Working Brief 6

# Evidence Advisory System Briefing Notes: Ghana

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November 2016

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GRIP-Health Programme

GETTING RESEARCH INTO HEALTH POLICY AND PRACTICE

GRIPHEALTH

# Contents

There has been a growing global concern for improving the use of evidence to inform health policy in recent years. Increasingly there is recognition that individual projects or programmes building evidence synthesis skills, may be limited in their effect without a broader consideration of the systems in place which 'embed' or 'institutionalise' evidence informed policy making practices (Alliance for Health Policy and Systems Research and WHO 2007).

The GRIP-Health programme is a five-year project supported by the European Research Council which studies the political nature of health policy to understand how to best improve the use of evidence. This explicitly political lens enables us to focus on the contested nature of health issues as well as the institutions that shape the use of evidence in health policy making. We understand institutions as including both formal structures and rules, as well as informal norms and practices (Lowndes and Roberts 2013). The GRIP-Health programme follows the World Health Organization's view that Ministries of Health remain the ultimate stewards of a nation's health, and further play a key role in providing information to guide health decisions (World Health Organization 2000, Alvarez-Rosette, Hawkins et al. 2013). As such, GRIP-Health is particularly concerned with the structures and rules created by government to gather, synthesise, or otherwise provide evidence to inform policy making.

This working paper is one of a series of six briefs covering a set of countries in which the GRIP-Health programme is undertaking research. This brief presents an overview of what is termed the 'Evidence Advisory System' (EAS) for health policy making within the country of interest, which is taken to encompass the key entry points through which research evidence can make its way into relevant health policy decisions. This can include both formal (government mandated) and informal structures, rules, and norms in place.

Individual reports in this series can be useful for those considering how to improve evidence use in specific country settings, while taken together the reports identify the differences that can be seen across contexts, permitting reflection or comparison across countries about how evidence advisory systems are structured – including which responsibilities are given to different types of bodies, and how well evidence advice aligns with decision making authority structures.

# 1   Introduction

This paper describes the Evidence Advisory System (EAS) in Ghana, a lower-middle income country located in West Africa and a member of the African Union.

Ghana is a unitary state with some decentralised functioning affecting health policy-making and planning, but with a great deal of authority remaining in the hands of the national Ministry of Health (MoH) and the Ghana Health Service (GHS). Ghana is a recipient of high levels of international donor finance and aid which has significant implications for policy-making and the use of evidence.

Ghana has embraced the language of evidence-based decision-making in health with a specific reference to health service management, including data usage and performance review.

Planning and research divisions/departments have been established within all health sector bodies, including the MoH, the GHS, and all the other ministerial agencies. These bodies are tasked with reviewing their performances against the strategic objectives set by the MoH (with the support of Development Partners (DPs)) in the Health Sector Medium Term Development Plan (Ministry of Health Ghana 2014). These reviews are supported by a well-established information management system, which is organized by the Policy, Planning, Monitoring, and Evaluation (PPME) division of the GHS, across all levels of governance: district, regional, and national. Evidence is mainly synthesised in the form of health performance indicators.

The predominant use of evidence for performance review has its counterpart in the governance structure of health decision-making. This is marked by a continuous collaboration with DPs in which evidence is used to evaluate health policy performances and inform policy-making. More challenging, however, have been in efforts to use evidence to plan resource allocation or priority setting across the health sector and health service more broadly. Reviews and performance indicators do not automatically translate into policy lessons and informative planning. The formulation of policy in health lacks clear lines of accountability between the MoH and its agencies across the national, regional and district level, clear coordination between DPs, the MoH, the Ministry of Finance (MoF) and the National Development Planning Commission (NDPC), and clear mechanisms of stakeholders' participation[1].

Further, a national framework for health technology assessment (HTA) in Ghana has not yet been implemented. This has direct relevance for decisions made by various stakeholders, including the National Health Insurance Authority (NHIA). In recent years, various DPs have supported a series of initiatives with the MoH and associated agencies to raise awareness on the role and value of using evidence-based approaches in decision making and priority setting within the health sector; however, many plans have not yet been fully developed (Ganoo 2015). There are some indications of progress in this area, though. For example, Ghana supported the HTA resolution at the 67th World Health Assembly (2014) calling for countries to work towards Universal Health Coverage using HTA as a tool for priority setting (World Health Assembly 2014, Ghana National Drugs Programme 2016); and the MoH is piloting the use of HTA to guide decisions on prioritisation within the NHIA, and is being applied to the selection of medicines and the development of Standard Treatment Guidelines for hypertension (Ghana National Drugs Programme 2016).

## 2    Background to Ghana

Ghana is classified as a lower-middle income country with a per capita GDP of US$ 1,381.4 as of the World Bank 2015 data (The World Bank 2016). Annual GDP per capita growth rate has fluctuated greatly over the past decade ranging from 1.7% in 2007 to 11.3% in 2011, with latest figures indicating a growth of 1.5% in 2015 (The World Bank 2016). Despite Ghana's elevated status as a middle income country (thanks, in part, to new oil revenues), it tends to the lower end of the middle-income spectrum largely due to challenges facing the power sector including a lack of adequate and secure quantities of reasonably priced fuel for power generation, and a

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[1] Information obtained through key informant interviews.

lack of adequate public funds to finance the sector's investment requirements (Mathrani, Santley et al. 2013).

Today, Ghana is recognized as one of the more politically stable and democratic countries in Africa. Consistently ranking among the top three in Africa for freedom of speech and freedom of the press, providing the country with considerable social capital (The World Bank 2016). Ghana became the first sub-Saharan country in colonial Africa to gain its independence in 1957 under Kwame Nkrumah, one of the fathers of Pan Africanism, who founded the Convention People's Party (CPP). Since 1992, after a series of coups d'état, Ghana has undertaken a democratic transition and is today a presidential democracy with a multi-party system. The political landscape is dominated by two parties, the New Patriotic Party (NPP) and the National Democratic Congress (NDC), which vie for control of the presidency and for legislative positions within a unicameral parliament. As of 2015, the NDC is in power, represented by President John Dramani Mahama, who serves as both head of state and head of government (Central Intelligence Agency 2016).

Ghana has a population of just over 27 million people with annual growth in decline since 2004, reaching a growth of 2.3% in 2015 (The World Bank 2016). By 2010 over half of the population lived in urban areas and the urbanisation rate is projected to increase to 72% by 2035 (African Development Bank Group 2016). Whether cities have the appropriate infrastructure to address the needs of a growing population is uncertain (Saleh 2013).

The health sector remains underdeveloped and continues to require substantial resources and technical support from foreign aid agencies ('Development Partners' or DPs). While some national indicators for health status have improved over the last decade, Ghana still suffers from great disparity between groups within the country. Inadequate coverage of key health interventions has resulted in a significantly higher burden of mortality and morbidity among rural and urban poor populations. Among the most important health indicators, under-5 mortality has declined significantly from 155 deaths per 1000 live births in 1988 to 60 deaths per 1000 live births in 2014 (Ghana Statistical Service (GSS), Ghana Health Service (GHS) et al. 2015). However, this does fall short of the Millennium Development Goal (MDG) of 43 deaths per 1000 live births by 2015 (World Health Organization Regional Office for Africa 2015). Mortality rates also differ significantly by region, with children in rural areas more likely to die young than children in urban areas (47 deaths per 1000 live births in Greater Accra compared with 111 deaths per 1000 live births in the Northern region (2014 data)) (Ghana Statistical Service (GSS), Ghana Health Service (GHS) et al. 2015). The maternal mortality ratio has also dropped sharply from 760 deaths per 100,000 live births in 1990 to 380 in 2013. However, again, it is unlikely to reach the target of 190 deaths per 100,000 live births as per the MDG (World Health Organization Regional Office for Africa 2015).

Ghana remains moderately affected by infectious diseases such as malaria, tuberculosis, and HIV/AIDS. Malaria remains one of the primary cause of morbidity and mortality, and was the third leading cause of death in 2012 (8.3% of all deaths) and is the leading cause of death in children under-5 years of age (20% of all deaths in 2013) (World Health Organization 2015). The HIV burden is also significant with a prevalence of 1.6% amongst adults (aged 15-49) in 2015 (UNAIDS 2015). The TB burden is moderate with an estimated incidence of 160 cases per 100,000 population in 2015 (World Health Organization 2016). Ghana is, however, undergoing

an epidemiological transition, with non-communicable diseases (NCDs) becoming a growing concern (Saleh 2013).

# 3    Primary decision making points for health

While there is a general use of terminology such as 'Evidence Based Policy' or 'Evidence Informed Policy' in the health sector, what 'policy' is, is all but unambiguous. 'Policy' can refer to a range of concepts from projects and programmes, to sector-specific plans, to broad statements of intent (Hogwood and Gunn 1984). Policy is also not the responsibility of a single body; rather, policy decisions affecting health take place across a range of governmental levels and authorities.

This lack of a universal object of study complicates health policy research. However, there are some types of decisions common to many countries' health sectors for which research evidence is often held as critical. This allows a basic classification of decision types to provide at least a starting point for comparisons/analyses of country evidence advisory systems, as follows:

- Public Health and Health Promotion: Usually high level decisions affecting large segments of the population. Can involve agencies outside the health service and broader sectoral interests. Often the responsibility of national legislatures, ministries of health, or devolved authorities. Common examples include: tobacco control, occupational health, healthy eating, sanitation, etc. A broad range of evidence will be relevant to such decisions, including epidemiological, economic, social attitude, and others which speak to relevant decision criteria.
- Health Service Priority Setting and Management: Decisions concerned with the allocation of resources across the health system or the structure of service provision and funding, including priorities within the system. Often the responsibility of ministries of health or national health services. Common examples: health system priorities, health worker responsibilities, resource generation or allocation decisions, etc. Relevant evidence forms include health technology appraisals/assessments (HTA), epidemiological and clinical studies, health services research, etc.
- Programme Planning: Decisions within the remit of specialised agencies, such as programmes dedicated to individual conditions (malaria, HIV, cancer, etc.). Decisions within these bodies often require evidence both about efficacy or cost effectiveness of different prevention and treatment options, but equally often are informed by locally generated data (e.g. routine data from surveillance or facility information).
- Service Provider Decision Making is the most specific and tailored to individual cases. It can be health centre or hospital policies, or individual clinician decisions about patient care. Relevant evidence may include specific case details or specific realities of the context as well as more top-down use of guidelines.

In addition to these types of health decisions, this working paper also recognises that decision making for health can take place at different levels within government hierarchies, with authority for decisions, and entry points for evidence resting in: national level bodies, sub-national (regional) level bodies, and local level bodies at times. In different country settings the various decision types listed above might be addressed at any of these three levels or may cut across more than one level. For instance, at the national level, the Ministry of Health usually functions as a decision point for certain types of decisions, but movements towards de-centralisation might lead to the shifting of decision-making from national levels to sub-national or local levels (England is a case study of that). This permits consideration of whether systems of evidentiary advice are well aligned with the decision authority structures in a setting. There can also be important considerations on the ways that national evidence systems link to influential non-state decision makers (e.g. development partners in low and middle income settings, or corporate bodies granted authority for health policy decisions).

## 3.1    National Bodies

### 3.1.1    Legislature

Ghana has a unicameral Parliament, which is elected for four year terms. It promulgates public health-related acts and bills devoted to health promotion policies and health organization. Besides law-making, the Parliament is also responsible for holding the Government to account in respect of its policies and administration. In health policy, the Parliament approves sectoral budgets, mobilizes and allocates resources, and exercises advocacy, but its capacity is constrained in several ways. For instance, the role of the Parliament in influencing national policy is limited by resources and by its constrained capacity to debate Government budget and scrutinize relevant evidence. Also, the Select Committee on Health has limited scope or initiative to make inquiry into matters that have not been referred to it by the Standing Orders of the House; however, it can compel the production of documents and papers relevant to their inquiry[2].

### 3.1.2    Ministry of Health

The Ministry of Health (MoH) is a Cabinet ministry and the Minister is appointed by the President of the Ghana with the approval of Parliament. The current practice is for the MoH to submit health policy proposals directly to the Cabinet. However, this practice is soon to be changed, with the MoH first submitting plans to the National Development Planning Commission seated under the Presidency[2]. The MoH has a specific mandate to access and monitor the country's health status, advise central government on health policies and legislation, formulate strategies and design programmes to address health problems, and implement, monitor and evaluate all health programmes and activities in the country in collaboration with other related sectors and agencies (Ministry of Health Ghana 2016). It provides overall policy direction for all stakeholders and players in the health sector. It is also responsible for vertical programs, such as Malaria and HIV control, which are administered by the Ghana Health Service (GHS) (Ministry of Health Ghana 2016).

The MoH (with the support of DPs) also devises the Health Sector Medium Term Development Plan which provides a framework for planning by agencies and stakeholders in the health sector. The framework identifies priority areas over a period of four years. The 2014-2017 document specifically highlights the need to improve access to quality and efficient health services and to improve the sectors responsiveness to the needs of the population(Ministry of Health Ghana 2014).

### 3.1.3    Ghana Health Service

The Ghana Health Service (GHS) is an autonomous Executive Agency of the MoH which has been delegated the responsibility to manage and operate all public health facilities, except for three teaching hospitals (Korle-bu, Komfo Anokye, and Tamale). It is under the control of the Minister for Health through its governing body - the Ghana Health Service Council. It is tasked with the planning, implementation, monitoring and performance assessment of health programmes and

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[2] Information obtained through key informant interviews.

services (Ministry of Health Ghana 2016). It is also responsible for a number of health programmes, including the National Malaria Control Programme (Ghana Health Service 2015).

The GHS is structured into sub-national offices at the regional and district level, reflecting the deconcentration of health services at three administrative levels (Ghana Health Service 2015). However, the involvement of local governance bodies, such as the District Assemblies, in the decision-making process is not consistent and marked by ambiguous lines of accountability between the local administrations of the GHS and District Assemblies, and local administrations of the GHS and regional offices[3].

### 3.1.4   National Health Insurance Authority

The National Health Insurance Authority (NHIA) is the primary body which decides on the package of services available to many citizens. It is an independent, centralized, government agency, which makes decisions on the procedures and services covered by the National Health Insurance Scheme (NHIS). The NHIA licenses and regulates the district mutual health insurance schemes (DMHIS), accredits public and private providers, processes claims, and reimburses DMHIS. However, the charges for each public facility are established by the GHS (Saleh 2013). The NHIS is financed on a national basis from a single risk pool fund and currently represents one of the largest sources of revenue of the health sector in Ghana (16% of total health spending in 2009)(Saleh 2013). The NHIS has been created as a single benefit package covering over 95% of both inpatient and outpatient services of all common illnesses, and exempting a large portion of the population – almost half – from premium payment (Fusheini 2016). This setting has now proved to be financially unsustainable and a large discussion is currently under way to revise the scheme through priority setting methodologies. The operationalization of the scheme is now piloted under a capitation framework (Saleh 2013).

## 3.2   Development Partners

While obviously not officially part of the state, development partners (DPs) are a particularly important group involved in decision making for a variety of programmes, from disease-specific interventions (i.e. vertical programmes) and health policy interventions, to health systems strengthening and technical capacity improvement. The financial contribution of DPs to the health sector has been decreasing over recent years; however, their role in the allocation of the operational budget is still key (in 2014, 15% of total health expenditure was financed by external sources (21% of total health expenditure in 2004)) (World Health Organization 2014).

DPs mostly work via national level joint decision making fora with the MoH, its agencies, and other stakeholders:

- A Health Summit, generally held in April, is devoted to presenting and discussing the interagency review assessment through the use of the so-called 'holistic assessment tool'. This tool provides a framework for assessing the health sector comprehensively, identifying factors that influence its performance. Its purpose is to facilitate and to structure the dialogue between the various stakeholders (Ministry of Health Ghana 2015). Indeed, according to one interviewee, the Health Summit is "the key policymaking structure within the sector"[3].

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[3] Information obtained through key informant interviews.

-   Quarterly Business Meetings are held to review past performances in the health sector and to determine the advancement of the annual Programme of Work (PoW) and to plan for the forthcoming year (Ministry of Health Ghana 2007, d'Almeida 2015).
-   A Health Sector Working Group (HSWG) meets monthly to facilitate policy and technical dialogue with health sector stakeholders. It consists of DPs, senior managers of the MoH and its agencies, and representatives of the private sector. Each meeting is chaired by the MoH (World Health Organization 2014).
-   A joint monitoring visit is conducted twice a year, preceding the two Business Meetings, and is devoted to the observation of health policy implementation on the ground (d'Almeida 2015).

### 3.3   Sub-National Bodies

The GHS has established its own decentralized structure across two levels of governance, the Regional and the District level, each having their own Health Administrations with their own Directors and Management Teams (Regional Health Administration (RHA) and District Health Administration (DHA)). Each is organised as a Budget and Management Centre for purposes of administering government and DP funds for planning and health services management (Ghana Health Service 2015).

### 3.4   Local bodies

District Assemblies (DA) represent local political authority and play a part in health policy formulation, development, planning, and financial, infrastructure and equipment support. Members of the DA sit in the District Health Committees, but coordination between DA and DHA remain unclear[4]. District governments have their own District Assembly Common Funds, but resources allocated for health are low and variable across districts (Saleh 2013).

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[4] Information obtained through key informant interviews.

# 4    Entry points for research evidence – The evidence advisory system

For research evidence to inform policy, it must have a conduit through which it can reach decision makers who might be usefully informed by it. There may be a wide range of structures and norms in place, both formal and informal, which, when taken together, form the evidence advisory system for health decision making. Taking as our starting point the stewardship role of Ministries of Health (and, by extension, national legislatures which govern ministries), we separate between:

1.   'Formal systems'- taken here to represent the officially mandated agencies tasked with evidence synthesis and provision for decision making processes. These can be within national governments (for example, Ministry of Health Research Departments), Semi-autonomous bodies (such as the National Institute of Health and Care Excellence – NICE – in the UK), or independent agencies, so long as they have a formal mandate to provide evidence to inform policy; and

2.   'Informal systems' - representing the systems of evidence provision that are not dictated by any formal decree or rule to provide evidence, but which are found to play important roles in evidence provision.

## 4.1    Formal systems

**Ghana Health Service**
Within the GHS, the Policy, Planning, Monitoring and Evaluation division (GHS-PPME) and the Research & Development division (GHS-R&D) are tasked with evidence generation. In terms of evidence advocacy, the PPME is the key division and is more effective than the R&D department[5]. The GHS-PPME is specifically mandated with translating evidence into policy. This includes both up-taking already elaborated evidence coming from external sources, and managing the data information system in order to enable sectoral monitoring and evaluation (Ghana Health Service 2015). Further, the Centre for Health Information Management (CHIM) is located within the GHS-PPME (Ghana Health Service 2015). It is the focal unit responsible for the collection, analysis, reporting and presentation of health service information in the GHS. The CHIM includes the District Health Information Management System (DHIMS), through which health information (e.g., administrative, demographic and clinical data) is transmitted from facility to district to region and finally to central health management levels. The main task of this information system is to produce reports that will feed into sector-wide indicators, milestone, and programmes indicators [5]. Three Health Research Centres exist within the R&D division of the GHS: the Navrongo Health Research Centre (responsible for the Sahelian ecological belt of Northern Ghana - Ghana's most impoverished and remote region), the Kintampo Health Research Centre (responsible for the middle belt of Ghana in the Brong Ahafo Region), and the Dodowa Health Research Centre (serving the southern belt of Ghana) (Nyonator, Akosa et al. 2007, Ghana Health Service 2015). These centres conduct research

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[5] Information obtained through key informant interviews.

within their designated sub-region as per the needs and priorities of the GHS. This information is then used to guide national-level decision-making and policy development (Ghana Health Service 2015). All centres have well established health and demographic surveillance systems and collaborate with a number of international partners and funders (Ghana Health Service 2015, Navrongo Health Research Centre 2016).

These Research Centres also play a significant role in piloting and evaluating features of the health system. A notable example of this is that of the Community-based Health Planning and Services (CHPS) initiative which aims to redirect primary health care services from sub-district health centres to more convenient community locations (Awoonor-Williams, Sory et al. 2013). This initiative began as a pilot project of the Navrongo Health Research Centre whose findings and innovations were then translated and scaled-up into national policy (Nyonator, Awoonor-Williams et al. 2003, Awoonor-Williams, Sory et al. 2013).

**Ministry of Health**
Within the MoH, the Research, Statistics and Information Management Directorate and the Policy, Planning, Monitoring and Evaluation division (PPME) are responsible for generating evidence and advising the MoH. The PPME, especially, works in close collaboration with DPs, which provide capacity building activities and financially support the use of technical tools for evidence production. Among MoH agencies, three teaching hospitals (Korle-bu, Komfo Anokye and Tamale) are also mandated to conduct health research (Ministry of Health Ghana 2016). However, evidence is mainly generated through the review of reports produced by MoH agencies and research institutes. The MoH is also responsible for strengthening interagency collaboration over operational research.

**National Health Insurance Authority (NHIA)**
The NHIA has an internal research and operation department. As a health purchaser, the NHIA collects and analyses clinical, financial and membership data from accredited facilities. It is also responsible for monitoring and evaluation across NHIS operations (Saleh 2013). However, as a result of unclear divisions of responsibility between the NHIA and the GHS, conflicts exist as to the generation and especially use of evidence, the capacity of accredited facilities to deliver insured health services, and the reimbursement of purchased services[6].

**The Common Management Agreement between MoH and DPs**
The performance of the health sector is discussed at the annual Health Summit informed by evidence collected via the holistic assessment tool. The use of indicator data represents the key package of evidence of health performance at the national, regional, and local level (Ministry of Health Ghana 2015). Joint Monitoring Visits (JMVs) are organised by the MoH in collaboration with DPs to understand how policies and strategies are being implemented at the peripheral level. The health issues to be monitored are set in advance by members of the health sector working group (HSWG). Evidence is collected through semi-structured interviews and observation. A detailed report is written and the key findings are usually highlighted for consideration during the HSWG and Business Meetings (d'Almeida 2015). The JMV crucially provides an opportunity for the exchange of information between national level staff

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[6] Information obtained through key informant interviews.

participating in the visit and staff at lower, local levels. It therefore creates a platform for interaction between the national and regional levels (d'Almeida 2015).

## 4.2   Informal/non-institutionalized systems

Evidence may also be provided via local academic research centres, for example, the School of Public Health of the University of Ghana and Nougouchi Memorial Research Centre. The former is particularly increasing its collaboration with the NHIA, while the latter is sometimes contracted to do specific research and feed it into the MoH. Further, international NGOs such as Oxfam and the Ghana Coalition of NGOs in Health, use evidence for advocacy but have only intermittent influence on the MoH. STAR-Ghana, which aims to increase the influence of civil society and parliament in the governance of public goods and service delivery, uses evidence as an informative tool for Parliamentary Committees, including the Committee on Health[6]. International experts from the WHO and other DPs, including the UN (UNICEF), USAID and Danida, may also collaborate with the MoH, GHS, and other research institutes on projects or programmes[7].

# 5   Discussion

Ghana faces many challenges typical of low-middle income countries in terms of its capacity for evidence use, yet its well-established bureaucracy and stable government gives it a strong position, compared to many other countries in the region, to institutionalise systems of improved evidence use. The country has committed to or shown interest in particular evidence-informed processes within the health sector – such as the use of HTA to help inform agenda setting by the MoH, and also has agencies like the NHIA and GHS which serve as clear organisational authorities into which evidence synthesis and utilisation can fit. As such, the next steps to increase or improve evidence use may revolve around implementation or scale up, rather than the need to establish new structures or ideas.

However, this does not mean that establishing well-functioning systems of evidence use will be easy. There are some challenges in terms of accountability and authority lying between or within those bureaucratic agencies that exist – with our interviewees highlighting unclear divisions of responsibility between the NHIA and GHS in particular. External evaluations of the democratic system in Ghana have also identified a 'winner take all', 'neo-patrimonial' system of governance which, according to one USAID funded report, "has created a parallel system of political patronage…which… undermines administrative accountability for the effective use of public resources to address the country's social and economic problems (Fox, Hoffman et al. 2011)." The STAR Ghana project, which worked to improve democratic representation and governance, has similarly noted a limited ability for the legislature in the country to keep check

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[7] Information obtained through key informant interviews.

on, or mitigate, patronage networks, providing a context which may limit how well it can bring evidence to bear on policy decisions (in health, or any other social sector) (Gyimah-Boadi 2013).

Reliance on development partners can also pose challenges to rationalising evidence use and ensuring local ownership over systems and processes through which evidence informs policy. On the one hand, donors do obviously provide finance for health services, and will no doubt at times be undertaking evaluations of programmes to provide some policy relevant evidence. Yet, such systems are external to national structures and local ownership, and thus risk hindering the establishment or development of a local evidence advisory system that is under the control and at the service of national authorities. The involvement of donors in the annual Health Summit has also been explored in more depth elsewhere, and it has been found that locally generated routine data is often directed to populate health system indicators that are developed with a large amount of donor input. This risks having a parallel system of data use outside of the established government hierarchies, but with accountability lines leading to non-state actors (Vecchione and Parkhurst 2015).

Overall, this mapping has aimed to highlight some of the key health policy decision points in Ghana, and identify some of the main ways that evidence can inform those decisions. Ultimately, however, understanding and improving systems of evidence use must engage with the complex political and institutional context in any country setting. As such, there may be both challenges and opportunities available in Ghana to increase or improve evidence use in the health sector.

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