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Working Paper No. 2

Implementation of MDG Acceleration Framework (MAF) as a Strategy to Overcome Inequalities in Access to Maternal Health Services in Ghana

By Pa Lamin Beyai, Patrick Kuma Aboagye, Nana Adutum, Mariam Salifu and Kordzo Sedegah

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Abstract

As the deadline of December 2015 for the achievement of the Millennium Development Goals (MDGs) approaches, Ghana's progress is mixed. While MDGs 1 and 2 are on course to be achieved, 3 and 7 are likely to be partially achieved, 6 has the potential to be achieved, and goals 4, 5 and the sanitation aspect of 7 are lagging. In order to at least bring these MDGs to the level of other MDGs, the Government of Ghana has to introduce innovative ways of dealing with them through the MDG Acceleration Framework (MAF). MAF was introduced to the Ghana Health Service (GHS) by the UN Country Team spearheaded by UNDP in 2010. MDG 5 was chosen over other lagging MDGs is because of its likely spinoffs effects on MDGs 5 and 7 as well as on other MDGs. Furthermore, it was believed that reduction of maternal mortality through the MDG Acceleration Framework would help improve health indicators in the regions lagging behind. Specifically, evidence has shown that the three northern regions are lagging behind the others in respect to reducing maternal mortality. They also suffer the most in terms of access to quality health care for pregnant women and deliveries assisted by skilled health care workers. For all these indicators, there are disparities between the northern and southern regions and also across urban and rural areas. Some problems associated with this include lack of knowledge by pregnant women, financial and transportation difficulties, long distances to health facilities, and long waiting periods at health facilities. The paper shares Ghana's experience in the development of MDG Acceleration Framework (MAF) for MDG 5. It identifies gaps in Ghana's existing policies; programmes in maternal health interventions, which inhibit the attainment of MDG 5; maps the various steps leading to the development of MAF for MDG 5; identifies, priorities, and states the bottlenecks, and their solutions to the attainment of MDG 5; outlines the successes and challenges of the MAF process from development to implementation; and makes recommendations for other countries intending to develop MAF. It will serve as a one-stop reference material for other countries intending to develop MAF.

Keywords:

MAF, Maternal mortality, Indicators, Quality healthcare, Healthcare facilities, Knowledge, Pregnant women, Disparities, Distance, Transportation.

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1. Statement of the Problem

Ghana's progress towards achieving the MDGs is mixed. While MDGs 1 and 2 are on course to be attained by 2015, progress on other goals is not so promising. MDG 6 is potentially achievable, and goals 3 and 7 are likely to be partially achieved. The lagging MDGs are MDG 4 on reducing child mortality, MDG 5 on maternal health, and part of MDG 7 on access to basic sanitation. Even for those MDGs where progress at the national level has been satisfactory, disparities by geographic location and socio-economic groups do exist, with the three northern regions tending to lag behind the rest of the country on a host of indicators. This has affected institutional maternal mortality ratios (MMRs) across the 10 regions in Ghana from 1992 to 2008. The maternal mortality ratio has decreased by up to 195.2 per 100,000 in the central and upper east regions; 141 per 100,000 in the northern and western regions; 120.1 per 100,000 in Volta and the eastern regions; and 59.7 per 100,000 in the upper west, Brong Ahafo and Ashanti regions. Surprisingly, in this case, the only region where maternal mortality rate has worsened is Greater Accra (by 87.6 per 100,000).

Antenatal care from health professionals (i.e., nurses, doctors, midwives or community health officers) increased from 82 percent in 1988 to 96.7 percent in 2008 (MICS 2011). However, the progress is uneven. While women in urban areas have better access to antenatal care from health professionals than their rural counterparts, the regional figures present a different scenario. The proportion of mothers in urban areas who receive antenatal care from health care professionals was 98 percent as against 94 percent for their rural counterparts. The range across all the regions is from 96 percent to 98 percent, except the Volta and central regions, where the antenatal care access rates were estimated to be 91 percent and 92 percent, respectively. In addition to challenges involving access, quality issues also exist especially in the rural areas. Lack of information on signs about pregnancy complications and access to basic laboratory services, particularly in the northern and upper west regions, affect the quality of antenatal care. In the northern and upper west regions, only six in 10 pregnant women have access to urine testing and two in three have access to blood testing. These are against the national average of 90 percent.

Deliveries assisted by a health professional recorded a slow progress, increasing from 40 percent in 1988 to 68.4 percent in 2011. In the northern region, nearly one in three compared to four in five children in Greater Accra region is likely to be delivered in a health facility. The availability of professional assistance at birth for women in urban areas was found to be twice as common as in rural areas (MOH, 2008). The available data showed that, in 2008, over 40 percent of women did not deliver in a health facility for different reasons. Some of them thought it was unnecessary, while others cited a lack of money, the long distance to a health facility, transportation challenges, a lack of knowledge as to where to go, and the unavailability of an escort (someone to accompany them). Others had issues with the services rendered at the health facility, including long waiting, the unavailability of a female doctor and inconvenient service hours.

The incidence of poorer nutrition indicators directly related to maternal and new-born health (such as anaemia) is higher in rural than in urban areas, and the risk of death was high for pregnancies occurring below the age of 15 and over 40 years (Tracking Progress Towards MDGs in Ghana, 2012).

In line with the MDGs, the maternal health target for Ghana is 185 maternal deaths per 100,000 live births in 2015, compared to 740 per 100,000 in 1990. Since 2000, numerous initiatives have been introduced to strengthen interventions that directly address the causes of maternal mortality, such as extending emergency obstetric care, improving the early detection of complications, and enhancing the coverage of family planning services. The Ghana Maternal Health Survey (2007) found that 14 percent of deaths of women of reproductive age are due to maternal causes and identified hemorrhage (24 percent) as the largest single cause of maternal deaths; abortion was the second single largest cause of death, accounting for 15 percent. Hypertensive disorders, sepsis, and obstructed labour were also cited as causes.

Since 1990, maternal mortality dropped accordingly to about 451 per 100,000 live births (GMMS 2007). The most current maternal mortality ratio is 350 per 100,000 live births (WHO/UNFPA/WB 2008), representing a 42 percent reduction in maternal mortality from the 1990s. By this trend, the rate of decline is so slow that it is unlikely that Ghana will attain the national MDG target by 2015 without acceleration. To overcome these challenges, a new strategy is being put in place to accelerate progress towards MDGs by 2015.

2. Objectives

The general objective of this paper is to share Ghana's experience in the development of MDG Acceleration Framework (MAF) for MDG 5 that will serve as a one-stop reference material for other countries intending to develop MAF. The specific objectives are to:

1. identify gaps in Ghana's existing policies and programmes in maternal health interventions that inhibit the attainment of MDG 5
2. map the various steps leading to the development of MAF for MDG 5
3. identify, prioritize, and state the bottlenecks and their solutions to the attainment of MDG 5
4. outline the successes and challenges of the MAF process from development to implementation
5. make recommendations for other countries intending develop MAF

3. Methodology

The methodology includes a desk review of literature on barriers to access to maternal health care. For this, documents related to the subject have been reviewed. In addition to the main literature on maternal health and inequality, the paper also reviews the policy measures for improving health care services in general and maternal care in particular, as enshrined in national medium-term development policy frameworks such as the Ghana Poverty Reduction Strategy (GPRS I), Growth and Poverty Reduction Strategy (GPRS II), the Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013, MDG reports, the MAF action plan on maternal health, and specific health sector policies and strategies.

Also reviewed were particular interventions put in place to address the high levels of maternal deaths such as the Safe-Motherhood Initiative, the Family Planning programme, the Prevention of Maternal Mortality Programme (PMMP), the Making Pregnancy Safer Initiative, the Prevention and Management of Safe Abortion Programme, the Intermittent Preventive Treatment (IPT), the Maternal and Neonatal Health Programme, the R3M programme, the Roll Back Malaria Programme, and, more currently, the Partnership for High-Impact Rapid Delivery Approach to achieving MDGs 4 & 5 programme (HIRDA).

Additional policies, strategies and interventions reviewed include: reproductive health strategy; Road Map for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Ghana; Standards and Protocols for Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services; Medical Eligibility Criteria (MEC) for Contraceptive Use; Road Map for Re-positioning Family Planning; Declaring maternal mortality a national emergency in 2008; a programme of free health care for pregnant women, including deliveries and complications through the national health insurance scheme; Strengthening of Community Health Planning Services (CHPS) to facilitate the provision of maternal health services; and expansion of community-based health service delivery.

Reviewed at the district level were the range of approaches that were used to increase supervised delivery, including targeting pregnant women for NHIS registration, raising community awareness through CHPS zones, outreach education for community health officers and mobilization of community leaders, among others; institutionalization of maternal death notification; decline in guinea worm cases; improved TB treatment; the establishment of steps aimed at revising the guidelines for the conduct of maternal death audits; and the establishment of a system of confidential enquiry into maternal death.

4. Rationale

Many countries in sub-Saharan African are at risk of not meeting most of the MDGs and there is a call for acceleration of efforts as the deadline of 2015 approaches. But this acceleration must be done cautiously; otherwise it will affect only the target MDGs without spill-over effects on others. Therefore, the choice of the particular MDG for acceleration and its interlinkages with other MDGs is important for the judicious use of the limited resources to support the acceleration process. As already indicated, Ghana has numerous initiatives to address maternal mortality, albeit with limited success, leading to the current state of maternal mortality in the country. At the time of developing MAF for MDG 5, over 40 different strategies, policies and programme documents on maternal health were reviewed and condensed into three key areas of intervention. This requires the cooperation and concerted efforts of all the stakeholders from government to the beneficiaries.

Ghana's choice of MDG 5 was mainly an entry point for maternal health as well as an attempt to address the perennial problem of MDG 4. Since the risk of child mortality is higher for those whose mothers die than for those with living mothers, it is not only an end in itself, but also a means toward attaining other MDGs. Therefore, a paper like this that systematically presents the development and implementation of MAF is overdue.

Organization of the Paper

The paper is organized into several sections. Section one states the research problem; this is followed by the objectives, rational and methodology in sections two to four. A review of the literature on inequalities as barriers to access to maternal health care in general, with specific focus on Ghana, is the subject of section 5. The findings are then reported and the end of the paper, with recommendations for those who may want to develop MAF in their countries.

5. Literature Review

Maternal death is a very serious development challenge in Africa. About 99 percent of maternal deaths occur in the developing world. A total of 11 countries account for about 65 percent of maternal deaths worldwide and Africa alone accounts for 57.4 percent (Ayodele Odusola, 2013). Rather than looking at it from the perspective of health alone, the MMR is also an indicator of the strength of the health system in terms of access, cost and the health infrastructure available to avert maternal death. Maternal mortality is also an important indicator for gauging social and economic conditions of women and girls (Ayodele Odusola, 2013).

Among the factors that affect maternal deaths are too few health services and poorly skilled providers, poor infrastructure, lack of transport, and low empowerment of women. As such, some of the main causes of preventable maternal mortality in Africa, including haemorrhage, sepsis, hypertensive disorders, unsafe abortion and prolonged or obstructed labour, are common. A simple intervention such as the provision of skilled health personnel to handle emergencies and post-partum care could reduce unnecessary maternal health (UN, 2011) and thereby reduce the health risks to mothers and babies. Therefore, efforts focused on providing antenatal care, ensuring skilled health attendance at birth, improving access to basic and comprehensive emergency obstetric and newborn care, and providing basic postnatal and newborn care are necessary to improve maternal health (MDG Report, 2012). The provision of maternal and reproductive health services within the framework of primary health care is fundamental to making such services available to all (MDG Report, 2012). Between 1990 and 2010, the world experienced a 47 percent reduction in MMR, which translates to a reduction from 543,000 to 287,000 during the period (WHO et al., 2012).

Several African countries have made progress in reducing maternal deaths between 2000, when the MDGs came into effect, and 2010. Women living in sub-Saharan Africa have a higher risk of dying in pregnancy-related situations than women in any other region of the world. For women 15 to 19 years old, the leading cause of death is childbirth. Out of the 46 countries in Africa, 29

have achieved more than a 40 percent decline in maternal deaths. The highest performer is Equatorial Guinea, with more than an 80 percent reduction, while Eritrea and Egypt are very close to 75 percent. The MMR (the number of women dying due to pregnancy complications and childbirth-related issues) has fallen from 850 deaths per 100,000 live births in 1990 to 500 deaths per 100,000 live births in 2010, representing a 41 percent decline. Regardless of this progress in general, some challenges still remain, especially at the disaggregate level.

While sub-Saharan Africa accounted for 56 percent of the global burden of deaths in 2010, countries such as Botswana, Cameroon, Chad, Congo, Lesotho, Somalia, South Africa, Swaziland and Zimbabwe actually retrogressed within the same time period. In some countries, such as Chad, Niger, Sierra Leone, Liberia, and Guinea Bissau, one in at least 25 pregnant women is at risk of maternal death. The same ratio in Estonia, Greece, and Singapore is one in 25,000 pregnant women (WHO et al, 2012).

These deaths are unnecessary since ample evidence shows that maternal death in Africa is preventable and the 2015 target is achievable with appropriate and innovative interventions that facilitate continuous access of the poor to quality and affordable maternal health services (Ayodele Odusola, unpublished 2013). Many countries in Africa have increased the availability of maternal health care, but most women still have no full access to such care. Inequality also plays a role.

Inequalities within countries, especially between the urban and rural settings as well as between socio-economic groups, beset access to skilled birth attendants and other reproductive health services. In sub-Saharan Africa, women in urban areas are almost twice as likely as those in rural areas to deliver with a skilled health personnel. Niger, CAR and Djibouti have the largest urban–rural divide. In Niger, 71 percent of women in urban areas deliver with a skilled health attendant against 8 percent in rural areas. The difference between urban and rural access in Tunisia, Botswana and South Africa is less than 10 percent (MDG Report, 2012).

Income inequalities are bigger than the urban–rural gaps in accessing skilled health care in Africa. About 80 percent of those in the high-income quintile deliver with the assistance of skilled health personnel against the proportion of only 24 percent for the lowest income earners. Women in the richest quintile are more than three times more likely to give birth with the assistance of a skilled health attendant than the poorest women. Western and Central Africa have the largest sub-regional inequality in terms of income. The gap is 86 percent against 8 percent between the extreme income groups. Cameroon, Mauritania, Sudan (North and South), Eritrea and Ghana have more than a 70 percent point difference between the two quintiles (MDG Report, 2012). Burkina Faso has a relatively equal proportion of women across all wealth (65 percent in the highest and 56 percent in the lowest). Similar patterns exist in Algeria and São Tomé and Príncipe (MDG Report, 2012).

One of the main barriers to access to maternal health services in Africa is cost. Although some countries such as Ghana have tried to reduce or eliminate user fees for maternal health services, professional health care still remains too expensive for many women in Africa. Surveys of West African women found that more than half listed cost as the reason for not seeking health care (Africa Progress Panel Policy Brief, 2010). The proportion of those who could not access health care for cost reasons in Burkina Faso, Cameroon, Guinea and Niger is as high as 60 percent.

These costs include user fees, services and cost of drugs, among others. Transport to and from health facilities and the opportunity cost of time can be exorbitant enough to deter women from seeking care at health facilities. In addition to access cost, expensive treatment costs, especially for obstetric complications for pregnant women, are additional barriers, which make women twice as vulnerable. Another barrier to access in some countries that introduce community-wide health care plans is the registration cost. For instance, Ghana's National Health Insurance Scheme (NHIS) covers more than half of the population in the first four years of operation, but coverage is much lower among the country's poorer people partly because of the registration fees (Africa Progress Panel Policy Brief, 2010). In the light of that, the Government has recently waived fees for all maternal health services.

Women in parts of Africa are often unable to access quality maternal health care at the time of need, partly due to the shortage of skilled health care providers. On average, only 13.8 nursing and midwifery personnel exist per 10,000 people, and the ratio is far less than one per 100,000 people in the poorest countries. In Malawi, only 13 percent of health facilities had 24-hour midwife care (Africa Progress Panel Policy Brief, 2010). In addition to the shortage are disparities in geographic distribution of health workers at

the disadvantage of rural areas, where few health care workers want to work. For instance, in South Africa, even though the rural areas account for about 46 percent of the population, only 12 percent of doctors and 19 percent of nurses work in the rural areas (Africa Progress Panel Policy Brief, 2010).

Poor road infrastructure and the lack of transportation are barriers to effective maternal health care. Long distances from health facilities make the few rural health facilities inaccessible to many rural poor. In Zimbabwe, transportation problems were cited in 28 percent of maternal deaths in rural areas, compared with only 3 percent in Harare (Overseas Development Institute (ODI)). Even in countries such as Tunisia, where government has scaled up maternal care and in the process has reduced maternal mortality, less progress was made in the rural areas. A study in Ghana shows that the use of public health facilities nearly doubled when distances to clinics or hospitals were halved (Africa Progress Panel Policy Brief, 2010).

Gender inequality also has a role in access to maternal health care and thus an indirect effect on maternal mortality. In many parts of Africa, women must seek permission from their husbands or family to seek health care. Even where permission is granted, other barriers could play a role because most women would have to rely on their husbands for user fees and transport fares. As a result, women may find it difficult to get the money to pay for services or to obtain transport to get to health facility. In sub-Saharan Africa, 73 percent of women receive at least one antenatal care visit, but only 44 percent receive the required number of at least four visits. Illiteracy among women prevents them from making informed decisions on when to seek care.

As shown, the barriers to access to maternal health care in Africa range from cost to the social position of women in society. These, together with other barriers, affect the use of health services by many women in Africa. To overcome these, innovative approaches should be explored to better access to maternal health care for the achievement of MDGs by 2015 (Africa Progress Panel Policy Brief, 2010).

6. MAF Development Process

The development of the MAF in Ghana was led and owned by the Ministry of Health, which provided strategic guidance and direction for the analytical work, and the Ghana Health Service providing technical leadership. They were supported financially and technically by the United Nations Country Team. One significant feature of the MAF is that it is neither new nor a stand-alone intervention. Other key national institutions such as the National Development Planning Commission, the Ministry of Finance and Economic Planning and key civil society organizations also took part at a later stage. An inception meeting was organized at the beginning of the analytical work to provide orientation and sensitization to stakeholders and to chart a path for the processes.

The process for developing the MAF was participatory and interactive through a Ministerial Technical Team with technical support from the UNCT, i.e., UNFPA, WHO and UNICEF with UNDP as convener and facilitator. An inter-agency team was established to provide technical support to the national team. The UNDP MDG Team at HQ and the Regional Service Centre (RSC) in Dakar also provided technical backstopping to the country process. The key stakeholders/partners who took part in the MAF roll-out included: the Ministry of Health; the Ghana Statistical Office; the National Development Planning Commission; medical and dental associations; the private sector; civil society/NGOs engaged in health-related issues; metropolitan, municipal, district assemblies in selected districts; and UN agencies (UNICEF, UNFPA, WHO, UNDP)

A broad-based approach was adopted to ensure that all relevant institutions/organizations, including metropolitan, municipal and district assemblies (MMDAs), civil society organizations, UN agencies and development partners, participated in the MAF roll-out.

The technical team was further supported by two local consultants. The work of the consultants included reviewing the existing documentation and interviewing key stakeholders (CSOs/NGOs, the private sector, development partners), etc. They also conducted field interviews and visited health facilities and communities in selected rural and urban areas to gather additional information to complement the secondary data. The analysis provided the overview of the bottlenecks to the effective implementation of

the existing interventions and identified interventions that can be scaled up to accelerate progress on MDG 5. It also organized stakeholders meetings and assigned roles and responsibilities for the interventions/solutions to accelerate progress towards MDG 5.

The Ghana MAF analysed the bottlenecks that hamper the desired progress on MDG 5 and developed cost-effective innovative solutions. The priority areas were derived using a set of criteria: (i) impact, (ii) sustainability, (iii) speed, (iv) coverage, and (v) capacity availability to review and streamline the existing policies and interventions with great impact on maternal health. The identified bottlenecks, acceleration solutions, potential partners, estimated resource requirements, available resources and the resource gap were analysed.

The Ghana MAF Action Plan was drawn from existing nationally owned policies, strategies and frameworks and constitutes prioritized actions, urgently needed to accelerate progress towards attainment of MDG 5. A workshop was organized to validate the draft report.

As the coordinator of the overall process, the responsibility of UNDP included leading the initial consultations to get UN Country Team buy-in and jointly select key lead agencies among the UN system for the country process; contributing to the inter-agency technical support team and participating in the consultation with government officials and other relevant stakeholders; making payments for logistical support and contractual issues; facilitating the link between the Ghana team and HQ/RSC teams and national technical committee; and ensuring that they received the necessary knowledge and technical support for the work. In close collaboration with the sector ministry, UN agencies with technical support from HQ/RSC prepared terms of reference for consultants and supported the recruitment process.

The three key interventions that emerged from the process are family planning, skilled delivery, and emergency obstetric and neonatal care. The details are in the Ghana MAF for MDG 5. The subsequent steps involved at the end of the analytical work were stakeholder validation of the MAF Country Action Plan. After final consultations with senior government officials, the MAF plan was approved for implementation.

7. MAF Implementation

The MAF on MDG 5, if properly implemented, is likely to directly improve the indicators related to MDG 5 and to indirectly improve those of other MDGs. Although the strategy is to cover the entire country, emphasis is on those areas with lower access to antennal care and maternal health care provided by professional health care providers. The implementation of the MAF is seen to be the business of all sectors — hence the inclusion of roles by sectors such as those responsible for transport infrastructure. The provision of ambulances, communication facilities such as mobile phones to care providers, agreement with transport unions as well as the building of road networks especially in the remote parts of the country will reduce that gap. The scaling up of the training of health care professionals and their postings to deprived areas will bring quality health maternal care to the reach of the poor and marginalized. By increasing the indicators in deprived locations while maintaining the performance in urban areas, the average MDG indicators for maternal health and other MDGs will increase and Ghana may be en route to attaining MDGs by the year 2015.

From the literature review, it can be concluded that women in Africa are more likely to die due to pregnancy-related issues than women in the Western world. The reason is that, in some parts of Africa, about one in 25 pregnant women risks maternal death while about one in 25,000 pregnant women in parts of Europe suffers from this risk. Also, inequality in access to maternal health care is wide across income levels. Eritrea, for example, has succeeded in reducing maternal mortality by close to 75 percent. Despite this significant progress, there is about a 70 percent difference in access to quality health care services between women in the richer quintile and those in the poorer quintile, with the richer women having more access. In some countries like Ghana, efforts have been made to remove some of the barriers to access of health care. The country's National Health Insurance Scheme covers more than half of the population, but does not extend to the country's poorer people partially due to the registration fees. To allow more of the poorer women to join the NHIS, the registration fees were waived for maternal health services. Due to the generally low standard of

living, lack of infrastructure and social amenities like potable water, electricity, varieties of food, etc., health care personnel are less willing to work in rural areas. For example, only 12 percent of doctors and 19 percent of nurses work in South Africa, although people in rural areas account for 46 percent of the population. The poor road infrastructure and transportation issues in these areas are also a concern. In Zimbabwe, problems with transportation were involved in 28 percent of maternal deaths in rural areas as compared to 3 percent in Harare. When distances to clinics and hospitals are reduced, the use of these public facilities increases, as seen in the case of Ghana.

The Ministry of Health, the Ghana Health Service and the UNCT are committed to the MAF implementation, which is in two parts: pursuing advocacy and sensitization to mobilize additional partners and new resources to finance the identified gap; and implementation of existing programmes for which funding is secured. The first part of implementation has ranged from stakeholders' meetings (including development partners, parliamentary select committee on health) and sector meetings. Every opportunity has been used to advocate for MAF. These activities have brought the EU on board as a new partner to the health sector and specifically to maternal health. It has attracted additional funding from The Netherlands and intensified commitment from existing partners like DANIDA, USAID, Japan/JICA, UNICEF, UNFPA, WHO, DFID and some NGOs.

With the second part of implementation, funding has mainly come from existing partners either through the sector budget support (SBS) or programme/project support. For example, through SBS, DANIDA support for the High-Impact Rapid Delivery (HIRD) has been channelled to MAF implementation. US$3.5 million of the total 2011 budget of US$5.758 million has so far been released. Additionally, the government has made some policy changes to improve SD access and coverage. They include: (i) the midwifery training policy, which has been reviewed and has reintroduced the two-year post basic and auxiliary midwifery certificate course, which had been abolished some six years ago; and (ii) the Traditional Birth Attendants (TBA), who are currently being supported as agents to encourage and bring pregnant women in deprived communities due for delivery to use health facilities. Additionally, the health facilities in rural areas, in particular, respond to the needs of clients by allowing pregnant women to adopt delivery positions of choice, such as squatting (a dominant position used in home/TBA deliveries), to make maternal health services more culturally sensitive and to increase the proportion of deliveries attended by skilled providers. An incentive system has been introduced to inspire the nurses to improve customer care, to encourage TBAs to bring more rural women to use the facilities, and to motivate clients to seek skilled delivery care.

In collaboration with USAID, smart/mobile phones have been procured and are being used in capturing family planning (FP) logistics data in two districts to prevent stock out of FP commodities. This project, called "Early Warning System", is expected to be scaled up after the initial pilot phase. There is also on-going district training on DHIMS 2 in all 170 districts. The advocacy for procurement of FP commodities has been strengthened. DFID's first consignment of FP commodities was received in the third quarter in addition to the commodities supplied by USAID, UNFPA and other partners. The current meetings being held with the MLGRD have included advocacy for District Assemblies' contribution to funding maternal health interventions. Engagement with the National Health Insurance Authority (NHIA) to advocate for the inclusion of FP on the health insurance package either for reimbursement and/or declaring FP a free service is also on-going. There is a contraceptive security plan under preparation and FP advocacy will be launched by the end of the year to mobilize partners towards improving demand and access for FP commodities. There is the establishment and institutionalization of a national family planning week to educate people on the advantages of family planning together with a review conducted by the Ghana Health Service in collaboration with engender health for a policy change that will allow community health nurses to provide contraceptive implant services. Between January and August 2011, USAID supplied commodities worth US$2,723,331, while an additional supply worth US$3,344,160.54 has been ordered.

There has been an EmONC assessment to determine the grading system and also an upgrade in the health institutions in all regions covering 1,271 health facilities from public, private and quasi-government institutions. Seven midwifery training institutions have started student training in the 2011/2012 academic year and an additional school was completed at the end of 2011. Of these seven schools, three are newly established midwifery institutions in Nandom, Goaso and Pramso in the upper west, Brong Ahafo and Ashanti regions, respectively. The remaining four are existing schools (in Bolgatanga, Jirapa, Asante Mampong and Atibie) that have been expanded to provide post-basic midwifery certificate courses. There is also a discussion within the health sector about the

enhancement of the curriculum of the midwifery to embrace 'task shifting' to train midwives to do some obstetric surgery, including Caesarean section. This will enhance the human resource base for the provision of essential and comprehensive obstetric care. Some community health nurses will have their skills upgraded to include comprehensive midwifery services as well as the insertion of contraceptive implants as part of the task shifting.

Work to improve the referral system and reduce delays in delivery is being pursued. The fleet of ambulances was also increased from 24 to 400 vehicles in December 2012. In addition, the use of cell phone technology is being promoted to improve access to the ambulances. Health bills, including the blood transfusion services, have been lodged with parliament. GHS, jointly with MOH, have organized several meetings with the Parliamentary Select Committee on Health to facilitate the process of passing the bill.

The EmONC interventions have short- to medium-term impact as the improved referral system, reliable ambulance system and blood transfusion services are in place.

8. Resource Mobilization

Partnership and resource mobilization are important elements for MAF implementation. The resource availability of US$86.4 million out of the total MAF budget of US$157.3 million leaves a financing gap of almost 45 percent (i.e., US$70.8 million). This has been taken seriously and, since January 2011, the government, with strong support from the UNCT, has used the MAF extensively to mobilize new partners and strengthened existing relationships. For example, the MAF was presented to the EU MDG meeting in March 2011, which led to the mobilization of an EU MDG grant of about €52 million in June 2011 for three-years. Another application for a US$23 million mixed loan/grant (63.63 percent loan; 36.37 percent grant) for a three-year implementation period submitted to The Netherlands through the ORIO initiative — Boosting Reproductive and Child Health in Ghana — has received approval. At the private-sector level, Access Bank Ghana has expressed interest in donating US$100,000 to the Ghana Health Service for MAF implementation. Expected new/potential funds are estimated at US$64.2 million. If all these funds become available, Ghana will have reduced the gap from US$70.8 million to only US$6.6 miilion (Table 1).

Table 1: Summary of New Funding for MAF Implementation

Source of Funds/ New contributions	*Expected Amount (USD)*	*Remarks*
European Union	41.1 million	€30 million @ exchange rate of €1 to US$1.37 (as at 15 September 2011)[a]
The Netherlands	23 million	€14.6 million €16.8 million @ exchange rate of €1 to US$1.37 (as at 15 September 2011) loan; €8.4 million grant
Access Bank, Ghana	0.1 million	€73,000 @ exchange rate of €1 to US$1.37 (as at 15 September 2011)
Total Funds	**64.2 million**	**€46.9 million @ exchange rate of €1 to US$1.37 (as at 15 September 2011)**

Note: *a. source: fx-rate.net/Eur/USD*

Resource Mobilization

Apart from the above potential, new funds are being sought. The existing partners are financing the MAF implementation either through the health sector budget support (within the Multi-Donor Budget Support-MDBS modality) and/or direct programme/ project support with geographical and thematic focus. The partners, mainly bilaterals and UNCT, include DANIDA, DFID, The Netherlands, USAID, JICA, UNFPA, UNICEF, WHO, and UNDP. Examples of the project-focused support are:

- USAID supports family planning commodities, strengthening staff capacity to improve performance in reproductive & maternal health and HIV/AIDS and providing equipment and support to EmONC matters in Greater Accra and the central and western regions.

- JICA's assistance has focused mainly on improving maternal and child health care through strengthening the capacity of health service providers and health systems in the upper west region (at the regional, district and community levels). Specific interventions have focused on construction of the CHPS compounds, supporting facilitative supervision through coaching and mentoring, and strengthening the referral system, among other activities. In the near term, JICA will support simple road construction to increase accessibility and coverage of the CHPS in remote areas in order to reduce maternal mortality.

  Within the UN system, there has been an immense effort to popularize the MAF document. The UNCT (under the leadership of the WHO) has used the MAF to bring partners together to support implementation. The WHO, in particular, provided briefings to other sector ministers, the EU and the WHO Africa Regional Office. The WHO played a significant role in the preparation and submission of the concept note/grant application to the EU, providing continuous technical backstopping to government and regular updates to the UNCT and other development partners on the MAF implementation.

- UNICEF support to MAF implementation has been financial and technical from the MAF development phase to implementation of the preparatory activities. With the WHO, it coordinated partners' meetings and contributed to the advocacy for the selection of MDG 5 for the EU grant. UNICEF jointly with UNFPA contributed technical and financial support to the EmONC assessment.

- UNFPA's support to the MDG 5 MAF has been consistent through technical assistance and project-focused. After the Country Programme (CD) that ended in December 2011, UNFPA has factored the MAF into the next Country Programme 2012-2016. From January to August 2011, UNFPA indicated that it had contributed US$960,181.58 to the MAF implementation. This assistance is concentrated in five regions, including the three northern regions (i.e., northern, upper east and upper west regions) and the central and Volta regions.

- UNDP's contribution to the MAF development is highly recognized by government partners, particularly the GHS. Specifically, UNDP contributed technical assistance support and catalytic funding to support MAF development. It was deeply involved in the conceptualization, stakeholder consultation, coordination, development and publishing of the MAF document. UNDP plans to support the capacity development for monitoring & evaluation of MAF at the Ministry of Health, and Ghana Health Service.

Over 10 NGO partners were identified as contributors to the MAF implementation. The area of focus of the activities involved FP commodities and advocacy, safe abortion, safe delivery, ICT, reproductive health and human right issues. These include DELIVER, Marie Stopes International, IPAS, the Willows Foundation, Engender Health, the Grameen Foundation, EXP Social Marketing, DKT International, the Planned Parenthood Association of Ghana, Pathfinder International, the Alliance for Reproductive Health Rights, and Precision Development Experts. Other partners in the MAF implementation are the Population Council, the Ghana Registered Midwives Association (GRMA) and faith-based organizations like the Christian Hospitals Association of Ghana (GHAG). The CHAG has been particularly involved in improving SD through midwifery training programmes and creating health facilities for deliveries.

9. Monitoring and Evaluation

The coordination and monitoring of MAF implementation is pursued through the existing health sector structures. The Policy, Planning, Monitoring and Evaluation Directorate of the Ministry of Health leads M&E while GHS is responsible for coordination. The existing monitoring system applies a combination of approaches: (i) routine monitoring; (ii) quarterly review meetings; (iii) regional and district review meetings; (iv) a Health Summit in April and November every year; and (v) periodic field visits by combined teams of national and development partners. Where weaknesses are identified, strategies are put in place to address them.

10. Strengths/Challenges/Risks

Even though MAF mostly has its strengths, some challenges and risks are bound to persist if necessary care is not taken.

Strengths

The strong government leadership and ownership combined with the strong team work from partners makes the MAF a unified sector plan giving alignment to most existing donor support. This made partners' subscription to the MAF easier.

i. The MAF is a simple and clear framework. It is a useful tool to generate consensus among all stakeholders and talk with one voice. It sets the right agendum and provides a single focused framework valuable to solicit resources and build partnerships. For example, partners gave full support to the Ministry of Health to apply for the EU MDG grant because there was a MAF document that had significantly assessed the bottlenecks and prioritized intervention solutions to put Ghana on track to achieve MDG5.

ii. The MAF provides a single government-led framework, which has received endorsement and buy-in from development partners, key sector ministries and the legislature. It has the potential to increase partnership and resource mobilization into the health sector.

iii. The MAF provides a strong case to build and maintain inter-sector and donor collaboration/coordination.

iv. The MAF provides a tool to tap into the resources of other stakeholders such as sector ministries, NGOs, MMDAs, and the private sector (including local businesses and financial institutions, foundations and philanthropists).

v. The MAF promotes PPP for the MAF roll-out. The UN and other related agencies have included MAF as an integral part of their programme support areas.

Challenges/risks

Even though impact cannot be measured now, government and its partners have demonstrated significant commitment towards the implementation of the MAF. The existing interventions with funding are on-going. The MAF as a document focusing on MDG 5 is only one year old. The country is eager to drive the process and bring Ghana on track towards achieving MDG 5 by 2015. However, more remains to be done to achieve the full implementation. The constraints and challenges jointly identified with the stakeholders are outlined below:

i. Road infrastructure: poor road networks, particularly at the local level, were a huge limitation to health facility accessibility and coverage. The arrangement with the Ghana Private Road Transport Union to convey pregnant women to health facilities will work only if roads are accessible. Therefore, the optimum results cannot be achieved if the situation remains the same for a long time, especially for inaccessible rural areas.

ii. There was indication that inter-sectoral coordination was inadequate: Sectors and the MMDAs still work in silos on their own priorities. Even though efforts have been doubled, they are not sufficient to demonstrate much alignment, integration and complementarity of sector priorities to facilitate the MAF implementation.

iii. The time between the preparation phase and actual implementation took longer than necessary. For example, the slow procurement process was cited as an impediment to MAF implementation. Other activities that may cause delay include the gestation period between the construction of new midwifery schools, staffing and producing additional midwives. All these impinge on the timely accessibility and coverage.

iv. Another constraint identified was the low level of engagement with the private sector, civil society and the local financial institutions. So far, the MAF advocacy has been strong among international development partners. Although CSOs had previously been invited to MAF validation meetings and the Health Summit in November, there has not been enough time to bring them on board as partners and allies for MAF implementation.

v. Government-owned financial contribution to MAF was considered inadequate. Though the development of the MAF Action Plan was completed in September 2010, the 2011 budget did not make any statement to back MAF funding. Rather, the HIRD funding, which consisted of donor contributions through sector-budget support, was re-directed to finance MAF implementation.

vi. Capacity constraint was also identified. The inflow of additional resources and the urgency in MAF implementation need stronger structures and capacity to manage the coordination, monitoring & evaluation as well as documentation of the experiences/lessons to develop knowledge products.

vii. MAF popularity, partnership and resource mobilization are strongly championed by individuals and their agencies in the UN system. Change in the positions and institutions of these individuals can affect the leadership role to promote MAF implementation in Ghana.

11. Conclusion and Recommendations

The Ghana MAF provides one single framework directing the attainment not only of MDG 5, but of other MDGs as well. It has received the endorsement of the Minister of Health, the Parliamentary Select Committee on Health, and development partners. It is a key deliverable for national periodic review. The MAF is well-positioned in national and sector development policies and enjoys strong ownership and leadership from MOH/GHS as well as good collaboration with the UNCT. This is perhaps due to the teamwork established between the two partners during the development of the MAF Action Plan.

The MAF has extensively been used as an advocacy tool to mobilize resources from new and existing partners. This is evident from the recent applications under the ORIO initiative for a mixed loan/grant of €23 from The Netherlands, and an EU MDG grant of €52 million. Existing partners in the health sector, i.e., USAID, JICA, DFID, The Netherlands and UNCT (WHO, UNICEF, UNFPA), have declared their support for MAF implementation. Partners such as UNDP provide capacity development/technical support to strengthen MAF coordination and M&E systems.

Ghana is delivering on the existing interventions where funding has been secured for the three priority areas, i.e., FP, SD and EmONC. Though impact cannot be measured at this stage, the interventions are being followed. Procurement of FP commodities has surged. USAID alone has contributed over US$6 million to FP commodity supply. Under SD, the government has reintroduced the two-year post-basic and auxiliary midwifery certificate course, established three new midwifery schools and expanded four existing schools to increase the numbers of midwives to support improved SD in the country. EmONC deliverables have included the EmONC assessment conducted in the first quarter of 2011 and the procurement of 161 ambulances to support the referral system.

Conclusion and Recommendations

Notwithstanding the progress in the implementation of the MAF, there are some challenges, such as the extended procurement processes, weak sector coordination, the poor road network, the long gestation period between school construction, and the lack of staffing and training to produce midwives, that might reduce the likelihood that the MAF will attain MDG 5. The dominant threat identified was a lack of funding for complete roll-out of MAF. However, opportunities exist to pursue aggressive resource mobilization. These include engagement with the private sector, including domestic financial institutions, CSOs and many untapped resources.

Recommendations

Based on the preceding analysis, the following recommendations are proposed:

i. MAF requires massive advocacy to get the buy-in, endorsement and support from the private sector, CSOs, domestic financial institutions and the MMDAs for full MAF roll-out. It will also be useful to promote Public-Private Partnership (PPP).

ii. Donor coordination should be strengthened and, where some funds can be moved, should be redirected to support the MAF implementation.

iii. It is important to note the relevance of sector coordination across the board so that the responsible ministry/sector (such as the Ministry of Health) can tap into their resources to complement the efforts to achieve the success of the MAF.

iv. Maintain strong coordination and M&E, including accountability systems and the development of knowledge products for learning by others. This should include a system to track resources for MDG 5 for accountability to donors and all stakeholders.

v. Accelerate capacity building for the M&E department of the Ministry of Health and the division responsible for the implementation of MAF.

vi. Issues of sustainability should be given attention now to reduce shocks when donor resources dry up. Perhaps government may wish to increase its financial commitment to balance the donor funds.

vii. Accelerate the preparation of the detailed MAF activity/work plan.

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