Annual Review – Summary Sheet

This Summary Sheet captures the headlines on programme performance and the agreed learning over the course of the review period. It should be attached to all subsequent reviews, in order to build a complete picture of actions and learning throughout the life of the programme.

Title: Ghana Adolescent Reproductive Health (ARH) Programme		
Programme Value: Adolescent Reproductive Health (ASRH): £12.3 million Family Planning (FP) Commodities: £4.7 million		**Review date:** 2–15 January, 2015
Programme code:	**Start date:** 2013	**End date:** 2017

Summary of programme performance

Year	**2013**	**2014**	
Programme score	**C**	**A**	
Risk rating	**Medium**	**Medium**	

Summary of progress and lessons learnt since last review

Overall the programme has met expectations, scoring A. This is significant given that the year included the six-month inception phase and six months of full implementation. The project achieved A+ in outputs 2 and 3, but C in output 1 and B in output 4. After a rocky start implementation is moving quickly. There has been strong collaboration between the programme and the coordinating body, the National Population Council (NPC). At all levels the multisectoral approach has fostered a good partnership for addressing the needs of adolescents.

Output 1: Increased provision, knowledge and awareness of ASRH services in the focal region

This output substantially did not meet expectations because, following a needs assessment, it was discovered that all the adolescent service platforms[1] proposed by the districts either needed re-designing, renovating or re-equipping to make them adolescent-friendly. Therefore a surveyor has been engaged to visit all the facilities, re-design them and prepare a bill of quantities for renovation. The programme has targeted 60 adolescent service platforms in a region that has 542 facilities—a coverage of only 11%. Without rapidly scaling up adolescent services, the teenage pregnancy rate will not reduce significantly.

Output 2: Output 2: Adolescent-friendly sexual reproductive health services developed and provider capacity developed

This output exceeded expectations. The current three-arm funding mechanism for grant disbursement remains valid. Grants were disbursed to three institutions at the national level, the Regional Coordinating Council (RCC) in the region and all the 27 district assemblies in Brong Ahafo Region. In 2014 the programme plans to contract non-government organisations (NGOs) to implement some community-based activities, but there is a need to appraise the mechanisms for contracting and financing NGOs in a decentralised, multisectoral ASRH programme.

Output 3: Better evidence of factors affecting uptake of ASRH and FP

This output exceeded expectations. Three longitudinal operations research (OR) studies have been selected. The ORs will identify lessons learnt and good practice, which will inform programme design and provide global evidence for ASRH programming. However, to ensure that research findings inform policy and are adopted by local managers current engagement with stakeholders should be strengthened.

Output 4: Increased availability of FP commodities

[1] Adolescent-friendly service platforms are any service delivery points (SDPs) adolescent and youth-friendly health centres or adolescent health corners that deliver sexual and reproductive health care services and information to adolescents and youth. These SDPs may fall into three categories: (1) health care setting, (2) schools, (3) community-based programme. (Source: FGE Monitoring and Evaluation Plan).

This output moderately did not meet expectations because one of the milestones was over-ambitious. Investments in contraceptive procurement have eliminated stockouts at the Central Medical Stores (CMS) and improved availability of FP commodities at the operational level. Government is working to address the supply chain problem at the regional level. However, delays in implementing the free FP policy are hindering the uptake of FP services; therefore, advocacy on the free FP policy should be strengthened.

Summary of recommendations for the next year

A. Recommendations for programme

Output 1 detailed recommendations (See page ix)

- Futures Group Europe (FGE) should work with the Brong Ahafo Regional Director of Health Services to scale up the adolescent-friendly platforms;
- FGE should follow up on the parent–adolescent dialogue meetings and fund community-led action plans;
- FGE should consolidate current interventions, but should also work to improve the quality of communication regarding changing interpersonal behaviour, by using evidence from empirical behavioural theories;
- FGE should develop a programme to appropriately target traditional and religious authorities, following the positive outcomes that have resulted from the recent advocacy programmes; and
- FGE should implement a phased programme to re-organise existing service delivery points to provide adolescent services in addition to the standalone corners (as previously planned). Given that the adolescent problem is most acute in the rural areas, and the existing corners are predominantly urban-based, there is a need to re-organise service delivery in health facilities, especially the Community-Based Health Planning and Services (CHPS) zones, to facilitate the scaling up of adolescent interventions.

Output 2 detailed recommendations (See page xi)

- FGE should work with the Steering Committee to appraise the options for financing and contracting NGOs in a decentralised, multisectoral ASRH programme;
- FGE should review the Grants and Finance Manual to reflect recent reforms in public financial management and decentralisation. This should be integrated into the training of grantees and implementing partners;
- FGE should meet regularly with signatories to the contract (e.g. District Coordinating Director and District Finance Officer) at least half-yearly, to review the progress of implementation and address issues that arise;
- The Steering Committee should appraise the options for contracting and financing NGOs in a decentralised, multisectoral ASRH programme;
- FGE should mainstream gender in the ASRH programme; and
- FGE should work with the RCC and the district assemblies to mainstream the ASRH programme into the medium term development plans, to ensure the programme's sustainability.

Output 3 detailed recommendations (See page xii)

- FGE should communicate the revised logframe to all grantees, to increase their understanding of the project's expectations and to allow them to strategise to achieve them;
- The NPC and FGE should work with the Health Research Unit of the Ministry of Health (MOH) to obtain ethical clearance for the three studies identified; and
- FGE should continue to work with local research organisations to complete the research studies.

Output 4 detailed recommendations (See page xiv)

- FGE should explore the possibility of providing the Regional Training Resource Centre in Brong Ahafo Region with reproductive health equipment and learning materials to support the training of staff in ASRH and FP;
- The NPC should work with stakeholders to reduce the spreading of misinformation about FP by herbalists; and

- The Ghana Health Service (GHS) should work with the School Health Education Programme to ensure the integration of the Cyclebead in reproductive health programmes in basic and secondary schools, as a way to help girls to understand their menstrual cycles.

Recommendations to the Department for International Development (DFID)

- Ensure the logframe is in place before a programme is tendered. Also, review the revised logframe to address problems that have been identified with several indicators, baselines, milestones and targets (see page vii);
- Ensure policy-makers and managers are consulted in setting targets in the logframe and are informed about revisions, to ensure targets are realistic ;
- Continue to strongly engage in debating the policy regarding free FP services: resurrect the costing study and join forces with USAID in policy-informing work;
- Coordinate the ASRH programmes implemented by FGE and Marie Stopes International (MSI) in the field;
- Engage in policy dialogue with the Government of Ghana (GOG) and other donors on the implications of free FP;
- Engage with donors and FP implementers to better understand the effects of the changing FP market;
- Better evaluate the operational costs and their feasibility during the tender processes; and
- Now that implementation is underway, consider the legacy and sustainability of this programme, particularly in terms of the government's plans to pay for FP commodities once donor support ends, and how the experience from Brong Ahafo Region will impact future policy.

A. Introduction and context (1 page)

DevTracker Link to Business Case:	http://devtracker.dfid.gov.uk/projects/GB-1-202819/documents/
DevTracker Link to Log frame:	http://devtracker.dfid.gov.uk/projects/GB-1-202819/documents/

Outline of the programme

What support is the UK providing?

The UK Government is providing £17 million for the ASRH programme from 2013 to 2017, which aims to contribute primarily towards the achievement of Millennium Development Goal 5 (MDG5).[2] This programme is included in DFID Ghana's Operational Plan and is consistent with GOG's policies on reproductive health. The programme is being implemented in two components:

- **Service delivery and operational research**. This is coordinated by the NPC, and managed by FGE. This component delivers ASRH services in 27 districts of Brong Ahafo Region with a value of £10.9 million and an operational research budget of £390,375. Initially 21 districts were targeted but in 2014 the Steering Committee, which coordinates all ASRH programmes, increased the number of districts to 27 at no additional cost to the programme; and
- **The procurement of FP commodities**. £4.7 million is allocated to deliver high quality, long-acting FP commodities to improve contraceptive commodity security, aiming to reduce unmet need for FP. This component is managed by Crown Agents and is governed by a Memorandum of Understanding signed between DFID and GOG.

This is the second annual review and covers the period from January to December 2014. During the period, the following disbursements have been made:

- **Service delivery and operational research**: £2,255,711 to support the Ghana ASRH programme managed by FGE; and
- **Procurement component:** £1,146,947 to procure FP commodities for the MOH.

The contract with FGE was signed in January 2014 and the inception phase concluded in June 2014. Thus, essentially this component of the programme has been fully operational for six months.

What are the expected results?

The expected results of the programme are:

1. Improved reproductive health knowledge and behaviour for up to 350,000 adolescents;
2. A strengthened national FP programme resulting in:
   - 90,000 unwanted pregnancies being avoided;
   - 240 maternal deaths being averted; and
   - 2000 health staff being more able to provide FP services.

What is the context within which UK support is provided?

Although Ghana has made some progress towards achieving many of the Millennium Development Goals (MDGs), without additional efforts MDG5 is unlikely to be achieved. One in every 300 pregnancies results in maternal death. Making up about 22% of Ghana's population, adolescents (10–19 years) are particularly vulnerable because of a low level of risk perception, limited information and access to services, and pervasive gender inequalities. Although knowledge about FP is high, the contraceptive prevalence rate (CPR) for modern methods for all women was only 17% in 2012, a decline since 2003. Contraceptive security has been poor, with the country recording stockouts in 2010, which were only alleviated in 2011 by DFID's 'emergency' procurement of injectables and implants.

The GOG's policy goals for FP are to ensure access to free FP services[3] and to increase contraceptive prevalence to 50% by 2020.[4]

[2] MDG5 aims to reduce maternal mortality.
[3] Ghana's commitment at FP 2020 Summit in London
[4] National Population Policy, 1994

Ghana is revising the 2000 Adolescent Reproductive Health Policy to strengthen the legal regime that protects the rights of adolescents and consequently reduces some of the barriers to accessing care. The Steering Committee has prepared a draft of the revised policy, targeting ages 10–24 years. The revised policy seeks to mainstream the sexual and reproductive health of young people in the national health and development process. Among the strategies proposed are advocacy for increased GOG budgetary allocation, integration of ASRH into social media, elimination of legal barriers and the development of an implementation plan to support a multisectoral adolescent programme.

B: Performance and conclusions (1–2 pages)

Annual outcome assessment
The outcome of the programme is to strengthen reproductive health in Ghana, with a focus on adolescents. The two indicators for tracking this outcome are the percent of adolescents (15–24 years) who had sex before age 15, disaggregated by sex; and the percentage of women (15–49 years) currently married or in union who are using a modern method of FP, disaggregated by age groups 15–19 years and 20–24 years. Both indicators will be collected using survey data such as the Demographic and Health Survey (DHS) and the Multi-Indicator Cluster Survey (MICS).

The programme is on track to meeting the outcome targets. Most of the structures that will facilitate implementation are already in place e.g. availability of manuals, educational materials and trainers. Also, the FGE is strengthening its human resource capacity to provide technical assistance and monitor the field work. Further, the pace of implementation is expected to quicken in 2015 because of strong commitment from local leaders and programme managers.

Overall output score and description
Overall the programme moderately met expectations, scoring **A** in 2014, compared to **C** in 2013.

The theory of change recognises that achieving behaviour change requires long-term inputs and that four years is an inadequate period in which to achieve significant outcomes. By the end of the project in February 2017, 2.5 years of implementation would still be too short a time in which to achieve an impact on the adolescent birth rate and maternal mortality. By the end of 2015, significant progress is expected to be made to increase awareness and advocate for political and traditional authority support. However, without bringing adolescent services to scale, the teenage pregnancy rate is unlikely to reduce, especially since only 60 adolescent-friendly service platforms will have been established, in a region with 542 health facilities.

One key assumption – that there would be opposition to providing adolescent services – is unfounded, because although the GES does not promote the provision of contraceptive services in school, the GHS policy makes these services available to adolescents. So far, support for the programme by parents, traditional authority, political and religious leaders has been strong.

On risks, most risks identified remain valid; however, the risk level has changed for some risks and new risks have been added, e.g. the impact of the country's deteriorating macro-economic situation may increase the incidence of transactional sex in adolescents from poor households. The macro-economic situation will also limit poor people's access to school and delay government's implementation of the free FP policy.

Key lessons
Information and communication

- Parent–adolescent dialogue meetings are important channels for sharing the problems confronting adolescents in their communities and developing a means to address them collectively; there is therefore a need to scale these meetings up; and
- Behavioural modelling, using an important person with a rural background, should be scaled up as this has been found to be effective in communicating to adolescents the need to set their goals in life.

Service delivery

- There is a need to address the re-organising of service delivery in health facilities so that they provide adolescent-friendly services. Unless this is done, the proportion of adolescents who have access to such facilities will be low, given that the project target is only 60 adolescent-friendly service platforms;

- Cyclebeads[5], a standard day FP method, can potentially be used to educate adolescents about their menstrual cycles, and should be introduced into the school-based programmes; and
- Long-acting FP is proving popular among adults. MSI's policy of providing long-acting contraceptive commodities free of charge has increased the number of users of implants in the districts visited in Brong Ahafo Region and offers important lessons for scaling up the delivery of FP services.

Organisation and management

- There is a need to plan operational costs better. A small number of local staff cannot effectively manage a project which has a large programme management component. The FGE programme was designed with a large technical assistance (TA) component and a small local operational staff component. However, given the scope of the grants, the project has had to recruit additional local staff to monitor grantees, strengthen financial management and provide TA;
- District assemblies will only commit funds to a project if the plans are integrated with the assembly's medium term development plan; and
- District Coordinating Directors are more likely to provide effective oversight if they are appropriately oriented towards project objectives and expectations.

DFID programme management (central and country-managed programmes):
Effective coordination at the project conceptualisation stage between DFID centrally-managed programmes and DFID Ghana-managed projects reduces conflicts during implementation. The centrally-funded MSI-managed Preventing Maternal Deaths from Unwanted Pregnancy (PMDUP) and the FGE programme are both being implemented in the Brong Ahafo Region. Although the focus of the PMDUP programme is on maternal health in general, if care is not taken there may be duplication of activities. DFID has worked with NPC to organise regular technical meetings of all ASRH partners to coordinate activities and share experiences.

Key actions

See Recommendations, page ii.

Has the logframe been updated since the last review? Yes, it was updated by DFID in the second quarter of 2014 and finalised in September 2014. The revision became necessary because the tender was slow, and no implementation took place in the first year.

The output indicators in the revised logframe have been reduced from six to four, though this does not significantly affect the planned activities. Also, some targets have been reduced. For instance, the OR target has been reduced from six to four. Furthermore, unlike the old logframe, the new logframe has a lot of composite indicators. Composite indicators are problematic because the achievement of a single milestone depends on many variables. This increases the probability of underperforming if only one sub-milestone is not achieved, thereby giving a false sense of overall underperformance. A few indicators either do not have a baseline or the targets are over-ambitious.

Recommendations to improve the logframe:

- Output indicators 2.5 and 3.2 and corresponding milestones share many similarities, so there appears to be a degree of repetition. For instance, the 2014 milestone for indicator 2.5 is 'OR studies commence' while for indicator 3.2 it is 'OR implementation studies commenced by Nov. 2014'. If it is assumed that the two indicators are different, the following recommendation is made: revise indicator 2.5 to 'Grantees involved in determining research agenda act on findings and adapt services to respond to relevant evidence';
- Accordingly, the 2014 milestone will be 'Evidence of grantee participation.' The 2015 milestone will be, 'Findings of OR disseminated to grantees, practitioners and other key stakeholders'; and the 2016 target will be, 'Evidence that policy-makers and practitioners act on findings of OR';
- Indicator 2.5 appears to have been numbered incorrectly because there is no indicator 2.4;
- Indicator 4.2 does not have a baseline, thus making it difficult to track progress effectively. In fact, it appears that the milestone of 70% for 2014 was over-ambitious, because data reported by the

[5] Cyclebeads is a fertility regulation method used for FP.

Family Health Division suggest that the percentage of health facilities with implants increased from 18% in 2012 and 29% in 2013 to 40% in 2014. In light of this, the following milestones are recommended: 40% in 2014, 50% in 2015 and 60% in 2016, reaching a target of 65% in 2017; and

- Indicators should be developed to track teenage pregnancy and school drop-out rates. The theory of change aims to reduce the teenage pregnancy rate and to increase the number of girls who transition to senior secondary school. However, the outcome indicators do not include these indicators, even though they are collected routinely. The GES collects routine data on the school drop-out rate while the GHS collects routine data on the adolescent pregnancy.

C: Detailed output scoring (1 page per output)

Output title	*Increased provision, knowledge and awareness of ASRH services in focal region*		
Output number per LF	1	**Output score**	***C***
Risk:	*Medium*	Impact weighting (%):	25%
Risk revised since last AR?	*N*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Milestones for 2014**	**Progress**
1.1 Number of adolescent-friendly service platforms newly created or strengthened, disaggregated by type of service platform (health facility, school, other)	21	12 (senior secondary schools) – Partially achieved
1.2 Number of adolescents receiving ASRH services, disaggregated by sex and service platform (health facility, school, other)	18,000	0 – Not achieved
1.3 Number of a) information and advocacy materials related to ASRH developed and distributed, b) awareness-raising events disseminating messages on ASRH conducted, c) individuals reached with messages about ASRH, disaggregated by type of individual and sex	a) 20,000 b) 25 c) 20,000	a) 23,150 b) 260 c) 35,557 – Exceeded

Key points
This output focuses on changing the sexual and reproductive health behaviour of adolescents, both in-school and out-of-school. It also seeks to address some of the socio-cultural factors which prevent information and skills being acquired by adolescents. **This output scored C because both milestones 1.1 and 1.2 were not achieved but only milestone 1.3 was achieved.**

Services sites
Following a needs assessment, most of the adolescent platforms proposed by the districts require re-designing, renovation or re-equipping. Consequently, the project has contracted a surveyor to visit all the proposed corners to plan the sites and prepare a bill of quantities for the remedial works. The project is also working with the Family Health Division of the GHS to procure the necessary equipment and logistics. Given the investments required to make adolescent platforms functional, scaling up adolescent interventions will be slow unless existing services are re-organised to make them adolescent-friendly. For instance, service providers in CHPS zones suggest that adolescent-friendly services can be provided late in the evening, using existing facilities. This complementary strategy for the provision of corners is now being explored.

Service delivery
An innovation has been introduced whereby school health clubs in 12 secondary schools have been re-organised, as part of the Integrated School Health Programme strategies. Under the supervision of teachers, these clubs will provide information and counselling to their peers and will refer them to the school clinic for ASRH services, if necessary. The ultimate aim of the clubs is to train well-informed students who will be change agents in their schools, homes and communities. The priority in the first phase was to inaugurate and strengthen the clubs in providing information and counselling. In the second phase, expected to be completed in the first quarter of 2015, the school clinics will be equipped and the staff

trained to provide clinical ASRH services. Therefore, the service component at the clinics has not yet started.

Communication and advocacy messages
There are opportunities for improving the quality of communication messages. The project is recruiting a Communications Officer to build the skills of the implementing partners and to guide the design and implementation of the communication and advocacy strategies.

There is a lot of scientific evidence in behaviour change theories that have not been applied in developing the communication component of the programme. Interventions in behaviour change should be linked with an individual's stage in behavioural control. For instance, the Transtheoretical Model describes six stages in behaviour change: pre-contemplation, contemplation, preparation, action, maintenance and termination. Whereas awareness-raising will be effective in the pre-contemplation stage it is not likely to be sufficient in the contemplation stage.

Although the adolescent–parent dialogue meetings are effective fora for mobilising communal action to address the needs of adolescents, unless there is follow-up action they risk becoming 'talking shops'.

Summary of responses to issues raised in previous annual reviews (where relevant)
Actions have been taken to address issues raised in the previous annual review. FGE has established national and regional offices, the district plans have been completed and implementation has started. The project's engagement with the education sector has fostered national-level partnerships for action to strengthen ASRH programmes in secondary schools.

C: Detailed output scoring (1 page per output)

Output title	*Adolescent-friendly SRH services developed and provider capacity developed*		
Output number per LF	2	**Output score**	***A+***
Risk:	*Low*	Impact weighting (%):	35%
Risk revised since last AR?	*N*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Milestones**	**Progress**
2.1 Number of grants awarded by the project to a) public and b) private stakeholders	21	32 – Exceeded
2.2 Number of grantees that met at least 85% of their planned targets	18	20 – Achieved
2.3 Number of individuals a) trained and b) with correct knowledge and positive attitudes to ASRH disaggregated by sex, type of individual (health care provider (HCP), teacher, peer educators, other)	GHS/HCP – a) 50 b) 50%; GHS/Teachers – a) 25 b) 40%; Peer educators – a) 200 b) 40%	Total = 580 (GHS/HCP – a) 187 b) 60%; GHS/Teachers – a)213 b) 55%; Peer educators – a) 99 b) 47%; Others – 81, comprising focal persons, Finance Officers and Staff of National Youth Authority) – Exceeded
2.5 Processes in place, by grantees, to act on findings from the operational research component, to adapt services to respond to relevant evidence	OR studies commence	Research proposal developed; stakeholder consultation done; ethical review committee in place, but implementation of OR studies has not commenced – Partially Achieved

Key points

This output aimed to give grants to 21 local authorities (district assemblies) to coordinate a district-wide, multisectoral ASRH response as well as to strengthen institutional capacity at district, national and regional institutional levels. **The output score was A+ because only milestone 2.5 was partially achieved.**

The current three-arm funding mechanism for grant disbursement remains valid. Other options previously appraised and not found feasible were transfer of funds to the regions and districts through the various sectors or through the NPC. In the current mechanism, disbursements of the grant are made directly from FGE to the national level (GES, GHS and NPC), to the RCC in the region and to all 27 district assemblies in Brong Ahafo Region, using the government system. This funding mechanism is superior to the other options appraised because it is not only consistent with government's public financial management and decentralisation reforms but it is also the most feasible for the coordination of a multisectoral ASRH response. Under the public financial management reform all funds should be consolidated into a common account, the sub-consolidated account. However, there are minor operational challenges that need to be addressed by the project. For example, some newly-transferred District Coordinating Directors and Finance Officers failed to provide the required oversight because they were new to the project.

The Steering Committee expanded the operational districts of the FGE programme from 21 to 27, taking over the six districts previously funded by the UN Population Fund (UNFPA). This decision was taken

because UNFPA's programme covered maternal health broadly, so concerns were raised that ASRH would be less prioritised.

The role of and mechanism for financing NGOs in a multisectoral ASRH programme coordinated by the district assembly is problematic. Next year FGE plans to contract directly with NGOs to implement some community-based activities. Funding NGOs directly would not only fragment the multisectoral arrangement but will also be contrary to public financial management reforms that seek to consolidate all public funds passing through the Ministry of Finance. There is a need to appraise the options for financing NGOs within a decentralised system.

Summary of responses to issues raised in previous annual reviews (where relevant)
No issues were raised in the previous annual review.

C: Detailed output scoring (1 page per output)

Output title	*Better evidence of factors affecting uptake of ASRH and FP*		
Output number per LF	3	**Output score**	***A+***
Risk:	*Medium*	Impact weighting (%):	20%
Risk revised since last AR?	*N*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Milestones**	**Progress**
3.1 Number of OR projects conducted	2	3 – Exceeded
3.2 Processes in place for research findings to inform individual grantees decision-making in real time, to ensure service delivery takes account of latest evidence	OR implementation studies commenced by Nov 2014	Structures and processes in place, including sharing findings at Steering Committee meetings and GES and GHS review meetings, but the study has not commenced – Partially achieved
3.3 Lessons learned across the operational research projects synthesised and used to inform future decision-making about service delivery	OR committee ensures activities and OR aligned and complimentary	OR committee in place and the proposal has been reviewed at two stakeholders' meetings – Achieved

Key points
This output aims to support OR to increase understanding of ASRH behaviour and the selection of effective interventions. Three longitudinal studies have been selected.[6] The OR will identify lessons learnt and good practice, which will inform programme design and provide global evidence for ASRH programming. Led by a research team from FGE, this OR will be conducted in collaboration with local research institutions, in partnership with the Health Research Unit of the MOH. **The output was scored A+ because all the milestones exceeded the targets except 3.2 that was partially achieved.**

The OR implementation process has started, and the studies commenced by 31 December, 2014. The research questions were identified through two stakeholder workshops that were held in in Accra and Sunyani. The workshops also deepened the understanding of the OR agenda, the application of the theory of change model, built consensus on the priority activities and identified potential additional areas for OR. Although the research findings are expected to inform the development of the FGE 2014/2015 workplans, they are unlikely to be completed by 31 March, 2015, the end of the 2014/2015 workplans.

Summary of responses to issues raised in previous annual reviews (where relevant)
The issue raised was the delay in identifying the OR questions, which has since been addressed. FGE has worked with the GHS and the NPC on the research agenda.

[6] 1) exploring the knowledge gap between awareness of FP and use, 2) communications methods for reaching adolescents (types, platform/medium, message content, etc.), and 3) examining the best means of providing services to adolescents – what constitutes good practice.

C: Detailed output scoring (1 page per output)

Output title	*Increased availability of FP commodities*		
Output number per LF	4	**Output score**	***B***
Risk:	*Medium*	Impact weighting (%):	20%
Risk revised since last AR?	*Y*	Impact weighting % revised since last AR?	*N*

Indicator(s)	**Milestones**	**Progress**
4.1 Number of months of stock of implants in CMS (national)	12 months	Total is 16.6 months[7] (7.6 months' stock of Jadelle and 9 months' stock of Implanon) – Exceeded
4.2 Percentage of health facilities in focal region with implants (Brong Ahafo Region)	70%	40% – Not Achieved
4.3 Couple years of protection (CYP) (National)	1,284,066	1,509,591 – Achieved

Key points
This output is increased availability of FP commodities. **The output score was B because milestone 4.2 was not achieved.**

Government's policy: The GOG will face funding challenges once the free FP policy is enacted. Currently, even though the FP commodities are free, clients pay a small service charge. The government intends to change this policy so that FP commodities and services are free under the National Health Insurance Scheme (NHIS) benefit package. This has not been implemented due to delays in revising the NHIS law and concerns regarding the cost of the policy. The NHIS has, since June 2014, already become heavily indebted to providers.

Towards the implementation of the policy, GHS submitted a technical paper to the MOH, including a recommendation to phase implementation, starting with the exemption of clinical methods (implants, intrauterine devices (IUDs) and sterilisation). However, the new Minister has yet to give his views on the subject. In addition, Parliament has commissioned the NPC to coordinate the costing of the new policy, and a draft report has been submitted. Providers interviewed in the field stated that unless public education is intensified and sanctions applied against unauthorised charges, this policy will be ineffective.

There is a potential risk of commodities expiring if uptake in the public sector is reduced because of financial barriers to accessing care. Unless FP commodities are free in the public sector, the private providers that offer free services will crowd out the public sector. The current price differential in FP commodities favours MSI products because they provide free services while the public sector offers them at a subsidised fee.

Advocacy on FP 2020: Ghana needs to strengthen its communication and advocacy on the FP 2020 objectives. There is no common document to inform the public about FP 2020. Rather, Ghana's FP 2020 objectives, strategies and targets are scattered in various documents, such as the National Population Policy and the Millennium Accelerated Framework. In addition, no advocacy materials have been

[7] This indicator refers to the total months stock of implants at the CMS. Since a client receives only one type of implant (Jadelle or Implanon) the total months stock is a sum of the two types of implants.

developed to inform policy-makers about FP 2020. As a result most managers in the health sector are not aware of FP 2020.

Providers of FP commodities: In 2014 DFID maintained its commitment to procure commodities. DFID spent £1,083, 339 on 30,000 units of Jadelle and 1,100,000 units of Depo-Provera. This translates into CYP of 114,000 for Jadelle and 275,000 for Depo-Provera, totalling CYP of 389,000. During the review an effort was made to collect information on the financial contributions from other donors, but not all donors were available. Although GOG did not provide any direct funding for the procurement of FP commodities, it contributed indirectly through tax exemption, staff salary, infrastructure and transport of commodities, though this has not yet been costed.

FP stocks: FP stocks for all methods have improved considerably at the CMS. At the end of November, 2014, stock levels in the CMS ranged from a minimum of 7.6 months' stock of Jadelle to a maximum of 34.7 months' stock of Norigynon. While most districts visited had between two to four months' stock of all FP commodities one had stockouts of Norigynon and the female condom. The country needs to strengthen its forecasting, to avoid over-stocking some commodities, e.g. Norigynon.

Supply chain management: Supply chain management is most problematic at the regional level, because of a lack of transport and the bulky nature of some FP commodities. To address this, the GHS has moved away from a 'pull' to a 'push' system, where FP commodities will be delivered every quarter from the CMS to the regions. GHS is also leveraging trucks provided by the Global Fund to the National Malaria Control Programme to deliver contraceptives as well. This represents a major efficiency gain.

Service delivery: The majority of health facilities in Brong Ahafo Region do not provide implant services. According to GHS policy, only facilities with trained staff are supplied with implants. The GHS introduced the task-shifting policy of training Community Health Nurses (CHNs) to provide implant services in February 2012, so the majority of CHNs have not been trained. Most of the non-government hospitals in Brong Ahafo Region are Catholic, and therefore do not provide modern FP services. Analysis of the data suggests that health centres recorded the highest proportion of health facilities with implants in stock (89%), while CHPS zones and hospitals recorded fewer proportions, with 30% and 48% respectively. Therefore, unless massive investments are made in training, scaling up implant services will be slow. Indeed, if appropriately resourced, the 250-capacity Regional Training Resource Centre can be utilised to scale up the training of health workers in implants and reproductive health in general.

Summary of responses to issues raised in previous annual reviews (where relevant)
Under the NPC's leadership a task-force has been formed to develop a costed implementation plan to harmonise FP programming and resources.

D: Value for money and financial performance (1 page)

Key cost drivers and performance
The business case identified four main cost drivers: (i) TA and programme support, (ii) training cost and ASRH interventions, (iii) coordination and management, and (iv) procurement of FP commodities. These remain valid.

Value for money performance compared to the original value for money proposition in the business case
The business case identified the cost drivers listed above for a value for money assessment.

A. Value for money for FGE programme
FGE has established systems for ensuring that value for money is central to the management of project resources. It completed and submitted to DFID in September 2014 its outline of its value for money approach. The principle is to integrate value for money principles into all aspects of programming and project management. The document describes the indicators and measurement approach for, and the limitations of, the data collection methods. Data collection and analysis of the value for money framework started in October 2014 and is expected to be reported quarterly. However, at the time of the review this report had not been completed so it is too early to make judgements on the value for money. Nevertheless, some specific value for money initiatives have already been undertaken.

The project has contracted preferred suppliers of hotel and car rental services and made cost savings. For instance, in the second quarter of 2014 the project made cost savings of about £3,300 from hotel accommodation for short-term TA in Accra alone. This is projected to result in cost savings of over £30,000 during the project's lifespan.

By contracting with only one grantee at the district level, instead of four, the project has made efficiency gains by reducing the total number of district grantees from 108 to 27. To ensure value for money the procurement of the vehicle was done through local competitive tender, taking into consideration the suitability of the vehicle to the local conditions. The Regional Office was found to be the most competitive, after an evaluation of the costs of two similar properties in town.

One of the main objectives of DFID's development assistance is to address the needs of the vulnerable in society. This need is partly addressed through the allocation of resources between the centre and the local level. Also, a formula for resource allocation was developed to target more funds to populations most at risk of adolescent pregnancy. To ensure that majority of the funds actually address the needs of the population, the project allocated more funds to district and community levels. In addition, a formula was developed to allocate funds to favour districts with a higher teenage pregnancy rate. Even in the start up of the programme, districts with higher adolescent pregnancy rates were selected as part of the first batch of grantees.

B. Value for money for contraceptive commodities
The unit cost of Jadelle implants of £5.93 is close to Bayer HealthCare's current selling price of US$8.50.[8] Following global negotiations on the price of FP commodities, the price of the Jadelle implant marketed by Bayer HealthCare has actually dropped from US$18.

Assessment of whether the programme continues to represent value for money
Yes, the programme continues to represent value for money. First, the investments in contraceptives remain one of the most cost-effective steps towards the achievement of MDG5, and it indirectly impacts on MDG1 (poverty reduction), MDG3 and MDG5 (child mortality). Second, investments in adolescent reproductive health avert unintended pregnancies, school drop-out and maternal deaths, and ultimately improve female empowerment. Third, FGE has introduced stringent systems to reduce fiduciary risks.

[8] Bayer HealthCare has reduced the cost of implants from US$18.0 to US$8.50.

However, the critical success factor will be the project's ability to rapidly scale up the adolescent-friendly services.

Quality of financial management

So far the FGE programme has issued grants to 32 public sector organisations to support the implementation of their workplans. The grantees account for the use of the funds directly to the FGE programme, although the funds are also subject to GOG's internal and external controls. The project has instituted procedures and controls to ensure effective management of project resources. DFID has approved the systems in place and the financial reports that have been submitted so far.

- Funds are released to grantees based on an agreed workplan, deliverables, budget and time-frame;
- Due diligence assessments were carried out on all grantees to assess their capability and capacity to manage project resources;
- Grants and Operations manuals have been produced to guide the project staff and grantees on the project requirements. These documents are comprehensive and cover procurement, travel, assets management, etc.;
- Grant managers have been trained, to build their capacity in grant policies, procedures and internal controls;
- The FGE Grants and Contracts Officer has undertaken financial monitoring of districts to review financial documentation, assess the integrity of internal controls and identify implementation challenges;
- The FGE Grants and Contracts Officer communicates regularly with District Finance Officers to assess progress, discuss emerging issues and agree on immediate action;
- The project has submitted regular financial reports to DFID;
- However, monitoring 28 grants in Brong Ahafo Region was challenging because there was no accountant in the regional office. The project is currently engaging one; and
- From January 2015, the project plans to introduce a cost-effective means to rapidly review all district financial records. Known as the zonal review, this will bring together district assembly accountants from a defined geographic area to review their financial records and reports.

Disbursement of funds has been efficient: it took three weeks from submission of completed plans to receipt of funds by district assemblies. Specifically, it took seven days to approve plans at the headquarters; two days to approve payment; two days to process the transfers; two days for processing the transfers at Western Union; and five days before the money hit the grantee's account at the district.

Date of last narrative financial report	
Date of last audited annual statement	

E: Risk (½ page)

Overall risk rating: Medium
The overall risk for the programme remains **medium**.

Overview of programme risk

Risk	Impact/ Probab.	Change over past year	Additional mitigation strategies
Community opposition from traditional/religious leaders to FP.	Medium/ Medium **Change to Low/ Medium**	Following the stakeholder sensitisation and advocacy, traditional/religious leaders are demanding more active involvement in the programme **so the risk should reduce to low.**	– The mitigation strategy was to strengthen advocacy. Communities are more receptive than predicted. Need to identify champions among traditional and religious leaders to strengthen engagement and actively involve them in addressing cultural barriers.
Lack of government support for the programme, particularly in the light of general elections at the end of 2016	Low/ Medium No change	This risk remains low because the project is aligned with GOG's priorities, consultation has been broad and the anticipated high level inertia did not arise.	**–** The mitigation strategy was to broaden the consultation and align the programme with GOG's priority. This has largely been achieved, but there is a need to improve the frequency of engagement with public institutions; **–** Improve communication on logframe and project deliverables.
DFID's procurement of FP commodities means that government does not take forward this commitment to FP.	Medium/ Medium **Change to High/ Medium**	In 2014 GOG did not procure any FP commodities **so the risk should increase to high**. However, GOG is showing a commitment to improve the supply chain.	**–**Continue ongoing participation in DFID-funded programmes, such as Evidence for Action (E4A) – DFID to begin a discussion on the sustainability of the programme and challenge GOG on its plans post project to absorb costs as donor financing gradually declines.
Increased availability of commodities does not reach intended users or there is inadequate training for service providers.	Low/High No change	The risk was rated low and remains so because contraceptive commodities are more available at service delivery points. Besides, GOG's policy to make FP services free will reduce financial barrier to accessing services.	– Increase advocacy with political leadership to make FP free; – Increase public awareness about FP2020 to generate demand.
OR and other evidence is not taken up in practice.	Medium/ Medium	This was rated medium, and should remain so	The OR is being executed within national guidelines

	No change	because the OR studies have not been completed and there is no evidence that the research results will not be taken up.	and is overseen by a national body. Additional mitigation strategies include sensitising managers and providers in Brong Ahafo Region on the OR, to increase the likelihood of using the results.
New risks identified in this reporting year	**Impact/Prob.**	**Consequences**	**Risk mitigation**
Potential unwillingness of the private sector to market contraceptives if the free FP policy becomes operational.	Medium/ Medium	- Uptake of non-clinical methods, such as emergency contraceptive pills, oral contraceptives and the condom will reduce – Increased risk of sexually transmitted infections and unwanted pregnancies.	– GOG should actively engage the private sector on implementation of the free FP policy. DFID should engage with their partners and their co-donors at the policy level.
Deterioration of the country's macro-economic situation which increases the risk of transaction sex among adolescents from poor households.	High/ Medium	– Increased transaction sex – Higher school drop-out because of financial barrier – GOG cannot fund the free FP policy	- Intensify advocacy at top government level
Herbalists spreading misinformation about FP.	Medium/ High	– Fear of negative effects discourages use of FP methods – Increase in unwanted pregnancies, abortions and maternal deaths	– Districts assemblies should regulate use of community information centres for disseminating false information – FGE programme supports dissemination of correct information about FP in communication strategies.

Outstanding actions from risk assessment
Included in table above.

F: Commercial considerations (½ page)

Delivery against planned time-frame

FGE commenced the contract later than expected because of delays in the original tendering process. The inception phase ended in June 2014, so implementation has only taken place for six months. This was compounded by the resignation of the Regional Coordinator of the project in Brong Ahafo Region in June 2014. Also, some activities at the district level had to be preceded by capacity-building initiatives at the national and regional levels, e.g., training of trainers and the development of manuals. Consequently, the project has underspent the grant budget, but it is expected to achieve and possibly exceed all the milestones by the end of the 2014 workplan year in March 2015. The project plans to engage three more staff in the regional office, which will strengthen its capacity to monitor and provide TA to the grantees.

Performance of partnership (s)

Feedback on FGE: Generally, beneficiaries interviewed at the national, regional and district levels described the working relationship with the FGE as very good, though many were unhappy that they did not receive any information about the revised logframe. At the district level, beneficiaries welcomed the TA, mentoring and supervisory visits made by the monitoring and evaluation (M&E) and Grant/Contracts Officers, but some complained about a lack of clarity in the lines of communication. Following the resignation of the former Regional Coordinator, headquarters and regional staff were communicating directly with the districts, so sometimes messages were conflicting. However, the situation is expected to improve following the recruitment of the new Regional Coordinator. A few managers in the region were unhappy that FGE does not consult them. This engagement is necessary to enhance the project's visibility and receive direct feedback and inputs into programming.

Asset monitoring and control

In accordance with DFID regulations, the project maintains strict procedures for the management of assets. The Team Leader and the Grants and Contracts Officer bear principal responsibility for the management of all project assets. Asset management is incorporated into the project's operational manual. It defines an asset as any item which has a normal life expectancy of at least one year and cost over US$100 per individual item. The manual describes how to register, dispose of and safeguard assets, as well as discussing the protection of intellectual property. All assets are branded, coded for easy identification and regular spot checks are conducted. The grantees update and submit their asset registers to FGE quarterly.

DFID will conduct its first annual asset verification on FGE and its grantees assets procured under the Ghana adolescent reproductive health project in February 2015. This will include a desk review and on the spot check in the field.

G: Conditionality (½ page)

Update on partnership principles (if relevant)

The last general assessment of DFID's partnership principles, in June 2014, deemed that the GOG had satisfied all four partnership principles over the 2013/14 period.

The ASRH programme does not involve transfers of financial aid to the GOG. Therefore, the partnership principles have a less direct relevance to the programme compared to other DFID Ghana interventions. Nevertheless, there is a relationship between the programme and three of the four principles, as detailed below.

Poverty reduction: Ghana has shown a commitment to poverty reduction and has delivered progress against the MDGs. Without increased effort, however, MDG 5 (maternal and reproductive health) will not be achieved. Ghana's pledges on FP 2020 demonstrate its commitment to meeting this target. This programme will help address this by improving the knowledge and behaviour around the reproductive health of adolescents, as well as through the provision of FP commodities.

Human rights: Ghana has a good track record on upholding human rights. The ASRH does not contribute to political rights but does contribute to reproductive rights. All FP provision should be voluntary and all clients should make informed choices.

Domestic accountability: Ghana's record on strengthening domestic accountability is strong. The programme does contribute to accountability – particularly in relation to service quality and to generating a greater awareness of the services young people can, and should, expect from government.

H: M&E (½ page)

Evidence and evaluation

There is currently no new evidence that will have implications for the project. However the ongoing OR may bring about new evidence that might reshape the programme. The original plan was to contract another organisation to conduct an independent evaluation of the programme, in parallel to the implementation being carried out by FGE. This included conducting a baseline during the inception period, followed by a mid-term evaluation in two years and a final impact evaluation at the end of the project. However, the contract for the independent evaluation did not go ahead because of delays in the contracting process and reduction of the implementation period from four to three years. In place of the independent evaluation the project received an exemption to engage FGE to carry out OR alongside the implementation of the main programme. The Kintampo Health Research Centre is currently supporting FGE to conduct the OR in the Brong Ahafo Region.

Preliminary results of the 2014 Demographic and Health Survey are expected to be published in February 2015; and plans are far advanced for the 2015 Multicluster Indicator Survey (MICS) that may provide data for the evaluation of the project.

Routine data is available to track annual progress at the outcome level. The objectives of the programme were to reduce the adolescent pregnancy rate and ultimately reduce the school drop-out rate for girls. Although the GHS routinely collects data on adolescent pregnancy and the GES collects data on school drop-out rate, indicators have not been developed to track these.

Monitoring progress throughout the review period

This review was carried out by Dr Kobina Atta Bainson, an independent consultant. No economist was included in the team. Although the review period was from 2 to 15 January 2015, preliminary data had to be collected in December 2014, to improve the response rate. Secondary data analysis was used to: assess progress towards achieving the milestones for outputs and outcomes; determine whether the programme is achieving value for money; review the project's contribution towards achieving FP 2020 and assess risk mitigation strategies. Primary data collection through in-depth interviews with stakeholders at the national, regional and district levels were used to assess the relationships between the DFID contractor and the GOG implementing ministries, departments and agencies; assess the effectiveness of project governance structures; identify implementation challenges; and also assess the extent to which risk is being monitored.

The first batch of nine district grantees were selected for the field work because they had the longest period of implementation. Originally four districts were purposively selected, but this had to be increased to six in order to obtain an adequate sample size from which to draw conclusions. The districts visited were: Tano South, Dormaa East, Jaman South, Sunyani West, Nkoranza North and Nkoranza South. The consultant took the opportunity to participate in the quarterly review of the project in order to listen to the discussions regarding the implementation challenges.