encouraged and adequately funded on long term basis as part of the health service delivery system.

4. CONCLUSION

Child and maternal health in Ghana has seen considerable improvement since the inception of the GAVI HSS/ISS /CSO support for immunization. The findings from this evaluation highlight the fact that improving immunization coverage has very important implications for the social, physical and economic health of the entire citizenry. The expanded immunization coverage, is contributing tremendously to women especially in the rural communities to adopt positive health seeking behaviours including family planning practices.

1.0. INTRODUCTION

1.1. Brief Background

Ghana has been at the forefront of showcasing immunization as the platform for health systems strengthening. The country launched the Expanded Programme on Immunization (EPI) in June 1978 with six antigens – BCG, measles, Diphtheria-Pertussis-Tetanus (DPT) and oral polio for children under one year of age together with Tetanus Toxoid (TT) vaccination for pregnant women. The launch was in response to the national health policy to reduce morbidity and mortality of vaccine preventable diseases, which then contributed significantly to both infant, and child mortality reduction in the country. It is within the context of the immunization policy of the government, which sought to ensure that all children receive these vaccines before their first birthday of life.

The Global Alliance for Vaccine and Immunization (GAVI) is a unique organization that aligns public and private resources in a global effort to create access to immunization services. The mission of the GAVI is to save lives of children and protect people's health by increasing access to immunization in poor countries. GAVI therefore has been supporting the introduction of life saving vaccines and providing Health Systems Strengthening (HSS) support, including technical assistance in these poor countries. It brings together key actors in immunization and health systems including developing countries, research and technical Agencies, Civil Society Organizations, Bill and Melinda Gates Foundation and other private philanthropists.

GAVI has been supporting Ghana since 2000 with vaccines and health systems strengthening. When GAVI opened the health systems strengthening window, Ghana applied and got approval for the period 2007 to 2012. This support was extended to 2013. This evaluation is particularly focused on assessing the GAVI HSS/ISS/CSO support towards immunization and the concomitant effect on child and maternal health over this period (2007 – 2013). The table below shows the proposals from the Ghana Health Service (GHS)/ Ministry of Health (MOH) that were approved for implementation during the period under review.

Table 1: List of Proposals from GHS/MOH Approved for Implementation

No.	*Approved Proposals*	*Date of GAVI Approval*
1	Proposal for NVS - MR campaign support: Ghana	15 February 2013
2	Proposal for NVS - HPV demo support: Ghana	31 January 2013
3	Proposal for NVS - MenA support: Ghana	26 September 2011
4	Proposal for NVS - PCV, Rota, MSD support: Ghana	26 September 2011
5	Proposal for CSO support: Ghana	29 July 2010
6	Proposal for ISS support: Ghana	21 April 2009
7	Proposal for HSS support: Ghana	01 November 2007

The GAVI support was delineated into Health System Strengthening (HSS), Immunization Systems Support (ISS) and financial support to Civil Society Organizations (CSOs). The Health Systems Strengthening (HSS) support was designed to equip the health directorates and facilities at the various levels and to ensure that these various levels are well positioned in terms of human resources (both in quality and quantity) to support the child and maternal health delivery including immunization. This provides capacity building support in terms of training and on-the-job skills improvement. Immunization Services Support (ISS) focused on cold chain equipment and related logistics including vehicles and the availability of vaccines for immunization across the country in a timely manner.

There are a number of CSOs and NGOs operating in the health sector in every region across the country. The active involvement of those involved in immunization programmes ensured that community members were duly aware of the need to immunize infants and children. The CSOs usually mobilize the communities and also sensitize them prior to immunization activities. The limited GAVI support to the CSOs (for about 18 months to 2 years) was targeted at enhancing the active community sensitisation and mobilisation roles of these local community-based organizations.

1.2. Country Profile

Ghana is a tropical country lying between longitudes 3^{o}.15' W and 1^{o}.12 E, and latitude 4^{o}.44' and 11^{o}.15' N. The country is bordered to the East by the Republic of, to north by Burkina

Faso, to west by La Cote d'Ivoire and to the south by the Gulf of Guinea. Ghana has 10 administrative regions covering a total land area of 238,533 km^2 with an Exclusive Economic Zone (EEZ) of 110,000km^2. The country has a coastline of 550km^2. Half of the of the country lies less than 152m above sea level, and the highest point is 883m above sea level.

In 2013, Ghana's population was estimated at 25,199,609 based on the 2010 population census estimate of 24,658,823. The 2010 and 2000 populations census showed a 30.4% increment and an inter-censal average annual growth rate of 2.5%. Ghana's age structure is based on the 2013 population estimates is as follows: **0-14 years:** 38.7% (male 4,902,094 / female 4,858,630); **15-24 years:** 18.8% (male 2,360,293 / female 2,382,573); **25-54 years:** 33.7% (male 4,120,921/female 4,363,889); **55-64 years:** 4.7% (male 577,431/female 610,716); and **65 years and over:** 4.1% (male 476,297/female 546,765).

Based on the 2013 population estimates Ghana's birth, death and net migration rates respectively stands at 31.7 births/1000 population, 7.53 deaths/1000 population and -2.23 migrants/1000 population.

The infant mortality rate was estimated at 39.7 deaths/1000 live births in 2013 whilst the maternal mortality rate was estimated at 350 deaths/100,000 live births at in 2010. Life expectancy at birth was set at 65.32 years, fertility rate was 4.2 children born/woman. Based on the 2010 estimates, the literacy rate stood at 71.5%, the average household size 5.1, 86% of the total population had access to safe water (91% -urban population and 80% -rural population), and the human development index stood at 0.558.

Ghana has been enjoying relative peace with democratic governance since 1992. This culminates in the economy of Ghana being strengthened by a stability, relatively sound management, a competitive business, and sustained reductions in poverty levels. The country is endowed with a wealth of natural resources. Agriculture employs more than half of the country's workforce and accounts for almost a quarter of the gross domestic product (GDP). The services sector accounts for about 50% of GDP. The major sources of foreign exchange are gold and cocoa production and individual remittances. Oil production in Ghana began in 2010 at the offshore Jubilee field in Western Region.

1.3. The Health System in Ghana

Ghana's health service delivery follows a three-tier arrangement: peripheral primary, secondary and tertiary levels. In that order there are three levels of management: district, regional and central or national headquarters. The Ministry of Health is responsible overall policy coordination and oversight for health and health service delivery in the country. The Ministry of Health has the mandate to formulate national health policies, mobilize resources, prudently allocate the available resources to sector agencies, and monitor and evaluate the health system. The health services providers under the MOH are made up of the public service provider and the private sector which includes the missions and churches, the private for profit sector and the traditional health services providers.

The Ghana Health Service (GHS) is the major public health service providing agency of the MOH. The GHS provides basic research, primary, secondary and tertiary health services. The Teaching Hospitals provide tertiary health care services, research and professional development and are at the apex of the referral hierarchy of the health service delivery system. The Regulatory agencies are responsible for professional development, professional ethics and consumer protection. In a bid to improve the financial access to health care services the National Health Insurance Authority (NHIA) was established under the National Health Insurance Act 2003, Act 650. The Ministry of Health has also established the Private Sector Unit under the Policy Planning Monitoring and Evaluation Division (PPMED) to develop the policies that will enhance the effective participation of the private sector, which includes Civil Society Organisations and communities in the delivery of quality health care services.

There are various structures documented in the Common Management Arrangements (CMA-IV) of the Ministry of Health for ensuring the effective collaboration and co-ordination with the private sector and development partners in the planning, provision of services and management of health sector interventions. Among the existing modalities for dialogue as stated in the health sector CMA-IV are:

a. the Inter-agency Leadership Committee (IALC),
b. Sector Working Group Meetings,
c. Business Meetings,
d. Annual Summit and
e. Decentralized Level Dialogue.

The existing structures provide the opportunity for gathering information, analysis, documentation and dissemination of health information. The District Health Information Management System (DHIMS) is the main data collection, analysis and storage system of the health sector. Suggestions made from GAVI were incorporated into subsequent planning especially those related to financial management.

2.0. OBJECTIVES

The overall thrust of this evaluation was to assess the extent to which planned objectives of GAVI HSS/ISS/CSO support have been achieved. The evaluation further sought to assess the overall contribution of the supports to the achievement of the health sector objectives as defined within the Health Sector five year Programme of Work (2007-2011) and Medium Term Development Plan 2010-2013.

The specific objectives of the GAVI support evaluation were the following:

a. To ascertain the design and implementation measures put in place to ensure effectiveness of the cash based support
b. To ascertain measures undertaken to ensure efficiency in use of resources and delivery of the package of interventions
c. To appraise extent to which results have been achieved in terms of outcome and outputs of GAVI HSS, ISS and CSO cash based supports
d. To assess measures put in place to ensure the sustainability of different outputs and outcomes
e. To assess the strategies, lessons learnt, challenges and success in achieving expected outputs.

In general, the broad questions to be answered by the GAVI support evaluation include but are not limited to the design and implementation of the GAVI support; efficiency in the implementation; results achieved; and the sustainability of the innovation introduced (see Annex A for full Terms of Reference). The GAVI support is intended to provide inputs and contribute to the health outcomes of Ghana. The evaluation will therefore focus on the contribution GAVI has made to health service delivery rather than on attribution. Specifically, the evaluation was intended to address the following questions raised under specific headings:

1. Design and Implementation

a. To what extent, and in what ways, did Ghana's HSS, ISS and CSO applications demonstrate clear linkages and contribution to immunization outcomes?

b. To what extent was the active involvement and collaboration between the Donor Partners, Ministry of Health, GHS and CSOs in the development and implementation of the HSS, ISS and CSO proposals?

c. To what extent were the activities set out in the HSS, ISS and CSO application implemented as planned (quality, quantity, ways and means)? A particular focus should be given to the following questions:

   (1) To what extent, if at all, were planned activities reprogrammed? What process was followed for this reprogramming?

   (2) To what extent did programme management appropriately adapt to challenges, changes in context and delays?

   (3) To what extent were the contracted CSOs effective in delivering immunization services?

   (4) What are the lessons learnt during the implementation process? What worked well and why? What did not work well and why?

d. To what extent were activities, resources and results appropriately coordinated, monitored and reported by the MOH to the GAVI Secretariat and the Alliance partners?

   (1) What were the challenges associated with monitoring and reporting of the HSS/ISS/CSO grants?

   (2) To what extent was the feedback received useful and led to appropriate actions?

e. To what extent were the findings/recommendations from previous evaluations and assessments, including those commissioned by the GAVI Alliance, helpful and used to inform actions at the country level, including the preparation of Ghana's HSS application for the 2014-18 periods?

2. Efficiency

a. To what extent were the funds used efficiently and as planned for HSS, ISS and CSO activities?

b. What contextual factors explain the utilization rate of the funds received for HSS, ISS and CSO?

c. What could have been done to improve the efficiency for HSS, ISS and CSO activities?

d. To what extent did Ghana use the ISS, CSO and HSS funds in a complementary and coherent manner?

3. Results

a. To what extent did the programme achieve the objectives and targets as described in HSS, ISS and CSO funding?
b. To what extent has CSO support contributed to improved immunization outcomes in deprived and hard to reach areas compared to those that did not benefit directly from the support?
c. To what extent did the HSS, ISS and CSO programme contribute to observed trends in the following indicators:
   (1) Under-five child mortality?
   (2) DTP3 coverage?
   (3) Percentage of districts attaining at least 80% Penta3 coverage?
   (4) Other indicators selected by the country as part of its HSS, ISS and CSO grants?
d. To what extent did the grants effectively address bottlenecks to immunization identified in the original proposal and subsequent analyses?
e. What added value did GAVI HSS, ISS and CSO supports offer compared with other types of financing (both donors and domestic)?
f. To what extent were GAVI's HSS, ISS and CSO funds catalytic to other funding sources in the health sector?
g. To what extent were GAVI's HSS, ISS and CSO funds complementary to other funding sources in the health sector?
h. What were the positive and negative unintended consequences of the HSS, ISS and CSO programme?

4. Sustainability

a. How sustainable, in financial and programmatic terms, are the achievements of the HSS, ISS and CSO programmes at national, regional and operational levels? For example:
   (1) To what extent has the training supported by the HSS, ISS and CSO programmes been integrated into the country's routine health workforce training programmes?
   (2) To what extent has turnover of trained staff affected sustainability?

(3) To what extent has the various types of investments (capital versus recurrent) contributed to sustainability at the country level?

5. Lessons for the future

What are the major lessons that can inform improvements to future design, implementation and monitoring of HSS programmes in Ghana and elsewhere?

(1) What were the major strengths and weaknesses of this GAVI HSS, ISS and CSO grant?

(2) To what extent does the current HSS application guideline address the main issues identified?

It is recognized that the GAVI support is intended to provide inputs and contribute to the health outcomes of Ghana.

3.0. CONTEXT OF THE GAVI CASH SUPPORT EVALUATION AND LIMITATIONS

As a continuing health sector support feature, the Ghana Health Service has been receiving the GAVI HSS/ISS/CSO financial support since 2007 towards immunization in the country. Though the GAVI financial support programme was originally planned to have ended in 2011, it was extended to 2013. Since GAVI has no direct office secretariat in Ghana and does not implement its own planned programmes, the financial support is directly invested in the immunization programmes of the Ghana Health Service (GHS) based on the GHS planned immunization programme budgets. As indicated earlier in this report, the GAVI financial support is part of the wider support received by the health service delivery system. The evaluation is therefore expected to show the contributing effect of the GAVI support to immunization and health care in Ghana.

4.0. DESCRIPTION OF METHODOLOGY FOR THE ASSIGNMENT

4.1. Design of the Assignment

As a key principle, the Results-based Evaluation or Assessment technique (also known as managing for results) was adopted in undertaking the evaluation exercise. Results here refer to the outputs, outcomes and impacts from the various interventions, which may be intended/unintended, expected/unexpected, positive/negative or direct/indirect. Under the

GAVI evaluation assignment, the focus of results is more on outputs and outcomes rather than impacts.

The consultant used a set of participatory methodologies anchored in programme management principles and organisation and community development concepts to supplement the desk study and field visits in undertaking this evaluation assignment. The application of appreciative inquiry techniques and approaches during the data gathering interviews and dialogue processes helped in identifying the prevailing attitudes, perceptions and understanding of issues and organisational cultures which were used by and informed the actions of various actors in the project and how these impacted on the results achieved.

4.2. Identification and Selection of Stakeholders (Sampling)

Within the frame of the provisions made in the ToR, a multi–stage sampling approach integrating both random and structured purposefully selected beneficiary and stakeholder units at the various levels of the system was adopted for the assessment. The country was divided into three zones (Northern, Middle and Southern) out which two regions were selected per each zone. In each region two districts, two sub-districts per each district and a functional CHPS zone were selected. The Figure 5 presents a schematic diagram of the selections of sample districts for the evaluation exercise. Special focus was given to the regions with CSOs implementing activities with GAVI support (Central and Volta).

In conformity with the ToR, structured questionnaires were employed to elicit data from stakeholders and beneficiaries at all levels of the health service which essentially covered the following organizations and agencies: senior MOH and GHS officials (including key GAVI cash support focal persons in PPMED and PHD), development partners (WHO, UNICEF, NGOs, bilateral partners, etc.) and CSO representatives in the two districts where they were operational (Ati-Mokwa and Agortime-Ziorpe in the Central and Volta Regions respectively).

The Consultants visited the six selected regions to interview the Regional Health Management Teams (RHMT) and District Health Management Teams (DHMT) and other relevant health officials to discuss the implementation of the GAVI support. In each of the six regions, two districts and two sub districts (within the districts) were visited to elicit information relating to the evaluation. One of the key criteria applied in selecting the regions, districts and sub districts involved in the evaluation was the implementation of CSO activities

as part of the GAVI support in the area where they operated. Particular attention was paid to assessing the sustainability of activities or capital investments funded as part of GAVI support.

The team reviewed the activities of the CSOs in this regard to obtain an understanding of how this support was provided, the approach, how it benefited the communities and its impact on the health outputs of those communities. This evaluation also assessed the capacity of the CSOs in delivering these services and the perception of both the health staff and the communities about the work of the CSO.

Considering the fact that Ghana's development governance paradigm is strongly embedded in a decentralized local government system, the local government frame (Metropolitan, Municipal and District Assemblies) was considered as a critical focal and leverage point for undertaking the GAVI evaluation. Another factor considered in selecting the districts for the evaluation was the geographic representativeness particularly across the three zones to achieve the stated objectives of the evaluation whilst considering time and other resources as well as environmental challenges. Furthermore, the evaluators in consultations with the DHMTs selected communities where CSO activities were undertaken for the evaluation. The criteria for selecting communities included the need to have a fair coverage across the district and engaging with high-rated performance communities and low-rated performance communities. The consideration informing these criteria was the need to learn lessons from both high-rated and low-rated performance areas.

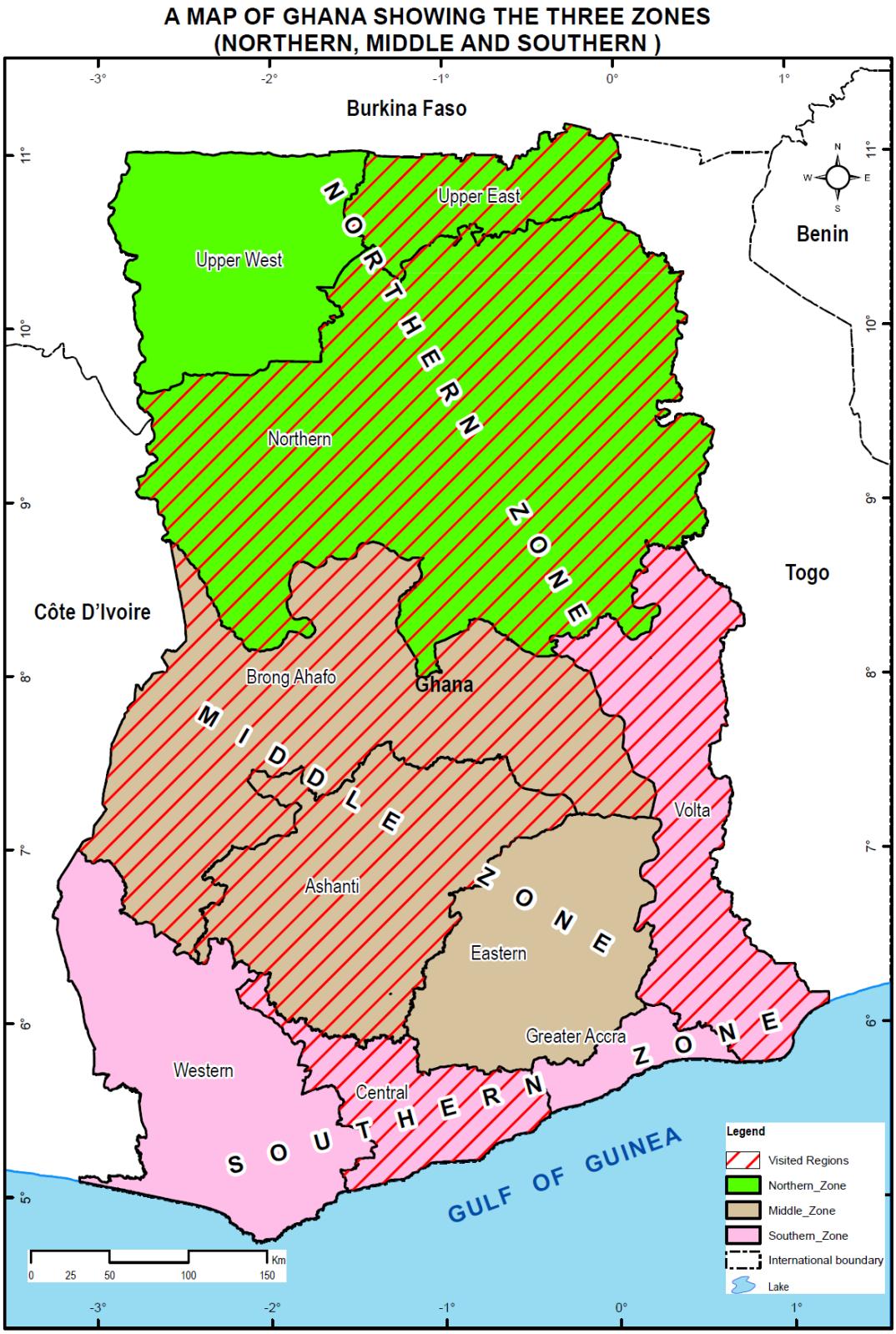

Figure 1: Map of Ghana Showing the Three Zones (including the Regions visited)

(Source: Tettey & Associates, 2015)

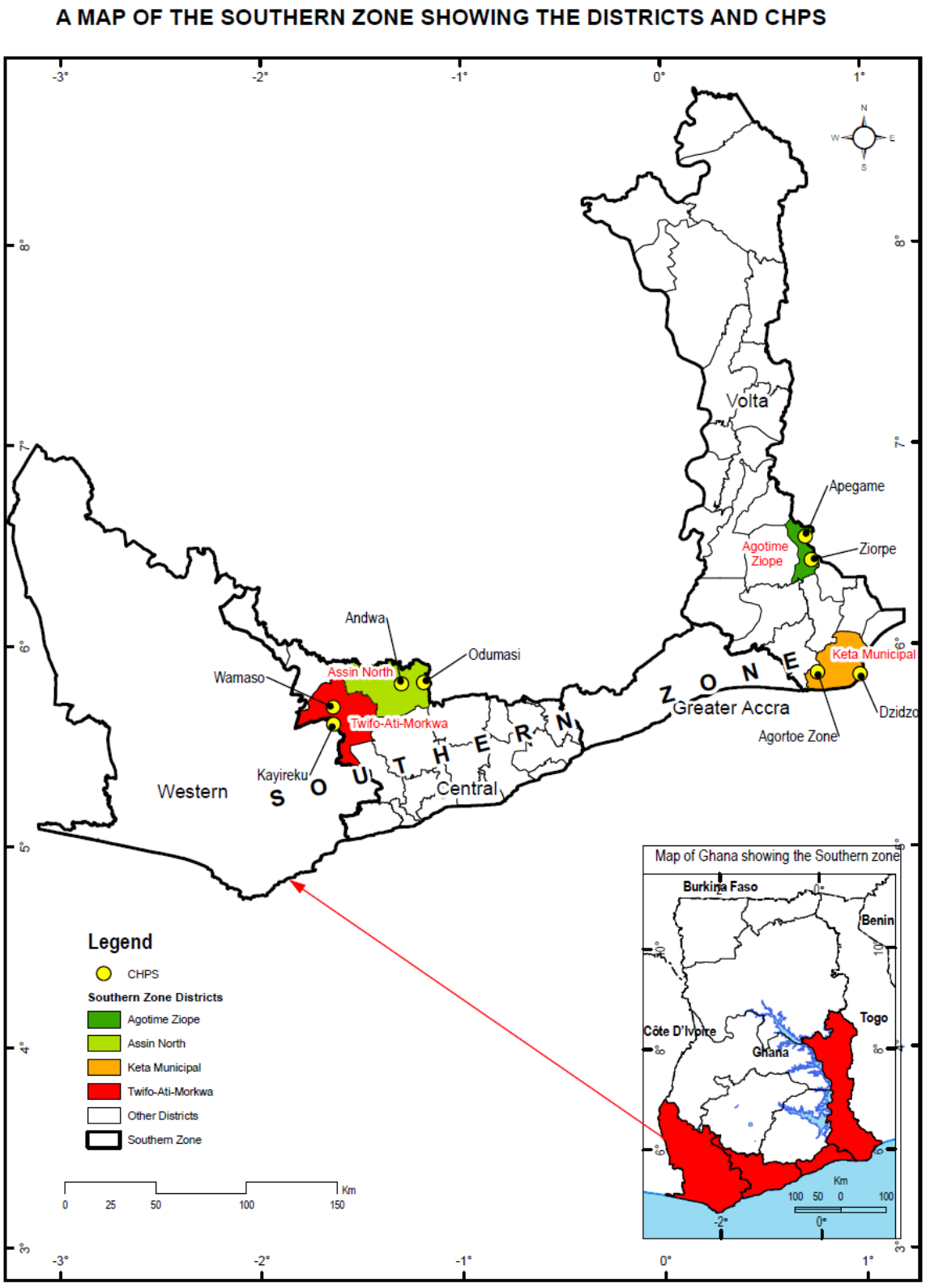

Figure 2: Map Showing the Southern Zone (including the Districts & CHPS visited)
(Source: Tettey & Associates, 2015)

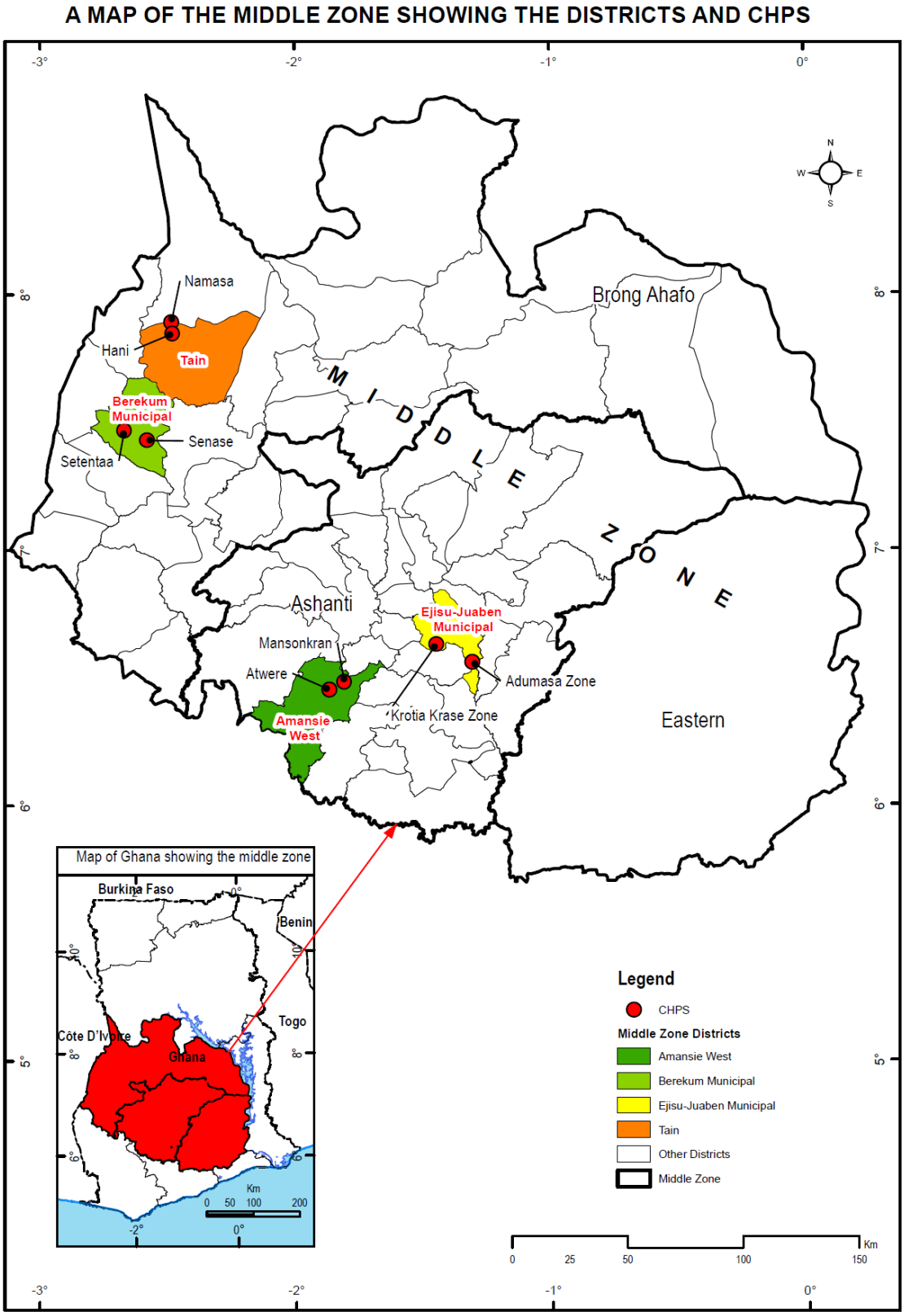

Figure 3 Map Showing the Middle Zone (including the Selected Districts & CHPS)

(Source: Tettey & Associates, 2015)

A MAP OF THE NORTHERN ZONE SHOWING THE DISTRICTS AND CHPS

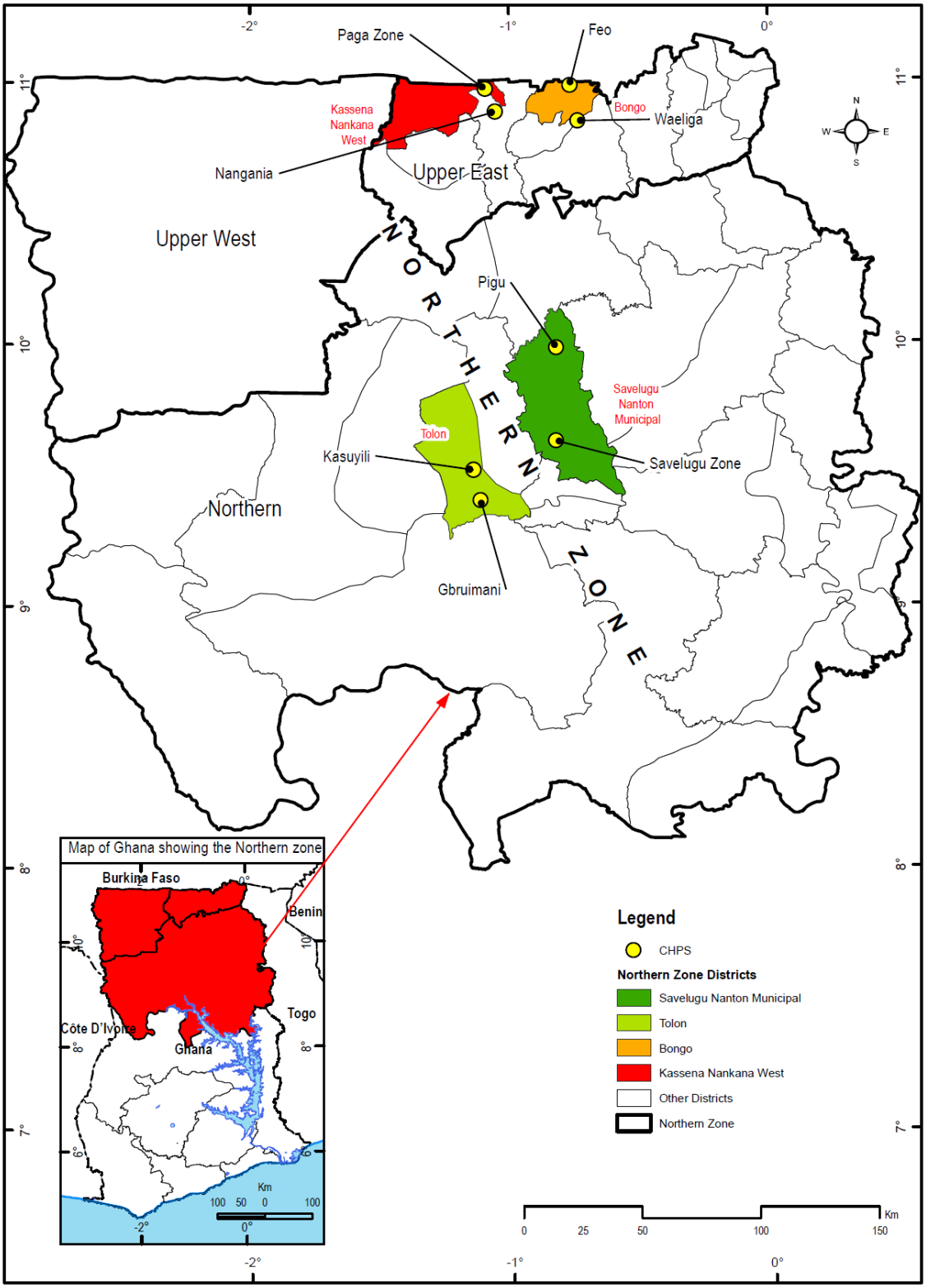

Figure 4 Map Showing the Northern Zone (including Selected Districts & CHPS)

(Source: Tettey & Associates, 2015)

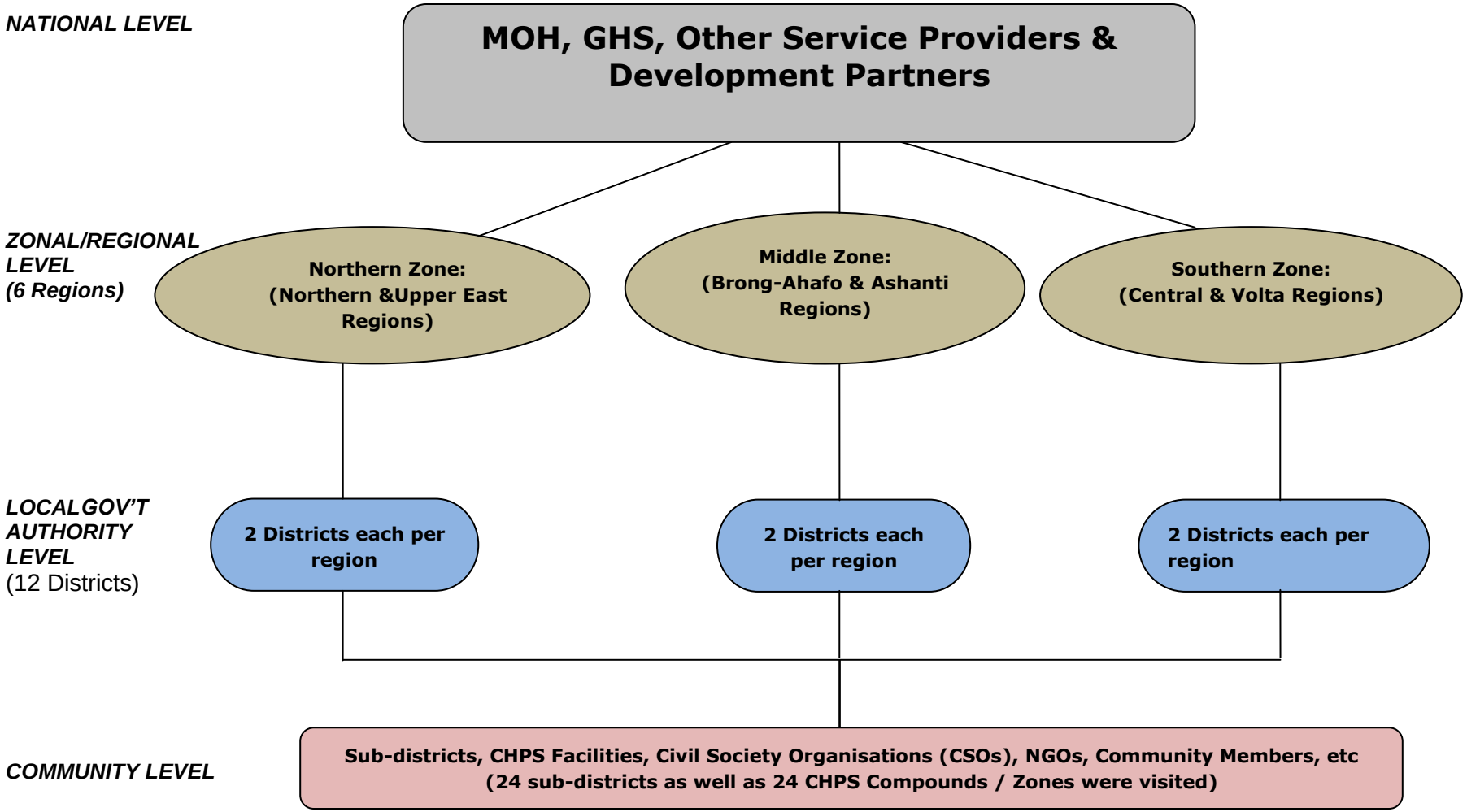

Figure 5: Schematic Diagram Illustrating National, Regional and MMDAs Visited

4.3. Expanded Programme on Immunization and GAVI Support

The mission of the Immunization Programme in Ghana is to contribute to the overall poverty reduction goal (MDG1) of the government through the decrease in the magnitude of vaccine-preventable diseases. This is to be achieved through the use of cost effective, efficacious and safe vaccines, new and under used vaccines and technologies to protect more people. These measures will contribute to the overall health systems strengthening in an integrated manner.

In 1992, the Government of Ghana added yellow fever vaccination to the National Immunization Programme (NIP). The Polio Eradication Initiative (PEI) introduced in 1996 offered a major boost to the NIP through the resources offered for capacity building at all levels. These resources include funds for operational activities, adequate cold chain logistics, health systems strengthening, partnerships and transportation facilities. Ten years after the addition of yellow fever vaccination to the NIP (January 2002), the Government of Ghana has increased the number of antigens with two new vaccines - the Hepatitis B and the Haemophilus influenza "Type B" (also known as Hib). The two new vaccines were combined with the DPT into DPT-HepB+Hib (commonly referred to as the Penta-valent vaccine in the country). This was done in partnership with the Global Alliance for Vaccine and Immunization (GAVI) initiative and support from other health development partners such as Global Fund, WHO, UNICEF, World Bank, USAID, JICA, Rotary, DFID, DANIDA and Civil Society Organizations.

Presently three key strategies are employed for the delivery of the immunization services in the country. These are;

(1) Static immunization services at health facilities;
(2) Outreach programmes in the communities; and
(3) Immunization campaigns reaching out to most of the unreached populations.

The static and outreach immunization services are delivered mostly at Child Welfare Clinics (CWC) by Public Health Nurses, Community Health Nurses (CHNs), Disease Control Officers (DCOs) and other service providers. Immunization campaigns are undertaken particularly to heighten awareness about immunization and to cover all children within the age group who have not been immunized.

The Government of Ghana has been responsible for the total cost of the traditional vaccines and supplies for injections since the inception. The government shares the cost of the Pentavalent and Yellow Fever with GAVI as agreed upon in the financial sustainability plan at the beginning of the introduction of the Penta-valent vaccine in 2002 until 2007. The country thereafter, rolled-on to the co-payment scheme under the bridge financing mechanism. Development Partners (DPs) provide support in various forms. Some of the partners support needy districts with additional resources to improve on their immunization programmes.

4.4. The Global Alliance for Vaccine and Immunization (GAVI) Support

As stated earlier, the Global Alliance for Vaccine and Immunization (GAVI Alliance) is a unique organization that mobilizes and aligns public and private resources in a global effort to create access to immunization services. The mission of the GAVI Alliance is to save lives of children and protect people's health especially women in child bearing age by increasing access to immunization in poor countries. GAVI therefore has been supporting the introduction of life saving vaccines and providing Health Systems Strengthening (HSS) support, including technical assistance in these poor countries. It brings together key actors in immunization and health systems including developed and developing countries, research and technical Agencies, Civil Society Organisations, Bill and Melinda Gates Foundation and other private philanthropists.

GAVI Alliance has been supporting Ghana since 2000 with vaccines and health systems strengthening. When GAVI opened the health systems strengthening window, Ghana applied and got approval for the period 2007 to 2011. This support was extended to 2013. GAVI Alliance over this period has also provided resources to support immunization programmes and Civil Society Organizations' activities.

The support provided over the years had a set of health outputs and outcomes to be achieved. During the period of implementation, some earlier programmed activities were revised to respond to the emerging needs of the sector. The programme implementation phase witnessed activities and innovations, which can be very useful for lessons learning, and as best practices. There were some strategies that worked well and some that did not

work so well according to the implementation plan. There is therefore the need to undertake an in-depth evaluation of the GAVI support to the country to help crystallize identifiable results, extent of programme effectiveness, efficiency and ensure sustainability.

5.0. FIELD WORK

In-depth interviews were conducted (with structured questionnaires) with relevant persons at all levels of the health service (national, regional, districts, sub-districts and CHPS). This involved senior officials of MOH and GHS (including key GAVI support focal persons in PPMED and PHD), development partners (UNICEF, WHO, Ghana Coalition of NGOs in Health) and CSO representatives.

In total, six (6) regions, twelve (12) districts, twenty four (24) sub-districts and twenty four (24) CHPS zones were covered. In each of the selected regions, two districts and two sub-districts as well as two CHPS (in the selected districts) were visited. Field visits were carried out between 6th January and 5th March, 2015. These were covered in two phases, namely;

(1) National level government institutions, agencies and development partners as the initial phase; and
(2) Regional Directorates of Health Services (RDHS), District Directorate of Health Services (DDHS), sub-District level health institutions, non-governmental organizations (NGOs) as well as community members.

5.1. National Level

At the national level contacts were made with the Ministry of Health (MOH), the Ghana Health Service (GHS) and other relevant Development Partners. The key outcomes from the discussions are elaborated in sessions below

1) Ministry of Health (MOH)

Officials interviewed at the MOH include the Chief Director, Director PPMED, Director of Administration and Financial Controller, and Head of Private Sector Unit as well as the Head of Financial Reporting and Monitoring Unit.

2) Ghana Health Service (GHS)

At the GHS on the other hand, the Director General, Director Administration, Director PPMED, National EPI Coordinator, Director of Finance, Director – Stores and Supplies, and the Deputy Director, Transport as well as the Transport Manager were interviewed.

3) UNICEF

At the UNICEF, the Chief Health and Nutrition Officer and the Assistant Health Officer were also interviewed to share their views, experiences and suggestions on the GAVI support to the GHS immunization.

4) World Health Organization (WHO)

The Health Economist at the WHO offices in Accra who has been a very strategic partner in providing advisory services to government public health activities including immunization was on hand to share his views and experiences as well as recommendations for improving the health status of Ghanaians.

5) Ghana Coalition of NGOs in Health (GCNH)

The team also had discussions with the National Coordinator of the GCNH as well as the coalition's Administrative Secretary on the GAVI Support in general but with special emphasis on the CSO Support.

5.1.1 Key Roles Played By UNICEF, WHO and CSOs

The support of all Development Partners contributed to the EPI in Ghana. However, the UNICEF, WHO and the CSOs are directly involved in the logistics procurement and operationalization of field activities towards immunization.

a) UNICEF

Immunization is at the core of the UNICEF programmes. It plays critical role in shaping national policy, strategies and the preparation of comprehensive multi-year plan through research. It provides cold chain equipment, vehicles, motor cycle and other logistical support to the system. It provides financial and technical support for training and capacity building, bottleneck analysis, and comprehensive cold chain inventory as well as vaccine management and assessment. The major role UNICEF plays in the GAVI support for immunization is to procure vaccines paid for by GAVI, GoG and other Development Partners. All financial support from GAVI goes directly to the Government of Ghana. UNICEF acts as a communication channel for the financial support from GAVI to GoG by facilitating, monitoring utilization and reporting on same.

In the area of HSS, UNICEF jointly works with the government to identify priority areas, draw programmes with the sole aim of making impact. It also plays key role in developing proposals. It provides technical support in the implementation, carries out evaluation and assessments of such programmes. It is involved in the revision of immunization plan every five years to develop the comprehensive Multi-year Immunization Plan (cMyP). On the common management arrangement, the ICC has served its purpose in terms of providing the platform for all stakeholders in the health sector to provide technical guidance and play the role of advocacy. However the new paradigm is the proposal to have the National Immunization Technical Advisory Group (NITAG) to provide purely technical advice whereas the ICC plays the advocacy role. The ICC meets quarterly.

The support has contributed immensely to the improvement in immunization coverage, and reduction to almost zero case of all major child vaccine preventable diseases thus resulting in drastic reduction in the child morbidity and mortality rates as well as significant improvement in maternal health.

b) The World Health Organization (WHO)

The World Health Organization (WHO) is one of the partners working with the Government of Ghana (GoG) in the health sector. In terms of immunization the WHO provides technical support by contributing to setting standards and norms for drugs safety and maintenance of logistics at the national level. These standards and norms are then applied to activities of immunization at the sub-national levels. WHO supported the MOH in the formulation of policies and contributed to the development of operational guidelines by the GHS. For instance, the WHO contributed extensively to the preparation of the comprehensive Multi-Year Plan - (cMYP). The WHO also provides capacity building for GHS personnel as a contribution to enhancing competence and performance at the national level. This is generally towards health promotion. The WHO's direct contribution to immunization in Ghana, focuses more on capacity building as part of health system strengthening (HSS) and assisting Ghana maintain acceptable international standards.

c) Ghana Coalition of NGOs in Health

There exists a Ghana Coalition of NGOs in Health with a membership of well over 400 registered CSOs across all the ten regions of Ghana. The Hope for Future Generations for example operates in all the ten regions in Ghana.

There is also a CSO Technical Committee chaired by the Director, PPME–GHS. It is an arrangement between the Coalition and the GHS that provides a monitoring platform relating to GAVI funded activities as well as other community level health delivery activities such sensitization on malaria, HIV and AIDS, etc. In this regard, the GHS has an oversight responsibility to the Coalition.

Proposals are prepared with specific CSOs and funding for approved proposals is channelled through the GHS to the Coalition to the CSOs. The Coalition monitors the activities of CSOs through its established monitoring team.

5.2. REGIONAL AND DISTRICT LEVELS

At the Regional Level, officials of the various RHMTs, D/MHMTs, Sub-Districts, CHPS and CSOs as well as Community Volunteers were interviewed. The field visits were also undertaken in selected districts that benefited from support under the HSS/ISS and CSO supports. Assessment of performance against targets of activities financed by GAVI support in the regions and districts concerned was made. Particular attention was paid to assessing the sustainability of activities and capital investments funded as part of GAVI support.

Activities of the CSOs in the regions (Central and Volta) where they (CSOs) were involved in the GAVI immunization exercise were reviewed to obtain and understand how the GAVI support was provided, and how the approach benefited the communities and its effects on their health activity outputs. The evaluation assessed the capacity of the CSOs in delivering these services and the perception of both the health staff and the community about the work of the CSOs.

Interviews were conducted and facilities inspected (especially cold chain facilities, vaccine storage, and temperature monitoring). The table 2 provides a summary of all the places visited.

Table 2: List of Regions, Districts, Sub-districts and CHPS Zones Visited

Southern Zone					
Region	**District**	**Sub District**	**CHPS**	**Sub District**	**CHPS**
Volta	Agortime Ziorpe, CSO	Kpertoie CSO	Apegame CSO	Ziorpe CSO	Wudzedeke CSO
	Keta Municipal	Shime	Agortoe Zone	Tegbui	Dzidzorve
Central	Atimokwa CSO	Twifo Mokwa CSO	Wamaso CSO	Praso CSO	Kayireku CSO
	Assin North Municipal	Assin Akropong	Odumasi	Assin Bereku	Andwa Zone
Middle Zone					
Ashanti	Amansie West	Kenyiago	Mansonkran	Manso Nkwanta	Atwere
	Ejuso Juabeng Municipal	Bonfa	Adumasa zone	Kwaso	Krotia Krase Zone
Brong Ahafo	Berekum Municipal	Berekum	Senase	Jinijini	Setanta
	Tain	Debibi	Namasa	Seikwa	Hani
Northern Zone					
Northern	Savelugu –Nanton Municipal	Savelugu Reproductive & Child Health Unit	Savelugu Zone	Diare	Pigu
	Tolon	Nyankpala	Gbrumani	Wantugu	Kasuyili
Upper East	Bongo	Soe	Feo	Beo	Waeliga
	Kassena-Nankana West	Paga Health Center	Paga Zone	Chiana	Nangania

CSOs: *Central Region: - Hope for Future Generations.*
Volta Region: Seek to Save Foundation.

6.0. KEY FINDINGS FROM THE EVALUATION

6.1. GAVI Involvement and Commitment (EPI, HSS, ISS, and CSOs)

GAVI does not have a secretariat in Ghana. It works through the national health care delivery system and the development partners (especially UNICEF) in-country. Initially, there were 50 districts that benefited directly from the GAVI support. The number of beneficiary districts increased to 77 in 2007. To date the total number of administrative districts is 216 with the creation of new districts. During the period of support under the current evaluation (2007 to 2013), GAVI provided funding in the procurement of vaccines, cold chain equipments and other related logistics. Fifty-three (53) Great Wall and 49 Ford pick-up trucks were also procured under the programme. See Appendix C for details of vehicles and allocation to districts.

6.2. Logistics

On annual basis and at the national level in the vaccine and logistics supply chain, cost estimates (budget and plans) based on national vaccine targets are submitted to GAVI and UNICEF through the Ministry of Health. Vaccines are either fully paid for independently by GoG, and GAVI or co-funded by the two. In all cases, the procurement process is managed by UNICEF. The procurement and delivery process are closely monitored such that advanced information on arrival schedule is made available to the EPI managers at the headquarters. This makes it possible for an awaiting cold chain van at the airport to cart the vaccines to the National Storage Room at Korle-Bu in Accra.

Vaccine carriers were available even though some districts did not have adequate quantities at one time or another. The inadequacy is usually due to equipment breakdown over time. For instance during the evaluation field visits, 7 sub-districts in Tolon (Northern Region) and Kassena-Nankana East (Upper East Region) and Tain (Brong-Ahafo Region) reported that their vaccine carriers are quite old. More than 30 percent of cold chain fridges across the visited districts are not functioning. The health personnel in such affected places have had to resort to use of domestic fridges to store vaccines. Health personnel are faced with a huge challenge with the size of the new vaccine carriers since these are large and pose challenges when carried about. Another area of concern is the use of vaccine carriers for conveying samples to headquarters. These carriers usually get locked up at the headquarters in Accra. This situation is due to the fact that the regional officers fail to collect

the vaccine carriers back to their various districts. There have been no reported shortages of syringes, needles and cold boxes within the period under review.

There were functioning vaccine refrigerators but the main problem had to do with frequent power outages in some areas. Where this happens, the institutions send their vaccines for storage at the nearest facilities which have power supply. Facilities tend to use domestic fridges to store the vaccines for short periods when they experience breakdown of vaccine refrigerators.

The Medical Refrigeration Technical Management Team under the Biomedical Engineering Unit of Ministry of Health is charged with the responsibility of installation and maintenance of Cold Chain Equipment in the country. The technical team ensures proper and effective protection of EPI Vaccine. There is a system of servicing the vaccine refrigerators from the national through regional to facility levels but the servicing was not regular due to inadequate trained technical staff. The difficulty in getting replacement spare parts was also cited as a reason for non-functioning equipment. The technical team has a responsibility to conduct planned preventive maintenance on cold chain equipment and to also assess the reasons for the frequent breakdown of the solar-powered refrigerators. Some of the identified challenges include lack of spare parts, infrequent serving and frequent break-down of batteries. It was found out that the team was also instrumental in the installation of seven (7) Walk-in Cold Rooms in seven regions and other equipment in various facilities in the country in 2011. The seven regions are Brong-Ahafo, Upper East, Upper West, Central, Ashanti, Volta and Eastern Regions.

6.3. Vaccines

The following are the vaccines currently in use in Ghana:

1. BCG
2. Measles
3. Penta
4. Yellow Fever
5. Measles Rubella
6. PCV
7. Rota-virus
8. Tetanus for Women
9. Polio

For the period under review (2007 – 2013) there was no reported shortage of vaccines. There were functioning cold stores with adequate stock of vaccines. The national level annually calculates the quantities of vaccine requirements with total budget based on targets set at all levels. There was a standard quarterly (national) and monthly (regional through district to facility levels) vaccine distribution schedule. GAVI is also supporting Human Papilloma Virus (HPV) vaccine as an HPV Demonstration Project. Ghana will embark on a full scale operation of this if the demonstration project becomes successful.

6.4. Transportation

Based on statistics received from the Ghana Health Service (Head Office), all the regions visited were supported with vehicles. However, at the district and sub-district levels, the health management team has no documentation to indicate that the vehicles were from the GAVI support. Most of the vehicles were not serviceable at the time of the visit. The worst affected vehicles were the JIALENG and NANFANG brand of motor bikes. There was also a major challenge with the availability of funds to ensure regular supply of fuel for field work. Hard to reach areas are accessed by motor bikes and boats. It was reported by the district and sub-district health management teams that under certain conditions, officers had to walk long distances to administer vaccines and to undertake other health service delivery activities. The inadequacy of transportation facilities compels officers to use personal motor-bicycles and public transport system for immunization and other allied health activities. In the Upper East Region, tricycles were modified (figure 6) for use for field activities and as ambulance.

Figure 6: Modified Tricycles as Ambulance

6.5. Data Collection, Analysis, Storage and Retrieval

Data collection schedules have been put in place in all the districts visited. Data are generally collected and transmitted, as the case may be, from CHPS Compounds to sub-districts which in turn submit reports to the districts and thence to the regions for onward submission to the national level. Data (figures) collection occurs at the CHPS and sub-district and recorded in absolute figures. These are transmitted to the district, onward to regional and national levels for analysis and feedback. Data collection forms are quite explicit. Record keeping at the CHPS and sub-districts levels is unsatisfactory due to the inadequacy of trained staff. Where substantive officers were not at post, it was almost impossible to access any meaningful information.

6.6. Information Management (National, Regional, Districts and Sub-District)

There exist a well-designed system of data transmission and feedback throughout the health delivery levels with follow up and monitoring regime to check anomalies and fill in identified gaps. At the national level, there is complete information on all districts and regions in terms of coverage and disease surveillance. Platforms such as weekly management meetings, health committee meetings and performance reviews (quarterly, half-yearly, and annually) for health information management at the district, regional and national levels were reported to be in existence. However detailed inventory data and information regarding the status of vaccine carriers and other local cold-chain equipment is scanty at the regional and national levels. It was also observed that, once there was a change of staff it became extremely difficult to have access to any meaningful information due to poor record management at the CHPS facilities and other sub-district facilities.

6.7. Monitoring and Supervision

Monitoring schedules are in place. There are established regional level quarterly monitoring and supervision and district-wide monthly monitoring and supervision, as well as the regional-parent arrangements. A regional parent is an RHMT member with oversight responsibility for a particular district. However, these planned monitoring and supervision activities are not undertaken regularly mainly because of the huge transportation and financial challenges the system is faced with.

There were visitors' books available at almost all the places visited. However, where standard visitors' books were not available, there was no column for remarks in the improvised books. Additionally, it was noticed that some visitors did not make entries in the visitors' book.

6.8. Adequacy of Staffing

Staffing was generally adequate at the higher levels of the health care delivery system in terms of the numbers and skills for performance. However, towards the peripheral levels, it was noticed that the number, skill-mix, quality and skill of staff was not adequate. The CHPS Compounds are designed to be manned by Community Health Nurses (Community Health Officers). In a few cases based on the exigencies and initiative of the District Health Management Teams midwives are stationed to man the CHPS compounds.

6.9. Financial Management

The main sources of funding for operational activities are Government of Ghana (GoG), (budgetary allocation), Internally Generated Funds (IGF) which includes National Health Insurance Fund and direct payments by patients, private funding such as donations from corporate organizations and other philanthropic, and Development-Partners support. The GAVI funds are lodged with the GHS headquarters and disbursed to the various regions according to agreed budgeted programmes.

It was noticed that in the Amansie West District in the Ashanti Region the Millennium Villages Project (MVP) of the UNDP has been designed to show that the MDGs are achievable given the critical mass of resources. One Health Centre and six (6) CHPS compounds are being provided for with the critical funding needs. The field staffs are also given monthly stipend. As part of the MVP all health staffs were given mobile phones. Also the community volunteers were also given transport allowance as motivation. Other DPs such as the USAID through Family Health International are also providing support.

It however needs to be noted that the GAVI financial support is identified at the national and transfers to the regional levels. However, beyond the regional level to the district and sub-district levels the fund transfer are aggregated and transferred based on planned programme of activities and does not indicate the source (GAVI financial support). This makes it difficult – if not impossible – to track detailed GAVI fund support at the District and

sub-district levels. This observation applies to fund transfers as well as training support, logistics and other equipment to the districts and sub-districts.

Funds from the national level were disbursed to the regional levels in accordance with planned budget activities. These funds are however mostly aggregated at the regional and district levels and disbursed in accordance with planned activities and needs. In most cases, timely release of funds, even if available, was a challenge. It was observed that, in general, returns on funds received were not submitted regularly to regional and national levels. It has been reported at most of the facilities visited that funding of the health service delivery system is generally inadequate.

6.10. Community Volunteerism and CSO Involvement

There are community volunteers in various aspects of the health service delivery system across the country. Various incentive modalities for volunteers have been identified on the field. The volunteers are usually given allowances for transport as and when it is due. In some other cases they are given T-shirts and caps and visors with the name of the funding DPs, the CSO and the programme activity boldly inscribed on them. These have been observed to serve as a motivation for the volunteers.

There was targeted GAVI direct funding for two specific CSOs in immunization in the Volta and Central Regions. In the Volta Region, there was the Seek to Save Foundation operating in the Agotime-Ziope District. In the Central Region, the Hope for Future Generation International operated in the Ati-Morkwa District in the Twifo Praso area. These are districts with some of the lowest immunization coverage in the country. Though the activities of these CSOs have ended, volunteerism is being sustained in these communities. It must be noted however, that there are a number of NGOs/CSOs in the health sector operating in other areas across the country. In communities where these GAVI supported CSOs worked, they (the CSOs) are known as “the GAVI people”. Meanwhile in other communities and even a majority of district staff in other parts of the country visited have no knowledge of GAVI and its operations. There are also ad-hoc volunteer groups used throughout the country in all zones especially during NIDs. It was found that community volunteerism was effective and critical for the Northern Zone because of its sparsely populated communities scattered over a large area coupled with poor transportation facilities and inundated with numerous hard-to-reach areas. GAVI project contribution

through Seek to Save to District EPI (July 20013 – July 2014) is shown in Table 3 below. Similarly Table 4 below shows GAVI CSO Support for Child Immunization (July 2012 – May 2013) Hope for Future Generations.

It was observed in the field that some Development Partners are funding certain health service delivery activities in their areas of preference. These activities are not usually clearly defined and captured in the health service delivery system. These activities are usually implemented by CSOs.

6.11. The Case of Amansie West District Health Service Support

It was noticed that in the Amansie West District in the Ashanti Region the Millennium Villages Project (MVP) of the UNDP has been designed to show that the MDGs are achievable given the critical mass of resources. The programme begun in 2005 and it is winding up by December, 2015.

One Health Centre and six (6) CHPS compounds are being provided for with the critical funding needs. All these CHPS Compounds are headed by trained mid-wives. The field staffs are also given monthly stipend. The first tele-medicine facility has been established in the district capital at the Amansie West District Hospital (St. Martin's Catholic Hospital at Agroyesum). This aids the immunization process by promoting interaction between the centre and peripheral facilities. As part of the MVP all health staffs were given mobile phones. Also the community volunteers were given transport allowance as motivation. Other DPs such as the USAID through Family Health International are also providing support.

The district Director of Health Services indicated that but for the project and the district hospital, all vaccine would have to be stored in Kumasi, the regional capital, due to the challenges with power supply.

Table 3: GAVI Project Contribution to District EPI (July 2013 – July 2014) through Seek to Save Foundation

Antigen	GAVI	District	%Contribution of GAVI to District
OPV 0	192	910	**21.1**
BCG	209	958	**21.8**
DPT1	252	1123	**22.4**
OPV1	247	1137	**21.7**
Pneumo1	241	1163	**20.7**
Rota1	237	1128	**21.1**
DPT2	240	1136	**21.1**
OPV2	242	1124	**21.5**
Pneumo2	239	1212	**19.7**
Rota2	229	1164	**19.7**
DPT3	210	1121	**18.7**
OPV3	214	1126	**19.0**
Pneumo3	207	1164	**17.8**
Measles1	241	1298	**18.6**
YF	240	1300	**18.5**
Measles2	228	1125	**20.3**

Table 4: GAVI CSO Support for Child Immunization (July 2012 – May 2013) through Hope for Future Generations

Indicator	District Achievement (July 2011 – June 2012)	District Achievement (July 2012 – May	HFFG's Contribution (July 2012 – May	Year to Date Change	% Contribution by HFFG (July 2012 – May
BCG	5893	6482	596	589	9.2
OPV3	5196	4686	1175	-510	25.1
Rotavirus 2	375	4827	1222	4452	25.3
Penta3	5196	4744	1165	-452	24.6
PCV3	0	4298	1175	4298	27.3
Measles1	4693	4722	1048	29	22.2
Yellow Fever	4693	4665	1048	-28	22.5
Measles2	-	-	1122	-	-

6.12. Hard-to-Reach Areas

In all the regions visited, there are hard-to-reach communities. These communities are hard-to-reach as a result of one or more of the following factors:

a. Riverine areas

b. Thick Forest with no roads

c. Very bad roads (e.g. without bridges)

d. Roads completely not motorable in rainy season

e. Heavy sand banks (e.g. Keta)

f. Sparsely populated and widely scattered communities in very vast geographical area in the northern zone

There are hard-to-reach areas in virtually all the 12 districts visited.

The CSOs which operated in the two (2) GAVI supported regions (Hope for Future Generations – Central Region and Seek to Save in the Volta Region) reported identifying some communities which were hitherto not known to the Ghana Health Service system.

6.13. Immunization

There is an established national immunization schedule throughout the whole country. There is also a schedule for the collection and distribution of vaccines and related logistics throughout the whole country. Facilities provide static services on daily basis and all facilities have monthly community outreach programmes. Mop-up exercises and mass campaigns are scheduled as necessary. National Immunization Days (NIDs) are also scheduled and undertaken once or twice in a year depending on availability of resources.

It was observed that some facilities record over 100% immunization coverage. This is said to be due to influx of visitors during market and festive days. There was also movement of people from the border towns/villages of neighbouring countries (e.g. Burkina-Faso, Cote d'Ivoire and Togo) to benefit from the immunization programmes and NIDs. Another problem was with the population base received from the national census in some places which makes the denominator for the calculation of coverage smaller than the actual population on the ground. This could also partly explain the persistent low coverage in some areas.

6.14. Disease Surveillance

There is a well established disease surveillance system across the country. Aspects of the disease surveillance system in the country use the services of volunteers at community level. These volunteers are trained and given case-definitions. The detected cases by volunteers are reported to the sub-district or district level. There is follow-up verification of the cases and confirmed cases are reported on a weekly communicable diseases notification form. The data are transmitted from the sub-district system to the district level

through the regional to the national levels. Outbreaks of some diseases are notified to the national headquarters for rapid response.

Table 5 below shows the national trend in reported cases of three vaccine preventable diseases (Measles, Yellow Fever and Polio) between 2007 and 2013.

Table 5: Reported Cases of Three Vaccine Preventable Disease 2007-2013 (National trend)

Disease	2007		2008		2009		2010		2011		2012		2013		Total	
	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases
Measles	588	0	1305	82	683	101	692	36	1635	596	1610	329	762	168	7275	1318
Yellow Fever	237	0	206	0	206	0	315	0	581	31	306	3	435	7	2286	41
Polio	154	0	222	0	273	0	216	0	278	0	199	0	342	0	1684	0

Source: Ghana Health Service

Because of very few cases of confirmed diseases like measles and polio it is becoming increasingly difficult to get active cases to demonstrate to student and other health professionals. No deaths from measles have been recorded in Ghana for the past ten years.

Table 6: Seven-Year Trend of EPI Coverage by Figures and Percentages

Antigen	2007		2008		2009		2010		2011		2012		2013	
	Fig	Cov (%)	Fig	Cov (%)	Fig	Cov (%)	Fig	Cov (%)	Fig	Cov (%)	Fig	Cov (%)	Fig	Cov (%)
BCG	6249	125.9	6988	137.8	7165	138.4	6555	127	6599	124	7344	138.8	6975	123.3
MEASLES	4193	84.5	4420	87.1	4015	77.5	4210	80.5	4473	84	4793	87.3	4729	83.6
PENTA 3	4070	82	4601	90.7	4711	91	4394	85.1	4556	85.6	4385	79.9	4229	74.7
OPV 3	4080	82.18	4533	89.37	4594	88.72	4402	85.26	4557	85.61	4367	79.57	4241	75
YF	3901	78.57	4040	79.65	3789	73.17	4060	78.64	4337	81.48	4780	87.10	4730	83.6
TT 2+	3341	67	3787	73	4429	85.5	3916	74	3869	71.7	4690	85	4665	82.4

Source: Ghana Health Service

Table 7: Reported Neonatal Tetanus Cases by Region, Ghana, 2007 - 2013

Region	2007			2008			2009			2010			2011			2012			2013		
	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths	Suspected Cases	Number Investigated	Deaths
Ashanti	0	0	0	0	0	0	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Brong Ahafo	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Central	0	0	0	1	1	1	2	2	1	0	0	0	1	1	1	0	0	0	0	0	0
Eastern	0	0	0	0	0	0	2	2	1	1	1	1	0	0	0	0	0	0	0	0	0
Greater Accra	0	0	1	1	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Northern	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Upper East	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Upper West	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Volta	9	8	7	4	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Western	0	0	0	0	0	0	1	1	1	0	0	0	3	3	1	0	0	0	1	1	1
Ghana	10	9	9	7	6	4	8	7	5	1	1	1	5	5	2	0	0	0	1	1	1

Source: Ghana Health Service

Table 8: Reported Polio Cases by Region, Ghana, 2007 - 2013

Region	2007		2008		2009		2010		2011		2012		2013	
	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV	Suspected Cases	Confirmed WPV
Ashanti	17	0	27	0	44	0	41	0	49	0	28	0	45	0
Brong Ahafo	13	0	38	0	37	0	26	0	35	0	38	0	72	0
Central	25	0	16	0	34	0	15	0	21	0	26	0	33	0
Eastern	13	0	27	0	41	0	17	0	25	0	20	0	30	0
Greater Accra	8	0	18	0	19	0	19	0	15	0	9	0	33	0
Northern	19	0	34	0	25	0	24	0	41	0	20	0	33	0
Upper East	8	0	18	0	22	0	8	0	20	0	14	0	33	0
Upper West	9	0	10	0	13	0	12	0	16	0	15	0	21	0
Volta	14	0	13	0	18	0	27	0	29	0	16	0	21	0
Western	28	0	21	0	20	0	27	0	27	0	13	0	21	0
Total	154	0	222	0	273	0	216	0	278	0	199	0	342	0

Source: Ghana Health Service

Table 9: Reported Yellow Fever Cases by Region, Ghana, 2007 - 2013

Region	2007		2008		2009		2010		2011		2012		2013	
	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases
Ashanti	53	0	43	0	42	0	76	0	105	0	59	1	48	0
Brong Ahafo	38	0	43	0	19	0	26	0	57	3	96	1	152	2
Central	15	0	8	0	19	0	15	0	20	0	7	0	9	0
Eastern	23	0	25	0	32	0	20	0	61	1	40	0	61	4
Greater Accra	11	0	9	0	5	0	2	0	10	1	6	0	11	0
Northern	20	0	30	0	16	0	44	0	97	13	29	1	9	0
Upper East	11	0	7	0	36	0	30	0	67	3	18	0	32	0
Upper West	21	0	16	0	12	0	17	0	116	10	25	0	63	1
Volta	10	0	11	0	16	0	50	0	39	0	14	0	30	0
Western	35	0	14	0	12	0	35	0	9	0	12	0	20	0
Total	**237**	**0**	**206**	**0**	**206**	**0**	**315**	**0**	**581**	**31**	**306**	**3**	**435**	**7**

Source: Ghana Health Service

Table 10: Reported Measles Cases by Region, Ghana, 2007 - 2013

Region	2007		2008		2009		2010		2011		2012		2013	
	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases	Suspected Cases	Confirmed Cases
Ashanti	114	2	221	11	95	4	163	2	521	181	208	27	117	37
Brong Ahafo	53	0	137	21	97	6	89	3	130	40	189	12	236	56
Central	32	0	73	1	29	1	47	15	108	44	109	5	32	6
Eastern	145	3	247	4	110	2	135	0	213	82	285	12	97	20
Greater Accra	141	0	395	7	117	19	88	1	209	80	173	20	55	8
Northern	27	0	78	24	71	35	37	0	64	16	195	140	27	4
Upper East	11	0	19	9	49	25	20	2	44	6	87	37	45	9
Upper West	6	0	14	4	13	1	19	0	46	12	93	18	44	2
Volta	21	1	70	1	54	1	60	9	156	72	96	5	69	17
Western	38	0	51	0	48	7	34	4	144	63	175	53	40	9
Total	**588**	**6**	**1305**	**82**	**683**	**101**	**692**	**36**	**1635**	**596**	**1610**	**329**	**762**	**168**

Source: Ghana Health Service

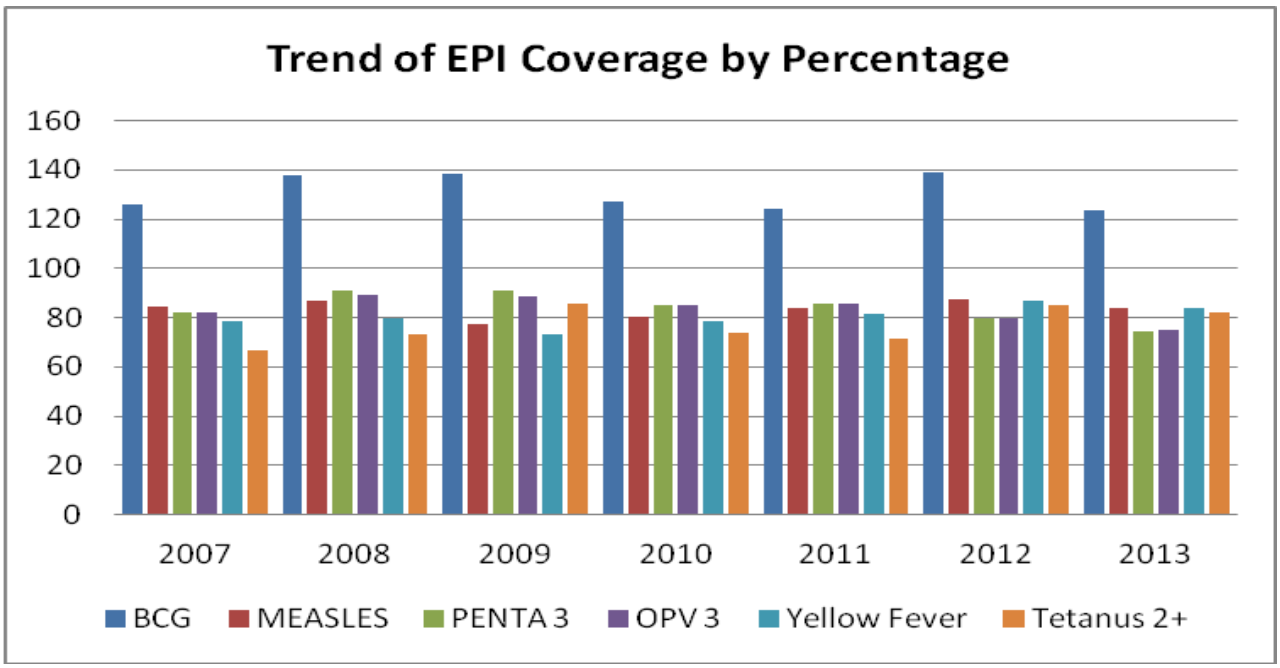

Figure 7: Seven-Year Trend of EPI Coverage by percentage

Generally in the health sector, Penta-3 is used as a proxy for measuring and assessing immunization performance. Hence the immunization rate using coverage for Penta-3 is a fair indication of immunization assessment and performance.

Table 11 shows (below) that Penta–3 coverage in general have been over 80% in all the regions except Greater Accra which persistently recorded below 80% and Volta which only recorded below 80% in 2013. Persistent over 100% coverage could be due to wrong population base data, population movement in relation to market centre and influx from etc. Table 6 (above) also shows fluctuations in Penta-3 performance trends during the period under review.

Table 11: Penta-3 Performance (2007 – 2013)

Penta-3 Performance							
Regions	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Ashanti	72.3%	82.8%	88.1%	91.0%	89.4%	92.1%	92.6%
Brong-Ahafo	100.2%	103.3%	100.0%	99.2%	99.2%	100.7%	97.0%
Central	92.6%	97.1%	101.7%	99.2%	100.4%	90.6%	87.1%
Eastern	93.0%	99.3%	99.5%	98.5%	97.8%	91.8%	88.7%
Greater Accra	67.8%	73.0%	76.5%	73.8%	69.6%	78.5%	77.9%
Northern	123.7%	122.9%	129.5%	114.9%	120.2%	115.3%	114.2%
Upper East	101.6%	98.1%	111.5%	87.5%	91.2%	88.4%	87.2%
Upper West	93.9%	97.8%	94.9%	86.0%	87.1%	79.9%	82.8%
Volta	83.8%	90.6%	87.3%	85.7%	85.4%	81.8%	79.4%
Western	93.3%	95.3%	93.3%	90.9%	93.2%	99.9%	92.9%
Ghana	87.8%	92.4%	94.1%	91.7%	91.6%	92.2%	90.2%

Source: Ghana Health Service

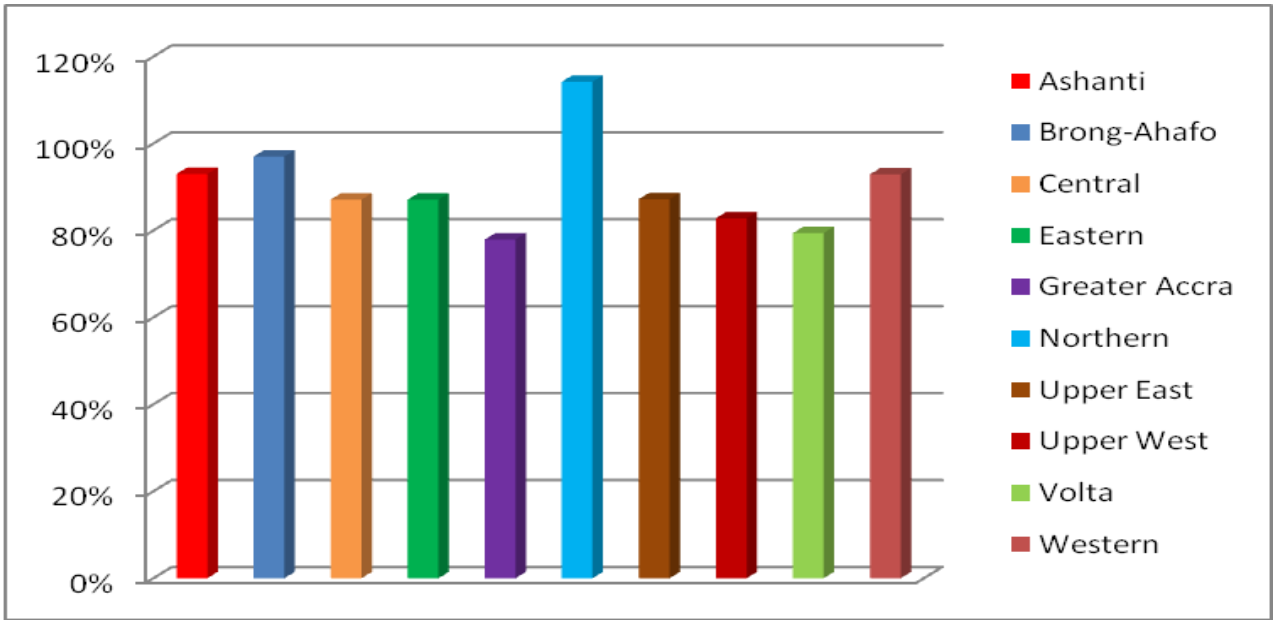

Figure 8: Penta-3 Performance by Region in 2013

Source: Ghana Health Service

7.0. ASSESSMENT OF KEY EVALUATION CRITERIA

The overall thrust of the evaluation is to assess the extent to which planned objectives of GAVI HSS/ISS/CSO support have been achieved. The evaluation further seeks to assess the overall contribution of the supports to the achievement of the health sector objectives as defined within the Health Sector Medium Term Development Plan 2007-2011.

7.1. Design and Implementation

The GAVI HSS/ISS/CSO support to the health system of Ghana was designed and targeted at primarily contributing to child immunization and maternal health in the country. The process is designed to actively involve all stakeholders from the national to the local/community level. At the national level, Ministry of Health and its service delivery agency Ghana Health Service, and institutional partners including the Development Partners and other stakeholders have been collaboratively involved in the design and implementation of the GAVI support. The key element in the design is the lead role played by the Ministry of Health and Ghana Health Service in the design and implementation of the Health Sector Medium Term Plan. The Ghana Health Sector Five Year Programme of Work (2007-2011) is the base document for discussions among stakeholders regarding maternal and child mortality and morbidity targets. Immunization targets set for the health sector also draw from the medium term plan as an integral part of the health agenda for the entire country.

The World Health Organization (WHO) and UNICEF support the national immunization programme by providing standardization guidance for Ghana's health sector requirements. Such guidance helps the GHS and other service providers set and review their targets appropriately. UNICEF operates as the "liaison" between the MOH and the manufacturers/suppliers in relation to securing the vaccines and related logistics for the health sector. In terms of implementation, the GHS is primarily responsible for the implementation of the child and maternal health programmes as outlined in the comprehensive Multi-Year Plan (cMYP).

The statutory institutional structures of the GHS and private sector (including all NGOs) are engaged in the implementation of the child and maternal health programmes. The design involves national level stakeholders defining strategic direction, procurement of the relevant vaccines, equipment such as the cold chain equipment and other logistics such as vehicles and motorbikes among others. The national level transfers the resources through the Regional Health Directorates. The Regional Directorates then transfer these resources to the district health directorates. The District Health Directorate distributes resources to all service providers within the district based on their assessed

needs. The immunization programme is validated also on the strength of the reporting mechanism put in place from the sub-district level all the way to the national EPI Unit of the GHS. It was observed that the MMAs' financial contribution to EPI was minimal. Table 12 below shows the timeliness of reporting on immunization returns across the regions:

Table 12: Timeliness Reporting of Immunization Returns

Regions	No. of Districts	Reports Expected	2010		2011	
			Received on time	%Timely	Received on time	%Timely
Ashanti	27	324	313	96.6	323	99.7
Brong-Ahafo	22	264	253	95.8	234	88.6
Central	17	204	169	82.8	136	66.7
Eastern	21	252	252	100.0	208	82.5
Greater Accra	10	120	108	90.0	120	100.0
Northern	20	240	222	92.5	240	100.0
Upper East	9	108	107	99.1	98	90.7
Upper West	9	108	101	93.5	100	92.6
Volta	18	216	176	81.5	214	99.1
Western	17	204	169	82.8	147	72.1
Ghana	**170**	**2,040**	**1,870**	**91.7**	**1,820**	**89.2**

Source: Ghana Health Service

Due to GAVI support for immunization to specific CSOs involved in immunization programmes "GAVI" is well known in communities where these CSOs operate and the name GAVI is easily and commonly associated with immunization. It has become common place that the participating CSOs are often referred to as the "GAVI people".

According to available data from the GHS, planned activities were duly followed and were generally implemented on schedule. District Health Directorates liaised with their respective sub-district institutions to ensure that immunization activity schedules were followed through. Supplies from district to sub-district facilities are promptly released on submitted request. The challenge has however been with cold chain equipment maintenance and erratic power supply. Thus the evaluation shows that the design and implementation of the GAVI HSS/ISS/CSO support has been well coordinated and has ensured achievement of results.

7.2. Results

The GAVI support has contributed extensively to improvement in maternal and child health status. Observed improvements in the health status of community members during the period under review cannot be exclusively attributed to the GAVI support. The health status of any community/individual is achieved by multiple factors. However, it was abundantly evident that the GAVI support has contributed immensely to the improved trends in maternal and child health status. **Error! Reference**

source not found.6 (above) presents the 2007-2013 EPI performance for routine antigens at the national level. The declining performance is due to several challenges which include non-availability of adequate funds, broken down vehicles and hard-to-reach areas.

The trend as shown in the Tables 5-10 above gives an indication of the need to be consistent and maintain a high tempo in the implementation of immunization programmes. During the period (2007-2013), there were no reported or documented cases of polio across the entire country. For the same period no deaths from measles have been recorded. In all the districts and their respective sub-districts, including the CHPS facilities, available data show reducing trends in infant, child and maternal morbidity and mortality. Incidence of most of the childhood killer diseases in the country has declined significantly.

Health personnel as well as some community members interviewed indicated that due to the reduction in child morbidity and mortality, the local women now give birth to fewer children. The revealing reason given for this was that prior to the current extensive and intensive immunization regime, infants and children were dying so rampantly that families gave birth to so many children with the hope that when some die, others will survive for the family. In the words of two women from the Tolon and the Kassena-Nankana Districts;

"Because of measles, we give birth to plenty children so that after measles and other sicknesses have taken their portion (of the children), some will be left for us".

Another literal statement from a respondent is that:

"Previously when women give birth, measles come to take its share before you get what is left". (Hajia Sophia, Tolon District; GAVI Evaluation, February 2015).

The indicators (Figures 9 & 10 see Table 11 below) show that infant mortality at birth has been reducing over the period. This has the effect of children growing in families with lesser infant and child mortalities. Thus immunization is clearly contributing to families subscribing to family planning and less number of children per family. The above respondent statements (quotes) were corroborated in various ways in other communities across the regions visited.

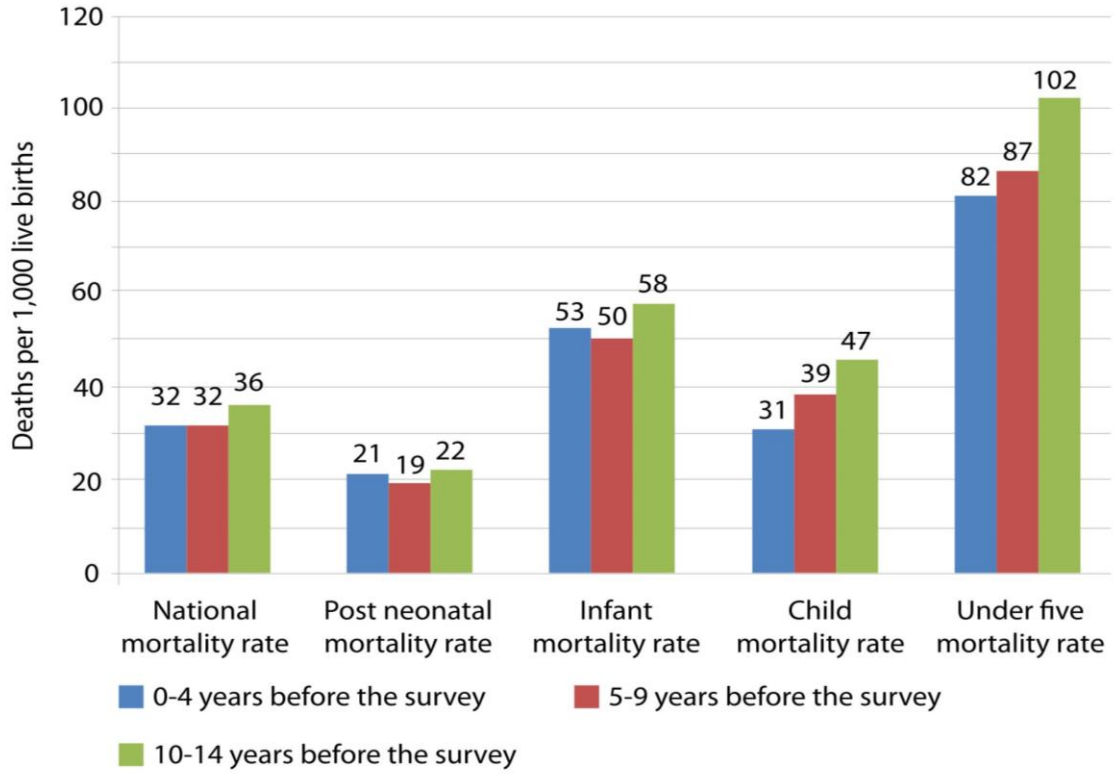

Figure 9: Trends in Childhood Mortality Rates, Ghana, 2011

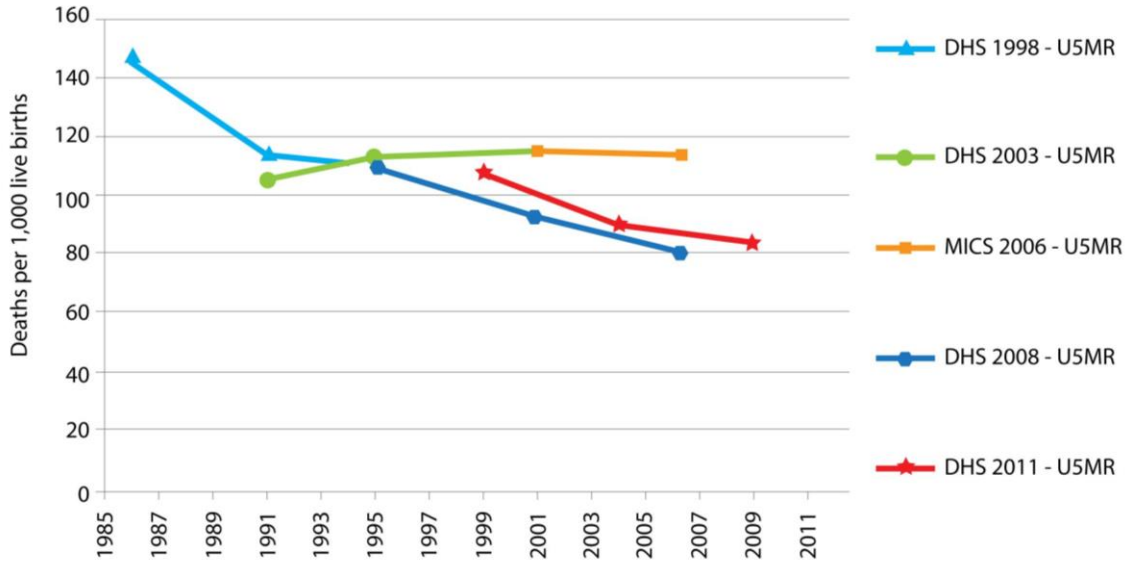

Figure 10: Trends in Under-five Mortality Rates in Ghana, (Various Sources of Data)

Table 13: Life Expectancy at Birth of Ghana for Men and Women (1960 – 2013)

Date	Life expectancy	Life expectancy - Men	Life expectancy - Women
2013	61.10	60.16	62.08
2012	60.95	60.03	61.91
2011	60.79	59.89	61.73
2010	60.60	59.72	61.52
2000	56.99	56.23	57.78
1990	56.75	55.68	57.88
1980	52.27	51.08	53.52
1970	49.33	48.45	50.26
1960	45.83	45.53	46.15

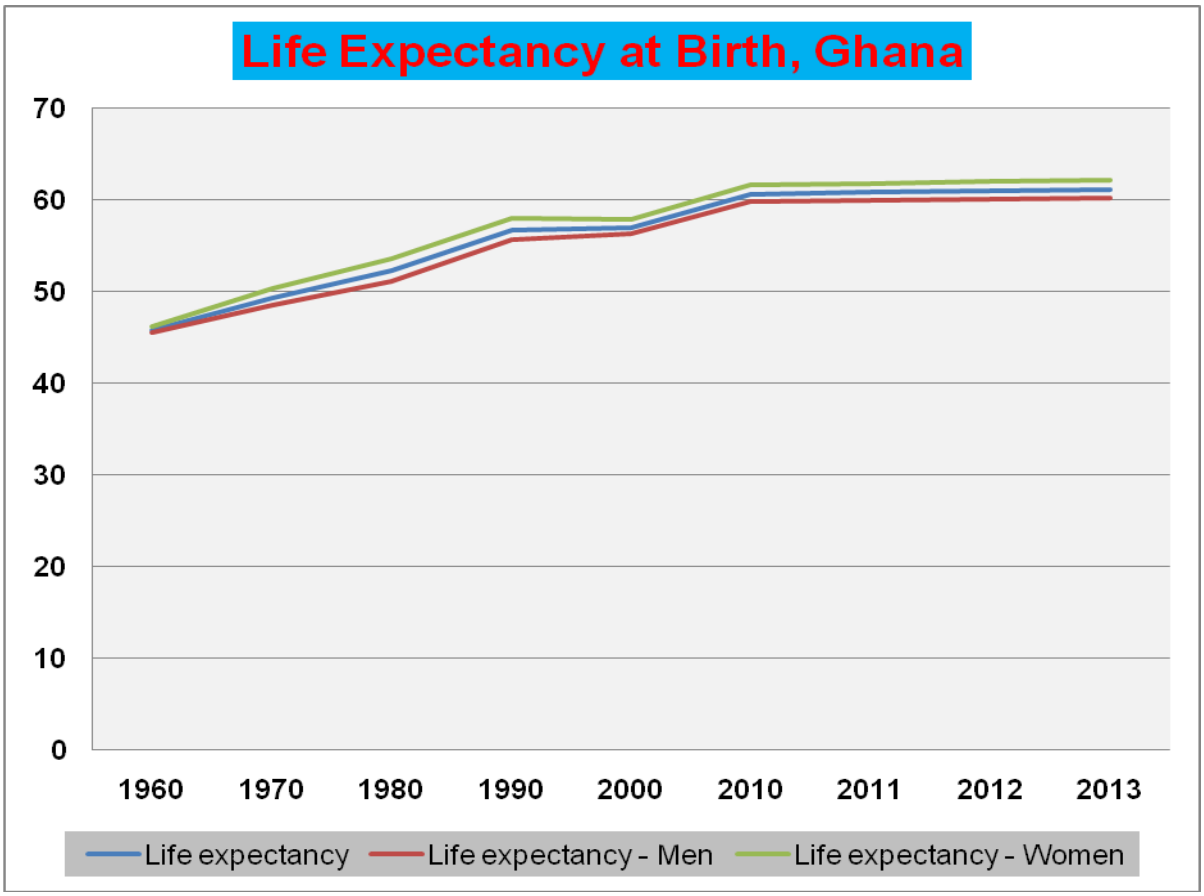

Figure 11: Life Expectancy at Birth, Ghana (1960 – 2013)

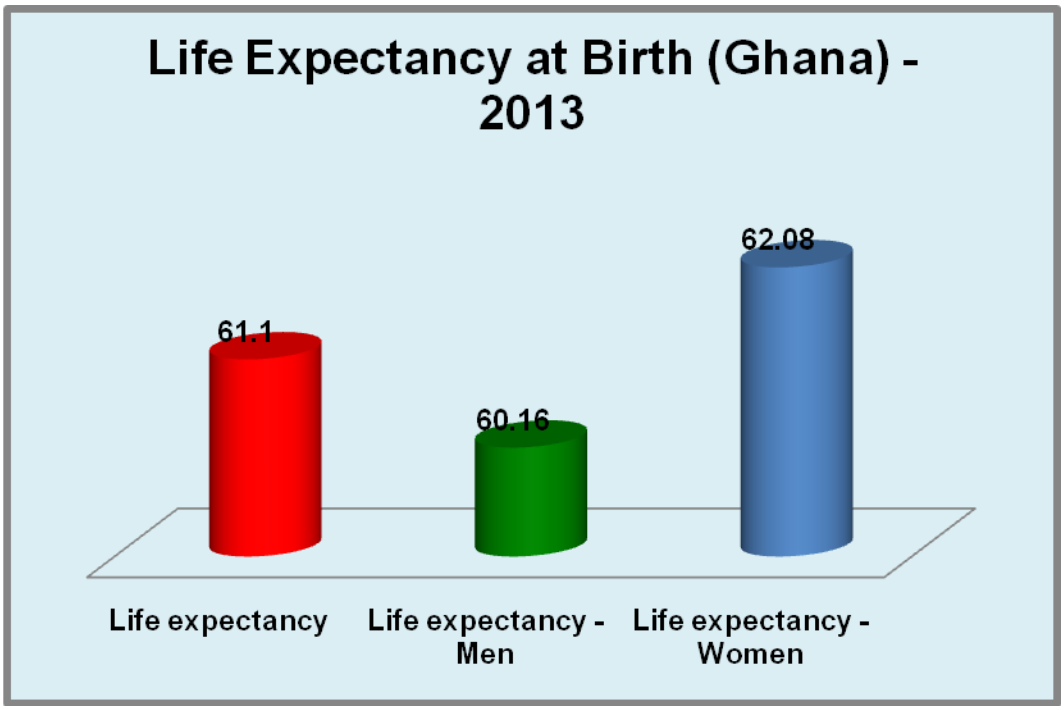

Figure 12: Life Expectancy at Birth (2013)

7.3. Effectiveness

In the context of this evaluation, effectiveness is operationally defined as a measure of the extent to which outlined activities attains objectives. In evaluating the effectiveness of the project, the evaluators considered the extent to which the objectives were achieved / are likely to be achieved; and what were the major factors influencing the achievement or non-achievement of the objectives?

Generally the design and approach adopted in implementing the EPI has been effective in its essence. Under the HSS, systems have been put in place to ensure that governance systems for the immunization process are working effectively. The three-pronged approach adopted for immunization – static, outreach and NID campaigns – ensures that the target population are covered. The management of the immunization processes are coordinated at various levels – national, regional, district and sub-district. The coordination covers vaccines, equipment and cash disbursements. At the national level, the Ministry of Health and the Health Sector Working Group provide oversight coordination to ensure that vaccines are timely procured with UNICEF playing a key intermediary role. Regular (quarterly) meetings of the Health Sector Working Group provide the platform for periodic update and review of health sector issues including immunization.

There were clearly defined processes for requesting and procuring vaccine supplies from the national to sub-district levels. Vaccines were procured based on aggregated population needs gathered from

the communities. The sub-district health facilities working in consonance with their respective District Directorates compile the anticipated vaccine and related cold-chain equipment needs. These are then forwarded through the regional health directorates to the national level. Thus procurement and distributions from the national stores to the regional directorate stores are based on the submitted requests. Based on the requests submitted by the respective district health directorates, supplies are made from the regional stores. The same relationship applies between the district health stores and the sub-districts. It is interesting to note that there is no bureaucratic bottleneck in the vaccines request and supplies process. The transactions at the regional through districts to sub-district levels are instant and unhindered. The procurement and limited distribution of cold chain equipment and motorbikes to District Health Directorates contributed to reaching a wider section of the rural communities.

Available immunization data from the EPI Department of the GHS indicates that more populous metropolitan cities of Accra, Kumasi and Sekondi-Takoradi also have the highest number of un-immunized children.

7.4. Efficiency

The GAVI support complemented the Government of Ghana funds in administering immunization activities in Ghana. The support was used for the HSS, ISS and CSO activities as planned. The existing institutional systems were used in the administration of the fund. This allowed for an integrated approach of using existing structures in the implementation of activities.

The disbursement of funds follows through the existing administrative systems of the GHS. Thus from the national level, funds are released to the regional health administrative system to the districts and sub-districts. Though funds are released without much of bureaucratic bottlenecks from the GHS head office to the regional health directorate, on occasions there are hold-ups which are more often due to the bank transfer process.

Other resources such as motor-bikes and cross country vehicles are periodically procured for the regional and district directorates to enhance immunization programme implementation. Due to the inadequacy of officially procured motor-bikes and other vehicles, the health staffs especially at the district and sub-district levels use personal vehicles and motor-bikes to visit communities for immunization. In some cases, the district health administration provides fuel for these personal staff motor-bikes for use during immunization programmes.

From what has been observed so far in the field, the nation should provide the critical mass of resources needed for the implementation of health programme at all times. As observed at Amansie West MVP which has the focus of demonstrating that given the amount of resources required

desirable results are achievable. In general inadequate funds, untimely release of funds, breaking down of vehicles and other equipment, erratic power supply, non availability of required infrastructure and inadequate skill staff negatively affected the efficiency of the programme.

7.5. Sustainability

It has been demonstrated that immunization goals are achievable at all levels given adequate critical mass of resources with adequate numbers of personnel. The EPI had been supported from external sources since its inception. The vaccines and other logistics are all procured from outside the country. The gains made so far through the support from GAVI and other partners can be sustained only through continuing commitment and provision of adequate critical mass of resources by the Government of Ghana. It has been adequately demonstrated that failure to maintain the programme with adequate resources will lead to complete negation of gains made so far with devastating health, social and developmental consequences. From all indications, there is the need to sustain the programme in terms of funding, vaccine and related logistics, skilled staffing and improved management strategies. It was observed during the evaluation that by January – Feb 2015 there has been default by the Government of Ghana in the payment of counter-part funding for vaccines and some logistics. There are documented shortages of BCG Vaccines and Syringes. This raises a “red flag”.

Summary Assessment of Key Evaluation Criteria

Key Evaluation Criteria	What Worked Well	What Needs Improvement	Lessons Learnt
Design & Implementation	• Wide stakeholder consultations and active participation in the design and implementation process. • Implementation is based on programme of GHS rather than Development Partners. • Using the existing institutional system of the GHS to implement rather than setting up parallel structures.	• Close monitoring of implementation process by Development Partners.	• Active and genuine participation of Development Partners and local stakeholders yield very fruitful and tangible results.
Results	• The implemented programmes were based on very authentic needs from the lower levels of the health care delivery system. • The GAVI cash support was more results focused than activity focused. Thus there was some degree of flexibility in programme implementation. • High sense of commitment of health sector staff to immunization agenda and national programmes. • The role of UNICEF and WHO in providing technical support and ensuring adherence to global standards	• Harmonization of the district and sub-district population figures with that of the Ghana Statistical Service will reduce some of the apparent performance discrepancies in percentage terms (over 100% immunization coverage). • Adequate provision of spare parts and replacement of equipment parts would improve immunization coverage performance in some rural areas.	• Focus on GHS immunization agenda & programme promotes commitment • Inaccurate statistical projections affect both planning projections and implementation results.
Effectiveness	• Bureaucracy was very minimal across the various levels of the health system.	• The use of solar cold chain equipment (such as fridges) would enhance the storage of vaccines;	• Volunteerism is effective with intrinsic project implementation motivation and self fulfillment.

	• Information flow was not inhibited. This allowed for quick corrective measures to be taken especially at the District and sub-district levels. • The active involvement of CSOs community sensitization and mobilization helped the process.	• Token provisions of T-shirts and other incentives to volunteers would serve as a boost for more effective involvement of community volunteers	• Project efficacy was enhanced by effective administrative procedure for implementation and information flow across the organizational hierarchy
Efficiency	• The utilization of the existing institutional system for immunization ensured minimal cost in programme implementation. • The supply of motor bikes to some sub-districts (especially remote ones) to support immunization and other health service delivery programmes. • Free flow of information across the various levels of the system and the zero-waiting days for supply of vaccines on request.	• Periodic audit of logistics (e.g. vaccine fridges and carriers, vehicles, etc.) provided under the programme •	• Were different institution and structures created for the implementation of the GAVI support overall undertaking immunization and allied activities might have been more expensive
Sustainability	• Community sensitization by CSOs promoted citizen awareness about the immunization as an imperative for pregnant women and infants / children. • Progressive involvement of local government authorities (MMDAs) enhances chances of their (MMDAs) involvement in a more elaborate way in future.	• Improved commitment of the Government of Ghana to provide for immunization activities across the country. • Increased involvement and support of corporate organizations towards immunization activities in Ghana.	• The acceptance, ownership and involvement of project intervention by direct/indirect beneficiaries very critical to its sustainability. • Continuous and timely provision of the required resources and effective management of these resources ensures sustainability.

8.0. SUMMARY OF KEY FINDINGS

The support from GAVI and other development partners has contributed immensely to improve EPI, health care service delivery and health status in Ghana. From the information so generated from the evaluation, the following conclusions are drawn and some recommendations made:

(1) There is a well-structured and coordinated system for the design, planning and implementation of the GAVI and other donor partner support to the Ghana health service delivery system especially towards child and maternal immunization. This structured system includes Government Ministries, Departments and Agencies (MDAs), and International Development Partners (bi-lateral and international agencies like UNICEF, WHO, USAID, DFID, Royal Netherlands, Denmark, Japan, Global Fund, and others). Local Civil Society Organizations (CSOs) are also an integral part of the process.

(2) Due to the effective monitoring system in place for reporting, even delayed reports from the districts are followed up and received at the regional and national levels. As part of the institutional arrangements within the GHS system, regular monitoring visits are conducted to ascertain the state of health issues in the districts and sub-districts. This has contributed to the rather favourable percentage of report submission.

(3) The liaison role of UNICEF (with its international or global presence, capacity and influence) in ensuring the effective and efficient procurement of the necessary appropriate vaccines for EPI cannot be over-emphasised. Meanwhile the WHO also complements efforts by ensuring that global health systems standards are maintained in Ghana's EPI.

(4) In Ghana there have been few pockets of unnecessary concerns about immunization based on people's beliefs (for instance, certain faith based organisations refusing immunisation) but none has really affected the EPI programme. The need for immunization is now well accepted across the whole country as a result of the collaboration from all stakeholders with leadership from the Ghana Health Service. The Ghana Coalition for NGOs in Health has also been instrumental in community sensitization and mobilization. It is on record that since 2003, no child has died of measles in Ghana. Polio cases have also not been recorded.

(5) Generally it is evident that all indices for the health sector relating to immunization have improved essentially. Though not perfected, the immunization coverage has contributed to improved health status across the country.

(6) In the absence of the GAVI support, it is obvious that the Government of Ghana will have very severe challenges sustaining the gains made through immunization. This conclusion comes on

the heels of the imminent gradual withdrawal of the GAVI support over the next seven (7) years – ending year 2022.

(7) The breakdown and challenges (including power outages) associated with maintaining cold chain equipment for storage of vaccines threatens the sustainability of gains made so far by the EPI coverage.

(8) Again the absence of adequate vehicles and other logistics in parts of Ghana is posing considerable challenges to the outreach services. Remote rural communities and other hard-to-reach areas are often under threat of abandonment due to poor access by health personnel.

(9) The continued sustenance of the EPI hinges on a deeper and more active participation of local community stakeholders including MMDAs, traditional leaders, faith-based organizations as well as private sector businesses.

(10) The CSOs have been very instrumental and effective in the mobilisation of community members and the training of community leaders and volunteers. Since the CSOs are community based, they are in closer contact with the generality of the citizenry and gain more acceptability in community mobilisation and development issues.

9.0. RECOMMENDATIONS

(1) It is very important that the Government of Ghana recognises the gains made in the management and/or elimination of childhood killer diseases. Considering the imminent withdrawal of GAVI funding support for Ghana's immunization programme, alternative funding arrangements should be commenced now to forestall the roll-back of gains made over the years.

(2) As much as possible cold-chain facilities should be established at all sub-district levels and CHPS compounds especially in regions with wide geographical area and hard-to-reach areas.

(3) The cold chain maintenance team needs to be further decentralized to the MMDA level and strengthened. Resources should be provided to make sure cold chains are maintained at working levels at all times. The availability of cold-chain equipment replacement parts, the availability of the technical maintenance team on demand by health facilities to maintain and replace broken-down parts is very essential.

(4) In-service training and career development programmes should be intensify with adequate resources so as to ensure that skill levels are improved and updated at all levels.

(5) It was observed that there are a lot of training manuals (e.g. Management Manual for Sub-Districts, GHS, 2011; GHS Manual on General Administrative Practices and Procedures) in the system which are not being used on regular basis for continuing professional development of staff. Therefore, efforts should be made to institutionalise regular in-service training for continuing professional staff development at all levels. The existing manuals should be reviewed and brought up to date.

(6) It has been indicated that the withdrawal of GAVI support has been noted and transition arrangements are being made graduated to start from 2015 for the next seven years such that Ghana will be fully responsible for immunisation investments by 2022.

(7) Solar fridges should be provided for the sub-district and CHPS facilities to ensure the sustained supply of electric power for the storage and preservation of vaccines and other medical supplies.

(8) The data management system should be improved with adequate training and infrastructure for the management of records. In data collection, storage and retrieval.

(9) CSOs should be encouraged and adequately funded as part of the health service delivery system. This is because they tend to have close intimate relationship with the communities in which they operate. They, however, need to be more closely monitored by the Ghana Health Service and Ministry of Health.

10.0. CONCLUSION

Child and maternal health in Ghana has seen considerable improvement since the inception of the GAVI ISS/HSS/CSO support for immunization. The findings from this evaluation highlight the fact that improving immunization coverage has very important implications for the social, physical and economic health of the entire citizenry. The expanded immunization coverage, is contributing tremendously to women in the especially rural communities adopting family planning practices. This is because there is a higher guarantee for child survival. There is therefore no need to have many children out of which measles and other childhood killer diseases will “come and take their own and leave some” for the family as stated by one respondent. Mothers therefore also have more healthy lives and are able to devote considerable time and resources to economic activities for improved family incomes. It is imperative that the sustenance of the current positive immunization coverage trends and its concomitant effects require continued funding. The Government of Ghana (GoG) must therefore make every effort to ensure the availability of funds for this all-important health activity which can be a proxy for and also signifies the quality of life from infancy.

APPENDICES

Terms of Reference

Evaluation of Global Alliance for Vaccines and Immunization (GAVI) Supports to Ghana

Republic of Ghana

Ministry of Health

Ghana Health Service

June 2014

Table of Content

1.0 LIST OF ACRONYMS

Abbreviation	-	Description
ATL	-	Assistant Task Team Leader
CSO	-	Civil Society Organization (Support)
GAVI	-	Global Alliance for Vaccine and Immunization
GHS	-	Ghana Health Service
ISS	-	Immunization Service Support
HSS	-	Health System Strengthening
MOH	-	Ministry Of Health
NGO	-	Non-Governmental Organization
PPMED	-	Policy Planning Information Monitoring And Evaluation Division
RFP	-	Request For Proposal
SSDM	-	Stores, Supplies And Drugs Management
SSNIT	-	Social Security And National Insurance Trust
TL	-	Team Leader
TS	-	Technical Staff
VAT	-	Value Added Tax

2.0 PURPOSE

The integrated evaluation of the Global Alliance for Vaccine and Immunization (GAVI) cash-based support to Ghana comprising of Health System Strengthening Support (HSS), Immunization Service Support (ISS) and Civil Society Organisation Support (CSO) is being commissioned by the Ministry of Health through the Ghana Health Service (GHS).

The purpose is to evaluate the relevance, effectiveness, efficiency and results of the above-mentioned GAVI supports. The result of the evaluation will provide useful lessons learnt and experience for Ghana, GAVI and other stakeholders to improve upon future funding support to Ghana and other countries. The results will further be used to inform strategic modification of activities that have been sustained as a result of implementing the GAVI support to Ghana. This will be an important input for the development of the next Country Multi-Year Plan (2015-2019) and implementation of the GAVI HSS support proposal 2014-2018.

3.0 REQUEST FOR PROPOSAL (RFP) INSTRUCTIONS

General

i. The GHS invites competitive bids from interested service providers to respond to this Request for Proposal (RFP) to undertake the integrated evaluation of GAVI HSS/ISS and CSO cash-based support to Ghana with the intent of providing lessons and experience for strengthening and sustaining high immunization coverage.

ii. This entire RFP and all related discussions, meetings, exchanges of information and subsequent negotiations that may occur are confidential and are subject to the confidentiality terms and conditions as relates to conflict of interest statements.

iii. Disclaimers and GHS Protection Clauses:

- The issuance of this RFP does not constitute award commitment by GHS to any interested service provider
- The GHS may choose not to justify its business rewarding decision to the participants to this tender
  - GHS may reject some or all responses received from intended service providers
  - GHS reserves the right to disqualify any bid based on initial evaluation of bids without further discussion with interested service providers
- GHS may award its total requirements to one service provider or apportion those requirements among two or more service providers, as may deem necessary.
- GHS reserves the right to waive minor proposal deficiencies that can be corrected prior to award determination to promote competition
- GHS will be contacting shortlisted bidders to confirm institutional details and consent of proposed technical team including validity of business registration, business addresses and location.
- GHS may reject any proposal without obligation or liability to the potential Service Provider;
  - Withdraw this RFP at any time before or after submission of bids, without prior notice, explanation or reason;
  - Modify the evaluation procedure described in this RFP;
  - Accept other than the lowest price offer;
  - Award a contract on the basis of initial offers received, without discussions or requests for best and final offers;

iv. Bids shall be submitted in two separate volumes, sealed in separate envelopes;
  - Volume I being the Technical Proposal
  - Volume II being the Financial Proposal

v. All bids must indicate that they are valid for not less than sixty (60) days from the quotation due date.

vi. Faxed or email copies will not be accepted.

vii. All bids must be submitted in three hard copies, accompanied by the same electronic version on a pen drive

viii. Submission of bids after deadline will be subjected to rejection

ix. GHS reserves the right to request additional data, information, discussions or presentations to support part of, or the entire bid proposal.

x. Service providers or their representatives should be available when necessary to discuss the details of their proposal during the evaluation process.

xi. All responses should be submitted in electronic and hard copy version.

xii. The proposed time plan set out below indicates the process GHS intends to follow. If there are any changes to this time plan, GHS will notify you in writing.

4.0 TABLE 1: TIMELINES

Event	***No of Days***	***Responsible Division***	***Timeline***
Commencement of service provider recruitment process including EoI and ToR Development	10	PPMED	By end of 1st week July, 2014
Advertisement (Call for EoI)	20	SSDM	2nd week in July – 1st Week August, 2014
Evaluation of EoIs, Short listing of Bidders including submission of ToR to shortlisted Service Providers	5	PPMED & SSDM	By end of 2nd Week in August, 2014
Bid opening meeting	1	PPMED & SSDM	1st Week September, 2014
Bid evaluation & notification	5	PPMED & SSDM	2nd week in September, 2014
Meeting to award contract	1	PPMED & SSDM	3rd week in September, 2014
Contract negotiation meeting	1	PPMED & SSDM	3rd week in September, 2014
Conduct of Evaluation and Reporting by Service Provider	60	Service Provider	October-December, 2014
Workshop for validation of draft report	1	PPMED	2nd Week, January, 2015

5.0 RFP PROCESS AND CONTACT INFORMATION:

Interested Service Providers are to send letters expressing their interest including questions for clarifications to the contact provided below:

TABLE 2: CONTACT INFORMATION

Contact Information			
Related Issue(s)	**Contact Person**	**Contact Role/Title**	**Contact Information**
Contractual RFP& Contract Terms & Conditions, Proposal Format, etc.	Dr. Kwesi Addai-Donkor	Director, Stores, Supplies and Drugs Management	Dr. Kwesi Addai-Donkor Ghana Heath Service SSDM P.M.B, Ministries Accra Phone: +233-302-6887821 ext. 1068 Email: kwaaddai@yahoo.co.uk
Technical RFP Deliverable Specifications & Requirements	Mr. Dan Osei	Deputy Director, Planning	Mr. Dan Osei Ghana Heath Service PPMED P.M.B, Ministries Accra Phone: +233-244-364221 Email: dnao.osei@gmail.com
Submission of expression of interest	Dr. Kwesi Addai-Donkor	Director, Stores, Supplies and Drugs Management	Dr. Kwesi Addai-Donkor Ghana Heath Service SSDM P.M.B, Ministries Accra Phone: +233-302-6887821 ext. 1068 Email: kwaaddai@yahoo.co.uk

6.0 REQUIRED PROPOSAL FORMAT & PROPOSAL CONTENT

Responses to this RFP must be in **English** and consist of the following:

1. Cover letter, which includes:
   - Name and address of the Service Provider
   - Name, title, telephone number, and e-mail address of the person authorized to commit the Service Provider to a contract
   - Name, title, telephone number, and e-mail address of the person to be contacted regarding the content of the proposal, if different from above
   - A signature of this letter done by a duly authorized representative of Service Provider
2. Hard copies of Technical and Financial Proposal in separate volumes
3. Electronic copy of proposals and other relevant documents
   - Documents and spread sheets in Office 2003-2007 format.

7.0 BACKGROUND

The mission of the Global Alliance for Vaccines and Immunization (GAVI) is to save lives of children and protect people's health by increasing access to immunization in poor countries. GAVI therefore supports the introduction of life saving vaccines in the poorest countries. In addition, they provide Health Systems Strengthening (HSS) support and technical assistance to these countries. GAVI Alliance is a unique organization that aligns public and private resources in a global effort to create access to immunization services. It brings together key actors in immunization and health systems including developing countries, research and technical Agencies, Civil Society Organisations, Bill and Melinda Gates Foundation and other private philanthropists.

GAVI has been supporting Ghana since 2000 with vaccines and health systems strengthening support. When GAVI opened the health systems strengthening window, Ghana applied and got approval for the period 2007 to 2012. This support was extended (at no extra cost) to 2013. GAVI over this period has also provided resource to support immunization programmes and Civil Society Organizations' activities as per the table below:

TABLE 3: TIMELINES

No.	***Approved Proposals***	***Date of Approval***
1	Proposal for NVS - MR campaign support: Ghana	Date of GAVI approval: 15 February 2013
2	Proposal for NVS - HPV demo support: Ghana	Date of GAVI approval: 31 January 2013
3	Proposal for NVS - MenA support: Ghana	Date of GAVI approval: 26 September 2011
4	Proposal for NVS - PCV, Rota, MSD support: Ghana	Date of GAVI approval: 26 September 2011
5	Proposal for CSO support: Ghana	Date of GAVI approval: 29 July 2010
6	Proposal for ISS support: Ghana	Date of GAVI approval: 21 April 2009
7	Proposal for HSS support: Ghana	Date of GAVI approval: 01 November 2007
8	Proposal for INS support: Ghana	Date of GAVI approval: 01 November 2002
9	Proposal for ISS, NVS - DTP, Hep B, Hib, YF support: Ghana	Date of GAVI approval: 01 September 2000
10	Proposal for ISS, NVS - YF, Penta support: Ghana	Date of GAVI approval: 01 July 2000

The support provided over the years had a set of health outcomes and outputs to be achieved. During the period of implementation, some activities were revised to respond to the needs of the sector. There were also some innovations and best practices and lessons learnt (some of the strategies that worked well and what did not work well according to the implementation plan). There is therefore the need to undertake an in-depth evaluation of the GAVI support to the country.

8.0 OBJECTIVES

The overall thrust of the evaluation is to assess the extent to which planned objectives of GAVI HSS/ISS/CSO support have been achieved. The evaluation further seeks to assess the overall contribution of the supports to the achievement of the health sector objectives as defined within the Health Sector Medium Term Development Plan 2007-2011.

The specific objectives are the following:

f. To ascertain the design and implementation measures put in place to ensure effectiveness of the cash based support
g. To ascertain measures undertaken to ensure efficiency in use of resources and delivery of the package of interventions
h. To appraise extent to which results have been achieved in terms of outcome and outputs of GAVI HSS, ISS and CSO cash based supports
i. To assess measures put in place to ensure the sustainability of different outputs and outcomes
j. To assess the strategies, lessons learnt challenges and success in achieving expected outputs.

The specific questions to be answered by the evaluation are,

1. Design and Implementation

a) To what extent, and in what ways, did Ghana's HSS, ISS and CSO applications demonstrate clear linkages and contribution to immunization outcomes?

b. To what extent was the active involvement and collaboration between the Donor Partners, Ministry of Health, GHS and CSOs in the development and implementation of the HSS, ISS and CSO proposals?

c. To what extent were the activities set out in the HSS, ISS and CSO application implemented as planned (quality, quantity, ways and means)? A particular focus should be given to the following questions:

i) To what extent, if at all, were planned activities reprogrammed? What process was followed for this reprogramming?
ii) To what extent did programme management appropriately adapt to challenges, changes in context and delays?
iii) To what extent were the contracted CSOs effective in delivering immunization services?
iv) What are the lessons learnt during the implementation process? What worked well and why? What did not work well and why?

d. To what extent were activities, resources and results appropriately coordinated, monitored and reported by the MOH to the GAVI Secretariat and Alliance partners?

i) What were the challenges associated with monitoring and reporting of the HSS/ISS/CSO grants?
ii) To what extent was the feedback received useful and led to appropriate actions?

e. To what extent were the findings/recommendations from previous evaluations and assessments, including those commissioned by the GAVI Alliance, helpful and used to inform

actions at the country level, including the preparation of Ghana's HSS application for the 2014-18 period?

2. Efficiency

a) To what extent were the funds used efficiently and as planned for HSS, ISS and CSO activities?

b) What contextual factors explain the utilization rate of the funds received for HSS, ISS and CSO?

c) What could have been done to improve the efficiency for HSS, ISS and CSO activities?

d) To what extent did Ghana use the ISS, CSO and HSS funds in a complementary and coherent manner?

3. Results

a) To what extent did the programme achieve the objectives and targets as described in HSS, ISS and CSO funding?

b) To what extent has CSO support contributed to improved immunization outcomes in deprived and hard to reach areas compared to those that did not benefit directly from the support?

c) To what extent did the HSS, ISS and CSO programme contribute to observed trends in the following indicators:

i. Under-five child mortality?

ii. DTP3 coverage?

iii. Percentage of districts attaining at least 80% Penta3 coverage?

iv. Other indicators selected by the country as part of its HSS, ISS and CSO grants?

d) To what extent did the grants effectively address bottlenecks to immunization identified in the original proposal and subsequent analyses?

e) What added value did GAVI HSS, ISS and CSO supports offer compared with other types of financing (both donors and domestic)?

f) To what extent were GAVI's HSS, ISS and CSO funds catalytic to other funding sources in the health sector?

(i) To what extent were GAVI's HSS, ISS and CSO funds complementary to other funding sources in the health sector?

(ii) What were the positive and negative unintended consequences of the HSS, ISS and CSO programme?

4. Sustainability

a) How sustainable, in financial and programmatic terms, are the achievements of the HSS, ISS and CSO programmes at national, regional and operational levels? For example:

i. To what extent has the training supported by the HSS, ISS and CSO programmes been integrated into the country's routine health workforce training programmes?

ii. To what extent has turnover of trained staff affected sustainability?

To what extent has the various types of investments (capital versus recurrent) contributed to sustainability at the country level?

5. Lessons for the future
    a) What are the major lessons that can inform improvements to future design, implementation and monitoring of HSS programmes in Ghana and elsewhere?
        i. What were the major strengths and weaknesses of this GAVI HSS, ISS and CSO grant?
        ii. To what extent does the current HSS application guidelines address the main issues identified?

In conducting this evaluation, we recognize that GAVI cash support is intended to provide inputs and contribute to the health outcomes of Ghana. Therefore the evaluation will focus on contribution rather than attribution.

9.0 DESCRIPTION OF ASSIGNMENT

This assignment will review activities covering HSS, ISS and CSO support by GAVI since 2007-2013. It will therefore require a Service Provider with a combination of expertise covering public health with specialties in immunization, community participation, health systems, financial management and procurement. The detailed professional qualifications required for each of the specialties are in the annex. The health system person of the Service Provider will be the team leader for the evaluation and will be supported by other multi disciplinary personnel.

10.0 SCOPE OF WORK

For the purpose of HSS and ISS evaluation, the country will be zoned into three sectors –northern, middle and southern sector. The country has ten (10) health administrative Regions and 216 districts. All Regional Health Directorate will be visited during the evaluation. In each of the Regions, two beneficiary districts will be randomly selected. Two sub districts and one CHPS Zone will be selected in each of the four districts. The selection of the sub districts and CHPS Zone will be based on urban/rural and high/low performing in DPT-Heb B-Hib and measles.
At the national level, the evaluation will focus on policy makers and managers in PPMED, Public Health (including EPI), Finance, procurement and Family Health divisions. The rationale is to identify the perception of managers about the GAVI support (cash and vaccines) and the role of GAVI Alliance secretariat and its country level partners (WHO and UNICEF) in supporting the implementation of activities.

The scope of CSOs evaluation will focus on all the three implementing districts with visits to selected sub-districts.

The specific scope of work for the assignment is as follows:

1. Review and discuss comments on the Terms of Reference with MoH, GHS and CSOs.
2. Develop the conceptual framework and methodology to guide the evaluation
3. Develop specific activities and set specific timelines within the broad scope of work
4. Review relevant desk documents and present brief report to GHS

5. Design strategies and timelines for data collection in consultation with MoH, GHS and other relevant stakeholders
6. Data collection
    i. Develop open and close ended questionnaires for individual interviews and focus group discussions
    ii. Organise the evaluation team and equip them to undertake data collection
    iii. Conduct fieldwork and visits for data collection
    iv. Undertake effective management of field work activities
7. Determine the mode of analysis of both qualitative and quantitative data and information; and analyze the data.
8. Prepare initial draft report for discussion with the MoH, GHS based on agreed format
9. Take comments and finalize report
10. Organize a stakeholder review meeting to discuss the report
11. Finalize and submit report

11.0 METHODOLOGY

The selected service providers are expected to apply a mix of qualitative and quantitative methodologies, whilst minimizing potential sources of bias and guaranteeing the independence of the evaluation. The qualitative approach will be a series of participatory dialogue and interviews with beneficiaries of the support within the GHS and also stakeholders that have interest in improving immunization services in the country. The quantitative part on the other hand will complement the findings from the qualitative analysis by providing facts and figures as well as statistics that support the assessment of contribution from the various supports.

The specific components of the proposed approach are as follows:

Desk Review

The initial review of documents should allow the research questions, content of structured interviews and quantitative analysis to be refined. It should include, at minimum, documentation held by GAVI on HSS/ISS/CSO, a thorough assessment of the application made by Ghana including all relevant annexes, GAVI's responses to the application, IRC reports, Annual Progress Reports and other relevant analyses or reports.

As highlighted above, it is essential that the evaluators use the previous evaluations of HSS undertaken by GAVI, including the 2009 HSS evaluation. These reports are available at:http://www.gavialliance.org/country/ghana/documents/#hssevaluation

12.0 FIELD WORK

The service provider will conduct interviews (with structured questionnaires) at all levels of the health service and will involve the following individuals and organisations: senior MOH and GHS officials (including key GAVI cash support focal persons in PPMED and PHD), local partners (WHO, UNICEF, NGOs, bilateral partners, etc.) and CSO representatives including beneficiaries at the community level and other key stakeholders.

The Service Providers will visit three selected regions where they will interview the Regional Director of Health Service (RDHS) to discuss implementation of the GAVI cash support. In each of the

regions, two districts and three sub districts (within the districts) will be visited. The selection of regions, districts and sub districts will take into consideration areas where CSOs implemented their activities. Specific communities will be visited to assess the implementation of the work of the CSOs in those communities.

13.0 FIELD VISITS

Evaluators are expected to undertake field visits in selected districts that benefited from support under the HSS programme. These visits should provide confirmation that activities financed by GAVI cash support were indeed carried out, and allow assessment of performance against targets in the districts and regions concerned. Particular attention should be paid to assessing the sustainability of activities or capital investments funded as part of GAVI cash support. In-depth interviews should be conducted with relevant persons at national, regional and district levels.

The CSOs activities were geared toward CSO mapping and supporting hard to reach and needy communities. The list of these communities that the CSOs worked with will be provided. The team will review the activities of the CSOs in this regard to obtain an understanding of how this support was provided, the approach, how it benefited the community and its impact on the health outputs of those communities. This evaluation should also assess the capacity of the CSOs in delivering these services and the perception of both the health staff and the community about the work of the CSO.

14.0 ANALYTICAL WORK

This will involve the presentation of qualitative data in the form of discussions and recommendations relating to thematic issues in the areas of the key evaluation questions i.e. the design and implementation, efficiency, results, sustainability and lessons learnt for the future. Where possible, correlation and regression analysis using appropriate techniques should be undertaken in order to assess the effect of GAVI HSS, ISS and CSOs contribution to improve immunization outcomes. It is also recommended that qualitative analysis in the use of percentages and frequencies can be employed to also augment the analytical work.

15.0 EXPECTED OUTPUTS/DELIVERABLES

Inception Report: The service provider prior to the commencement of field activities will issue an inception report to guide the undertaking of the assignment. The inception report will detail out the service providers understanding and commitment to the undertaking of the assignment as negotiated. There will be a meeting between the service provider and GHS to facilitate the development of formal introductory letters to stakeholders and to elicit contribution to the evaluation. The meeting will also help to strategize for data collection and also create the opportunity to discuss logistics and provision of background information to the service provider. The proposed conceptual framework for the evaluation will be discussed and other clarification to ensure smooth implementation of the project articulated.

Evaluation Report: An evaluation report that presents the achievements, drawbacks, challenges, lessons learnt and recommendations for implementation of future support. The evaluation report should be structured into three sections as stated below to provide needed information for management:

First Section: Executive summary that outlines critical considerations for management decision-

making regarding the background of the GAVI HSS, ISS and CSO support, major conclusions in relation to the objective of the GAVI HSS, ISS and CSO, lessons learnt and recommendations.

Second section: Detailed report outlining the following:

- Background
- Review of relevant documents,
- Literature review and conceptual framework for the evaluation and analysis,
- Methodology
- Study results and findings
- Discussions, Implications and recommendations
- Limitations
- Study instruments and other explanatory documents should be added in the annex to explain critical issues.

Third section: A 15-minutes power point presentation to debrief managers on the study findings and recommendations

16.0 CONFLICT OF INTEREST STATEMENT

The service provider together with the client shall ensure the avoidance of conflict of interest that may affect the outcome of the evaluation. The Ghana Health Service conflict of interest statement draws its fundamental principles from the Public Procurement Act 2003 (ACT 663).

Two broad areas of conflict of interest are taken into account as noted in the GHS generic form that must be signed by the service provider. The first is avoidance of upstream or ex ante conflicts of interest. This is to ensure that no member of the service provider's team might have been involved in the design, implementation, supervision or coordination of any of the three windows of GAVI Cash Support, namely; HSS, ISS and CSO to Ghana. The second consideration is the avoidance of downstream activities (ex post conflict) whereby favorable conditions are intentionally created at the various levels of evaluation including those who will be interviewed with the purpose to influence the outcome of the evaluation.

For the purpose of ensuring impartiality, confidentiality and independence of the evaluation, a declaration would be signed by selected evaluators to declare any conflict of interest that might exist due to any past or present relationship with any of the Service Providers (See Annex… for copies of evaluator's form to be signed). The basis of signing the attached conflict of interest form is to establish a condition in which the service provider's analysis, findings and recommendations would be valid and reliable. The Service provider therefore owes it an obligation to disclose to the GHS any situation of actual or potential conflict that might impact its capacity to serve the best interest of providing the service. The failure to disclose beforehand the existence of any conflict of interest may lead to rejection of proposal or termination of contract and other punitive actions in accordance to the Public Procurement Act 2003 (ACT 663).

17.0 RESPONSE TO PROPOSAL SPECIFICATIONS

Interested service providers must include in their application a detailed technical and financial proposal with the following components:

10.1. *Technical*

- Understanding and interpretation of the ToR
- Methodology to be used in undertaking the assignment
- Work plan/Implementation schedule
- Organizational and Personnel Capacity Statement
- Relevant experience related to the assignment
- Curriculum Vitae of key personnel
- Institutional details e.g. corporate documents confirming the legal status of the service provider (Business Registration, SSNIT, VAT)
- References: verifiable list with contact information of organizations for which similar work had been undertaken

10.2. *Financial*

- Summary budget by broad activity categories
- Detailed budget
- Detailed budget for remunerations
- Detailed budget for reimbursable

18.0 SELECTION OF SERVICE PROVIDER

The method and process for selecting a service provider will be in accordance with the Ghana Public Procurement Act 2003 (ACT 663) and provisions of GAVI policy for undertaking evaluation of its supports. The method for selecting will based on service provider's qualification and responsiveness. The decision to award any contract as a result of this RFP process will be based on Service Providers' responses to this RFP and any subsequent negotiations or discussions. The decision making process will consider the ability of each Service Provider to fulfill GHS requirements as outlined within this RFP, and the cost of the proposed work.

Collectively, the service provider should demonstrate experience and competencies in the following areas;

- Adequate knowledge and experience of the workings of the Ghana health system;
- Capability of using advanced evaluation methods, including both qualitative and quantitative techniques;
- Provide evidence of having undertaken evaluations of a similar scale in Ghana and/or elsewhere;
- Submit a proposal that demonstrates that the service provider's team has the capacity to successfully undertake and complete the required work within the stipulated deadlines
- The service provider's team has excellent knowledge of issues related to health and immunization, including experience with immunization programmes and CSO in health operations in Ghana

Proposals will be assessed against the following criteria:

10.3. *Technical Criteria*

Appropriate, feasible and innovative design and methods proposed for undertaking the work.

- **Capacity to deliver**
  - Proposed methodology
  - Adequacy of work plan in meeting the objectives of the assignment
  - Project management capabilities

- Knowledge of country context
- Past experience with similar work
- Profile of staff involved in the support (qualifications of the initial core team, including CVs). See Table 4 for composition of expected expertise.
- *Skill Mix of Service Provider's Personnel*: The proposed key staff for delivery of the service should have proven track record in qualitative and quantitative evaluation research methods, and clear understanding of data analysis and reporting.

10.4. *Financial criteria*

- Realistic costing of the proposal based on proposed activities and timelines to achieve the objective of the evaluation.

The specific expertise of staff that should be assembled by the service provider for the purposes of this evaluation is as follows:

TABLE 4: COMPOSITION OF EXPECTED EXPERTISE

Composition of Expertise	***Task***	***Minimum Qualification and Experience***	***Required Man-days***
Task Team Leader (TL) – Health Systems	• Coordinate the overall implementation of the evaluation and will be responsible for the final report. • Work with the GHS PPMED to plan the timelines and arrange for all meetings and interviews • Work with the rest of the team and coordinate their activities • Lead in the presentation of draft and final report	• A masters degree (MSc., MPH, MBA) in Public Health and/or Administration • Ten years experience in working in the health sector at senior position or has undertaken similar assignments • Familiar with the health system in Ghana • Considerable experience in monitoring & evaluation of health system interventions • Ability to manage teams and excellent skills in communication	60
Assistant Task Team Leader (ATL) -Public Health	• Work with the TL to develop standard questionnaires and tools for assessment • Review proposals and reports for GAVI cash based support over the period and synthesize results of EPI programme over the same period • Conduct field interviews with key informants • Work with other team members to analyze results of interviews and production of reports • Provide inputs to the overall discussions during the evaluation and support the TL in the preparation of the final report presentation and dissemination	• A Masters in Public health with ten years of post qualification experience • Specific experience working in immunization or consulted in immunization services and delivery • Experience in work of similar nature	60
Technical Staff (TS)- Financial Management & Accounting Specialist	• Review the ToR and all other documentations related to the assignment • Review and analyze financial reports of GAVI cash based support to Ghana • Work with TL and ATL to construct the	• Qualified accountant or MBA in Accounting or Finance with three years experience • Experience in the health sector and in undertaking work of similar nature	30

Composition of Expertise	***Task***	***Minimum Qualification and Experience***	***Required Man-days***
	results chain looking at inputs, outputs and contribution to the health budget • Assist to develop questionnaires and tools for conducting interviews and analysis of the responses • Assist to synthesize the issues and produce report of the assessment according to ToR • Provide inputs to the overall report		
Technical Staff (TS) – Expertise in Community Development	• Review the ToR and all other documentations related to the assignment • Assist to develop questionnaires and tools for conducting interviews and analysis of the responses • Assist to synthesize the issues and produce report of the assessment according to ToR • Provide inputs to the overall report	• A minimum of five-years work experience in implementation, monitoring and evaluation of health related interventions especially in child health and immunization services, demand creation at community level. • A certificate in community development, Public health and M&E will be a plus. • Worked at community level and experience in community health service delivery	40

19.0 COMPUTATION OF TECHNICAL AND FINANCIAL SCORES

The weights given to technical and financial proposals are: 80% and 20% respectively. The proposal will be ranked according to their combined technical (S_t) scores using the weights (T+F=1) with the expression: $S = [S_t \times T] + [S_f \times F]$.

20.0 WORK PLAN AND TIMELINES

The service provider will undertake a series of activities. The specific activities will be guided by the scope of work in the ToR. The table below depicts the key deliverables, minimum required information and timeframe. The timeframe should be adhered to and expected deliverables reported accordingly. The total man-days required for the conduct of the evaluation is 60 days

TABLE 5: **DELIVERABLES AND TIMELINES**

Deliverables	***Minimum Information***	***Timeframe***	***Responsibility***	
			Service Provider	***Ghana Health Service***
Review of ToR, including contract negotiation and award	Detailed description of assignment with clear understanding of objectives, outputs and methodology	By close of day 1 after award of contract	Participate in negotiation and make comments on ToR	Review a ToR and finalized as input into final contract document. Award contract
Inception Report	Documentary review focusing on background and contextual information (Synthesized report of previous cash based support from GAVI to Ghana focusing on proposals and relevant reports relating to the objectives and outputs). Revised method and approach to the assignment (embodying: detailed work plan and timelines for all persons to be interviewed, questionnaires (if standard) and agreed dates and times including fieldwork)	7 days after award of contract	Service Provider submits inception report To Ghana Health Service, PPMED.	Review and make comments to fine-tune field activities within 3days
Interim Fieldwork Report	Brief report of key issues from the field (Include briefing on data entry and synthesis)	20days after award of contract	Service provider submits Field work Report	Review and make comments in the report to facilitate further activities
Draft Evaluation report	Detailed final draft of report according to the ToR	45 days after award of contract	Service provider submits Draft Evaluation Report	Organise review and validation meeting and submits comments to service provider
Submission of final report	Final report for circulation and dissemination	By close of day 60 after award of contract	Service provider submits Final Evaluation Report (Electronic and hard copies)	Final Report accepted

21.0

22.0 MANAGEMENT AND OVERSIGHT

The evaluation will be outsourced in its entirety to an in-country local service provider in using Ghana's public procurement process. The PPMED of GHS will be the secretariat for the evaluation and provide the necessary logistics and administrative support for the Service Provider.

The GHS SSDM with the support of the PPMED-GHS will conduct a procurement exercise to recruit the Service Provider. The GHS PPMED will assume responsibility for day-to-day management of the evaluation process and will provide reports through the Director General to the ICC and Health Sector Working Group during their periodic meetings.

23.0

24.0 ANNEXES

Annex 1 - Technical Proposal Basic Forms

- 1AA - Proposal Submission Form
- 1A - Technical Proposal Submission Form
- 1B - Service Provider Track Record and Experience
- 1C - Team Composition
- 1D - Curriculum Vitae of Proposed Staff Form
- 1E - Staff Certification and Consent Form
- 1F - Service Provider Structure Declaration Form

Annex 2 - Financial Proposal Basic Forms

- 2A - Financial Proposal Submission Form
- 2B - Financial Proposal Submission Guide

Annex 3

- **3A - Evaluators Conflict of Interest Declaration Form**

APPENDIX B: LIST OF INTERVIEWEES

MINISTRY OF HEALTH

NO	NAME	DESIGNATION
1	Dr Silvesta Anemana	Chief Director,
2	Dr Afisa Zakaria	Director PPMED,
3	Dr Maureen Martey	Head of Private Sector,
4	Mr. Appiah	Director of Administration
5	Dr Hemans Dosu	Financial Controller
6	Mr. Samuel Boateng	Head of Financial Reporting and Monitoring Unit.

GHANA HEALTH SERVICE

NO	NAME	DESIGNATION
1	Dr Ebenezer Appiah Denkyera	Director General
2	Mr. Yaw Brobbey Mpiani	Director of Administration
3	Dr Akongo	Director PPME
4	Dan Osei	Deputy Director PPME
5	Kwame Quandahor	Ag. Deputy Director PPME
6	Dr Sarkodie	Director – Public Health
7	Dr George Bonsu	National EPI Coordinator
8		Head of Surveillance
9	Ramatu Ude Umanta	Director of Finance
10	Robert Anane	Deputy Director of Finance (Treasury)
11	Kirstey Agbasi	Senior Accounts Officer (GAVI Funds)
12	Dr Anthony Ofosu	Head of Information Monitoring and Evaluation
13	Dominic Kwabena Atweaam	Health Systems Analyst
14	Patrick Larbi-Debrah	Health Information Management Officer
15	Denis Leonard Adaletey	Senior Statistician
16	Dr Addae-Donkor	Director – Stores and Supplies
17	Ebo Hammond	Deputy Director -Transport
18	Emmanuel Ampadu	Transport Manager

UNICEF

NO	NAME	DESIGNATION
1	Victor Ngongalah	Chief Health and Nutrition Officer
2	Daniel Yayemain	Assistant Health Officer

WHO

NO	NAME	DESIGNATION
1	Selassi Amah dÁlmeida	Health Economics Advisor

GHANA STATISTICAL SERVICE (GSS)

NO	NAME	DESIGNATION
1	Peter Peprah	Principal Statistician
2	Michael Beckoe	Senior Statistician
3	Rebecca Ninson	Statistician

GHANA COALITION OF NGOs IN HEALTH

NO	NAME	DESIGNATION
1	Millicent Akoto	National Coordinator
2	Harriet Nottingson	Administrative Secretary

NORTHERN REGIONAL HEALTH DIRECTORATE

NO	NAME	DESIGNATION
01	Dr Jacob Mahama	DDPH
02	Imoro Mahama	DDA
03	Charles Y. Oduro	Regional Accountant
04	Leslie Vanderpuije	DDPS
05	Amina Seidu	Regional EPI Coordinator

SAVELUGU – NANTON MUNICIPAL

NO	NAME	DESIGNATION
01	Joana Quarcoo	DDHS
02	Francis Atiagbo	MDCO
03	Emilia Kakarba	SFT
04	Sulemana Sahui	SEO
05	Fatima Abdul Kadiri	SSO
06	Margaret Pesewu	TO
07	Abitina Ninnang	MPHN
08	Musah Bashiru	MNO
REPRODUCTIVE AND CHILD HEALTH UNIT – SAVELUGU		
NO	NAME	DESIGNATION
01	Rubabatu Mahama	Snr. Mid Officer
02	Emelia Kakarba	SFT (DC)
03	Joseph Aniba	Staff Nurse
04	Abubakar Fauzia	CHN

TOLON DISTRICT HEALTH DIRECTORATE

NO	NAME	DESIGNATION
01	Hajia Sophia Mahama	DDHS
02	Samuel Moro	DCO
03	Janet Adisa Mahama	PHW
NYANKPALA SUB-DISTRICT		
NO	NAME	DESIGNATION

01	Agereba Philomena	SSN (in-charge)
02	Samata Mohammed	TO / (DC)
03	Adwaben Serwaa Charlotte	SN
GBRUMANI CHPS		
01	Nantomah Adam	S/N

UPPER EAST REGIONAL HEALTH DIRECTORATE

NO	NAME	DESIGNATION
01	Peter Boateng	DD – HASS
02	Akomiah George	HIO
03	Peter Larry	Internal Auditor
04	Jonas Firina	Procurement Manager
05	Charles Jongtey	Administrative Manager
06	Olivia Achuliba	DDNS (PH)
07	Ibahim Saheed	EPI Coordinator
08	Stephen Bordotsiah	Malaria Coordinator
09	Patrict Apania	DCO
10	Rofina Asum	DDNS (PH)
11	Baba Awuni	RSO
12	Ali Baba	MAF/RCH
13	Damsongor Gifty	SSN
14	Rexford King James Adjei	RHPO
15	Anyoka Joseph	TM
16	Edmund Edem Tsogbey	HRM
17	Asunoma Wenceslav	ACCT
18	Faustina Bezen	RDCO
19	Bimpeh Kwame	RHIO
20	Augustine A. Owusu	Regional Accountant

BONGO DISTRICT HEALTH DIRECTORATE

NO	NAME	DESIGNATION
01	Abaane Donatus N.	S.T.O (CH) / EPI Coordinator
02	Michael Atareyoo	P.T.O (DC) / DDCO
03	Dambayi Patience	T. O. (HPO)
04	Salamatu Seidu	DPHN
05	Bomawsaaw Hasaw	T.O (HC)
06	Vivian Adda	Physician Assistant
07	Alowri Freda	S M

KASENA - NANKANA WEST (PAGA)

NO	NAME	DESIGNATION
01	Mary-Stella Adapesa	DDHS
02	Agusika Jacob	DHPO
03	Duut Jamu	DDCO

04	Boah Michael	DNO
05	Akoyom Mary	DPHN
06	Amon Kotey Richard	District Accountant
07	Ebenezer Tagoe	DHIO
PAGA HEALTH CENTRE		
01	Mathilda Akugre	Snr. P. A.
02	Adjei Selina	Snr. Staff Midwife

BRONG AHAFO REGIONAL HEALTH DIRECTORATE

NO	NAME	DESIGNATION
01	Dr. Timothy Letsa	RDHS
02	Nana Owusu Boampong	DDA
03	Alexis Abbe	Regional Accountant
04	Opoku Agyeman	ACTO
05	David Nyarko	CHPS
06	K. Amofa Boateng	RDCO
07	Samara Oladele	TO (HI)
08	Pascaline Akaab	ACTO
09	Bachan Emmanuel George	STO (HI)
10	Osei-Yeboah Solomon	PTO
11	Mr. Nartey	RHIO

BEREKUM DHMT

NO	NAME	DESIGNATION
01	Dr. O. K. Afreh	MDHS
02	Daniel Konka	MDCO
03	Veronica Annordjoe	MPHN
04	Joseph Buabeng	MHIO
05	Serwah Antwi	DCO
06	Abigail Menka	DCO
07	Denis Obeng	NO
08	Innocent Dzinyedzi	NO
09	Oppong Bediako	MMS
10	Antwi Wilson	MHGS
11	Eugene Adu-Bonnah	ZIA
12	George Himeh	ZIA
13	Andrews Abambilla	Admin Manager
SENASE CHPS		
NO	NAME	DESIGNATION
01	Theresa Donkor	Snr Field Tech
02	Leticia Kyeremeh	Health Extension Officer
03	Doris Asuama Hinneh	Enrolled Nurse
04	Oforabau K. Ebenezer	CHN
05	Addai-Yeboah Linda	Enrolled Nurse
JINIJINI SUB-DISTRICT		

NO	NAME	DESIGNATION
01	Juliet S. Boateng	CHN Supt
02	Gyau Frimpong	Physician Assistant (In-Charge)
03	Grace Sekyewaa	SSM
04	Okomeng Asante	Field Technician
05	Priscilla Tagbor	CHN
06	Diana Okofo Dartey	CHN

TAIN DHMT

NO	**NAME**	**DESIGNATION**
01	Dr. Michael Adjei Rockson	DDHS
02	Mensah Priscilla Serwaa	STO
03	Asare-Ntow Kofi	HIO
04	Dorothy Akosua Baffoe	SE/O
05	Comfort K. Korkor	DPHN
DEBIBI SUB-DISTRICT		
NO	NAME	DESIGNATION
01	Iddrisu N. Mkah	Physician Assistant
02	Joshua Gyaminu	CHN
03	Adjei Eric Tabiri	Lab Tech Assist
04	Sumani Abana	Enrolled Nurse
05	Musah Sandulai	Accounts Officer
06	Frema Juliana	Enrolled Nurse
07	Antwiwaa Cecilia	Enrolled Nurse
08	Asantewaa Millicent	CHN
NAMASA CHPS		
NO	NAME	DESIGNATION
01	Lekure Cornelius Belbaar	Enrolled Nurse
02	Danor Ebenezer Sangmortey	CHN
03	Henneh Evelyn	CHN
04	Mahama Rockson	Principal Health Assistant
SEIKWA SUB-DISTRICT		
NO	NAME	DESIGNATION
01	Christiana Arthur	
HANI CHPS		
02	Philip Yeboah	In-charge

VOLTA REGIONAL HEALTH MANAGEMENT TEAM

No.	**Name of Staff**	**Designation**
1	Mr Adatsi	Deputy Director, Clinical Care
2	Mr Godwin Afegbe	Regional Manager, EPI
3	Mr Michael Annor	Regional Supplies Manager
4	Mr Robert Anafor	Principal Pharmacist in Charge
5	Mary Edwards-Addo	Field Technician Stores/ Cold Chain Manager

AGORTIME ZIOPE DISTRICT HEALTH MANAGEMENT TEAM

No.	Name of Staff	Designation
1	Faustina Amegashie Aheto	Principal Nursing Officer, Public Health
2	Setsoafia Fiawoyife	District Accountant
3	Elizabeth Ashiabi	District Public Health Nurse
4	Kelvin Etseh	Store Keeper
5	DzifaAdu	Disease Control Officer
Kpetoe Sub-District		
1	Madam Elizabeth Sagado	Senior Physician Assistant
2	Christina Agbada	Officer in Charge of family Health Unit
3	Isaac Aborbi	Community Health Nurse
4	Bless Dovlo Nyarko	Senior Nursing Officer
Afegame CHPs		
1	Kumiwaa Rejoice	Enrolled Nurse
2	Owusu Ansah Linda	Community Health Officer
3	Elias Alowodor	Community Health Nurse
Ziorpe		
1	Mizpah Mensah	Physician Assistant
Wudzedeke CHP Zone		
1	Rebecca Adobor	Senior Community Health Nurse
2	Gloria Agbo	Community Health Nurse
3	Nana Akua Ansah Asamoah	Community Health Nurse
4	Nancy Owoo	Community Health Nurse
Seek To Save		
1	Madam Commend Akpelo	Executive Director
2	Godwill Adovor	Regional Transport Officer

KETA MUNICIPAL HEALTH DIRECTORATE

No.	Name of Staff	Designation
1	Dr Andrews Ayim	Municipal Health Director
2	Joseph Jerela	Disease Control Officer
3	Agyemang Samuel	Disease Control Officer
4	Letsa Agbolu Sefam	Health Information Officer
5	Grace Kodadza	Deputy Director, Nursing Services
Shime Sub District (Agortoe CHPS Zone)		
1	Christian Gbekle	Senior Midwifery Officer
Tegbui Sub District (Tegbui Health Centre)		
1	Cynthia Debrah	Superintendent Community Health Nurse
Dziedzorve CHPS Compound		
1	Otieku Ruby	Community Health Nurse

CENTRAL REGIONAL HEALTH MANAGEMENT TEAM

No.	Name of Staff	Designation
	Dr. Quarshie	Regional Director
	Derry	Director of Administration
	Kwabena Afriyie Ennin	Regional Accountant
	Peter Dieter	Regional Disease Control Officer

	Charles Kofi Eshun	Reg. Surveillance Officer
	Richard Duku	Regional Health Information Officer
	Kwaku Karikari	Reg. Director of Public Health
	Stephen Anyomi	Ag. Dep. Director of Clinical Care
	Irene Opoku Asiamah	Regional Stores Director
	Ben Agyei	In Charge of Cold Room

ATI MOKWA DISTRICT

No.	Name of Staff	Designation
1	J. B. Annan	District Director
2	Nana Gyamfi Kwame	Disease Control Officer
3	Amonoo George	Disease Control Officer
4	Joseph Annor Kofi	CHPS Coordinator
5	Francis Agyei Sarpong	
Twifo Mokwa Sub-District		
1	Cecelia Addoteye	Physician Assistant
2	Ankra Nii Sarpong	Disease Control Officer
3	Aaron NiiAdjiri Doddoo	Staff Nurse
4	Lydia Ofosua Koranteng	Midwifery Officer
Wamaso CHPS		
1	Hanna Fosu	CHN
2	Patience Aidoo	Enrolled Nurse
3	Isaac Appiah Ayensu	Enrolled Nurse
4	Jemima Danful	CHN
5	Edward Ganu	Volunteer
6	Isaac Quansah	Health Extension Officer
Praso Sub District		
1	Mary Afful	CHN
2	Victoria Mensah	Principal CHN

ASSIN NORTH MUNICIPAL HEALTH DIRECTORATE

No.	Name of Staff	Designation
	Georgina Asimade	Director
	Seth Brako	Chief Technical Officer-Nutrition
	Anna Awudu	Adm Manager
	Belinder Twumasi Ankrah	Senior Staff Nurse
	Admire Owusu	Disease Control Officer
	Eric Asiedu Yeboah	

ASHANTI REGIONAL HEALTH MANAGEMENT TEAM

No.	Name of Staff	Designation
	Dr Alexis Nang-Beifuba	Regional Director of Health
	Yaw Boamah	Dept. Director, Administration
	Dr. Oduro	Dept. Director, Public Health
	Mr Everest Deri	Regional Accountant

	Douglas Kwesi Acheampong	Regional Cold Room Manager

AMANSIE WEST DISTRICT HEALTH MANAGEMENT TEAM

No.	Name of Staff	Designation
	Mr Dominic Dobbin	Dist. Director of Health
	Rose Acquah	Dist. Public Health Nurse
	Anin Forson	Disease Control Officer
	Nurudeen Aidoo	Accountant
Kenyiago Sub-District		
	Tahiru Zakariah	Staff Nurse
	Rita Adjei	Midwife
Manso Nkran CHPS		
	Dorcas Dwumah	Community Health Nurse
	Justice Akwesi Asamoah	Health Assistant
Manso Nkwata Sub-District		
	Mr Eleazar Tawiah Lartey	Physician Assistant
Atwere CHPS		
	Mrs Agnes Kusi Berko	In-Charge

EJISU JUABENG MUNICIPAL HEALTH MANAGEMENT TEAM

No.	Name of Staff	Designation
	Mr Mary Kodua	Public Health Nurse
	Mpoan Robertson	Disease Control Officer
	Adu Bobi	Disease Control Officer
	AdjeiFosu Yaw	Health Information Officer
	Sally Baaba Owusu Addo	Health Promotion Officer
	Mr Steven Antwi	Municipal Accountant
	Adwoa Osei Amponsah	Pharmacist
	Augustina Anum Doku	Estate Manager
	Eva Boakye Yiadom	Internal Auditor
Bonfa Sub-Municipal (Bomfa Health Centre)		
	Mr Emmanuel Kofi Nti	Physician Assistant in Charge
Adumasa CHPS		
	Vera Sarkodie	Community Health Nurse In Charge
Kwaso Sub Municipal		
	MrKwakuBuadu	Physician Assistant in charge
Krotia Korase CHPS		
	Nana Abena Agyemang Prempeh	Community Health Nurse

Appendix C: Vehicles Provided under the GAVI Cash Support

GAVI SUPPORT TO GHS (FORD VEHICLES)			
NO.	**REGION**	**DISTRICT/LOCATION**	**OUANTITY**
1	Western	Takoradi	1
2	Central	THLD	1
3	Central	Mfantsiman	1
4	Central	KEEA	1
5	Central	Effutu	1
6	Central	Upper Denkyira East	1
7	Central	AAK	1
8	Western		1
9	Central	Awutu Senya	1
10	Central	AEE	1
11	Central	Gomoa East	1
12	Central	RHD	1
13	Central	Agona East	1
14	Central	Assin South	1
15	Central	Agona West	1
16	Central	AOB	1
17	Central	Cape Coast Metro	1
18	Western	Switwi Ankontombbra	1
19	Central	Upper Dankyira	1
20	Central	Assin North	1
21	Central	Gomoa West	1
22	Volta	Keta	1
23	Volta	Dzodze	1
24	Volta	South Dayi	1
25	Volta	Nkwatia North	1
26	Volta	Jasikan	1
27	Volta	Bakoye District	1
28	Volta	Ho Municipal District	1
29	Volta	Kratchi East	1
30	Volta	North Tongu	1
31	Volta	South Tongu	1
32	Volta	Krachi East	1
33	Volta	Hohoe	1
34	Volta	Kpando	1
35	Volta	Adaklu Anyigbe	1
36	Volta	Ketu South	1

GAVI SUPPORT TO GHS (FORD VEHICLES)			
NO.	**REGION**	**DISTRICT/LOCATION**	**OUANTITY**
37	Volta	Ho	1
38	Volta	Kedjebi District	1
39	Volta	Nkwanta South	1
40	Volta	Akatsi District	1
41	Upper East	Kassima Nankana East	1
42	Upper East	Jirapa	1
43	Ashanti	RHD	1
44	Greater Accra	Ministry of Health, Headquarters	1
45	Greater Accra	Ministry of Health, Headquarters	1
46	Greater Accra	GTA	1
47	Greater Accra	GTA	1
48	Greater Accra	MOTEF	1
49	Northern		1

ALLOCATION OF WINGLE (GREAT WALL) VEHICLES (GAVI FUNDED)			
NO.	**REGION**	**INSTITUTION**	**QUANTITY**
1	Central	Assin South DHA	1
2	Gt Accra	Dangme East DHA	1
3	Eastern	Kwahu East DHA	1
4	Volta	Nkwanta North DHD	1
5	Eastern	Akyemansa DHA, Ofoase	1
6	Gt Accra	Ashaiman MHD	1
7	Volta	Ketu North	1
8	Volta	Kpando DHD	1
9	Upper West	Lambussie	1
10	Gt Accra	Ga East DHMT, Abokobi	1
11	Gt Accra	Ga South-Weija, Weija	1
12	Gt Accra	Adenta, DHMT	1
13	Gt Accra	Ledzekuku Krowor MHD	1
14	Eastern	Upper Manya DHD	1
15	Eastern	Akwapin North DHA	1
16	Eastern	Birim Nort DHA	1
17	Eastern	Fanteakwa DHD	1
18	Eastern	Birim South DHA	1
19	Northern	Kpandai DHA	1
20	Northern	Nanumba South DHA	1

ALLOCATION OF WINGLE (GREAT WALL) VEHICLES (GAVI FUNDED)			
NO.	**REGION**	**INSTITUTION**	**QUANTITY**
21	Northern	Karaga DHA	1
22	Northern	East Gonja DHA	1
23	Northern	Sawla Tuna Kalba DHA	1
24	Northern	East Mamprusi DHD	1
25	Volta	Krachi East DHA	1
26	Volta	Krachi West DHA	1
27	Ashanti	Offinso North DHA *(New)*	1
28	Ashanti	Afigya Kwabre DHA *(New)*	1
29	Ashanti	Sekyere Afram Plains DHA (*New)*	1
30	Ashanti	Atwima Kwanwoma DHA *(New)*	1
31	Ashanti	Asante Akim North DHA	1
32	Ashanti	Bosome Freho DHA *(New)*	1
33	Ashanti	Obuasi Municipal DHA	1
34	Volta	Biakoye DHA	1
35	Brong-Ahafo	Dorma East DHA	1
36	Upper East	Rhd, Bolga	1
37	Western	Shama DHA	1
38	Western	Ahanta West DHA	1
39	Western	Jomoro DHA	1
40	Western	Akontombra DHA	1
41	Western	Juabeso-Bia DHA	1
42	Western	Wassa Amenfi East DHA	1
43	Western	Prestea Huni Valley DHA	1
44	Western	Sefwi Akontombra DHA	1
45	Upper East	Rhd, Bolga	1
46	Brong-Ahafo	Kintampo South DHD	1
47	Brong-Ahafo	Sunyani West DHA	1
48	Brong-Ahafo	Nkoranza North DHA	1
49	Brong-Ahafo	Sunyani East DHA	1
50	Central	Ajumako Enyan Essam	1
51	Central	Asikuma Odoben Brakwa	1
52	Central	Agona East	1
53	Brong-Ahafo	Sene DHA	1

Appendix C References

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