GHANA

MDG ACCELERATION FRAMEWORK AND COUNTRY ACTION PLAN

MATERNAL HEALTH

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July 2011

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ABBREVIATIONS

ANC	Antenatal Care
BCC	Behavioural Change Communication
BEOC	Basic Emergency Obstetric Care
BTS	Blood Transfusion Service
CENC	Comprehensive Essential Neonatal Care
CEOC	Comprehensive emergency obstetric care
CHPS	Community Health Planning and Service
CSO	Civil Society Organization
DAs	District Assemblies
DHIMS	District Health Information Management System
DHMT	District Health Management Team
ENC	Essential Neonatal Care
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
GHS	Ghana Health Service
GNP	Gross National Product
GPRS I	Ghana Poverty Reduction Strategy I
GPRS II	Growth and Poverty Reduction Strategy II
GNP	Gross National Product
HIRD	High Impact Rapid Delivery
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICC	Inter-Agency Coordinating Committee
IEC	Information, Education and Communication
IUD	Intrauterine Device

LSS	Life Saving Skills
MAF	MDG Accelerated Framework
MDG	Millennium Development Goals
MDRI	Multilateral Debt Relief Initiative
MMDAs	Metropolitan, Municipal and District Assemblies
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MoWH	Ministry of Works and Housing
MNH	Maternal and Neonatal Health
MMR	Maternal Mortality Rate
NDPC	National Development Planning Commission
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
PDA	Personal Data Assistant
PMTCT/CT	Prevention of Mother to Child Transmission/Counselling and Testing
PNC	Postnatal Care
SD	Skilled Delivery
STI	Sexually Transmitted Infection
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

FOREWORD

"The Millennium Development Goals (MDGs) are achievable by 2015, if supported by the right set of policies, targeted technical assistance, institutional capacity, adequate funding and strong political commitment. The Government of Ghana, in collaboration with its development partners, is fully committed to achieving the MDGs by 2015.

Recent experiences in Ghana demonstrate that success is possible and that evidence-based effective interventions can be identified for realizing the MDGs. Nevertheless, although progress has been satisfactory in MDGs 1, 2, 3, 6 and 8, it has been less in other areas, MDGs 4, 5 and parts of 7. At the current pace of progress, Ghana may not meet the MDG target by 2015 with business as usual. The present MDG Acceleration Compact capitalizes on the existing commitment and captures the evidence available to put forward concrete and realistic proposals to scale up the achievement of the MDGs in the next five years…"

This MDG Acceleration Framework (MAF) – Ghana Action Plan was developed by the Ministry of Health and Ghana Health Service in collaboration with development partners particularly the United Nations Country Team and other stakeholders in Ghana. The focus of the Action Plan is on MDG 5 because the progress in reducing the maternal mortality ratio by three quarters by 2015 is off track. The 2010 MDG Report showed the maternal mortality rate to be at 451 per 100,000 live births. The slow progress has been of great concern to policy decision makers to the extent that Maternal Mortality was declared a national emergency in July 2008.

Therefore, the main reason for this MAF is to redouble efforts to overcome bottlenecks in implementing interventions that have proven to have worked in reducing the maternal mortality ratio in Ghana. The MAF focuses on improving maternal health at the level of both community and health care facilities through the use of evidence-based, feasible and cost-effective interventions in order to achieve accelerated reduction in maternal and newborn deaths. The three key priority interventions areas identified are improving family planning, skilled delivery and emergency obstetric and newborn care.

At the health facility level, emphasis is placed on the creation of an enabling environment, including equipment and supplies, for well-trained professionals to attend to pregnancy, childbirth and the newborn. The community level focuses on

equipping communities with knowledge and skills to enable them to adopt good health practices and better health-seeking behaviour and to recognize danger signs related to pregnancy and childbirth as well as with the newborn. This document takes cognizance of the inseparable dyad of the mother and the newborn as well as the interrelationships among all the eight MDGs.

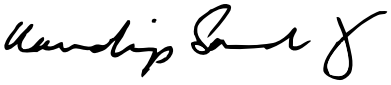
The MAF is not aimed at replacing existing interventions. Rather, it is meant to complement them with specific focused interventions for the achievement of MDG 5 by 2015. To achieve that, the Ghana MAF cannot be the business of the government alone, but requires the support of UN agencies, other development partners and CSOs to better understand the deep-rooted causes militating against positive outcomes in maternal health care and collectively work towards overcoming them. Once the CAP is implemented with the support of all stakeholders, Ghana will reduce the risks of maternal deaths and once again be on track to achieving MDG 5 by 2015.

The declaration of His Excellency Professor John Evans Atta Mills, President of the Republic of Ghana at the recent African Union Heads of State Conference in Kampala, Uganda, that "no woman should die while giving life" is a vision that the implementation of this Action Plan seeks people to support it through resource mobilization, implementation and Monitoring and Evaluation.

Minister of Health, Ghana

Hon. Dr. Benjamin Kunbuor

UN Resident Coordinator



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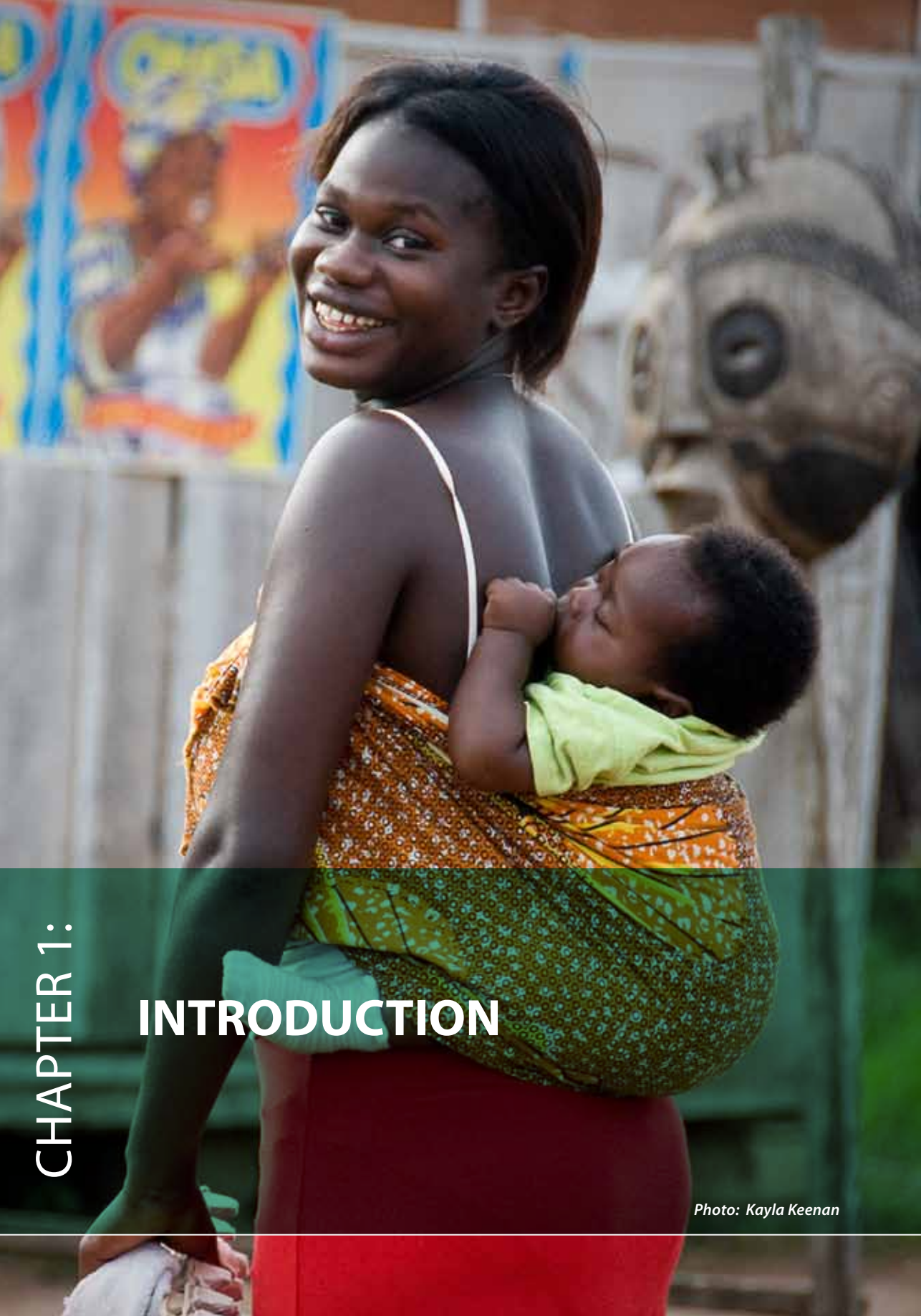


CHAPTER 1:

INTRODUCTION

Photo: Kayla Keenan

1.1: BACKGROUND

Ghana, a tropical country on the west coast of Africa, is divided into 10 administrative regions and 170 decentralized districts. The country has an estimated population of about 23.4 million (GSS, 2009) with a population density varying from 897 per km^2 in the Greater Accra Region to 31 per km^2 in the Northern Region. Life expectancy is estimated at 56 years for men and 57 years for women, while the adult literacy rate (age 15 and above) stands at 65 percent. The government is a presidential democracy with an elected parliament and independent judiciary. The principal religions are Christianity, Islam and Traditional African. Ghana's economy has a dominant agricultural sector (small-scale peasant farming) absorbing 55.8 percent (GLSS 5) of the adult labour force, a small capital intensive mining sector and a growing informal sector (small traders and artisans, technicians and businessmen). Since independence, Ghana has made major progress in economic growth. However, a number of questions arise as to how to accelerate equitable growth and sustainable human development towards attaining middle-income country status by 2015.

At the turn of the century, in September 2000, Ghana, along with 189 UN member countries adopted the Millennium Declaration that laid out the vision for a world of common values and renewed determination to achieve peace and decent standards of living for every man, woman and child. The eight Millennium Development Goals (MDGs) derived from the Millennium Declaration set time-bound and quantifiable indicators and targets aimed at halving the proportion of people living below the poverty line, improving access to primary education, promoting gender equality, reducing child mortality, improving maternal health, combating and reversing the trends of HIV/AIDS, malaria and other diseases, ensuring environmental sustainability, and promoting global partnership for development between developed and developing countries by 2015. This set of eight clear, measurable and time bound development goals were expected to generate unprecedented, coordinated action, not only within the United Nations system, including the Bretton Woods institutions, but also within the wider donor community and, most importantly, within developing countries themselves.

Ghana has since mainstreamed the MDGs into the country's successive medium-term national development policy framework, the Ghana Poverty Reduction Strategy (GPRS I), 2003 – 2005, and the Growth and Poverty Reduction Strategy (GPRS II), 2006–2009. The GPRS I focuses on macroeconomic stability, production and gainful employment, human resource development and the provision of basic services to the vulnerable and excluded, and good governance; GPRS II emphasizes continued macroeconomic stability, human resource development, private sector competitiveness, and good governance and civic responsibility. Within the same period of the two development policy frameworks, Ghana benefited from the Highly Indebted Poor Country (HIPC) initiative and other international development assistance support programmes including the Multilateral Debt Relief Initiative (MDRI), Multi-Donor Budget Support (MDBS) and the United States-funded Millennium Challenge Account programme, among others.

In addition to direct poverty reduction expenditures, government expenditure outlays were also directed at policies and programmes to stimulate growth, which have high potential to support wealth creation and sustainable poverty reduction.

Total poverty reduction expenditure as a percentage of total government spending declined from 34.56 percent in 2006 to 22.82 percent in 2007 and further down to 22.3 percent in 2008 (2008 APR). In terms of sector shares, the largest share of total poverty spending went to basic education, which accounted for 41.42 percent in 2007 and 47.24 percent in 2008. This was followed by health sector spending at 19.5 percent in 2007 and 18.05 percent in 2008. Expenditure on rural electrification, water supply and feeder roads ranged from 1.57 percent to 7.23 percent in 2007 and 1.36 percent to 5.04 percent in 2008. Such declines in poverty spending have implications for the achievement of the MDGs despite the country being on track to achieve poverty and related targets which form the focus of subsequent discussions.

1.2 OVERALL PROGRESS IN ACHIEVING THE MDGS IN GHANA

According to the 2010 MDG Report, Ghana's progress in achieving the MDGs is mixed. **The country is largely on track to achieve the MDG 1 target of reducing by half the proportion of the population living in extreme poverty.** The overall poverty rate has declined substantially over the past two decades from 51.7 percent in 1991–1992 to 28.5 percent in 2005–2006 while the proportion of the population living below the extreme poverty line also declined from 36.5 percent to 18.2 percent over the same period against the 2015 national target of 26 percent and 19 percent respectively. **Although current data on poverty is not available, trends in economic growth suggest a further decline in poverty between 2006 and 2008**. However, despite the significant decline in poverty at the national

level, regional, occupational and gender disparities exist. Some regions did not record improvements in poverty, particularly the three Northern regions where high levels of poverty persist. Over 70 percent of people whose incomes are below the poverty line live in the Savannah areas. The 2009 Human Development Report (HDR) shows Ghana's Human Development Index (HDI) rank had declined and inequality remained high. Thus the high growth rate has not necessarily been consistent with improved human development indicators as the country continues to face challenges in health and other social services.

With regard to MDG 1 Target 1C, halving the proportion of people who suffer from hunger, Ghana is on course to achieving the child malnutrition indicators ahead of 2015. The prevalence of children suffering from wasting and stunting that characterized the late nineties continued to be reversed in 2008. The incidence of wasting has declined from a peak level of 14 percent in 1993 to 5.3 percent in 2008, while the occurrence of underweight children has declined from about 23 percent in 1988 to 13.9 percent in 2008. In terms of districts facing chronic food production deficits, the trend has seen continuous reduction from 22 in 2005 to 15 in 2006, and further down to 12 in 2008. These achievements were made possible as a result of numerous programmes and interventions implemented by government, including fertilizer subsidies and the expanded maize and rice programmes which supported farmers with agricultural inputs (fertilizers, improved seeds), and subsidies to meet ploughing and labour costs.

Available data and trend analyses of MDG 2 — achieving universal primary education — show that Ghana is on track to achieving both the gross and net enrolment targets by 2015. The number of schools and enrolment rates have increased tremendously over the years due to various reforms and new policy measures instituted by the government. The number of kindergarten schools has increased from 14,246 in 2006–2007 to 15,449 in 2007–2008 following the government's policy of mandating each primary school to have a kindergarten attached to it. The Gross Enrolment Ratio (GER) for kindergarten has subsequently increased from 89 percent in 2006–2007 to 89.9 percent in 2007–2008. The number of primary schools rose from 16,903 in 2006–2007 to 17,315 in 2007–2008, while the GER increased from 93.7 percent to 95.2 percent over the same period. The area where challenges exist is the survival rate which has stagnated at 88 percent in 2007–2008 from 85.4 percent in 2006–2007.

With regard to the MDG 3 target of ensuring gender parity especially at the primary and junior high school levels, trends show that Ghana is on track to achieving both targets, although primary level parity has stagnated at 0.96 since 2006–2007, while the parity at the junior high school level increased slightly from 0.91 in 2006—2007 to 0.92 in 2007–2008. On the other hand, the parity at the kindergarten level has declined slightly from 0.99 in 2006–2007 to 0.98 in 2007–2008. Progress towards increasing the number of women in public life suffered a setback with the reduction of the number of women elected into parliament during the 2008 elections declining from 25 to 20. This had reduced the proportion to below 10 percent, and puts Ghana under the international average of 13 percent.

Although evidence shows that there has been significant reduction in both infant and under-five mortality rates in Ghana, it is unlikely that the 2015 target of reducing the child mortality rates will be easily met. The Ghana Demographic and Health Survey (GDHS) 2008 showed a 30 percent reduction in the under-five mortality rate, as it declined from 111 per 1,000 live births in 2003 to 80 per 1,000 live births in 2008, while the infant mortality rate in 2008 stood at 50 per 1,000 live births compared to 64 per 1,000 live births in 2003. The neonatal mortality rate also saw a decrease from 43 per 1,000 live births in 2003 to 30 per 1,000 live births in 2008. The proportion of children aged 12 to 23 months who received the measles vaccine increased from 83 percent in 2003 to 90 percent in

2008, showing an improvement in coverage in one of the key child survival interventions (MoH, 2008; GHS, 2003).

The key child health interventions are antenatal care (ANC), delivery care, postnatal care, immunization, nutrition, management of childhood illnesses and malaria prevention. In the last decade some progress has been made to improve child survival. Household ownership of insecticide-treated nets has improved to 61.6 percent (urban) and 66 percent (rural) areas, immunization coverage is high (Penta3 87 percent, see GHS 2008[1]), National Health Insurance Scheme (NHIS) coverage is high, antimalaria combination therapy is universally available and infant and child mortality have declined (see GSS 2008[2]; MICS[3]).

Maternal health care has improved over the past 20 years albeit at a slow pace. Between 1990 and 2005, maternal mortality ratio reduced from 740 per 100,000 live births to 503 per 100,000 live births, and then to 451 per 100,000 live births in 2008. If the current trends continue, maternal mortality will be reduced to only 340 per 100,000 by 2015, instead of the MDG target of 185 per 100,000 by 2015. The improvement, however, is not the same for all regions. There are disparities in the institutional maternal mortality rate (MMR) across the 10 regions in Ghana from 1992 to 2008 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. The only region where the ratio has worsened is in Greater Accra (by 87.6 per 100,000). Maternal death was declared notifiable within seven days in Ghana in January 2006 and the notification rate in 2007 was 71.8 percent. A quarter (75.4 percent) of 751 maternal deaths in Ghana (2007) were audited.

After a decline from a high of 3.2 percent in 2006 to a low of 2.2 percent in 2008, evidence from the 2009 Sentinel surveillance report suggests an increase in the HIV/AIDS prevalence rate in Ghana to 2.9 percent in 2009. According to the Ghana AIDS Commission, the current up-and-down movement in the prevalence rate between 2003 and 2008 signals a leveling effect or stabilization of the epidemic.

On MDG 7 – ensuring environmental sustainability – Ghana is on track to achieve the target of halving the proportion of people without access to safe water. Critical challenges exist in achieving the targets for reversing the loss of environmental resources, reducing the proportion of people without access to improved sanitation, and achieving significant improvement in the lives of people living in slum areas. Although up-to-date data on the rate of forest depletion is unavailable, evidence suggests that the country is depleting its forest cover at an alarming rate. Between 1990 and 2005, the forest cover declined from 32.7 percent to 24.2 percent.

While access to safe water services in rural areas has improved considerably, there has been slow progress on access to safe water within urban areas. Even though Ghana has made progress in reducing the proportion of the population without access to improved sanitation, the target may not be achieved by 2015 if the current trends continue. If the current trend is maintained, the proportion of the population with access to improved sanitation will reach 21.2 percent by 2015 instead of 52 percent. The proportion of the urban population with access to improved sanitation will be 23.4 percent instead of 55 percent by 2015, while in the rural areas, it would be only 20.6 percent instead of 50.5 percent. Also, though the proportion of urban population living in slums shows a decline, if the current pattern continues, a significant proportion (about 14 percent) will still be living in slum areas by 2020.

In terms of global partnerships for development, many developed countries have not met the 0.7 percent GNP target for aid. However, aid inflows to Ghana appear to have increased in nominal terms from $578.96 million in 2001 to $1,433.23 million in 2008. The current concern, however, is the level

1) GHS, Disease Control and Prevention Department 2008 Annual report.
2) GSS, Demographic and Health Survey 2008.
3) MoH, Multiple Indicator Cluster Survey (MICS) 2006.

of increases in real terms and the quality of the aid the country receives. In real terms, ODA inflows to Ghana have stagnated at about 8.7 percent of GDP between 2002 and 2008, after an initial rise from 6 percent of GDP in 1999 to 15 percent of GDP in 2001. The portfolio of aid inflows continued to be dominated by project aid, which constitutes more than 60 percent of ODA inflows. The global financial, oil and food crisis appear to have impacted negatively on the public debt position of Ghana, which is gradually approaching unsustainable levels. Ghana's public debt as a percentage of GDP increased from 41.4 percent in 2006 to 55.2 percent in 2008.

1.3: Past and emerging challenges and their impact on achieving the MDGs

The global food and energy crisis, as well as the effect of the global economic crisis and the presidential and parliamentary elections between 2006 and 2008 adversely affected pro-poor expenditures. While the debt relief fund for Highly Indebted Poor Countries continued to fund activities in support of both poverty reduction and growth enhancement, the Multilateral Debt Relief Initiative(MDRI) which came into effect in 2006 addressed the energy crisis as well.

Prior to the onset of the financial crisis, foreign inflows (export earnings, investment and remittances) were buoyant. In the beginning of 2009, however, the country recorded a budget deficit of 14.5 percent of GDP excluding divestiture receipts, and 11.5 percent of GDP including divestiture receipts; as well as a large current account deficit of 20.87 percent of GDP. The country faced a high base interest rate of 27.22 percent and an average annual inflation of 18.13 percent in 2008. Average depreciation recorded was 20.6 percent and 16.1 percent against the US dollar and the Euro, respectively. Ghana's high level of dependence on the world economy, with as much as 30 percent of budget support from international partners, and her strong trade links with the US and Europe, may imply that any disturbance emanating from the international financial system is bound to have an effect on the domestic economy. In terms of international trade and foreign direct investment, the global financial crisis does not show to have created a major setback as far as Ghana is concerned. Gold and cocoa, Ghana's main exports, were resilient in the face of the crisis and as a result of investments in the oil and gas fields, foreign direct investment has increased. It cannot therefore be argued that developments in international trade and FDI negatively affected the achievement of any of the MDGs in Ghana. However, the crisis brought with it negative consequences for the financial markets. Banks have been reluctant to provide credit to households, to small and medium enterprises (SMEs) as well as to big businesses, for fear of loan defaults. In addition, discount, interest, prime and lending rates have increased. As far as the stock market is concerned, the all-share index fell drastically and trade volume has also decreased. These developments have affected share prices paid to clients which may have further affected incomes of households.

The impact of climate change is now more than ever before being felt. There is clear evidence that the potential negative impacts of climate change are immense, and Ghana is particularly vulnerable due to its lack of capacity to undertake adaptive measures to address environmental problems and the socio-economic costs of climate change (EPA, 2000). For instance, in agricultural areas, particularly in the central and northern regions of the country, climate change has contributed to the deterioration of rural livelihoods, reflected in declining incomes, malnutrition and hunger. The flooding of coastal areas, which are already undergoing erosion, and low operating water levels of the only hydro-generating dam in the country are further problems. The vulnerability of people to daily shocks and stresses is intrinsically tied to the human adaptive capacity — and strategies created — to respond to floods, high

temperatures, coastal erosion, rises in the sea level, and other climate-related events. Climate change is likely to exacerbate these shocks and stresses, particularly among the poorest and most vulnerable populations and, therefore, may inhibit the attainment of the MDGs. The evidence of the implications of these phenomena for the attainment of the MDGs in Ghana may have been underreported. It is important that this is given the needed attention since it has the potential of not only eroding the gains already made, but also pf frustrating efforts being made to achieve the goals.

1.4: THE MAF, CAP AND OBJECTIVES

Various studies have indicated that globally achieving MDG 5 is off track and is not likely to be achieved in many countries, Ghana included, as both targets for measuring progress appear not to have been reached so far. A number of reviews have been made, challenges to implementation identified and various recommendations made. The number of policy documents, strategic plans and review reports on maternal health and reducing maternal mortality is very impressive. But implementation has almost always stalled, leading to minimal impact on the MMR. In the opinion of one of our development partners, "Many action plans, initiatives and working groups exist in Ghana to tackle MDG 5. We know the specific interventions required to achieve MDG 5 — these are well detailed in the various plans and initiatives. Several of these initiatives have been fully costed, so we even have a sense of the resources required. We do not require another action plan specifying what interventions to carry out, nor do we need another analysis of why maternal mortality is high in Ghana**."** He goes on to indicate that "what we need is why the specific interventions have not been implemented". Unfortunately, these recommendations for implementing the proposed interventions and overcoming identified bottlenecks are scattered in many documents, making it difficult to monitor the progress of implementation. As we approach the target year of 2015, all the identified bottlenecks, recommendations and action plans scattered in the various documents need to be brought together to help understand why the known specific interventions were not implemented.

The MAF, introduced by the UN System, falls in line with the concerns and priorities of the Government of Ghana. Thus the selection of Ghana along with 10 countries (four in Africa — Ghana, Tanzania, Togo and Uganda) to develop a Country Action Plan (CAP) or the acceleration of MDG 5, which is off track. MDG 5 is not likely to be attained by 2015 if efforts are not redoubled. The Ghana CAP contains the elaboration of the key prioritized interventions that are required to achieve MDG 5, identifies the bottlenecks to the interventions and suggests cost-effective solutions to address the bottlenecks and accelerate progress. The CAP includes an implementation and monitoring plan for tracking progress. This is expected to enable Ghana to address the critical constraints that hamper the progress towards achieving MDG5 and put maternal mortality target back on track by 2015.

1.4.1: MAF objectives

The MAF aims at supporting national governments, UN agencies and other development partners and civil society organizations (CSOs) working in the MDG areas to better understand the key causes affecting positive outcomes in a particular MDG, find key solutions and develop an action plan that can help to reduce the risks hampering progress of that MDG. In the case of Ghana, the MAF objectives seek to:

- review existing policies and interventions in the area of MDG 5 i.e., maternal health care;

- identify the key bottlenecks to the implementation and attainment of MDG 5;
- identify gaps in existing policies and interventions;
- develop cost-effective solutions that can accelerate progress towards the attainment of MDG 5;
- design an action plan for implementing the indicative interventions and monitor progress.

1.4.2: Methodology used in preparing the MAF CAP

An interactive and participatory approach was adopted for the MAF roll-out. A National Technical Team was established and two resource persons were recruited to manage day-to-day activities. A desk review of national policy documents, reports and roadmaps was undertaken covering 30 national reports on maternal health care delivery and 37 National Policy Documents. To fill in the information gaps, focus group discussions and rapid survey questionnaires to District Directors of Health Services were also carried out. Consultative meetings of the technical team were organized to review the initial findings (in terms of interventions and bottlenecks) and answer the question: Why have the specific interventions not been implemented? The key interventions, bottlenecks and solutions were prioritized using the method of ranking (high/medium/low) and selection criteria (impact, sustainability, speed, resources). Based on the findings, the technical team worked during workshops and consultations to develop the draft CAP.

1.4.3: MAF consultative process

The process of the MAF roll-out, including the preparation of the CAP, was nationally driven, interactive and participatory, and carried out under the overall leadership of the MoH. Ownership was further enhanced by engaging multiple stakeholders drawn from key sector ministries, CSOs, the UN Country Team (UNCT) and development partners involved in supporting maternal health care interventions. Stages for the MAF roll-out and preparation of the CAP were as follows:

A UNDP-led consensus building and introduction of the MAF with the key government sector, MoH, which in turn led to close consultation with key UN agencies (WHO, UNICEF, UNFPA, UNDP) to establish an inter-agency National Technical Team. The Ministry of Health(MoH) and UN agencies identified the MAF as timely and in line with their efforts to finding a solution to the high maternal mortality in Ghana.

- A national proposal on the MAF roll-out was developed and Ghana entered into a collaboration with the global UNDP MAF team for financial, technical and advisory support for the process.
- The Government of Ghana organized an inception meeting with selected partners including the UNCT and agreed on the methodology and identified bottlenecks for analysis, and reviewed and adopted the action plan for MAF implementation.
- A National Technical Team that comprised the MoH, UNICEF, UNFPA, WHO and UNDP was established by the MoH to support the MAF roll-out. While the specialized UN agencies provided technical inputs, UNDP played a coordinating role and provided quality assurance.
- Two national consultants were recruited to further support the Technical Team and manage the day-to-day process of the MAF roll-out.
- Initial activities involved (i) a desk review of National Policy Documents, reports and roadmaps (30 national reports on maternal health care

delivery, 37 National Policy Documents). The recently completed MDG Report for 2010 provided additional data and information on the MDGs including the impact (existing/potential) of the global economic crises and climate change on the attainment of the MDGs. Focused group discussions and rapid survey questionnaires to District Directors of Health Service were also conducted.

- The National Technical Team with the consultants and the UN inter-agency team, including a Resource Person from UNDP Regional Service Center, Dakar, undertook a five-day working session in Kumasi and reviewed the necessary interventions, identified and prioritized bottlenecks as well as sequenced the solutions to remove the bottlenecks for effective implementation to accelerate MDG 5.

- The Technical Team further reconvened in Accra to prepare the draft CAP including the Monitoring & Evaluation framework. At that point, additional resource persons from UNDP Regional Bureau for Africa (RBA) and Bureau for Development Policy (BDP) joined the team to share global experiences in the MAF process and provided technical inputs for quality assurance in line with the global programme.

- The National Technical Team briefed UNCT a day prior to the validation meeting to share the findings, and received inputs for consideration mainly in the areas of nutrition, gender empowerment, girls' education, HIV/AIDS and sexually transmitted infections in pregnancy and childbirth.

- On 12 August 2010, a validation meeting was organized with the wider stakeholders to discuss and build consensus on the draft MAF CAP. The validation provided further comments and recommendations that further enhanced the quality and ownership for the CAP. In all, 15 Agencies and 35 participants were represented.

- The National Technical Team, including the UN Country Team, incorporated stakeholders' comments and contributions into the MAF CAP.

- The document was duly endorsed and finalized as a true reflection of Ghana's MAF National Action Plan for the acceleration of MDG 5 over the next five years until the target date of 2015.

From the review of the existing policies and interventions available for attaining MDG 5 in Ghana, the team assessed the implementation status (whether partially or not implemented) and the expected contributions to the acceleration of MDG 5. It identified and ranked the various interventions by using the following set of criteria: impact, sustainability, speed, coverage and available capacity for the intervention. The three key interventions that emerged as having great impact on maternal health were **family planning (FP)**; **skilled delivery services (SD)**; and **emergency obstetrics and neonatal care (EmONC)**.

Using the above three key intervention areas, the team identified and prioritized the key bottlenecks by answering questionnaires and ranking the bottlenecks as high, medium or low/small, in the areas of policy/planning, financing, service delivery, service utilization and cross-cutting on the interventions. The bottlenecks that emerged from this ranking included accessibility, availability, coverage, knowledge, acceptance, poverty, quality and intersectoral coordination. Using available costing, the team developed cost-effective solutions for the three interventions to accelerate progress of MDG 5 using 'accelerating solutions prioritization criteria' based on impact (magnitude, speed and sustainability) and feasibility (governance, capacity and funding availability).

The outputs from the overall MAF process included (i) **an analysis of the national-, regional- and district-level constraints** to implementing the well-defined actions required to make progress on MDG 5, with emphasis on answering the question:

Why have the specific interventions not been implemented; (ii) a **two-to-three-year business plan/ CAP** outlining how all stakeholders could work together to implement the various plans and initiatives. The CAP elaborates on key prioritized interventions that are required to achieve MDG 5, identifies the bottlenecks, and suggests cost-effective solutions to address the bottlenecks and accelerate progress. It also contains an implementation and monitoring plan for tracking progress. All these are with a view to addressing the critical constraints that hamper progress towards reducing maternal mortality in Ghana and once again put the country on track to achieving MDG 5 by 2015.

1.4.4: September 2010 MDG Summit

In September 2010, 10 years after the historical event of the MDG declaration in 2000, the global leaders involved in formulating the declaration met again to review the progress made, and galvanized political commitment and collective action towards the 2015 deadline. In line with the country's own concerns and plans, Ghana was selected by the UN system along with 10 countries (four in Africa — Ghana, Tanzania, Togo and Uganda) to develop a CAP for the acceleration of MDG 5. The results of the pilot, which was part of a synthesis report, was tabled at the 2010 MDG Summit in September 2010 in New York.

CHAPTER 2:

PROGRESS AND CHALLENGES IN ACHIEVING MDG 5

Photo: Kayla Keenan

2.1: OVERVIEW OF MDG REPORT 2010 ON MDG 5 — MATERNAL MORTALITY IN GHANA

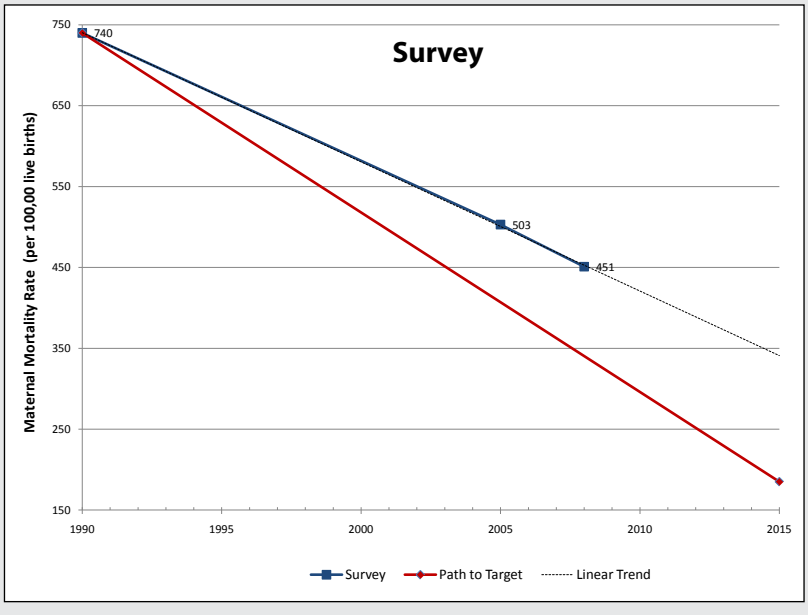
Although Ghana has achieved progress in the past 10 years of MDG implementation, challenges of inequalities, geographical disparities and sustaining progress still remain. With only five years remaining to the MDG deadline, Ghana will have to accelerate its efforts towards the achievement of all the MDGs, especially those lagging behind such as MDG 4 (child mortality), MDG 5 (maternal health) and part of MDG 7 (environment). The death of a mother, especially during pregnancy, is a calamity for the family, community and society at large, something that has been long accepted by all societies. Consequently, it has been a concern of the international community and various governments to initiate policies, programmes and strategies to improve maternal health and reduce maternal mortality and morbidity. Unfortunately, the MMR is just too high in developing countries, including Ghana, and the indicator is accepted as a key to assessing the level of development of a particular country. While the MMR in developed regions was 9 per 100,000 live births in 2008, the ratio was 450 per 100,000 in developing regions (MDG Report 2010). Obviously, a lot needs to be done in developing regions to bring down the MMR if MDG 5 is to be achieved.

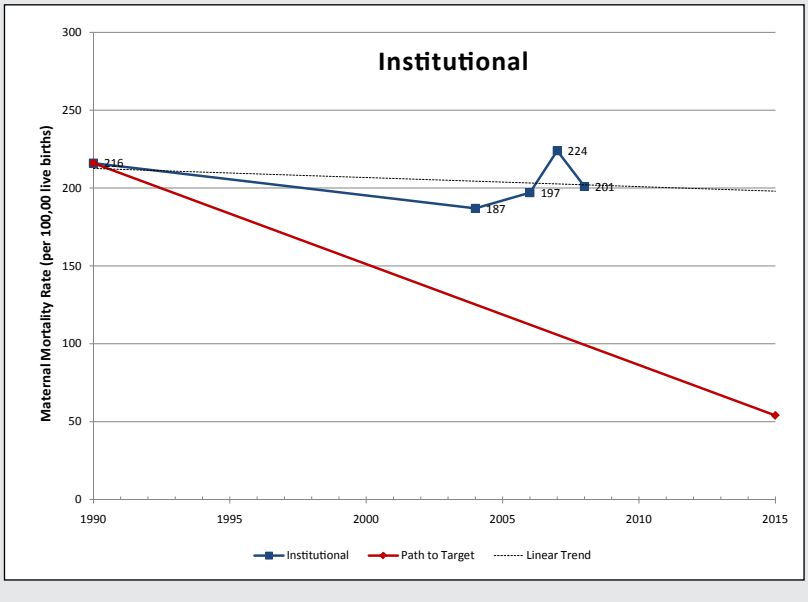
The MMR as captured by both survey and institutional data has shown an improvement over the past 20 years. However, the pace has been slow. Between 1990 and 2005, it reduced from 740 to 503 per 100,000 live births and then to 451 deaths per 100,000 live births in 2008. This trend is also supported by institutional data which suggest that maternal deaths per 100,000 live births have declined from 224 per 100,000 in 2007 to 201 per 100,000 in 2008, after an increase from 187/100,000 in 2004 to 197 per 100,000 in 2006. If the current trends continue, maternal mortality will be reduced to only 340 per 100,000 by 2015 instead of the MDG target of 185 per 100,000 by 2015. Moreover, the improvements recorded are not evenly distributed. There are disparities in the MMR (institutional) across the 10 regions in Ghana from 1992 to 2008. The MMR has decreased 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. The only region where the MMR has worsened is Greater Accra (by 87.6 per 100,000) (fig. 2). This shows a clear inequity in the per capita distribution of health facilities and health personnel across the various regions and districts and underscores the need to improve it.

Unless extreme efforts are made by all stakeholders, Ghana is unlikely to meet the MDG target (fig.1). The Ghana Maternal Health Survey 2007 found that 14 percent of deaths of women within the reproductive age are childbirth-related 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 of maternal death.

The MMR remains unacceptably high in Ghana in spite of the efforts being made to reduce it. Maternal health has remained a national priority and as such, has become a core indicator for poverty reduction in the Ghana Poverty Reduction Strategy (GPRS). Additionally, improving maternal health and thereby reducing maternal mortality is one of the priorities of the health sector's programme of work (POW).

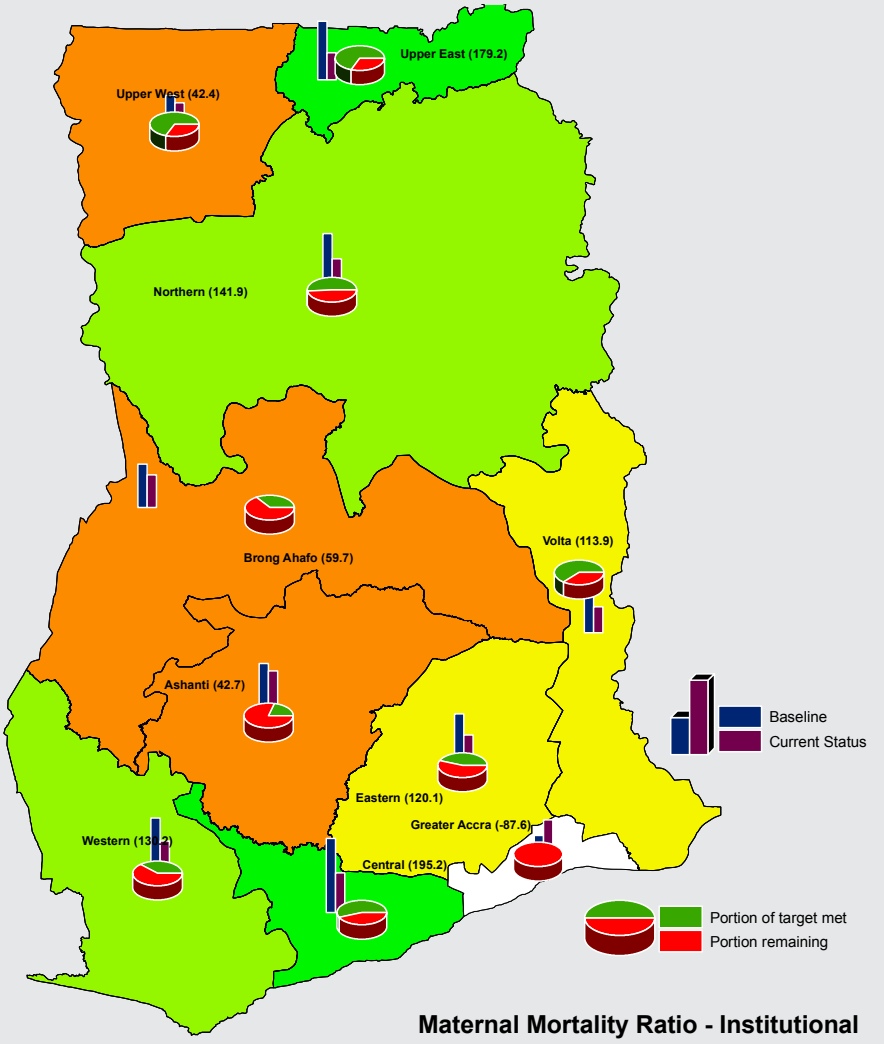
FIGURE 1 **TRENDS IN MATERNAL MORTALITY**





Source: *Ghana's Health Sector Review Report, 2009; MOH, 2008.*

FIGURE 2 MAP OF INSTITUTIONAL MATERNAL MORTALITY RATIO IN GHANA BY REGION



Source:
Centre for Health Information Management
Ministry of Health

Prepared for National Planning Commission (Ghana)
By African Centre for Statistics, UNECA
April 2010

While acknowledging the importance of focusing on MDG 5, we also recognize that all the eight MDGs are interrelated and mutually reinforcing. **Poverty, gender inequality, low productivity, inadequate income opportunities, poor education, environmental non-sustainability are all undermined if health care is poor and the reverse is true in some cases.** For instance, MDGs 4, 5 and 6 are closely linked. The mother is the fulcrum around which family life revolves and her death jeopardizes the survival of her young children. For example, the risk of death for children under five is higher for those whose mothers die in childbirth than those with living mothers. Reducing death in pregnancy and childbirth does not only improve the productivity of women, and increase labour supply and the economic well-being of communities, but is arguably also a human rights issue. Given the numerous issues that beset maternal health care leading to slow progress in achieving MDG 5, and the inter-linkages between improved maternal health and MDG 4, the MAF roll-out in Ghana chose to focus on MDG 5. The status of the MDGs in Ghana over the last 10 years is shown in table 3.

2.2: OVERALL ASSESSMENT OF PROGRESS TOWARDS MDG 5

Policy measures for improving health care services in general, and maternal care in particular, are enshrined in the national development policy frameworks including the GPRS I, GPRS II and the draft Medium-Term National Development Policy Framework 2010–2013 as well as specific health sector policies. Furthermore, Ghana has numerous initiatives in place to address the issue of maternal mortality but the results have not led to desirable improvement in MDG 5. Particular initiatives put in place to address the high levels of maternal deaths include the Safe-Motherhood Initiative, Ghana Vitamin A Supplement Trials (VAST) Survival Programme, Prevention of Maternal Mortality Programme (PMMP), Making Pregnancy Safer Initiative, Prevention and Management of Safe Abortion Programme, Intermittent Preventive Treatment (IPT), Maternal and Neonatal Health Programme and the Roll Back Malaria Programme. However, funding and other cross-cutting constraints have hampered the full implementation of some of the initiatives.

Resource allocation to the health sector in nominal terms has increased over the years. However, as a percentage of the national budget it declined from 16 percent in 2006 to about 12.76 percent in 2009.

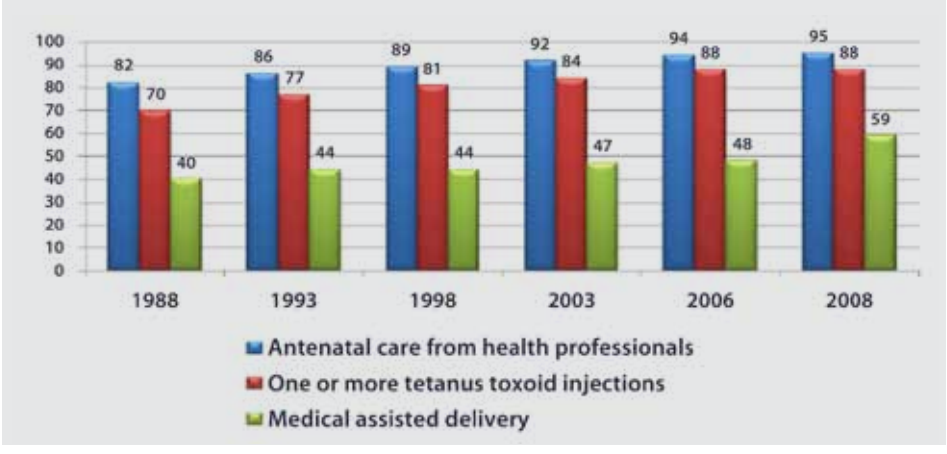
TABLE 1 HEALTH BUDGET 2006-2009

Year	2006	2007	2008	2009
MoH	478,654,800	563,756,400	752,233,368	921,929,472
National budget	2,948,398,300	3,869,832,200	5,059,808,063	7,226,913,484
Total share of health in the national budget	16.23%	14.60%	14.90%	12.76%

Source: *Annual Budget Statement, MoH, Government of Ghana.*

Apart from the general bottlenecks that affect the entire health system of the country, there are also specific urban and rural challenges with implications for maternal mortality. ***Antenatal care*** from health professionals (nurses, doctors, midwives or community health officers) increased from 82 percent in 1988 to 95 percent in 2008 (see figure 3). However, the progress is unevenly distributed. While women in urban areas receive more antenatal care from health professionals (98 percent) than their rural counterparts (94 percent) the regional figures are different: 96 percent to 98 percent of women across all the regions received antenatal care from health professionals. The exception is women in Volta and the Central regions whose antenatal care access rate is estimated at 91 percent and 92 percent respectively. However, the lack of information available to women about signs of complications in pregnancy, 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, and two in three have access to urine testing and blood testing respectively. These are against the national average of 90 percent access to these services.

FIGURE 3 **SELECTED INDICATORS OF REPRODUCTIVE HEALTH CARE, 1988–2008**

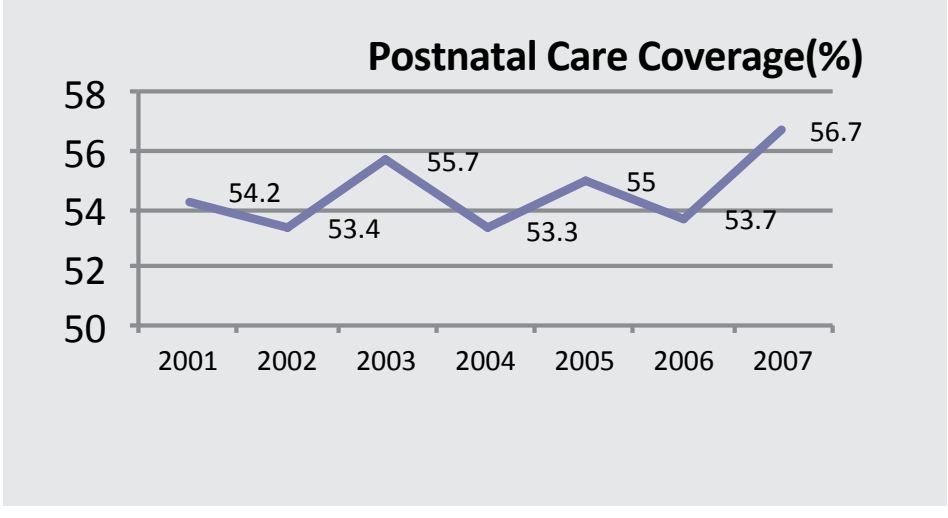


Source: *Ghana Statistical Service (2005, 2008), Ministry of Health (2006).*

Deliveries that were assisted by a health professional recorded slow progress, increasing from 40 percent in 1988 to 59 percent in 2008. In the Northern region, one in four compared to four in five children in the Greater Accra region are likely to be delivered in a health facility. Professional assistance at birth for women in urban areas was found to be twice as likely to occur as in rural areas (MOH, 2008a). The available data show that over 40 percent of women did not deliver in a health facility because some of them thought it was unnecessary to do so, while others cited lack of money, accessibility problems like distance to a health facility, transportation problems, not knowing where to go, and the unavailability of someone to accompany them to the facility. The Reproductive and Child Health Policy recommends a minimum of four visits per client and a haemoglobin check at registration and at term. The four-plus visit coverage has stayed below 60 percent against the target of 80 percent and the proportion of women whose haemoglobin is checked at term remains below 10 percent.

While puerperal sepsis is a significant cause of maternal deaths, ***postnatal care*** coverage has persistently remained low and stagnated between 53 percent and 56 percent from 2001 to 2007 (fig. 4).

FIGURE 4 **POSTNATAL CARE COVERAGE**



FP prevents unwanted pregnancy and reduces the risk of maternal deaths from pregnancy-related complications and unsafe abortions. But the FP acceptor rate has seen only a marginal rise from 21.2 to 25.4 percent of women in their reproductive age between 2007 and 2009. Greater Accra and the Western and Ashanti regions have particularly low acceptor rates. The Upper West and Brong Ahafo regions record the highest FP acceptor rates (fig. 5). The preferred methods are Depo (44.3 percent), male condom (27.7 percent), combined pills (15.9 percent) and injectable Norigynon.

FIGURE 5 FAMILY PLANNING ACCEPTOR RATE BY REGION, 2007–2009

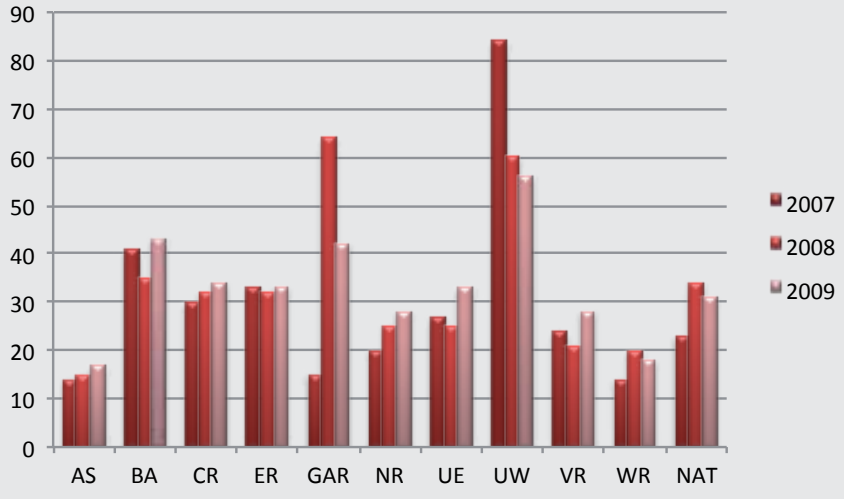
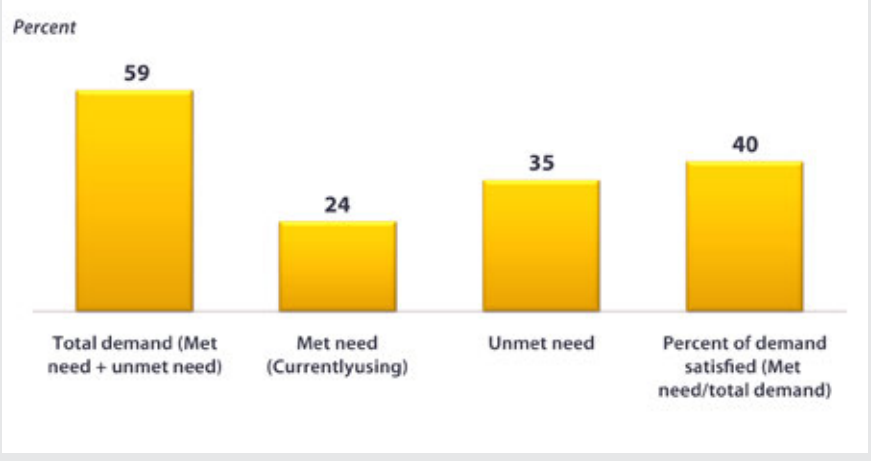


FIGURE 6 DEMAND FOR FAMILY PLANNING AMONG CURRENTLY MARRIED WOMEN



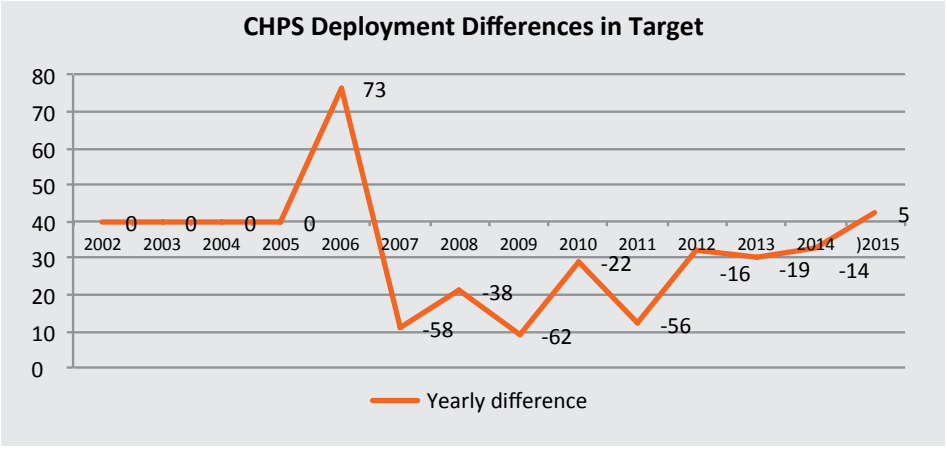
Ghana has a National Contraceptive Security (CS) Strategic plan, supported by a Financial Sustainability Plan (FSP). In 2007, however, there was a "near crisis" in the supply of male condoms as the country almost ran out of stock of Neo Sampoon spermicide, which is the most preferred type. The demand for FP among currently married women is 59 percent, out of which only 24 percent have their demand satisfied and 35 percent have an unmet need (fig. 6). The main challenges in FP include contraceptive security issues (funding gap in procurement, and in information, education and communication) and method-specific issues (low patronage of contraceptive devices such as intrauterine devices (IUDs) and female condoms due to low male involvement and fear of side effects). The current funding requirement (2010–2012) prior to the MAF process is estimated at $41.2 million as shown in table 2.

TABLE 2 TOTAL CONTRACEPTIVE FUNDING REQUIREMENTS BY PROGRAMME, 2010–2012 (IN MILLIONS USD)

Product	2010	2011	2012	Total
MoH (PPAG/MBI)	11.6	8.4	13.5	33.5
EXP SM	2.9	2.4	2.4	7.7
TOTAL	14.5	10.8	10	41.2

The ***Community Health Planning and Service (CHPS)*** was initiated in Ghana in 2000 to bridge the equity gap in health services by partnering health provider and community efforts, to bring health services closer to the doorstep of households. It involves subdividing sub-districts (15,000–30,000 population) into zones with a population of 2,000 to 5,000, assigning trained health workers, providing them with logistics and with support from community health volunteers, delivering preventive and curative care and in some cases midwife services. Currently, it is estimated that 2,200 CHPS zones are functional in Ghana (fig. 7). While the concept is good, it is challenged by inconsistent targeting (both in numbers and in relation to the Ghana poverty map), lack of human resources and very often a different interpretation of what constitutes a functional CHPS zone.

FIGURE 7 **VARIATIONS IN CHPS DEPLOYMENT TARGETING**



Behavioural change communication (BCC) is another key initiative to create awareness about pregnancy risk factors and danger signs, and increase demand and utilization of antenatal services, SD services, EmONC and postnatal care. The programme uses the media to inform, educate and communicate messages to promote the adoption of desired behaviours; prints posters, leaflets and fliers; engages in advocacy; involves traditional leaders and religious leaders and groups, and so on. Recently, with support from UNICEF, the Health Promotion Department of the Ghana Health Service (GHS) developed a common framework for behavioural change termed 'Communication for Development' (C4D).

The high maternal mortality in the country was declared a national emergency in 2008 and therefore emphasized the need to assign a higher priority to reproductive health services. Unfortunately, resource allocation was not aligned to match this good policy declaration. Furthermore, there is no systematic tracking of set targets such as focused antenatal care coverage, the percentage of facilities offering basic emergency obstetric care (BEOC), the percentage of districts offering comprehensive emergency obstetric care (CEOC), and the percentage of districts with transfusion service. Issues of accessibility often emerge as a bottleneck for pregnant women, particularly in rural areas. Sometimes, pregnant women are not able to afford transport or do not know where to access maternal health services.

TABLE 3 STATUS OF MDGS AND TRENDS TOWARDS ACHIEVING THEM

Goals/Targets	Indicator	1999	2001	2002
Goal 1. Eradicate Extreme Poverty and Hunger a. Halve the proportion of people below the extreme poverty line by 2015	Proportion below extreme poverty (national basic needs) line (%)	26.8	-	-
	Proportion below upper poverty line (%)	39.5	-	-
b. Halve the proportion of people who suffer from hunger	Proportion of children malnourished (%)			
	-Underweight	23 (1988)	23	20 (1998)
	- Stunting	34 (1988)	33 (1993)	31 (1998)
	- Wasting	9 (1988)	14 (1993)	10.0 (1998)
Goal 2: Achieve Universal Primary Education Achieve universal access to primary education by 2015	- Gross enrolment ratio (%)	72.7 (1990)	79.5 (2000)	-
	- Net primary enrolment ratio (%)	54 (1990)	61 (2000)	-
	- Primary completion/ survival rate (%)	63 (1990)	63 (2000)	-
Goal 3: Promote Gender Equality and Empower Women a. Eliminate gender disparity in primary and junior secondary education by 2009 b. Achieve equal access for boys and girls to senior secondary by 2009	Ratio of females to males in primary schools (%)	-	-	0.92
	Ratio of females to males in junior secondary schools (%)	-	-	0.88
	Ratio of females to males in senior secondary schools (%)	-	-	-
	Percentage of female enrolment in senior secondary schools (%)	-	-	-

Indicator Status						MDG Target
2003	2004	2005	2006	2007	2008	2015
-	-	-	18.0	-	-	18.5
-	-	-	28.5	-	-	25.8
18	-	-	-	-	13.9	15.5
35	-	-	-	-	28	15
8	-	-	-	-	9	3.8
-	-	85.7	92.1	93.7	95.2	100
-	-	59.1	69.2	81.1	83.7	100
-	83.2	82.6	75.6	85.4	88.0	100
0.77	0.93	0.95	0.95	0.96	0.96	1.0
0.88	0.88	0.88	0.88	0.91	0.92	1.0
-	-	-	-	-	-	-
-	-	43.5	49.5	-	-	-

Goals/Targets	Indicator	1999	2001	2002
Goal 4: Reduce Child Mortality	- Under-five mortality rate (per 1,000 live births)	122 (1990)	110 (1995)	109 (2000)
Reduce under-five mortality by two-thirds by 2015	- Immunization coverage (%)	61 (1990)	70 (2000)	-
Goal 5. Improve Maternal Health	- Maternal mortality per 100, 000 live births (survey)	740 (1990)	-	-
Reduce maternal mortality ratio by three quarters by 2015	- Maternal mortality per 100, 000 live births in health facilities (institutional)	216 (1990)	260	204
	- Births attended by skilled health personnel (%)	40 (1988)	44 (1993)	44 (1998)
Goal 6. Combat HIV/AIDS & Malaria, and Other Diseases a. Halt and reverse the spread of HIV/AIDS by 2015	National HIV prevalence Rate (%)	1.5	2.9	3.4
b. Halt and reverse the incidence of malaria	Under-five malaria case fatality (Institutional) (%)	-	-	2.9

Indicator Status						MDG Target
2003	2004	2005	2006	2007	2008	2015
111	-	-	111	-	80	39.88
83	-	84	85	89	90	100
-	-	503	-	-	451	185
205	187	205	197	224	201	54
47	-	-	48	-	59	100
3.6	3.1	2.7	3.2	2.6	2.2	≤1,5
2.8	2.7	2.4	2.1	-	-	-

Goals/Targets	Indicator	1999	2001	2002
Goal 7: Ensure Environmental Sustainability				
a. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	a. Proportion of land area covered by forest (ha/annum)	6,229,400 (27.4 % of total land area)	-	-
	b. Annual rate of deforestation (%)	1.82 (135,400 ha)	1.89 (115,400 ha)	-
b. Halve the proportion of people without access to safe drinking water by 2015	Proportion of population with access to safe drinking water (%)	56 (1990)	67 (1993)	70 (1998)
	-Urban	86 (1990)	90 (1993)	94 (1998)
	-Rural	39 (1990)	54 (1993)	63 (1998)
	Proportion of population with access to improved sanitation (%)	-	4 (1993)	5 (1998)
	-Urban	-	10 (1993)	11 (1998)
	-Rural	-	1 (1993)	1 (1998)
	Population with access to secure housing (%)	-	-	-
	Population living in slums (%)	27.2 (1990)	25.5	-

Indicator Status						MDG Target
2003	2004	2005	2006	2007	2008	2015
-	-	5,517,000 (24.3% of land area)	-	-	-	≥7,448,000 ha
-	-	1.7 (93,789 ha)	-	-	-	≤1.82%
69	-	-	-	-	83.8	78
83	-	-	-	-	93	93
55	-	-	-	-	76.6	69.5
8	-	-	-	-	12.4	52
15	-	-	-	-	17.8	55
2	-	-	-	-	8.2	50.5
-	-	11	11.4	12	12.5	18.5 (2020)
-	-	21	20.7	20	19.6	<13

Goals/Targets	Indicator			
		1999	**2001**	**2002**
Goal 8: Develop a Global Partnership for Development Deal comprehensively with debt and make debt sustainable in the long term	Public debt ratio (% of GDP)			
	External	152.8 (2000)	114.8	105.4
	Domestic	28.9 (2000)	26.8	28.5
	Total	181.65 (2000)	141.61	133.85
	External debt service as a percentage of exports of goods & services	7.8 (1990)	10.1	10.2
	ODA Inflows (% of GDP) Total	6	15	8
	Programme Aid	30	39	58

Source: *Ghana MDG Report 2010.*
** As reported in MoH-MNCH Strategy (2009–2015).*
*** MoH has changed the target from 80 percent to 55 percent in the MNCH Strategy (2009-2015).*
****Ministry of Agriculture and Forestry, Forestry Sector Strategy.*

Indicator Status						MDG Target
2003	2004	2005	2006	2007	2008	2015
100.7	73	59.6	17	24.6	27.7	-
20.5	21.2	18.8	24.4	26.2	27.5	-
121.26	94.18	78.35	41.42	50.87	55.2	-
5.2	5.6	5.8	3.2	-	4.3	-
9	10	9	8.1	8.1	8.6	-
49	40	35	37.6	31	37	-

CHAPTER 3:

STRATEGIC INTERVENTIONS

Photo: Kayla Keenan

3.1: STRATEGIC INTERVENTIONS OF HIGH IMPACT FOR THE ACHIEVEMENT OF MDGS

Most of the interventions that have been pursued to curb the high incidence of maternal mortality over the years are similar to those for under-five mortality. They include:

(i) establishment of at least one fully operational and furnished hospital in every district to deal with complications from maternal health delivery;

(ii) result-oriented strategies for under-five children, maternal health care and malnutrition;

(iii) increased access to health services under the NHIS;

(iv) high vaccination coverage, increased use of insecticide-treated nets;

(v) continuous advocacy to district assemblies (DAs) and DHMTs to devote more resources to maternal and child health;

(vi) expansion of community-based health service delivery.

Additional policies, strategies and interventions being pursued over the years to address the MMR include the following:

- 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;
- Wheel for Improving Access to Quality Care in FP: Medical Eligibility Criteria (MEC) for Contraceptive Use;
- Road Map for Repositioning FP;
- declaring maternal mortality a national emergency in 2008 and a programme of free health care for pregnant women including deliveries through the NHIS;
- strengthening of Community Health Planning Services (CHPS) to facilitate the provision of maternal health services; and expansion of community-based health service delivery;
- to increase supervised delivery at the district level, targeting of pregnant women for NHIS registration, raising community awareness through CHPS zones, Community Health Officers outreach education and mobilization of community leaders, etc.;
- continuous education to traditional maternal health service providers to ensure preventable maternal deaths;
- ongoing process to make maternal death a notifiable event backed by legislation;
- reduction of guinea worm cases, and improvement of tuberculosis treatment;
- introduction of steps to revise guidelines for the conduct of maternal death audits and to establish a system of confidential enquiry into maternal deaths.

Analyses of these policy and strategic documents and consultations with health managers have shown the multi-dimensional initiatives adopted by Ghana to address issues of maternal health. Further initiatives in addition to the ones above include free Ambulance Services for Obstetric Emergency, Focus ANC

and Supervised Delivery, Prevention of Mother to Child Transmission/Counselling and Testing PMTCT/CT for all pregnant women, free maternal care/delivery, comprehensive abortion care, adolescent health programmes, providing communications, logistics and equipment for referral systems, and supervision and monitoring of maternal services. Additional initiatives include the use of insecticide-treated nets, High Impact Rapid Delivery (HIRD) interventions, CHPS, expansion of blood transfusion services and promotion of good nutrition. In spite of these efforts maternal deaths still remain high at 503 per 100,000 live births in 2005 and 451 per 100,000 live births in 2007. If nothing is done to accelerate progress and the current trends continue, maternal mortality will be reduced to only 340 per 100,000 instead of the MDG target of 185 per 100,000 by 2015.

Under a Ministerial Task Team/Technical Team, the Government of Ghana has identified three key priority interventions, among several ongoing ones, with the objective of achieving maximum benefit and ensuring better coordinated effort and impact (table 5). These are:

1. Family planning
2. Emergency obstetric and neonatal care
3. Skilled attendant at delivery

3.1.1: Family planning

Effective FP is one of the high-impact interventions that reduce the risk of maternal deaths from pregnancy-related complications and unsafe abortions. But as indicated in the earlier chapter, the FP acceptor rate remained low, at 21.2 to 25.4 percent of women in their reproductive age, between 2001 and 2007. There are major regional variations in coverage. The interventions are intended to reposition FP to improve awareness methods especially at a time when Ghana has already revised its Contraceptives Procurement Tables and introduced an MEC wheel to improve procurement and quality, respectively.

The intervention will seek to improve FP coverage with specific focus on:

- improving supply and distribution of FP commodities;
- improving capacity in provision of FP services;
- improving public awareness and understanding of maternal health in different areas including FP, SD, EmONC, nutrition, sexually transmitted infections (STI), HIV/AIDS, gender issues, etc.

3.1.2: Skilled delivery coverage

The analysis also showed that SD is key to good maternal health care. Labour and delivery is the shortest and most critical period–childbirth continuum. Most maternal deaths occur from complications during delivery. Even with the best possible antenatal care, any delivery can become complicated. Therefore, skilled assistance is required for a safe delivery.

There have been several attempts to widen coverage of SD services and improve service utilization. These include posting announcements of the introduction of free delivery, NHIS, community education to improve demand, appointment of midwives to health centres and CHPS compounds, and offering training in life-saving skills. A mix of strategies exists to improve the quality of SD care, including monitoring the use of partographs, audits of maternal deaths and maternal death notification.

However, the SD rate has remained low, at 59 percent (GDHS 2008) annually, compared to the antenatal registrant rate of above 90 percent. The challenges explaining the low rate of SD, among others, are the provider's attitude, sociocultural challenges and inadequate number of midwives. Table 4 below shows the various categories and number of health staff in 2007 and the number required in 2010.

TABLE 4 HUMAN RESOURCE REQUIREMENTS (2010) AND STATUS AS OF 2007, GHANA

Category of staff	Total number 2007	Number required by 2010
Medical officers	2,026	3,732
Dental surgeons	31	50
Pharmacists	1,550	2,726
Expatriate doctors	200	-
Professional nurses	7,304	19,000
Enrolled nurses	2,956	-
Community health nurses	3,246	12,934
Registered midwives	2,810	8,205
Medical assistants	430	1,242
Allied health professionals	588	2,500
Traditional birth attendants	367	-
Non clinical & clinical support staff	27,918	31,100
Health assistants (clinical)	-	7,176

SD is central to achieving the MDG 5 target of a reduction in maternal mortality by three quarters. The interventions will seek to improve SD coverage, and the prioritized actions will involve:

- improving monitoring of all stages of labour (e.g., use of partographs) and the care of the newborn in the postnatal period;
- maintaining the implementation of the Free Maternal Delivery policy in line with the NHIS;
- rolling out CHPS, and strengthening referral and community support systems to address obstetric emergencies;
- Extending the reach of an integrated package of services through the HIRD approach.

3.1.3: Emergency Obstetric and Neonatal Care

Pregnant women die from obstetric complications that most times are not predictable. Improving access to basic and comprehensive essential obstetric care provides women with such complications the care they need to survive. The Ghana government through the MoH provides equipment, logistics and medicines for Comprehensive Emergency Obstetric Care (CEOC)and Comprehensive Essential Newborn Care (CENC), monitors availability of BEOC and Essential Neonatal Care (ENC) and expanded blood transfusion services to meet maternal health needs.

For a facility to provide SD and provide essential care, there is need for a midwife and/or a doctor with the requisite training and orientation. In the last few years, Ghana has established more midwifery schools

(Direct Midwifery Diploma programme 2003) and increased intake into existing schools. Despite this, the country continues to have inequities in access to health services resulting in large disparities in reproductive and maternal health indicators. The Ashanti region is the largest contributor to maternal deaths. Yet, the region disproportionately continued to receive financial support compared to inflows to each of the other four 'deprived' regions.

Ghana also experiences gaps in monitoring and tracking of EmONC, as well as gaps in selected essential outputs and outcomes as a percentage of facilities offering BEOC, the percentage of districts offering CEOC and the percentage of districts without transfusion services. As in the case of SD care, the availability of human resources and adequate distribution also remain a challenge. In 2007, Ghana prepared a road map for accelerating the attainment of MDG 5-related maternal and neonatal health in Ghana. It focused on HIRD as a framework to use evidence-based feasible and cost-effective interventions in resource-poor settings to achieve an accelerated reduction in maternal and newborn deaths, through increased ANC and PNC coverage, more SD, better access to CEOC, and the promotion of sound individual, family and community practices.

The three key areas prioritized for improving BEOC and neonatal care includes:

- scaling up the procurement and improving distribution of BEmONC and CEmONC equipment to health centres and hospitals, respectively;
- improving referral and strengthen Blood Transfusion Services (BTS) in line with the National Blood Transfusion Policy;
- scaling up Life Saving Skills (LSS) training and building Regional Resource Teams.

TABLE 5 SUMMARY MATRIX OF KEY PRIORITY INTERVENTIONS AND INDICATIVE INTERVENTIONS, GHANA

MDG	MDG indicator	#	Key interventions	#	Prioritized interventions (adapted to the country context) 2011–2015
Goal 5: Improve Maternal Health Target 5a: Reduce MMR by three fourths between 1990 and 2015 to 185 per 100,000 live births	5.1 MMR 5.2 Proportion of births attended by skilled health personnel (SD rate)	1	Improving FP coverage	1	Improving FP commodities supply and distribution
				2	Improving capacity in FP service provision
				3	Improving public awareness and understanding of maternal health including FP, SD, EmONC, Nutrition, STI, HIV/AIDS, gender issues, etc.
		2	Improving SD coverage	1	Improve monitoring of all stages of labour (e.g., use of partograph), of the care of the newborn and the postnatal period
				2	Maintain the implementation of the Free Maternal Delivery policy in line with the NHIS
				3	Roll out CHPS, strengthen referral and community support systems to address obstetric emergencies
				4	Extend the reach of integrated package of service provision through HIRD approach[4]
		3	Improving access to EmONC	1	Scale up the procurement and improve distribution of BEmONC and CEmONC equipment to health centres and hospitals respectively
				2	Improve referral and strengthen BTS in line with the National Blood Transfusion Policy
				3	Scale up LSS training and build Regional Resource Teams

4) The integrated package of services through HIRD includes some of elements of FP, SD and EmONC.

CHAPTER 4:

BOTTLENECK ANALYSIS

Photo: Kayla Keenan

4.1: BOTTLENECKS

In the execution of interventions to reduce maternal mortality, Ghana is challenged with many bottlenecks related to FP, SD and BEOC that have been identified during the implementation of initiatives and strategies or in their documentation that was shared among implementers and mangers. These bottlenecks relate to access, utilization, quality, commodity provision, governance, funding and partnership. These have been analysed to ensure that solutions match priority bottlenecks to maximize impact. Evidence shows that if these bottlenecks are removed, it can significantly improve maternal health.

The prioritization of bottlenecks was based on policy/planning, budget and financing, service delivery, service utilization and cross-cutting initiatives, as well as the time taken for the solution to address the bottleneck (table 6). The bottlenecks in the three priority areas are discussed below.

4.1.1: Family planning

Since the implementation of the 'repositioning of FP' to improve comprehensive FP coverage, the following bottlenecks, among many others, that slow down the achievement of set targets still persist:

- stock utilization and inventory management issues (including incomplete data, late reporting and the irregular physical count of commodities);
- poor counselling (for example, on how to use the MEC wheel) and low provider capacity for long-term contraception methods (IUDs, implant insertions);
- inadequate supervision and monitoring of service delivery;
- weak ownership of and support for maternal health interventions by DAs;
- cultural issues (low male involvement including lack of male service points, perception of the uptake of FP, and non-receptive maternity units/FP clinics);
- fear of side effects among women (irregular menstruation, amenorrhea, etc.).

4.1.2: Skilled delivery

The reach of SD has consistently remained below 60 percent in Ghana. It has been a major cause of worry to the sector and many strategies are being adopted to address the situation. Important measures put in place include expansion of midwifery school intake, the redistribution of midwives, LSS training, CHPS and free childbirth delivery. The major bottlenecks that remain include:

- improper application of an institutional grading system and lack of customized staffing ;
- weak supervision, monitoring and lack of a system to measure staff performance;
- inadequate number of midwives, doctors, obstetricians, and health tutors production;
- poor access to health facilities, -- geographically, financially, and culturally (e. g., CHPS, poor referral health system, i.e. (penetration and coverage of the National Ambulance service), community systems);
- inadequate funding for logistics and infrastructure;
- Poor alignment of donor support to government programmes.

4.1.3: Emergency Obstetric and Neonatal Care

Universal access to BEOC and neonatal care guarantees the best chances of survival of women who develop obstetric complications. Ongoing interventions towards this include providing theatres and equipping health institutions, improving referral through expansion of the National Ambulance Service, ensuring availability of doctors or obstetricians, providing safe BTS and improving customer care. Despite these, access to BEmONC and CEmONC is poor. The main bottlenecks underlining the poor access to EmONC are:

- inadequate funding for capital-intensive investments in infrastructure and equipment (e.g., CHPS compounds, EmONC equipment);
- inadequate accessibility to care services as a result of inadequate transport, poor road networks, weak referral systems;
- inadequate production and procurement of skilled health workers (midwives, doctors, obstetricians, gynaecologists, tutors);
- non-implementation of recommendations from previous EmONC assessments;
- lack of a policy framework;
- inadequate human resources capacity and equipment to expand coverage of LSS and ENC services.

Some bottlenecks are cross-cutting across the three priority interventions, and therefore, their removal has overarching impact on maternal health in the country. These are the following:

- ***Funding***: The enormity of the challenges faced seems to be bigger than what the available resources can accomplish. Thus, the inadequate mobilization of resources to address maternal health interventions is a major stumbling block.
- ***Capacity:*** This covers both individual and institutional capacities. There is a dearth of qualified health professionals and related workers to deliver an effective maternal health system care in the country. For instance, the population per midwife ranges between 5,357 (Upper West Region) and 14,646 (Northern Region), while women of reproductive age per midwife ranges between 920 (Volta) and 2161 (Ashanti). Incidentally, as in 2007, the Ashanti region remained the largest contributor (accounting for 20 percent of maternal deaths in Ghana). Institutional capacity is also an important issue in Ghana in terms of processes, practices and institutional coordination, often translating into weak absorptive capacity.
- ***Partnership coordination:*** There has been limited involvement of DAs, CSOs and non-governmental organizations (NGOs) as well as the private sector in the implementation of maternal health in the country. Although the programme of development partners in the health sector is aligned with national health priorities, the challenge is limited alignment in terms of sequencing, scope, and pooling of resources together to achieve a common target.
- ***Governance:*** A number of governance issues exist, relating to limited responsiveness to emerging issues, weak transparency and accountability, lack of effective leadership, and decentralization. Most maternal health activities are implemented at the district and subdistrict levels, and usually there is a significant mismatch between the work to be done and the resources allocated.
- ***Data generation and management:*** Effective monitoring of progress on maternal health requires substantial data. However, data generation and management constitute a major challenge to

progress monitoring in the country. Information on monitoring and evaluation is equally limited.

- ***Cultural values:*** Cultural factors are frequently mentioned in most national documents including the Roadmap for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Ghana 2007 and Ghana Democratic and Health Survey 2008. Sociocultural factors cause women not to use some health care services, especially when they are related to sexual and reproductive issues.

If women's lives can be saved, and maternal mortality reduced, every effort should be made to address these bottlenecks by applying the accelerating solutions proposed in Chapter V and the commitment of the Government of Ghana must be absolute.

TABLE 6: SUMMARY TABLE OF BOTTLENECKS TO KEY PRIORITY INTERVENTIONS TO ACHIEVE MDG 5 TARGETS, GHANA

Priority interventions Area(s)	Prioritized bottlenecks	Bottleneck category
Goal 5: Improve Maternal Health Target 5a: Reduce the MMR by three quarters between 1990 and 2015		
5.1 MMR 5.2 Proportion of births attended by skilled health personnel		
(1) Improve FP coverage	Stock utilization and inventory management issues (including issues relating to incomplete data, late reporting, irregular physical count of commodities, etc.)	Service delivery and cross-cutting issue across priority interventions
	Low capacity of providers of long-term methods (IUD, Implant insertions) and poor counselling (e.g., use of MEC wheel) Inadequate supervision and monitoring	Service delivery/management capacity
	Weak DA ownership and support for maternal health interventions Sociocultural barriers (low male involvement including inadequate male service points, perception of uptake of FP, and non-receptive maternity units/FP clinics)	Service utilization and cross-cutting
	Fear of side effects (irregular menstruation, amenorrhea, etc.)	Service utilization

Priority interventions Area(s)	Prioritized bottlenecks	Bottleneck category
(2) Improve SD coverage	Improper application of institutional grading system and lack of customized staffing norm	Policy/planning and service delivery
	Poor leadership and management practices, weak supervision, monitoring and weak performance measurement system s	Service delivery/cross-cutting across priority interventions
	Inadequate number of midwives, doctors, OBG specialists, anaesthetists and midwifery tutors	Service delivery/ cross-cutting across priority interventions
	(Inadequate funding for operations, logistics and infrastructure (Inadequate, late release, etc)	Financing/budget
	Poor alignment of donor support with government programmes, MoH policies and agencies, and resource allocation	Policy-planning/ financing-budget Cross cutting
(3) Improve access to emergency obstetric and neonatal care	Inadequate funding for capital-intensive investments in infrastructure and equipment (e.g., CHPS compounds, EmONC equipment, PPM) and operational funds for service delivery	Financing/budget
	Inadequate accessibility as a result of inadequate transport, poor road networks, weak referral system (i.e., penetration and coverage of national ambulance service)	Service utilization
	Inadequate production and procurement of skilled health workers (midwives and doctors, obstetricians and gynaecologists, and tutors (including for SD, IST, anaesthesia etc.)	Service delivery
	Non-implementation of recommendations of previous EmONC assessment	Policy/planning
	Lack of legal framework for BTS	Policy/planning
	Inadequate human resource capacity and equipment to expand coverage of LSS and ENC services	Service delivery/ cross-cutting

CHAPTER 5:

ACCELERATING MDG PROGRESS: IDENTIFYING SOLUTIONS

Photo: Kayla Keenan

GHANA ACTION PLAN

To address the prioritized bottlenecks identified in Chapter IV, cost-effective solutions in the three priority areas were proposed, based on impact (magnitude, speed and sustainability) and feasibility (governance, capacity and funding availability) to accelerate progress on MDG 5 (table 7). These are defined below.

5.1 IMPROVING FP COVERAGE

Key prioritized solutions proposed:

- Procure personal data assistants (PDAs) for FP data capture at service delivery points, stock utilization and inventory management at all points of the supply chain and for routine and periodic monitoring.
- Address District Health Information Management System (DHIMS) bottlenecks in DHIMS-2 and roll out training on PDAs and DHIMS at all levels of the service delivery chain.
- Develop proposal and mobilize the international community for funding.
- Improve funding by advocating for DAs to fund maternal health interventions through the District Development Fund.
- Advocate for free FP Services and its inclusion into the NHIS package.
- Improve capacity of comprehensive FP services through training in comprehensive FP, including counselling.
- Intensify public education and BCC efforts for integrated maternal and child health services, through measures such as targeting males to meet unmet needs for FP, and education on obstetric and neonatal danger signs, adolescent sexual and reproductive health, nutrition, gender, HIV/AIDS/STI, etc. Target in-school and out-of-school children and link these efforts to the communication for development framework.
- Strengthen advocacy on cultural factors affecting maternal health (specifically in the areas of FP, SD and EmONC).
- Improve performance management systems or independent review by, for instance, NGOs.

5.2 SKILLED DELIVERY

Key prioritized acceleration solutions:

- Develop grading system and upgrade health institutions accordingly (using EmONC assessment results).
- Categorize and provide realistic staffing norm (based on work load analysis to provide BEmONC at health centres and CEmONC at district hospitals).
- Sustain the new midwifery schools and expansion of midwives pre-service intake and OBG field sites.
- Sustain the contract recruitment of retired midwives and medical doctors.
- Strengthen leadership capacity of staff at all levels.
- Use EmONC assessment to establish the extent of access and referral gaps and make recommendations to address them.

- Strengthen advocacy on cultural factors affecting maternal health.
- Establish and strengthen a national multisector Inter-Agency Coordinating Committee (ICC) on Maternal and Newborn Health (with TOR to include ensuring implementation of recommendations from EmONC assessments).
- Advocate for an Office of the First Lady/Gentleman to champion maternal health and identify and appoint maternal health and newborn champions including traditional leaders (chiefs, Queen Mothers).
- Strengthen the National Secretariat of the FHD to support implementation of maternal and child health interventions.

5.3 IMPROVING ACCESS TO EMONC

Key prioritized solutions to improve access to EmONC:

- Strengthen country coordination of donor support in line with National Aid Policy.
- Advocate for the National Development Planning Commission and the Ministry of Local Government and Decentralization (MoLGD) to adopt maternal health indicators as part of DA performance monitoring.
- Develop proposals and mobilize the international community for funding.
- Strengthen intersectoral collaboration for delivery of maternal health services.
- Ensure implementation of recommendations of ongoing EmONC assessments.
- Periodic and routine assessment of EmONC and other essential maternal and health services (using appropriate tools, e.g., Systematic Coverage Evaluation, National Development Planning Commission monitoring framework).
- Strengthen audits of maternal deaths and institutionalize community audit of maternal deaths, linking it with the community-based surveillance system (which includes maintaining a records system, holding review meetings, and decision making to improve maternal health).
- Increase production of midwives and tutors, and target and train midwives and doctors to provide maternal and newborn care services.
- Strengthen the referral system to make it more responsive:
    - o Develop memorandum of understanding (MOU) with transport unions to improve transportation of pregnant women with complications.
    - o Develop MOU with communication agencies to strengthen and roll out mobile-phone-based emergency response linked with the maternal health policy.
    - o Expand the National Ambulance Service including DA ambulance support.
    - o Properly design the anaesthesia system.
- Lobby for the passage of the Health Bill including BTS.
- Strengthen LSS training and build Regional Resource Teams.
- Improve access to ENBC at all levels (includes neonatal resuscitation, kangaroo mother care, rooming-in).

TABLE 7 PRIORITIZED SOLUTIONS FOR ACCELERATING PROGRESS TOWARDS MDG 5 IN GHANA

Priority MDG	MDG indicators	Priority interventions area(s)	Prioritized bottlenecks	
Goal 5: Improve Maternal Health Target 5a: Reduce MMR by three quarters between 1990 and 2015	5.1 MMR 5.2 Proportion of births attended by skilled health personnel	(1) Improve FP coverage	Stock utilization and inventory management issues (including issues relating to incomplete data, late reporting irregular physical count of commodities, etc.)	
			Inadequate funding to procure commodities and build capacity for maternal health	
			Low provider capacity in the provision of long-term methods (IUD, implant insertions) and poor counselling (e.g., in the use of MEC wheel) Inadequate supervision and monitoring	
			Weak DA ownership and support for maternal health interventions Sociocultural barriers (low male involvement including inadequate male service points, perception of uptake of FP, and non-receptive maternity units/FP clinics) Fear of side effects (irregular menstruation, amenorrhea, etc.)	
		(2) Improve SD coverage	Improper application of institutional grading system and lack of customized staffing norm	
			Inadequate number of midwives, doctors/ OBG specialists and tutors	

	Prioritized acceleration solution	Potential partners
	Procure and use PDAs for FP data capture at service delivery points and at all points of supply chain and for routine and periodic monitoring of stock utilization and inventory management	MoH, GHS, WHO, UNFPA, UNICEF, USAID, DFID, GAVI
	Address DHIMS bottlenecks in DHIMS-2 and roll out training on PDAs and DHIMS at all levels of the service delivery chain	MoH, GHS, DANIDA, GF, GAVI
	1. Develop a proposal and mobilize the international community for funding 2. Advocate for DAs to fund maternal health interventions through District Development Fund 3. Advocate for free FP services and its inclusion into the NHIS package	MoF, MOH, GHS, WHO, UNICEF, UNFPA, UNDP, UNAIDS
	Improve capacity in comprehensive FP service provision Training in comprehensive FP including counselling Improved performance management systems or independent review (e.g., by NGOs)	MoH/GHS, UNFPA, PPAG, WHO NGO partners
	Improve public awareness and understanding on FP Intensify public education and BCC for integrated maternal and child health services (targeting males to meet unmet needs for FP, obstetric/neonatal danger signs, adolescent sexual and reproductive health, nutrition, gender, HIV/AIDS/STI etc.) including targeting in-school and out-of-school children and linking these efforts with framework Strengthen advocacy on cultural factors affecting maternal health (FP, SD and EmONC)	UNFPA, PPAG, WHO, MoH/ GHS MoH, MoWCA, GHS, UNFPA, UNICEF, WHO, NGO partners FBOs, CSOs
	Develop grading system and upgrade health institutions accordingly (using EmONC assessment results). Categorize and provide realistic staffing norm based on work load analysis to serve BEmONC (health centres) and CEmONC (district hospitals)	MoH, GHS, MoFEP, MoWH, WHO, UNFPA, WB, EU, OPEC, bilateral donors (Japan)
	Sustain the new midwifery schools and expansion of midwives pre-service intake and OBG field sites Sustain the contract recruitment of retired midwives and medical doctors Strengthen leadership capacity of staff at all levels	MOH, GHS, MoFEP, MoWH, MoE, MoESW, WHO, UNFPA, WB, EU, OPEC, bilateral donors

Priority MDG	MDG indicators	Priority inter-ventions area(s)	Prioritized bottlenecks	
			Poor access to health facilities in geographic, financial and cultural terms (e. g., CHPS, referral systems, community systems)	
			Weak overall intersectoral coordination for maternal health and risk of non-implementation of EmONC assessment recommendations	
		(3) Improve access to EmONC		
			Poor alignment of donor support with government programmes, etc.)	
			Inadequate funding for capital-intensive investments in infrastructure and equipment (e.g., CHPS compounds, EmONC equipment)	
			Inadequate accessibility as a result of inadequate transportation, weak referral system (i.e. penetration and coverage of National Ambulance Service) and poverty Non-implementation of recommendations of previous EmONC assessment	
			Inadequate production and procurement of skilled health workers such as midwives and doctors, obstetricians and gynaecologists, specialist and tutors (including for SD, IST, anaesthesia etc.)	

	Prioritized acceleration solution	Potential partners
	Use EmONC assessment to establish the extent of access and referral gaps and make recommendations to address them Strengthen advocacy on cultural factors affecting maternal health	MoH, GHS, GMA, NMWC, GMDC
	Establish and strengthen (ICC) on Maternal and Newborn Health (with TOR to include ensuring implementation of recommendations from EmONC assessment)	MoH, GHS, WHO, UNFPA, UNICEF, USAID, DFID, WB, EU, AfDB
	Advocate for Office of the First Lady/Gentleman to champion maternal health and identify and appoint maternal health and newborn champions including traditional leaders (chiefs, Queen Mothers)	MoH/GHS, UNFPA, UNDP, WHO
	Strengthen the National Secretariat of the FHD to support implementation of maternal and child health interventions	GHS
	Strengthen country coordination of donor support in line with National Aid Policy	MoFEP, MOH, GHS, UN, MDBS, core group members
	Advocate for DAs to fund maternal health interventions through District Development Fund Advocate NDPC and MoLGRD to adopt maternal health indicators as part of DA performance monitoring	MoH, NDPC, MoLGRD, MMDA
	Develop proposal and mobilize the international community for funding	MoFEP, MoH, GHS, WHO, UNICEF, UNFPA, UNDP, UNAIDS, MMDAs
	Strengthen intersectoral collaboration for delivery of maternal health services Ensure implementation of recommendations of EmONC assessments Periodic and routine assessment of EmONC and other essential maternal and health services (using appropriate tools, e.g., Systematic Coverage Evaluation, NDPC monitoring framework) Strengthen maternal deaths audit and institutionalize community maternal deaths audit linking it with the CBS system (records system, review meetings, decision making to improve maternal health)	MoE, transport unions, MoLGRD, MoFEP, MMDA, MoRH, NGOs/CSOs, ICC for Maternal Health
	Increase production of midwives, tutors, and target and train midwives and doctors to provide maternal and newborn care services	MoE, GHS, MoH, UNFPA, USAID, MDBS group members

Priority MDG	MDG indicators	Priority inter-ventions area(s)	Prioritized bottlenecks	
			Inadequate accessibility as a result of inadequate transport, poor road networks, weak referral systems (i.e. penetration and coverage of National Ambulance Service)	
			Lack of legal framework for BTS	
			Inadequate human resource capacity and equipment to expand coverage of LSS and ENC services	

	Prioritized acceleration solution	Potential partners
	Strengthen the referral system to make it more responsive - Develop MOU with transport unions to improve transportation of pregnant women with complications - Develop MOU with communication agencies to strengthen and roll out mobile-phone-based emergency response linked with the mobile health policy Expand the National Ambulance Service including DA ambulance support Design proper anaethesia system	MoH/GHS, transport unions, MoC
	Lobby for the passage of the Health Bill including BTS	ICC for maternal health, development partners
	Strengthen LSS training and build Regional Resource Teams Improve access to ENBC at all levels(neonatal resuscitation, kangaroo mother care, rooming-in)	MoH/GHS, development partners

CHAPTER 6:

MDG ACCELERATION PLAN: BUILDING A COMPACT

Photo: Kayla Keenan

Maternal mortality has increased in Ghana, making the objective to reduce maternal mortality unlikely to be fulfilled if current trends continue. However, progress in some regions of the country, such as the Northern, Western and Central regions, where maternal mortality improved to 195.2 per 100,000 (MDG Report 2010), clearly demonstrates that Ghana has the potential to accelerate progress on this MDG.

The Government has already accomplished major efforts in this direction by implementing two generations of the GPRS and the draft Medium-Term National Development Policy Framework 2010–2013 as well as specific health sector policies. Particular interventions put in place to address the high levels of maternal deaths have been indicated in the previous sections (Chapter 2, Section 2.2). However, as indicators show, many obstacles to policies, financing and service delivery are yet to be removed.

To accelerate progress on MDG 5, the three areas which have been chosen as particularly catalytic are:

1. Emergency obstetric and neonatal care
2. Skilled delivery coverage
3. Family planning

6.1 COUNTRY ACTION PLAN

The present MAF analysis has uncovered the most crippling bottlenecks as well as the most effective solutions to address them in the near term to effectively and quickly scale-up the coverage of these major interventions. However, the Government of Ghana will not be able to implement these solutions on its own. If these major bottlenecks to maternal health are to be effectively removed within the next five years, the Government of Ghana will need the support of all stakeholders who can have an impact on maternal health — not just the MoH and the GHS, but also other ministries and government agencies, bilateral and multilateral donors, UN funds and agencies, civil society and the private sector.

Therefore, this MAF constitutes the basis of a CAP which intends to bring together all the partners to be able to favourably impact upon the effective implementation and the scaling up of the three prioritized interventions. The Government of Ghana will be looking towards the UNCT, especially the H4, for technical support for the formulation and implementation modalities of the solutions identified. Additional resources will be needed, especially for emergency obstetric care, which may be met with the help of bilateral and multilateral donors. NGOs and CSOs will be able to support the implementation of solutions, especially — even if not limited to — those focusing on sensitization and advocacy for behaviour change as well as the monitoring of service delivery. The private sector will also be called upon to complement the public sector service delivery where additional unmet needs exist. It is only through this renewed and enhanced partnership with clearly attributed roles and responsibilities, buttressed by a robust accountability framework, and 'business as unusual' will high maternal deaths be reduced for the ultimate achievement of MDG 5.

This MDG 5 Action Plan does not replace existing nationally owned planning processes and frameworks. These will continue to be implemented to ensure continuity, complementarity and sustainability. It, rather, constitutes a subset of prioritized actions which need to be urgently undertaken to accelerate progress. However, to avoid duplication, it may be useful to constitute a starting point for the formulation of Ghana's submission to the Secretary General's Initiative on Maternal and Child Health as well as a key input into the new UNDAF (2010–2013), currently under formulation.

Table 8 presents an overview of the CAP including specific activities under each solution, expected partnerships for each, as well as the financing envelope necessary. The table includes current commitments (expectations based on previous commitments, government revenue forecasts, etc.) as well as the financing gap to be mobilized.

TABLE 8 GHANA ACTION PLAN

Priority intervention area(s)	Prioritized interventions	Prioritized bottlenecks	Prioritized acceleration solution
(1) Improve FP coverage	(a) Improving FP commodities supply and distribution	Stock utilization and inventory management issues (including issues relating to incomplete data, late reporting irregular physical count of commodities, etc.)	Procure and use PDAs for FP data capture at service delivery points and at all points of supply chain and for routine and periodic monitoring of stock utilization and inventory management
			Address DHIMS bottlenecks in DHIMS-2 and roll out training on PDAs and DHIMS at all levels of the service delivery chain
		Inadequate funding to procure commodities	1.Develop proposal and mobilize the international community for funding 2a. Advocate for DAs to fund maternal health interventions through District Development Fund 2b. Advocate for free FP services and its inclusion into the NHIS package 2c. Ensure FP commodity security (procure contraceptives)
	(b) Improve quality of comprehensive FP services	Low provider capacity for long-term methods (IUD, implant insertions) and poor counselling (e.g. use of Medical Eligibility Criteria (MEC) wheel)	Training in comprehensive FP including counselling
		Inadequate supervision and monitoring	Improved performance management systems or independent review (e.g. NGOs)

	Potential partners	Total cost (USD)	Available resources/ partners		Resource gap
	MoH, GHS, WHO, UNFPA, UNICEF, USAID, DFID, GAVI	3,812,500	280,000	GAVI	3,532,500
	MoH, GHS, DANIDA, GF, GAVI	560,000	70,000 5,000	PROMPT FOCUS	485,000
	MoFEP, MoH, GHS, WHO, UNICEF, UNFPA, UNDP, UNAIDS	28,000 66,660,000	5,000 29,225,000	Government of Ghana	23,000 37,441,000
	MoH/GHS, UNFPA, Planned Parenthood Association Ghana (PPAG), WHO, Non-govt. partners	889,600	400,000 50,000	UNFPA Government of Ghana	439,600

Priority intervention area(s)	Prioritized interventions	Prioritized bottlenecks	Prioritized acceleration solution
	(c) Increase demand for FP services	Weak DA ownership and support for maternal health interventions Sociocultural barriers (low male involvement including inadequate male service points, perception of uptake of FP, and non-receptive maternity units/FP clinics) Fear of side effects (irregular menstruation, amenorrhea, etc.)	1. Intensify public education and BCC for integrated maternal and child health services (targeting males to meet unmet needs for FP, obstetric/neonatal danger signs, adolescent sexual and reproductive health, nutrition, gender, HIV/AIDS/STI, etc.) including targeting in-school and out-of-school children and link with C4D framework 2. Strengthen advocacy on cultural factors affecting maternal health (FP, SD and EmONC) 3. Advocate for free FP Sservices and its inclusion into the NHIS package
(2) Improve SD coverage	(a) Improve monitoring of all stages of labour and the care of the newborn and the postnatal period	Improper application of institutional grading system and lack of customized staffing norm	Develop grading system and upgrade health institutions accordingly (using EmONC assessment results). Categorize and provide realistic staffing norm, based on work load analysis to provide BEmONC (health centres) and CEmONC (district hospitals)
		Inadequate midwives, doctors, obstetricians, gynaecologists, specialists and tutors	Sustain new midwifery schools and expansion of midwives pre-service intake and OBG field sites Sustain the contract recruitment of retired midwives and medical doctors Strengthen leadership capacity of staff at all levels
	(b) Maintain the implementation of the Free Maternal Delivery policy in line with the NHIS	Lack of funding	Develop proposal and mobilize the international community for funding Advocate for DAs to fund maternal health interventions through District Development Fund
	(c) Roll out CHPS, strengthen referral and community support systems to address obstetric emergencies	Poor targeting of CHPS Inadequate funding for capital-intensive investments in infrastructure and equipment	Use EmONC assessment to establish the extent of access and referral gaps and make recommendations to address them
	(d) Extend the reach of integrated package of service provision through HIRD approach[5]	Weak overall inter-sectoral coordination for maternal health and Risk of non-implementation of EmONC assessment recommendation	Establish and strengthen ICC on Maternal and Newborn Health (with TOR to include ensuring implementation of recommendations from EmONC Assessment)

5) Integrated package of services through HIRD includes some of elements of FP, SD and EmONC.

	Potential partners	Total cost (USD)	Available resources/ partners		Resource gap
	UNFPA, PPAG, WHO, MoH/GHS, Ministry of Women and Children's Affairs (MoWCA), GHS, UNFPA, UNICEF, WHO, NGO partners	242,500	120,000	UNICEF, John Hopkins University (JHU)	
	Faith-based organizations, CSOs	1,541,000	975,000	ORIO, Government of Ghana	566,000
	MoH, GHS, MoFEP, MoWHW, WHO, UNFPA, WB, EU, OPEC, bilateral donors (Japan)	26,094,000	17,204,000	Government of Ghana, Health Fund	8,890,000
		28,000	28,000	Government of Ghana	0
	MoH, GHS, MoFEP, MoWHW, MoE, MoESW, WHO, UNFPA, WB, EU, OPEC, bilateral donors	14,000,000	7,500,000	Government of Ghana, Health Fund	6,500,000
		2,080,000	200,000	GAVI	1,880,000
	MoH, GHS, Ghana Medical Association (GMA), Nurses and Midwives Council (MMC), Ghana Medical and Dental Council (GMDC)	20,000	20,000	Government of Ghana	0
	MoH, GHS, WHO, UNFPA, UNICEF, USAID, DFID, WB, EU, AfDB	40,000	20,000	UNFPA, Government of Ghana	20,000

Priority intervention area(s)	Prioritized interventions	Prioritized bottlenecks	Prioritized acceleration solution
			Advocate for Office of the First Lady/ Gentleman to Champion maternal health and identify and appoint maternal health and newborn champions including traditional leaders (chiefs, Queen Mothers)
			Strengthen the National Secretariat of the FHD to support implementation of maternal and child health interventions
(3) Improve access to EmONC	(a) Scale up procurement and improve distribution of BEmONC and CEmONC equipment to health centres and hospitals respectively	Poor alignment of donor support with government programmes	Strengthen country coordination of donor support in line with National Aid Policy
		Inadequate funding for capital-intensive investments in infrastructure and equipment (e.g., CHPS compounds, EmONC equipment)	Advocate for DAs to fund maternal health interventions through District Development Fund Advocate NDPC and MoLGRD to adopt maternal health indicators as part of DA performance monitoring
			Develop proposal and mobilize the international community for funding
		Inadequate accessibility as a result of inadequate transportation, weak referral systems(i.e. penetration and coverage of National Ambulance Service) and poverty Non-implementation of recommendations of previous EmONC assessment	Strengthen intersectoral collaboration for delivery of maternal health services Ensure implementation of recommendations of EmONC assessments Periodic and routine assessment of EmONC and other essential maternal and health services (using appropriate tools, e.g., Systematic Coverage Evaluation, NDPC monitoring framework) Strengthen maternal deaths audit and institutionalize community maternal deaths auditing, linking it with the CBS systems (records system, review meetings, decision making to improve maternal health)

	Potential partners	Total cost (USD)	Available resources/ partners		Resource gap
	MoH/GHS, UNFPA, UNDP, WHO	100,000	30,000	Government of Ghana	70,000
	GHS	100,000	40,000	WHO, UNICEF, Government of Ghana	60,000
	MoFEP, MoH, GHS, UN, core members of MDBS Group	-	-		-
	MoH, NDPC, MoLGRD, MMDA	50,000	10,000	Government of Ghana	40,000
		100,000	20,000	Government of Ghana	80,000
	MoFEP, MoH, GHS, WHO, UNICEF, UNFPA, UNDP, UNAIDS, MMDA	-	-		-
	MoE, transport unions, MoLGRD, MoFEP, MMDA, MoRHW, NGOs, CSOs, ICC for Maternal Health	9,240,000	4,620,000	Government of Ghana, Health Fund	4,620,000

Priority intervention area(s)	Prioritized interventions	Prioritized bottlenecks	Prioritized acceleration solution
		Inadequate production and procurement of skilled health workers including midwives, doctors, obstetricians, gynaecologists specialist and tutors (covers also SD IST, Anaesthesia, etc.)	Increase production of midwives and tutors, and target and train midwives and doctors to provide maternal and newborn care services
		Inadequate accessibility as a result of inadequate transport, poor road networks, weak referral systems (i.e. penetration and coverage of National Ambulance Service)	Strengthen the referral system to make it more responsive • Develop MOU with transport unions to improve transportation of pregnant women with complication • Develop MOU with communication agencies to strengthen and roll out of mobile-phone-based emergency response linked with the mobilehealth policy • Expand the National Ambulance Service including DA ambulance support • Design proper anaesthesia system
	(b) Improve referral and strengthen BTS in line with the National Blood Transfusion Policy	Lack of legal framework for (BTS)	Lobby for the passage of the Health Bill including BTS
	(c) Scale up LSS training and build Regional Resource Teams	Inadequate human resource capacity and equipment to expand coverage of LSS and ENC services	Strengthen LSS training and build Regional Resource Teams Improve access to ENBC services at all levels (neonatal resuscitation, kangaroo mother care, rooming-in)

	Potential partners	Total cost (USD)	Available resources/ partners		Resource gap
	MoE, GHS, MoH, UNFPA, USAID, MDBS group members	350,000	200,000	Government of Ghana	150,000
	MoH/GHS, transport unions, MoC	500,000	125,000	DAs	375,000
		100,000	0		100,000
		30,000,000	25,000,000	Government of Ghana	5,000,000
	ICC for Maternal Health, development partners				
	MoH/GHS, development partners	768,000	300,000	Health partners, Government of Ghana	468,000
		153,491,100	86,447,000		70,740,100

6.2 IMPLEMENTATION AND MONITORING PLAN

The MDGs remain achievable by 2015 if backed by the right policies, implementation strategies and actions, coupled with strong political commitment, and adequate funding and institutional capacities. Central to the success of this Action Plan will be the coordinated approach of implementation that targets effective service delivery for the provision of EmONC, SD and FP.

Usually, such an effort is hampered by a weak monitoring system, particularly in assessing the effectiveness of services in terms of their coverage or outcomes at all levels. By using the appropriate tools, for example the Systematic Coverage Evaluation tool and the NDPC monitoring framework , it is possible for service providers and health managers to stay on track and remain accountable.

The collaborative and inclusive process through which this MAF and CAP have been written are initial good steps in the right direction. The objective of the implementation and monitoring plan — as an integral part of the Country Action Plan — is to follow up on commitments made and, above all, track progress over time.

TABLE 9 GHANA MDG 5 IMPLEMENTATION AND MONITORING PLAN

Acceleration solution/activities	Indicator	IMPLEMENTATION TIME LINE (2011–2015				
		2010	2011	2012	2013	
Procure and use PDAs for FP data capture at service delivery point	Number of subdistricts/districts using PDAs for data capture. Number of PDAs procured.	X	X			
Address DHIMS bottlenecks in DHIMS-2 and roll out training on PDAs and DHIMS	DHIMS-2 completed. Number of districts using DHIMS-2 for data reporting	X	X			
Advocate for DAs to fund maternal health interventions through District Development Fund	Percentage of districts supporting maternal health through DDF	X	X			
Develop proposal and mobilize the international community for funding	Number of successful proposals for maternal health	X	X	X	X	
Periodic and routine assessment of EmONC and other essential maternal health services	Number of routine assessments done, % HFs providing ANC/PNC % ANC clients with 4+ visits. % ITN use; %HIV tested; % IPT2			X	X	

			Indicator for monitoring (yearly)						Responsible MDA (structure)
	2014	2015	2010	2011	2012	2013	2014	2015	
									See above table 8 for responsible partners
	X	X							
	X	X							

Acceleration solution/activities	Indicator	IMPLEMENTATION TIME LINE (2011–2015				
		2010	2011	2012	2013	
Training in and ensure the conduct of comprehensive FP services including counselling	Number of staff trained	X	X			
Intensify public education and BCC for integrated MCH Services (Targeting males to meet unmet needs for FP, and Obstetric/Neonatal Danger Signs)	Contraceptive acceptor rate, % private sector FP commodities supplumented, ratio of donor to GOG funds for contraceptives, % of CHWs and CHOs trained in HBLSS, number of BCC/IEC materials,		X	X	X	
Upgrade health institutions (using EmONC assessment results), categorize and provide realistic staffing norm (based on work load analysis to provide BEmONC (health centres) and CEmONC (district hospitals)	Number of health facilities upgraded % facilities offering BEOC % districts offering CEOC % districts with transfusion service		X			
Improve supervision and monitoring (horizontal etc.)	Improved quality of care according to national standards		X	X	X	
Sustain new midwifery schools and expansion of midwives pre-service intake and OBG field sites	New midwifery schools established. Number of enrolled midwives in training institutions		X	X	X	
Use EmONC assessment to establish the extent of access and referral gaps, make recommendations and address them	Access gaps established		X			

			Indicator for monitoring (yearly)						Responsible MDA (structure)
	2014	2015	2010	2011	2012	2013	2014	2015	
	X	X							

Acceleration solution/activities	Indicator	IMPLEMENTATION TIME LINE (2011–2015				
		2010	2011	2012	2013	
Establish and strengthen ICC on Maternal and Newborn Health with TOR to include ensuring implementation of recommendations from EmONC assessment	ICC established. Quarterly meetings held		X	X	X	
Advocate for Office of the First Lady/ Gentleman to champion maternal health and identify and appoint maternal health champions	Office of First Lady/Gentleman appoints champion for maternal health		X			
Strengthen country coordination of donor support in line with National Aid Policy	Proper coordination of donor support as per National Aid Policy		X	X	X	
Advocate for DAs to fund maternal health interventions through District Development Fund	**Repeated above		X	X		
Develop proposal and mobilize the international community for funding	**Repeated above		X	X	X	
Strengthen intersectoral collaboration for delivery of maternal health services (Ministries, departments, agencies, partners, Trade Union Congress)	Number of intersectoral meetings held on maternal health		X	X	X	

			Indicator for monitoring (yearly)						Responsible MDA (structure)
	2014	2015	2010	2011	2012	2013	2014	2015	
	X								
	X	X							
	X	X							
	X	X							

Acceleration solution/activities	Indicator	IMPLEMENTATION TIME LINE (2011–2015				
		2010	2011	2012	2013	
Increase production of midwives/tutors, and target and train midwives, and doctors to provide maternal and newborn care services	Number of staff produced		X	X	X	
Strengthen the referral system to make it more responsive - MOU with transport unions -Expansion of National Ambulance Service	Improved referral system as per national guidelines. Number of districts with MOU with transport unions		X	X	X	
Lobby for the passage of the Health Bill including BTS	Passage of health bills		X			
Strengthen LSS training and build Regional Resource Teams	Number of key staff trained in LSS. Number of skilled attendants		X	X		

NB: Use sector-wide indicators.

			Indicator for monitoring (yearly)						Responsible MDA (structure)
	2014	2015	2010	2011	2012	2013	2014	2015	
	X	X							
	X	X							

ANNEXES

Photo: Kayla Keenan

ANNEX 1: POLICY DOCUMENTS AND REPORTS

1. Road map for accelerating the attainment of the MDGs related to maternal and newborn health in Ghana
2. Road map for repositioning FP in Ghana 2006–2010
3. Prevention and management of unsafe abortion: comprehensive abortion services, standards and protocol
4. National reproductive health service, policy and standards
5. MoH 2010 POW
6. Improving access to quality care in FP, medical eligibility criteria for contraceptive use (MEC Wheel)
7. Revised child health policy 2007–2015, Dr. Aboagye/UNICEF
8. Reproductive health strategic plan 2007–2011
9. Safe motherhood protocol
10. FP protocol
11. Ghana Reproductive Health Strategic Plan (2006–2010)
12. Creation of Inter-Ministerial Task Force for Maternal Mortality Reduction (2008)
13. Creation of Making Pregnancy Safer Task Force
14. 'REDUCE' Model for improving maternal and newborn survival in Ghana
15. Proposal by UNICEF, UNFPA and WHO on achieving the health MDGs in Ghana (2009, enclosed)
16. CARMMA (AU Campaign on Accelerated Reduction of Maternal Mortality, 2009)
17. Development of Emergency Obstetric and Newborn Care (EmONC) Needs Assessment (2010)
18. Minister of Health declaring maternal mortality a national emergency (2008)
19. Report on the National Consultative Meeting on the Reduction of Maternal Mortality in Ghana (2008)
20. Launch of the Commission of Women's Health in the African Region (2010)

NATIONAL (GOVERNMENT) POLICY DOCUMENTS

21. Ghana Poverty Reduction Strategy 2003–2005
22. Growth and Poverty Reduction Strategy (GPRS II) (2006–2008)
23. The millennium villages project Bonsaaso Ghana cluster
24. Draft Medium-Term National Development Policy Framework 2010–2013

GENERAL HEALTH POLICY DOCUMENTS

25. National health policy
26. MoH gender policy
27. Adolescent reproductive health policy
28. National e-health strategy
29. Ghana health sector five-year programme of work 2002–2006, an in-depth review of the health sector response to maternal mortality in Ghana by 2003
30. Third health sector five-year plan 2007-2011
31. GHS five-year strategic framework for service delivery 2007–2011
32. Health sector medium-term development plan 2010–2013
33. Health Sector Policy and Annual Workplans
34. Guidelines on Nutrition
35. PMTC ***plus*** guidelines
36. Early Infant diagnosis (EID) 2009
37. Policies on orphans and vulnerable children (OVCs)

REPORTS

38. A paper on safe motherhood programme in Ghana, prepared for Africa population commission: West African regional conference 6–9 November 2006
39. Health sector in Ghana: Facts and figures, 2009
40. Annual Report RCH 2007
41. Annual Report FHD 2008, 2009
42. Monitoring visit report for 2008 HIRD implementation in all regions
43. Institutional analysis of safe motherhood policy-making in Ghana
44. Selected practices recommendation for contraceptive use 2008 update
45. MEC wheel evaluation report WHO, Dr Charles Fleisher
46. Strategic assessment of abortion care services in Ghana
47. Readiness for abortion care services
48. Time to take charge — advocacy tool for resource mobilization
49. EmONC baseline report, 2005
50. Annual Progress Reports of the GPRS I & II (2005, 2006, 2007, 2008, 2009)
51. Demographic Health Survey (2003, 2008)
52. Ghana Living Standards Survey (1999, 2006)
53. Ghana Maternal Health Survey (2007)
54. Evaluation reports with reference to maternal health care delivery
55. MDG Reports (2002, 2004, 2006, draft 2010 editions)
56. Millennium Villages Project (MVP) Assessment
57. Millennium Villages Project (MVP) reports
58. WHO Access meeting/Midwifery training and Pre-service curriculum reviews
59. MEC 2008 Update (ppt)
60. Ghana maternal health survey 2007 dissemination (ppt)
61. Maternal mortality in Ghana (ppt)
62. Reproductive health and maternal mortality in Ghana (ppt)
63. Contraceptive security issues at facilities review
64. HIRD progress report
65. Microeconomics in health
66. Health Sector Annual reports
67. Citizen Assessment Report of the NHIS
68. Senior officers of MOH/GHS at various levels of health care system

ANNEX 2: QUESTIONNAIRE ADMINISTERED TO DDHS GROUP

Dear DDHS

The high maternal mortality rate in Ghana has been of great concern to decision makers resulting in maternal being declared emergency in July, 2008. The MAF is aimed at supporting national government and her partners to better understand the deep-rooted causes militating against positive outcomes in maternal health care.

In this regard, your experience and expertise is being solicited.

In your opinion

1) What are some of the key existing policies on Maternal Health in Ghana?
2) What are some of the key existing interventions on Maternal Health in Ghana?
3) What are the gaps in the existing policies and interventions on Maternal Health Care in Ghana?
4) What are the major bottlenecks (challenges) to the effective implementation of the key interventions for accelerating progress on MDG5 in Ghana?
5) What are the key cost effective solutions that can accelerate progress of Maternal Health Care in Ghana?

ANNEX 3: MDG 5 DOCUMENTS, RECOMMENDATIONS AND LEVEL OF IMPLEMENTATION

MAF TECHNICAL TEAM WORKING SESSION, 9–13 AUGUST 2010 AT GHS, ACCRA

No	Document	Year	Recommendations
1	Improving access to quality care in FP: medical eligibility criteria for contraceptive use (MEC Wheel)[3]		To be used by all FP service points
			GHS/Partners "revised Contraceptives Procurement Tables (CPTs)" in March 2006
2	2010 MOH Programme of Work	2010	
3	A road map for repositioning FP in Ghana, 2006–2010[4]	2006	
			Expand service delivery sites
			Expand resource mobilization and contraceptive commodities
4	Road Map for Accelerating the attainment of the MDGs Related Maternal and Neonatal Health In Ghana 2007-2011[5]		Track the following indicators: -minimum of four visits per ANC client - % facilities offering BEOC - % districts offering CEOC - % districts with BTS - of HFs offering CAC - % of facilities with good referral system for maternal and neonatal health
5	Accelerating improvements in maternal and newborn health in northern Ghana, needs assessment report, Oct 2005, UNICEF, UNFPA, KNUST, GHS-RCH		Develop system to provide and track IST in LSS for midwives to provide BEmOC?

Level of implementation			Possible negative effect on MDG5 attainment			Comment
Partially	Fully	Unclear/nil	Minimal	Moderate	High	
		X		X		Not generally available
		X		X		Level of availability and use not certain
				X		
		X		X		
		X		X		
X					X X X X X	
		X				

	Document	Year	Recommendations
6	National reproductive health service policy and standards,[6] 2003, GHS		Decentralize greater proportion of funds for reproductive health shall be decentralized to the district level
			Clinical skills training,
			Equipment supply
			Build partnerships
			Integrate
7	A paper on safe motherhood programme in Ghana, Nov 2006, Odoi Agyarko et al.	2006	
8	Title: Ministry of Health (2009), Health Sector Gender Policy, April 2009		Address gender inequalities in health service delivery to ensures integration of gender issues in service provision
9	Title: Gender Issues Paper (Second Draft). Ministry of Health, Agyare-Kwabi		

Level of implementation			Possible negative effect on MDG5 attainment			Comment
Partially	Fully	Unclear/nil	Minimal	Moderate	High	
		X			X	
		X			X	
		X			X	
		X		X		
		X		X		

ANNEX 4: REFERENCES

Ghana Poverty Reduction Strategy 2003–2005: An Agenda for Growth and Prosperity. Volume 1, Analysis and Policy Statement. National Development Planning Commission, February 2003

This is a comprehensive national development policy framework in support of poverty reduction and growth. The document links HIV/AIDS strongly with poverty and defines interventions to prevent new infections of HIV, promote safer sex, prevent Mother to Child Transmission, ensure safe blood and blood products and improve STI management (target: base year 2000 to 24 percent by 2005). It also aims at providing a continuum of care or people living with HIV/AIDS (PLWHA) and their families, continuous supportive counseling and palliative care in the household and community and the management of opportunistic infections target: base year 2000 of 5.8 percent to 15 percent by 2005 for women and 2000 of 15.4 percent to 25 percent by 2005 for men). Other interventions laid out include effective institutional foundation (target: base year 2000 to 24 percent, 2005), joint interventions on health care and safe water and environmental sanitation, access to quality health and nutrition services, susstainable financing arrangements that protect the poor, and efficiency in service delivery with the following targets: IMR 57/1,000lbs (2000) to 50/1000 (2005); MMR 200/100,000lbs (2000) and 160/100,000lbs (2005) and SD 49 percent (2000) to 55 percent (2005).

Growth and Poverty Reduction Strategy (GRSP II) (2006–2009), Volume 1, Policy Framework, November 2005, National Development Planning Commission

Policy issues: The policy goal was to attain middle-income status (with a per capita income of at least $1,000) by the year 2015 within a decentralized and democratic environment. The main issues include a broad national development framework, health care, safe water and environmental sanitation, access to quality health and nutrition services, sustainable financing arrangements that protect the poor, and efficiency in service delivery. The intervention and targets were the MDGs 4 and 5 and the development and implementation of high-impact yielding strategies for U5M, maternal mortality, malnutrition and redistribution of health workers in favour of deprived areas and improvement of CHPS.

Monitoring Visit Report for 2008 HIRD implementation in all regions. (2008) GHS

The aim of this assessment was to look at HIRD implementation at regional, district and subdistrict levels. The assessment found that all regions had trained staff in LSS, usage of partographs and neonatal resuscitation. The main challenges were: (a) unavailability of necessary logistics; (b) insufficient health staff (quantity and quality); (c) insufficient funds; (d) lack of transportation; and (e) frequent breakdown of motorbikes and high maintenance costs (i.e., Jialing motorbikes).

Institutional Analysis of Safe Motherhood Policy-Making in Ghana, IMMPACT, NMIMR, 2005

The main aim of the safe motherhood policy is to reduce maternal mortality. It identifies the following areas to be tackled to achieve the policy objective: (a) low health education; (b) poor monitoring; (c) sustainability of free delivery; (d) sociocultural beliefs and practices (leading to a delay in seeking care); (e) institutional arrangement (dilemma of clinical care and public health); (f) insufficient health staff; and (g) cost of services (including transportation).

Under-five Child Health Strategy: 2007–2015. MOH, Ghana.

This strategic document focuses on achieving MDG 4 (reduction of child mortality from 111/1000 in 2006 to 10/1000 in 2015). The key interventions identified were antenatal care, delivery care, postnatal care, immunizations, nutrition, treatment of child illness and prevention of malaria.

Targets are set for focused antenatal care (FANC) and SD: proportion of deliveries undertaken by skilled birth attendants; 50 percent (2006) to 65 percent, neonatal interventions and children between the ages of 1 and 59 months.

Among the targets are increasing the following rates: exclusive breast feeding for six months, from 54 percent (2006) to 75 percent (2015); the proportion of children aged six to 59 months who have received a dose of vitamin A in the previous six months, from 60 percent (2006) to 90 percent (2011); the proportion of children aged 12 to 23 months who are fully vaccinated, from 64 percent (2006) to 70 percent (2011); the proportion of children sleeping under insecticide-treated nets the previous night from 22 percent (2006) to 55 percent (2011); the proportion of children with fever receiving an appropriate antimalarial within 24 hrs, from 61 percent (2006) to 70 percent (2011); the proportion of children with watery diarrhoea receiving ORT, from 37 percent (2006) to 60 percent (2011); the proportion of children with watery diarrhoea receiving ORT and an appropriate course of zinc, from 25 percent (2011); and the proportion of children with suspected pneumonia who received appropriate antibiotics, from 33 percent (2006) to 50 percent (2011).

National e-Health Strategy, MoH

The e-Health strategy, "the combined use of electronic information and communication technology in the health sector" (WHO definition) aims to improve access to information in support of safe, efficient and effective health care delivery in a timely manner and at the point of need. It guides the deployment of information and communication technology at all levels of the health system, to enable the communication and exchange of information among multi-disciplinary health teams to provide better coordinated and seamless health care, improve the quality and efficiency of decision-making to clinical practice through better access to health information, clinical evidence and clinical decision support tools, and provides access to appropriately packaged information to enable individuals to make informed health choices to manage, control and improve personal health outcomes in all parts of the country.

For the health care provider, it is to improve their systems for patient record keeping, web-based disease surveillance, electronic prescriptions, referral management, patient appointments and e-consultation and remote service. It aims to benefit health care managers by improving financial, performance, human resource and logistics management systems.

Consumers are to benefit by enhanced notification systems, scheduled appointment programmes, packaged public health messages and a health information resource network.

MoH 2010 Programme of Work, THE GHANA HEALTH SECTOR (Going Beyond Strategy to Action)

The goal of the health sector in the medium term (2010–2013) is to ensure a healthy and productive population that continues to reproduce safely.

The key issue is ensuring improved maternal and child care. It highlights five main priorities with regard to decreasing maternal and child mortality through improved FP, SD, access to blood services, comprehensive abortion care, neonatal care and malnutrition. There are also strategic budgetary al-

locations for infrastructure and equipment related to MDG 5.

Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use (MEC Wheel)

The wheel contains medical eligibility criteria and tells providers if a woman presented with a known medical or physical condition is able to use various contraceptive methods safely and effectively and has recommendations for combined pills, combined injectable contraceptive, progesterone-only pills, implants and copper-bearing IUD. This wheel, if used appropriately by providers, will protect women who want to use contraceptives from infections, and possible death from cardiovascular diseases, diabetes, cancers, hypertension and postpartum-related health issues.

A road map for repositioning family planning in Ghana, 2006–2010[6]

This document aims to ensure that FP becomes the fulcrum for strengthening and advancing reproductive health and rights and reposition FP as a national priority.

(It has eight elements, namely policy, advocacy, BCC, institutional coordination and collaboration, human resource development and capacity-building, expanding access to FP services, strengthening resource mobilization and research, and monitoring and evaluation.)

The rationale is to achieve a stabilized total fertility rate, by addressing the rapidly growing population, the persistent gaps between FP knowledge and use, and high unmet need for FP 34 percent, 22 percent for spacing and 12 percent for limiting- DHS 2003. The document recognizes the role of FP in the achievement of MDG 5 and states in the introduction: "There is growing concern among population and health experts in Ghana that under the existing scenario, the goals of the Ghana Poverty Reduction Strategy, key elements of the Millennium Development Goals (MDGs)… are unlikely to be achieved". Firm targets are to be set for CPR, TFR, MMR and IMR as stated in page 37. A comprehensive plan is to be prepared by the National Population Council with MoH/GHS and NDPC, with key stakeholder responsibilities defined. A well coordinated and integrated advocacy plan was developed and is expected to be implemented. Service delivery sites, resource mobilization and contraceptive commodities are to be expanded and standardized formats for data collection and analysis prepared. A comprehensive training programme was also prepared but lack of funding has limited its implementation.

Road map for accelerating the attainment of the MDGs related to maternal and neonatal health in Ghana 2007–2011[7]

The road map provides a framework for the implementation of HIRD which uses evidence-based, feasible and cost-effective interventions in resource-poor settings to achieve accelerated reduction in maternal and newborn deaths. The health care facility level interventions are skilled attendance, equipment and supplies and EmONC. The community interventions are IEC to improve good health practices and health-seeking behaviour and to recognize danger signs. The objectives are to increase ANC and PNC coverage; increase the proportion of skilled deliveries, improve access to comprehensive and basic essential obstetric care; increase the capacity of providers to implement appropriate ENC; expand FP providers and services; promote individual, family and community practices to improve maternal and neonatal health; strengthen systems and mobilize resources for maternal and neonatal health, and referral and HMIS systems; strengthen supervision and monitoring systems; and develop and implement a research agenda. The document outlines all strategies and

6) GHS, A road map for repositioning Family Planning in Ghana, 2006-2010.

7) GHS, Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Neonatal Health In Ghana 2007-2011

interventions and identifies implementing partners, progress indicators and a budget.

National Reproductive health service policy and standards[8] 2003, GHS

Issues: Sets out nine priority reproductive health areas and a child-centred continuum of care approach for integrated service delivery. These areas are:

1. Safe motherhood;
2. FP;
3. Prevention and management of unsafe abortions and PAC;
4. Prevention and management of RTIs (STIs/HIV/AIDS);
5. Prevention and management of infertility;
6. Prevention and management of cancer, including breast cancer;
7. Response to menopausal and andropause concerns;
8. Discouragement of harmful traditional practices;
9. Information and counselling.

The defined interventions are ANC, labour and delivery care, PNC, PMTCT of HIV, IEC, affordable commodities, infertility management and dual protection. Others include prevention of unwanted pregnancies (abortion care services, management of abortion-related complications).

Other interventions include the prevention and control of RTI (STI, HIV/AIDS), management and support (PLWHA), prevention of infertility, treatment of infertility, social support for infertile couples, prevention of cancer (early detection and treatment, managing the terminally ill), awareness and management (awareness of dangers, management and rehabilitation of victims) and advocacy, community mobilization, outreach programmes and database training.

Paper on the safe motherhood programme in Ghana, November 2006, Odoi Agyarko et al.

This paper reviews the safe motherhood programme as it started in 1987 in Ghana, outlines its objective and interventions, looks at progress made and challenges (funding gaps, inadequate empowerment, weak integration) and makes recommendations (improved maternal care services, BCEC/CEmOC, FP, AdH, AdV etc.) for the way forward. The paper, however, does not get to the bottom of why the safe motherhood interventions (HE, ANC, delivery care, PNC, FP, the prevention and management of unsafe abortions) are not giving the required results.

Accelerating improvements in maternal and newborn health in northern Ghana, needs assessment report, October 2005, UNICEF, UNFPA, KNUST, GHS-RCH

This needs assessment report is set against a target of at least one comprehensive and four basic EmOC and ENC facilities per 200,000 people (or per health district). Most of the health facilities surveyed have the capacity to provide EmOC and ENC services on a 24-hour basis, but only a few actually provided such services.

The report found that while the target was met for EmONC, the proportion of expected complications actually managed was low (0.6 percent). The CS rate was low. Among the challenges listed were lack of theatres, the absence of EMoC/ENC in most health centres, weak referral systems, inadequate midwives and limited training in LSS and SMI.

1. It was not possible to obtain information on the following critical questions related to EmONC and CHPS.
2. What proportion of district hospitals have theatres/doctors for CEmONC?
3. What proportion of HC/SDs have midwives and can provide BEmONC?

8) GHS, National Reproductive health service policy and standards.

4. What is new in the referral system in Ghana?
5. How many CHPS compounds does Ghana have and what proportion of them have midwives?
6. What is the system to provide and track IST in LSS for midwives and how do we know what percentage trained in the last five years?

MoH (2009). Health Sector Gender Policy. April 2009

This policy objective focuses on gender barriers in access to health care, promotion of professional ethics and human rights, improvement of quality of care, gender inequalities in health service delivery, HIV/AIDS, gender-based violence, health financing and governance.

Gender Issues Paper (Second Draft). MoH. Agyare-Kwabi

This paper focuses on addressing gender inequality in health policies and looks at the usual health services areas such as access, communicable and non-communicable diseases, reproductive health, HIV/AIDS, gender-based violence, mental health, and traditional and cultural gender issues.

The Children's Act, 1998. Act 560. Gazette notification 5 February 1999

This act focuses on the rights of the child and parental duties of care and protection, quasi-judicial and judicial child adjudication (child panels and family tribunals), parenting, custody, access and maintenance, foster care and adoption, employment of children, institutionalized care and miscellaneous matters.


FREEDOM
AND
JUSTICE