COUNTRY REPORT

GHANA

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services
New York, October 2012

UNFPA

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COUNTRY REPORT: GHANA

Ghana Country Office

Dr. Bernard Coquelin, Representative

Field Team

AGEG Consultants eG	
Field Team Leader	Poonam Thapa
Evaluator Reproductive Health	Deborah McSmith
Field support	Patience Agyare.Kwabi
Evaluation coordinator	Martina Jacobson Miriam Amine

E-mail: evb@unfpa.org Phone number: +1 212 297 2620

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EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Including the contribution of
the Maternal Health Thematic Fund

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List of Acronyms

ABC	American Broadcasting Company
AMDD	Averting Maternal Death and Disability
AWP	Annual work plan
BBC	British Broadcasting Corporation
CARDI	Caribbean Agricultural Research and Development Institute
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CCA	Common Country Assessment
CHAG	Christian Health Association of Ghana
CHPS	Community-based health planning and services
CMA	Country Midwifery Advisor
CNN	Cable News Network
CPAP	Country program action plan
CR	Country Representative
DAC	Development Assistance Committee
DFID	UK Department for International Development
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
EU	European Union
GDP	Gross domestic product
GHS	Ghana Health Service
GNI	Gross national income
GoG	Government of the Republic of Ghana
GPRHCS	Global Program to Enhance Reproductive Health Commodity Security
GPRS	Ghana Poverty Reduction Strategy
GSGDA	Ghana Shared Growth and Development Agenda
GSS	Ghana Statistical Service
H4	UNFPA, UNICEF, World Bank, World Health Organization (WHO)
H4+	UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRH	Human resource for health
HSMTDP	Health Sector Medium Term Development Plan
ICM	International Confederation of Midwives
ICPD	sInternational Conference on Population and Development

IUD	Intrauterine device
M&E	Monitoring and evaluation
MAF	Millennium Development Goals Acceleration Framework
MCAN	Media Communication and Advocacy Network
MDG	Millennium Development Goal
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Package
MMR	Maternal mortality rate
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MoUs	Memoranda of Understanding
MoWAC	Ministry of Women and Children Affairs
MVA	Manual vacuum aspiration
NADMO	National Disaster Management Organization
NGO	Non-governmental organization
NHIS	National Health Insurance Scheme
NPC	National Population Council
PMTCT	Prevention of mother-to-child transmission
SWAA	Society for Women and AIDS Action
SWAp	Sector wide approach
TD	Technical Division
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development
US$	US-dollar
WHO	World Health Organization

1. Purpose and scope of the evaluation

Maternal health remains a major challenge to health systems worldwide. The world is on track to reach some targets of the Millennium Development Goals (MDGs) by 2015, but falling short on others; maternal health is the least likely to meet the 2015 target. A recent analysis found an annual rate of reduction of 1.3 per cent during the period of 1990–2008, well short of the 5.5 per cent needed to attain the MDG target by 2015. At the current rate of decline, it will take more than 188 years to meet the goal of 100 per 100,000 live births.

Given the current lack of sufficient progress in tackling maternal mortality, it is critical that effective interventions are implemented and monitored. Careful evaluation of these interventions is crucial for determining what works and for ensuring that scarce resources are allocated effectively. This is particularly true for developing countries, where maternal mortality is highest and access to maternal health services is poor. For this reason, United Nations Population Fund (UNFPA) has launched the evaluation of its support to maternal health in the last eleven years and the mid-term evaluation of the Maternal Health Thematic Fund. Following the terms of reference, the evaluation covers the period from 2000 until 2010, and also includes information related to a number of interventions implemented in 2011.

The aim of conducting both evaluations in parallel; i.e. the Maternal Health Thematic Evaluation (MHTE) and the Mid-Term Evaluation of the Maternal Health Thematic Fund (MHTF); is to take advantage of potential synergies in the evaluation portfolio of UNFPA and obtaining deeper and better substantiated insights on the thematic area of maternal and reproductive health as a whole, as well as on the MHTF individually.

1.1 Scope of the Maternal Health Thematic Evaluation

The MHTE assesses to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within UNFPA mandate, including all activities financed from core and non-core resources; and those financed through UNFPA Reproductive Health Thematic Funds.[1] MHTE focuses on key elements of reproductive health including family planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC), i.e. the "three pillars" of reducing maternal mortality. The specific thematic scope of the MHTE is defined by a list of twelve evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.2 Scope of the Maternal Health Thematic Fund mid-term evaluation

The objectives of the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) are to assess to what extent MHTF support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The mid-term evaluation focuses on technical areas (midwifery, family planning and emergency obstetric and newborn care)

1. I.e., the Maternal Health Thematic Fund, the Global Program to Enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF Female Genital Mutilation Program.

and on the potential of the MHTF to act as a catalyst in these areas. The evaluation also covers the internal coordination and management processes of the MHTF (support to planning, programming and monitoring, coordination and management mechanisms, and the facilitation of the integration and use of synergies). Additionally, aspects of leveraging and visibility are assessed. The temporal scope of the mid-term evaluation covers the period since the launch of the MHTF in 2008.

The strategic framework of the MHTF (i.e., the MHTF business plan) provides a clear reference framework for the mid-term evaluation. The specific thematic scope of the mid-term evaluation of the MHTF is defined by a list of eight evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.3 Geographical scope of the overall evaluation

The scope of this evaluation is limited to those 55 countries whose maternal mortality ratio in the year 2000 was higher than 300 deaths per 100,000 live births. The main rationale for this delimitation of the scope is to allow the evaluation to a) include those countries that have or have not made improvements in addressing maternal heath since the year 2000; and b) to focus the analysis on those countries that, relative to others, have experienced the greatest challenges in improving maternal health in accordance with MDG 5.

1.4 Purpose and structure of the country report

This country report has been prepared following the completion of the country case study in Ghana and summarizes its findings and conclusions. The findings presented in this country report, together with nine other country reports, inform the final evaluation reports for the MHTE and the mid-term evaluation of the MHTF.[2]

The country report is structured as follows:

- Chapter 2 explains the case study methodology. It discusses:
    - The process and criteria for selecting case study countries overall, and the specific reasons for choosing Ghana as a case study
    - The preparation and implementation of the case study
    - The limitations and constraints experienced by the evaluation team
- Chapter 3 provides a short description of the reproductive health sector in Ghana, and describes the overall approach of UNFPA to supporting maternal health in the country.
- Chapter 4 presents the findings of the country case study.
- Chapter 5 presents the conclusions of the country case study drawing on the findings for each of the evaluation questions. While Chapter 5.1 draws conclusions for UNFPA overall maternal health support in the country, Chapter 5.2 focuses on the added value of the Maternal Health Thematic Fund.
- Chapter 6 presents the annexes of this country report with a list of all documents consulted and a list of people interviewed for this case study. The annexes also contain key data for Ghana, the methodological instruments utilized for this case study and a list of UNFPA interventions and activities in Ghana.

2. Final evaluation reports for MHTE and MHTF are available on the following web page: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094.

2. Methodology of the country case study

The methodology for the case study has been developed based on the overall methodology for the MHTE and the mid-term evaluation of the MHTF (see final reports for MHTE and MHTF). The purpose of the country case study is to use the field visit to collect data and information to verify the hypotheses developed during the desk phase of the evaluation and to further inform the answers to the evaluation questions.

2.1 The selection of country case studies

2.1.1 The process and criteria for selecting country case studies

The evaluators carried out a comprehensive staged sampling process to select the countries to be included in the field phase of both evaluations. The first sampling stage resulted in the selection of all 55 UNFPA program countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000.[3] In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country contexts were included in this second-stage sample, the countries were grouped and selected according to the following criteria (see Table below).

Criteria used to create a typology of desk phase countries

Selection Criteria
Relative success of program countries in improving maternal health (to include "high-performing" and "low-performing" countries);
Average income level in the different program countries (to include countries with different poverty levels as one determinant of maternal health);
Quality of the public administration (to include countries with different administrative capacities to develop and manage maternal health programmes); and
Relative prevalence of HIV (to include program countries whose maternal health situation was interlinked with a high incidence of HIV).

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase);[4] eight of these countries were recipients of the MHTF. Case studies were selected so that each type was represented by two cases: One country that had made large improvements; and a similar country (according to the above selection criteria) that only had made small improvements in reducing maternal mortality. Overall, this systematic approach to selecting countries for the field phase allowed for different types of country contexts to be equally covered by the evaluations.

3. The sampling criterion has been selected to establish a close ling to the MDG5 indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.
4. Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan, and Zambia.

2.1.2 Justification for selecting Ghana

Ghana was one of six countries that had made relatively large progress in reducing maternal mortality: Having started with a maternal mortality ratio (MMR) of 500 deaths per 100,000 live births in the year 2000, the country had been able to lower this ratio by about 30 per cent to 350 deaths per 100,000 live births in 2008.[5]

In 2008, Ghana has had a relatively high per-capita gross national income (GNI) of 1,385 US$.[6] The assumption for Ghana, as well as for the other countries in the field phase sample with relatively high GNI was that the higher resource availability would influence governments' and societies ability to address certain bottlenecks in maternal health service provision with its own resources; and that this circumstance would change the demands made on the ability of UNFPA to support the efforts of the government in reducing maternal mortality.

Based on a 2009 governance[7] index, Ghana also had scored highly in the category of 'quality of public administration'. This was interpreted as a reason that the country should have a greater capacity than other field phase countries to address many of its own challenges with greater independence from development partners.

Lastly, the prevalence of HIV and AIDS in Ghana was relatively low in comparison to countries such as Zambia or Kenya that also had been selected for the field phase. The low prevalence of HIV and AIDS was assumed to make the challenge of reducing maternal mortality less complex and therefore less challenging for the government as well as for UNFPA in comparison to these high-HIV prevalence countries.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence for answering the global evaluation questions and judgment criteria[8] of the two evaluations.[9] These evaluations draw on a number of different information sources. Consequently, this country case study provides only some of the information required to answer the global evaluation questions comprehensively.[10] The scope of the country case study is defined by the "issues to assess" that are listed at the beginning of the findings-section for each evaluation question, together with the judgment criteria they correspond to. These "issues to assess" were defined after analyzing the global maternal health strategy of UNFPA and its underlying theory of change. Based on this analysis, the evaluation team determined which parts of this theory of change were the most important for the overall success of the UNFPA maternal health strategy. The global list of "issues to assess" was then adapted to the context of the case study country.[11] The country case study focused on collecting information on these specific issues.

5. Based on data from (WHO, UNICEF, UNFPA, World Bank, 2010).
6. This puts Ghana into a group of countries with per capita GNIs higher than 1,000 US$, along with Cambodia, Lao PDR and Zambia.
7. See "Country and Policy Institutional Assessment", 2009 Assessment Questionnaire, Operations Policy and Country Services, World Bank, Washington DC; Source: The World Bank CPIA; http://data.worldbank.org/indicator/IQ.CPA.PUBS.XQ.
8. During the inception phase of this assignment, the focus of each of these global evaluation questions had been sharpened by defining a set of judgment criteria that specified which aspects of UNFPA associated support to maternal health should be at the center of attention for each evaluation question. These judgment criteria define in greater detail the specific conditions of success of UNFPA support in each of the thematic areas covered by the evaluation questions. For a more detailed explanation of judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
9. I.e., the Maternal Health Thematic Evaluation and the MHTF mid-term evaluation; see Chapters 1.1 and 1.2 above.
10. 12 evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.
11. Issues addressed may vary from one country case study to the other. Only issues which have been addressed in this specific country case study are shown in the tables in front of each evaluation question and in the annex. This might lead in some occasions to difficulties in linking issues and judgment criteria but this is unavoidable as the methodology has been designed for the overall global evaluations.

Its findings therefore do not amount to complete answers to the global evaluation questions.[12] Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/MHTF evaluations.

Since the 20 global evaluation questions of the two evaluations[13] are designed to assess the relevance, efficiency, effectiveness, and sustainability[14] of the support to maternal health provided by UNFPA, the issues to assess that were derived from the evaluation questions are also related to these four DAC standard evaluation criteria.

2.3 Preparation of the country case study

The evaluation team prepared this country visit in cooperation with the UNFPA country office. The evaluation team mapped the relevant stakeholders, selected interviewees, identified data sources and selected data collection approaches to ensure that information on each particular issue would be collected:

1. From different sources, such as from different stakeholders, to reflect potentially differing perspectives; or from different documents (data triangulation).
2. Using complementary data collection methods, i.e., a mix of quantitative and qualitative methods, such as the use of secondary data on maternal health from demographic health surveys; and the use of feedback from key informant interview and focus groups (methodological triangulation).[15]

An overview of the triangulation for each evaluation question is presented in Annex 6.2.

2.4 Data collection methods and analysis during the country case study Ghana

The evaluation team used the following approaches for collecting data during the country visit to Ghana:

- The evaluators conducted a series of individual interviews in Accra, i.e., with staff from UNFPA country office and with representatives of UNFPA main partners in the country, including governmental, non-governmental, development and other implementing partners. In these interviews, the team focused on the collection of qualitative data that would help to provide contextual information on UNFPA interventions, its contributions and roles in partnerships, etc.
- During the country visit, the team collected and reviewed additional documents that either had not been available during the desk phase; or that needed to be revised to verify particular information that had been received during one of the interviews.[16] Evaluators focused in particular on the following types of documents:

    - Annual work plans (AWPs), in particular those AWPs that had not been available to the evaluation team during the desk phase.
    - Relevant national strategic documents including policies and strategic frameworks for sexual and reproductive health policies, maternal health policies, family planning, EmONC and other relevant topics.

12. See also the final reports of the MHTE and MHTF evaluations for more details on the methodological approach.
13. The Maternal Health Thematic Evaluation and the MHTF Mid-Term Evaluation.
14. I.e., four of five standard Development Assistance Committee (DAC) evaluation criteria.
15. E.g., semi-structured interviews, focus groups, document reviews.
16. A comprehensive list of interviewees is presented in the annex.

- Needs assessments and other inputs into the policy-making process that UNFPA had supported or implemented, covering all relevant maternal health topics.
- Documents that described and defined UNFPA relationship with its partners in the country, such as Memoranda of Understanding (MoUs) with development partners or government.
- Evaluations or assessments of UNFPA maternal health support in the country that had not been available to the evaluation team during the desk phase of this evaluation.

- The team traveled to the Central Region to visit a selection of intervention sites funded by UNFPA. The team interviewed staff from the Regional Health Directorate, District Health Administration and members of four different community initiatives that had received UNFPA support.
- The team also conducted focus group discussions with beneficiaries and staff of implementing partners of UNFPA funded interventions.
- Throughout the preparation and conduct of the case study, the evaluators ensured that they differentiated between maternal health support financed by UNFPA core funds, and support financed by the MHTF.

At the end of the visit to Ghana, the evaluation team did a preliminary analysis of their findings for each of the evaluation questions. These findings were presented to the UNFPA country office prior to the departure of the team. In addition, the team formulated conclusions on a number of topics that cut across the thematic areas covered by the evaluation questions. These conclusions constitute an assessment of selected aspects of UNFPA support to maternal health in Ghana and on the added value of the MHTF. However, due to the selective nature of the case study, these conclusions do not necessarily form a comprehensive and complete assessment of UNFPA support of sexual and reproductive health in the country, as would have been the case in a country program evaluation of Ghana. These conclusions are presented in Chapter 5.

2.5 Limitations and restrictions

Overall, the information obtained during the country visit allowed the evaluation team to compile a coherent picture of UNFPA maternal health assistance. The specific challenges are detailed in the table below.

Table 1: Challenges or constraints encountered throughout the field phase and reactions

Challenges/constraints encountered	Reactions
A range of key informants were relatively new to their post and therefore were not able to provide information on their experience collaborating with UNFPA.	The evaluators identified alternative interviewees to provide the required information.
Two scheduled meetings with staff from the Ministry of Health could not be held, due to last minute changes in the schedules of the interviewees.	Information gaps were filled during meetings with the Health Service.

3. Short description of the reproductive health sector

3.1 Country Background

Ghana became a Republic on 1st July, 1960, after gaining independence on 6thMarch, 1957. The country has ten decentralized regions and 170 districts. Provisional results of the 2010 population census show that Ghana has a population of 24,233,431, with an annual growth rate of 2.4 per cent. The Ashanti Region has the highest population of 4,725,046. Greater Accra Region contains the country capital and is the next largest with a population of about 3,909,764.[17] Economically, the country has attained regular growth with an annual real gross domestic product (GDP) growth rate of a minimum of 4.1 per cent and a maximum of 7.3 per cent since 2003. Sources for revenue include diverse agriculture, extractive mining and specialized agriculture. Major oil reserves were discovered in 2007 and Ghana is expected to become the third largest oil exporter in Africa within the next five years.

Table 2: Key economic data for Ghana

Total population Ghana (2009)	23,837,000
GDP (2009 million current US$)	14.95
GDP/per capita (2009 million current US$)	627.1

Source: UN Statistical Service UNData.

Since 1997, Ghana has been guided by a sequence of medium-term development frameworks (health framework is described below). During this period the country experienced substantial progress in macroeconomic stability and sustainable poverty reduction. However, by 2008 serious challenges emerged in balance of payments, decline in remittances, high food prices and limited access to external financing as a result of the global crisis. In spite of strong GDP performance recorded in 2003-2009 agriculture, the pillar of the Ghanaian economy was showing decline and poverty levels increased in some regions and districts, which had a negative impact on the country progress towards some Millennium Development Goals (MDGs), especially MDG 4 and MDG 5. Despite these challenges, Ghana was officially declared a lower middle income country in October 2010 and started producing oil in commercial quantity in November 2010. It is expected that the imminent production of oil and gas will assure additional revenues for health and development.[18] Ghana is generally considered as being politically stable.

17. 2010 Preliminary census figures, provided by Ghana Statistical Survey.
18. UN country team (Ghana), UNDAF, final Draft 2011.

3.2 Ghana Health Sector

The Growth and Poverty Reduction Strategies (GPRS) I and II which reflect Ghana poverty reduction agenda, span a five year period. GPRS II ended in 2010 and was succeeded by the Ghana Shared Growth and Development Agenda (GSGDA 2011-2015) which was adopted as the national framework to accelerate growth and attain the MDGs.[19] The Health Sector was allocated approximately 20 per cent and 18 per cent of poverty reduction related funds in 2007 and 2008 respectively. However in 2009, Ghana human development index declined with high inequalities recorded, especially in maternal health.

The health policy was formulated within the overall priorities outlined in the (GPRS II) vision for health attainment. The health policy is supplemented by operational documents; the Program of Work 2007-2011 (POW III), the Common Management Arrangement 2007 and the associated Monitoring and Evaluation Framework which were developed separately but integral to the Health Sector Medium Term Development Plan (HSMTDP 2010-2013). The National Health Insurance Scheme (NHIS) was introduced in 2005 with a view to replacing the 'cash and carry system' and to make health accessible and affordable for all, especially the poor, by offering a substantial health benefit package to its members.[20]

Health services in Ghana have been fully decentralized since 2008. Ghana health delivery is divided into two parts: policy and service. The Ministry of Health (MoH) is fully responsible for policy and the Ghana Health Service (GHS) and the Christian Health Association of Ghana (CHAG) are the two main bodies responsible for service delivery. Both GHS and CHAG are UNFPA implementing partners for reproductive health/maternal health interventions.

The Ghana Health Service and Teaching Hospitals Act (1996) were passed to separate health policy formulation from operational management of health service delivery. This makes the MoH responsible for policy formulation, resource mobilization and allocation within the health sector, and monitoring and evaluation of overall sector performance. The Ghana Health Service was created with the responsibility to manage the provision of primary, secondary and some specialist health care.[21]

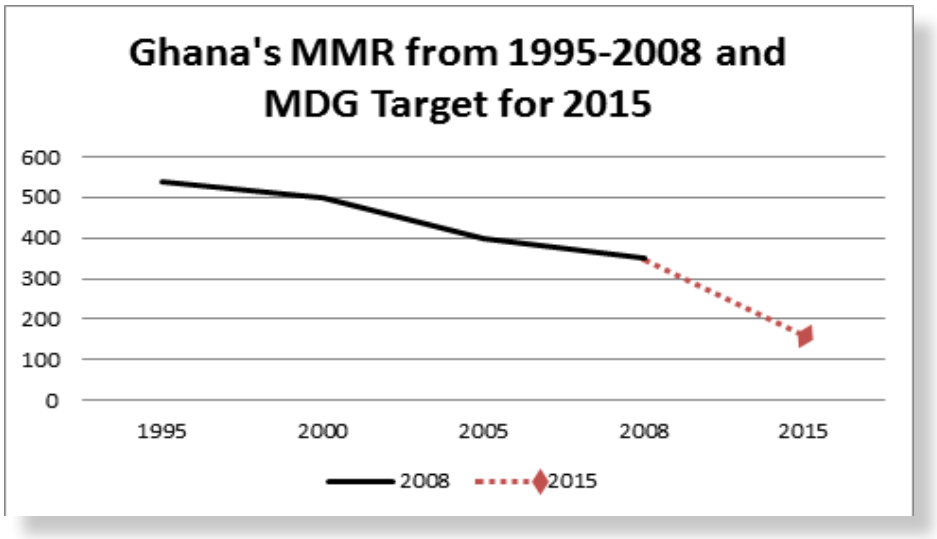
The MoH, represented by the Ghana Health Service owns half of the country health facilities, the private sector (including private maternity homes) owns approximately 21 per cent and (CHAG) owns the remainder. The Health Strategy 2002-2006 placed human resource development as a priority for Ghana.[22]

19. The Health Sector Medium Term Development Plan 2010-2013.
20. As of January 2007, 34 per cent of the population had registered with the NHIS (2006) and about 22 per cent of the population provided ID-cards that entitle them to receive free services contained in the benefit package.
21. GHWO – Health Resource for Health Country Profile, MoH, Ghana, 2011.
22. GHWA – Task force on Scalingup Education and Training for Health Workers, 2008.

3.3 Health Indicators

By 2008, Ghana had reached two out of three indicators for MDG one and will most likely reach the poverty target for MDG one by 2015.[23] However, in the field of maternal health progress it has not been as striking. In a worldwide comparison by UNFPA, United Nations Educational, Scientific and Cultural Organization, World Bank, World Health Organization (H4) in 2008, Ghana ranked 40th in maternal mortality ratio (MMR). In 2000 the MMR was 500 deaths per 100 000 life births. This rate has been reduced to 350/100,00 live births by 2008, but is still far from reaching the MDG four target of reducing MMR by three quarters to185/100,000 live births by 2015, as shown in Figure 1.

Figure 1: Maternal Mortality Ratio Ghana, 1995-2008 and 2015 MDG 5 target



Source: WHO Global Health Observatory Data Repository

According to the Ghana Demographic and Health Survey (2008), almost all Ghanaian women (95 per cent) received some antenatal care from a skilled provider, most commonly from a nurse or midwife (63 per cent) and a doctor (24 per cent). Important data on maternal and reproductive health include:

- More than three-quarters of women had the recommended four or more antenatal care visits, and 55 per cent of women had an antenatal care visit by their fourth month of pregnancy, as recommended.
- 87 per cent of women took iron tablets or syrup during their last pregnancy; 35 per cent took intestinal parasite drugs. More than two-thirds of women (68 per cent) who received antenatal care were informed of the signs of pregnancy complications.
- 72 per cent of women most recent births were protected against neonatal tetanus.
- Almost six in ten births (57 per cent) occur in health facilities - 48 per cent in the public sector and nine per cent in private sector facilities.
- Forty-two per cent of births occur at home. Home births are much more common in rural areas (58 per cent) than urban areas (17 per cent).
- Overall, 59 per cent of births are delivered by a skilled provider (doctor, nurse, midwife, auxiliary midwife, and community health officer/nurse).

23. The Health Sector Medium Term Development Plan 2010-2013.

- Another 30 per cent are assisted by a traditional birth attendant and eight per cent by relatives or friends. More than two-thirds of women received a postnatal checkup within two days of delivery. However, 23 per cent of women did not receive any postnatal care within 41 days of delivery.

There is a large disparity between poor and wealthy women and the ability to access means of transportation. Only 13 per cent of women in the highest wealth quintile cited this as a problem, compared with 50 per cent of the poorest women. Socio-cultural issues and traditional and religious beliefs have greatly influenced maternal health results in Ghana. These issues still remain unaddressed directly or consistently by maternal health initiatives especially in rural areas.

With respect to the other indicators in the area of maternal health (MDG 5), in the past 11 years some improvements could be noted. The percentage of births attended by skilled staff increased from 44 in 1998 to 57 in 2009 and the adolescent fertility rate has been reduced by 19.[24] The remaining two indicators focusing on 'pregnant women receiving prenatal care' and 'unmet need for contraception' remained rather unchanged, with the first at 90 per cent and the latter at 35 per cent in 2009.

According to the MDG report published in 2010, Ghana has made strong progress towards gender equality and reducing under-five mortality. The country is likely to meet the targets in both areas, especially if current child survival interventions remain successful. Furthermore, Ghana made progress in fighting major communicable diseases such as HIV/AIDS, malaria and tuberculosis. However, after the HIV prevalence rate had declined to 2.2 per cent in 2008 it increased to 2.9 per cent in 2009 again, which is mainly attributed to deficits in educational campaigns and activities to promote behavioral change. It is currently unclear whether Ghana will be able to meet the MDG six (combat HIV AIDS).

24. Births per 1,000 women ages 15-19.

Table 3: Maternal Health Indicators. Ghana Demographic Health Survey 2008

Maternal mortality ratio in 2008	n/a (in DHS)
MDG target for maternal mortality rate [25]	160
% HIV prevalence rates (aged 15-49) in 2008	2
% Contraceptive prevalence rate in 2008	23.5
% receiving antenatal care (ANC) from a skilled provider in 2008	95.4
% of births which were assisted by skilled birth attendants[26] in 2007	58.6
% Unmet need for family planning (total) in 2008	35

Source: Ghana Demographic Health Survey (DHS) 2008.

3.4 UNFPA response to maternal health in the country

The Millennium Declaration and the MDGs provide the basis for the United Nations (UN) strategic positioning and focus in supporting social, health and economic development globally, and this focus applies to Ghana. United Nations Development Assistance Framework (UNDAF) 2001-2005 and 2006-11 (2nd and 3rd UNDAF in Ghana and 4th on the way) encapsulate the collective results the UN system seeks to achieve in support of key priorities of the government development agenda. For UNFPA the HSMTDP is critical. The strategic focus and the logic of the two UNDAF (2nd and 3rd) have responded directly to central aspects of the GPRS/GSGDA (2000-2013) as evidence of co-ordination and harmonization. The 3rd UNDAF also aligned itself to Paris Declaration and Accra Agenda for Action in 2008 as Ghana is a signatory and has ratified the agenda.

25. UN Data.
26. Doctors, clinical officers, and nurse/midwives.

There are two maternal health road maps operating in Ghana based on south-south partnerships – the Maputo Plan (or the Abuja Call/Declaration) and Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The MDG accelerated framework for maternal health (or Millennium Development Goals Acceleration Framework (MAF)) is complete but awaiting funding.

Geographic coverage of UNFPA support:	Volta (1,878,316), Central (1,864,104), Northern (2,259,671), Upper East (1,001,926) and Upper West Regions (637,157)[27] (CPAP)
Population covered by UNFPA support in 2010 (only focus regions)	7.641.174
% of total population in Ghana covered by UNFPA support in focus regions	30,8
Total spending regular sources 2004-2010[28]	14.294.066 US$
Total spending regular sources per capita (based on focus regions)	1,87 US$
Total spending other sources 2004-2010	6.148.502 US$
Total spending other sources per capita (based on focus regions)	0,8 US$
Planned spending other funds CPAP 2006-2010	Total: 27.000.000 US$ out of which Regular sources: 15.000.000 US$ Other sources: 12.000.000 US$ Reproductive Health Component: 11.800.000 US$ Population and Development Component: 7.900.000 US$ Gender Component: 5.000.000 US$ Coordination and Assistance: 2.300.000 US$
Total spending MHTF	2009-10 Budget: 548,000 US$ Expenditure: 58,850 US$ (2009) Expenditure: 371, 108 US$ (2010)

Source: Calculation by evaluation team based on UNFPA sources

Collaboration between UNFPA and Ghana began in 1972. UNFPA started its assistance in two major areas – support to the National Population and Housing Census and the Regional Institute of Population Studies. During the first country program was initiated in the mid -1980s with emphasis on data collection and family planning. The second country program (1991-1995) was formulated before the International Conference on Population and Development (ICPD) in 1994. The third country program (1996-2000) was strongly cast in the mold of the ICPD which brought about a paradigm shift with the introduction of sexual and reproductive health and rights.[30] The fourth country program (2001-2005) was developed within the UNDAF framework reflecting the MDGs for the first time. During the fifth country program (2006-2011), the Maternal Health Thematic Fund (MHTF) and the Reproductive Health Commodities Security Thematic Fund (RHCSTF) were

27. Population numbers from Ghana Statistical Service 2010.
28. ATLAS data.
29. ATLAS data.
30. UNFPA Ghana Brochure 2011.

introduced as a targeted approach to promote maternal health (through promotion of skilled birth attendants (midwives), re-positioning family planning, assuring family planning commodity security and strengthening EmONC services. UNFPA support to the national development process is guided by the UNDAF and government health plans, especially the Health Sector Mid-Term Development Plan.

UNFPA provides support to the Government of Ghana (GoG), non-governmental organization (NGOs), and civil society at national level in five regions (out of ten) and in municipalities/districts. This assistance falls under three major pillars (mandate):

- Reproductive health (includes maternal health) and adolescent sexual and reproductive health
- Population and development
- Gender equality and empowerment of women

There are four focus areas within the UNFPA reproductive health component:

- Obstetric fistula: collaboration in comprehensive services with Ghana Health Service
- Humanitarian response: internally displaced and refugee communities
- Investing in midwives: collaboration with the International Confederation of Midwives (ICM) in advocacy for support in investment, training and practice of midwifery.
- Most at risk populations (HIV)

4. Findings of the country case study

The following section presents the findings of the country case study.

4.1 Findings related to the MHTE

4.1.1 Evaluation question 1: Relevance/Coherence

Evaluation question 1

To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria[31]	Issues to address (field phase)
1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups	To what extent do UNFPA/implementing partner monitoring tools include indicators to capture the specific situation of the most vulnerable?
	To what extent do UNFPA country offices utilize information from needs assessments other than the CCAs?
	Has UNFPA identified and targeted "vulnerable groups" for maternal health support beyond the extent that is described in situation analysis/problem analysis country program action plans (CPAPs)?
1.3. Needs orientation of planning and design of UNFPA supported interventions	To what extent are country offices using means alternative to UNDAF process for needs-oriented planning and the identification of the most vulnerable groups?`

Judgment criterion 1.2

- (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups

UNFPA has supported a large number of surveys and needs assessments that have increased the availability of data for planning of maternal health programmes and initiatives. Data have been collected through standard, macro-level surveys, such as the Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Surveys or the Household Income and Expenditure Survey. In addition, UNFPA has supported needs assessments in EmONC, both in 2007 (in three northern regions) and in 2011 (nationwide).

31. For indicators associated with the judgment criteria, please see the final reports of the MHTE and MHTF evaluations.

Over the last decade, UNFPA has provided financial support to government partners to conduct maternal health related needs assessments. In addition, the country office has technically and financially supported the implementation of an EmONC assessment. Data on income levels and poverty has been captured by DHS (2003, 2008), the Multiple Indicator Cluster Survey (2005, 2011) and the Household Income and Expenditure Survey which forms the basis for common country assessments (CCA) preparation and adaptations every five years. The country office has utilized all of the available assessments to inform the common country assessment (CCA), also known as the Ghana Country Assessment. Although this assessment is not a full blown CCA, it has helped the Government, development partners and implementing partners to form a common understanding of program needs, achievements and gaps.[32]

Maternal health was declared a national emergency in Ghana following the publication of the 2007 Maternal Health Survey that had been supported by UNFPA. The country office had also supported an EmONC needs assessment for the three northern regions that was carried out in 2007 as part of the Government of Ghana (GoG) High Impact Rapid Delivery strategy. In 2010 the first national EmONC needs assessment was carried out with support from UNFPA and UNICEF and with technical assistance from the Avert Maternal Death and Disability Program (AMDD) of Columbia University (financed by MHTF) and the government. The community-based health planning and services (CHPS) quality of service and readiness (highly utilized by poor and rural people) has formed the focal point of the enquiry along with district referral hospitals.[33] The country office has focused on high risk deliveries that affect 15 per cent of pregnant women. UNFPA has not given sufficient attention to pro-poor programmes that remove socio-cultural barriers or prevent pregnancy in the first place such as family planning.

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

UNFPA Ghana has neither formally defined "vulnerability" nor specific vulnerable groups within maternal and reproductive health. However, the term vulnerable is used widely in its maternal health publications in the area of fistula, humanitarian situations and domestic violence. There is a need to keep a balance between poor regions of high need with scanty population and pockets of extreme poverty, high population density with high maternal mortality rate located in rich regions, when planning interventions.

The MoH asked UNFPA to target five of the most difficult regions and districts/sub-districts with high maternal mortality ratios (MMR),[34] in accordance with the UNFPA mandate to focus on hard to reach target groups. UNFPA has been most active in the Northern Region which is rural and remote and whose population is poor and has only limited access to health resources and services. In each of the target regions, UNFPA has addressed a combination of issues, such as EmONC quality and readiness of health facilities, access to affordable quality family planning services, adolescent reproductive health, domestic/gender-based violence, fistula and HIV.

UNFPA has used population size in its target regions and districts as one criterion for the allocation of funding, in combination with several other health and social indicators.[35] However, the use of macro-level data for to the selection of target regions has meant that certain pockets of poverty were overlooked. Poor and deprived population groups in Accra, for example, such as women porters in the city markets that had received relatively little assistance until a Ghanaian NGO brought special attention to their situation.

32. CPA 2001-2005 and 2006-11.
33. EmONC Fact Sheet 2011.
34. UNFPA Ghana AWP 2009-10.
35. Results and Resource Framework for Ghana, CPAP 2006-2011.

4.1.2 Evaluation question 2: Harmonization and coordination of maternal health support and partnerships

Evaluation question 2

To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?

Judgment criteria	Issues to address
2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+)[36] at global; regional and country level	Compatibility of UNFPA rules, regulations and procedures with design and planning procedures of health SWAps it is participating in (or other joint implementation arrangements, i.e., in countries where no SWAp exists)
	What is the significance of H4+ country teams for country level maternal health harmonization and coordination;
	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation (e.g., common work plan) in UN joint programmes exist?
	What is the extent of use of pooled funding in UN joint programmes?
2.2. Harmonization of maternal health support through partnerships at country and South-South/regional	Does donor community consider national maternal health road maps to be viable components of national health policy that allows them to use it as a focal point for aligning their support with government structures and mechanisms?
	Is UNFPA financing activities to facilitate the adoption and implementation of maternal health road maps? (including activities that identify and address existing bottlenecks in maternal health road map operationalization and implementation at country level)

Judgment criterion 2.1

- Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global; regional and country level

UNFPA has participated in a large number of coordination meetings and has been co-chairing the working group on data collection and M&E. The status of the health SWAp and its significance for donor harmonization has declined. At the time of the evaluation, UNFPA was still contributing financially, however, no official SWAp-related meeting had been held since 2008.

36. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

UNFPA has been participating in monthly and quarterly business meetings with UN agencies and bi-annual national health summits and has also been an active member of the Health Sector Working Group (co-chaired by the MoH and WHO). UNFPA helped to set up and has been co-chairing the Health Sector Working Group on Data Collection and M&E. The country office also is a member of the Gender Sector Working Group.

The country office has been making annual financial contribution to the health SWAp. However, in 2010, the government asked the country office to reallocate these funds to support the 2010 census and its maternal mortality module.[37] Overall, however, support for the health SWAp has waned.[38] As of 2011, only UNFPA and the World Bank were still contributing financially to the SWAp. There has not been any SWAp meeting since 2008. At the time of this evaluation, the UNFPA reproductive health staff was awaiting further guidance from headquarters and a decision of the country representative on the continued involvement of UNFPA in the SWAp.[39]

Although UNFPA has held meetings with the global H4+ partners, these meetings have not been held under the H4+ initiative, but were seen to be components of the other numerous coordination mechanisms. UNFPA continues to work most closely with WHO and UNICEF but does not pool funds with either of them.

Judgment criterion 2.2

- Harmonization of maternal health support through partnerships at country and South-South/regional

Donor harmonization primarily has been driven by the MDG Accelerated Framework (MAF) and the Maputo Plan of Action. In addition, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) has caught the interest of both MoH and development partners. The Road Map for family planning languished for several years since its initiation in 2006 and is now being revived with the support of UNFPA.

UNFPA supported the development of the MDG Acceleration Framework (MAF) and also contributed to the adaptation of the Maputo Plan of Action. Both documents have been used to harmonize donor support and to align it with the national Health Sector Plan.[40] The MoH had also developed a Road Map on family planning (2006-2010), however, this document has received relatively little attention until recently. In 2009, UNFPA supported the re-activation of the family planning Road Map, with the support of the First Lady of Ghana. In 2011, the country office helped to launch an annual family planning week at district level in ten regions.[41]

The country office has contributed to the definition of the UNDAF outcome areas. It has participated in six out of the 12 outcome areas, has taken the co-lead with WHO in Maternal Mortality and Child Health (outcome areas six) and has been leading the efforts on data collection and M&E (outcome area 12).[42] UNFPA also supported the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA).

37. Interview with UNFPA.
38. Interview with external development partners.
39. Interview with UNFPA.
40. Interviews with external development partner and UNFPA staff.
41. Road Map for re-positioning family planning in Ghana 2006-2010, GHS, GoG.
42. Co-ordination mechanism of UNDAF outcome areas through the sectoral working groups.

4.1.3 Evaluation question 3: Community involvement/demand orientation and civil society organizations (CSO) partnerships

Evaluation question 3

To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with civil society?

Judgment criteria	Issues to address
3.1. Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support	Examples of policy advocacy and other UNFPA support to create legal frameworks, regulations and guidelines to facilitate full participation of communities and civil society organizations in policy and program development
	Can civil society organization/community participation in policy/program formulation (if occurring) be linked to greater awareness, and demand for maternal health services?
3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA	Examples of UNFPA human resource mobilization and institutional capacity development for civil society organizations to overcome weaknesses in transparency, service accountability and responsiveness to national civil constituencies at local level (including local public institutions outside ministries and departments).
	Example of how UNFPA has allocated funds to civil society and communities and how it overcomes the lack of financial support to civil society due to its own dependence on external funding which often leads to increased competition by government to lay claim to donor funds (in the name of health system strengthening and community systems strengthening).
	Examples of UNFPA coordination among implementing partnerships to bring together governments and civil society organizations at local level to generate social capital through community participation.
	Examples of UNFPA-government-civil society organization- Joint Action and Monitoring Frameworks as mentioned by CPAPs.

Judgment criterion 3.1

- Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support

UNFPA Ghana has no formal strategy on community involvement. Instead, the country office has supported innovations among communities through several national civil society organizations and regional health directorates.[43] However; these innovations have remained limited in scope and scale. The bi-annual National Health Summits have been critical avenues for UNFPA lobbying. Also, civil society organizations have been valuable partners in policy advocacy as their support of specific issues often led to its inclusion in the final official Aide Memoire, which is a prerequisite for further action by the MoH or other Ministries.[44]

Judgment criterion 3.2

- Civil society organizations involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA

UNFPA has been working with several civil society organizations to improve service delivery by promoting community partnerships for emergency transportation, awareness raising and other areas. Civil society partners have played a particular important role for the sensitization of communities on maternal health issues.

During its fourth and fifth country programmes, UNFPA has been working with eight civil society organizations in reproductive health, including large national NGOs such as the Planned Parenthood Association of Ghana, the Centre Population et Développement (CEPED) and the Christian Health Association of Ghana (CHAG) and faith based organizations. The NGOs have used UNFPA funding to experiment with strategies for improving service delivery through community partnerships in a number of different substantive areas, such as emergency transportation, raising awareness among youth, traditional leaders and rural women, training of health service providers and commodity distribution.[45]

Civil society organizations have played an important role in the sensitization of communities on maternal health issues. Trainings of traditional birth attendants by organizations like CHAG have helped to increase antenatal care and postnatal care utilization in many areas, at times by over 250 per cent.[46] UNFPA funding has been an important factor that has determined the ability of NGOs to be present in regions with high maternal mortality.

43. Interview with Regional Health Directorate staff.
44. Interview with government.
45. Interviews with UNFPA, MoH, civil society organizations.
46. Interview with civil society organization.

4.1.4 Evaluation question 4: Capacity development - human resources for health

Evaluation question 4

To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?

Judgment criteria	Issues to address
4.1. Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)	What mechanisms had UNFPA applied to ensure that policy makers include reproductive health in national human resource plans; and to what effect?
	To what extent was UNFPA involved in country needs assessments to inform policy makers for HRH planning (in particular also outside of MHTF countries or prior to MHTF launch)?
	To what extent was UNFPA involved in supporting the development of regulatory frameworks for reproductive health cadres in the HRH plans?
4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs	To what extent was UNFPA involved in supporting capacity development in management skills of policy makers and health administrative staff?
	What was the effect of the absence or existence of HRH management skills capacity development on the effectiveness/sustainability of maternal health technical training?
	Which mechanisms did UNFPA utilize to ensure applicability and usability of training; and to what effect?

Judgment criterion 4.1

- Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)

There is no specific committee for reproductive and maternal health human resources for health (HRH) planning. However, through the Health Sector Working Group, UNFPA has addressed reproductive and maternal health human resources, especially the issues of capacity development, shortages of midwives and skill gaps. The MoH and UNFPA both use health service annual reports to determine human resources needs but there is a need for UNFPA to scale up its involvement to influence budget allocation for HRH.

UNFPA has been working directly with two of the biggest service providers in reproductive and maternal health; the Ghana Health Service (GHS) and the Christian Health Association of Ghana (CHAG). In partnership with GHS, UNFPA participates in the formulation, implementation and monitoring and evaluation of effective human resources for health policies that guide the creation, management and training of the maternal and reproductive health related health workforce. UNFPA and other development partners, especially WHO and UNICEF, share lessons learned from other countries and advocate for governments to develop the strategies and policies to facilitate the availability of appropriately trained health cadres. For example, the biannual national health summits and the Aide Memoires provide a guide for human resources for health implementation. UNFPA has occasionally provided funds for trainings directly to the private sector, which then collaborates with GHS to organize life-saving training sessions for midwives in the private sector.[47]

47. Ghana: Implementing a National Human Resource for Health Plan, 2008, WHO and Global Health Workforce Alliance.

Maternal health in Ghana has been affected by acute human resources shortages and is not likely to meet its needs for midwives and other skilled birth attendants in the short term. Furthermore, the government/GHS has not yet developed sufficiently cohesive strategies to increase the number of qualified midwives, tutors, training sites, clinical sites and to explore new ways to incentivize remote posting including strategy assessment of how to phase out traditional birth attendants and phase in midwives.[48] However, the recent EmONC needs assessment, carried out with support from UNFPA and UNICEF, was used as an opportunity to discuss the human resources shortages and needs in a set of special meetings. The draft final report of the assessment contains an entire section on human resources needs in reproductive and maternal health.[49]

The MHTF has supported the position of the Country Midwifery Adviser (CMA) and related trainings. However, key challenges for expanding midwifery school capacity to train more midwives remain, among them the tutor qualification requirement at masters' level and the shortage of clinical practicum sites.[50] This point will be further discussed in section 4.2.

Judgment criterion 4.2

- Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs

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Training for reproductive and maternal health is the forte of UNFPA in Ghana and central to its support to implementing partners in the area of public health. Since 2005, UNFPA has provided capacity development trainings for national program component managers, resource teams, quality assurance teams, and an M&E Team in addition to the maternal health and family planning pre-service and in-service trainings it has supported at various levels of implementation.

UNFPA has provided funds to GHS, the Ministry of Women and Children Affairs and the National Population Council to support maternal health related training. In addition, UNFPA support has been critical to the success of decentralization of health services in Ghana and the development of the capacity of district health management teams (DHMTs). DHMTs are supported by regional resource teams and a national resource team. All national, regional, district and sub-district quality assurance teams have been supported by UNFPA through its support of the GHS.

A situational analysis conducted by UNFPA found that the majority of MoH midwifery training schools do not have full time tutors, instead, the schools contract practicing midwives and nurses in the private sector on a part time basis to provide teaching assistance to schools. UNFPA successfully advocated with the MoH to set up a reproductive health course at a university to train midwives as tutors for the midwifery schools. The country office also supported GHS to provide midwives with preceptorship skills and improve their teaching capacity.[51] Midwives who did not qualify as tutors could therefore be hired to practice as preceptors in clinical sites. Overall, these were small but critical steps towards the GHS goal of increasing the number of trained midwives from the current number of 600 to the MDG 5 goal of 8,000 by 2015. However, dual practice by trained midwives in the public sector has remained a challenge for GHS.[52]

48. Interviews with government.
49. GHWO: Human Resource for Health Country Profile, 2011.
50. Interview with regional training school.
51. Interview with Midwifery Association.
52. Interviews with government and civil society organizations.

4.1.5 Evaluation question 5: Maternal health in humanitarian contexts

Evaluation question 5

To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies (relief, emergency/crisis, post-emergency/-crisis)?

Judgment criteria	Issues to address
5.1. Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans	How does UNFPA monitor the effectiveness of maternal health mainstreaming activities?
	To what extent is UNFPA involved in monitoring the effective application of joint response activities and utilization of its tools?
	Does the health cluster response plan include sexual reproductive health based on UNFPAs intervention?
5.2. Accessibility of quality EmONC, Family Planning and reproductive health/HIV services in emergency and conflict situations	To what extent do UNFPA mechanisms/procedures facilitate timely/flexible response to maternal health needs in humanitarian situations What is the comparative advantage of UNFPA maternal health-support in post-emergency/humanitarian situations?
	What are the UNFPA mechanisms to ensure equitable and effective uptake of its products?
	How does UNFPA monitor the utilization and uptake of the tools in continuous training, planning and service delivery?
5.3. Accessibility to medical products in emergency and conflict situations	How does UNFPA ensure equitable commodity provision in humanitarian settings, and to what effect?
	To what extent does the UNFPA link the GPRHCS, the MHTF and the HF in the different Stream countries?

Judgment criterion 5.1

- Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans

UNFPA has mainstreamed a post-humanitarian response into its core program. It has supported capacity development for the National Disaster Management Organization (NADMO) and has supported procurement and pre-positioning of reproductive health and hygiene kits.

UNFPA has mainstreamed a humanitarian response into its core program, and has been involved in two aspects of humanitarian work: man-made and natural disasters.[53] In 2010 and 2011, the country office committed core program funds to support capacity development for the National Disaster Management Organization (NADMO) on the reproductive health/maternal health Minimum Initial Service Package (MISP) and data Management, procurement and pre-positioning of reproductive health and hygiene kits. This allowed UNFPA to participate in inter-coordination meetings and joint assessments with government, other UN agencies and civil society organizations and to facilitate a timely response to maternal health needs in humanitarian situations. The country office has been able to ensure the quick delivery of reproductive health kits from the procurement branch in Copenhagen. The availability of emergency relief funds from headquarters (such as the Central Emergency Response Fund) as well as the coordinated support from the sub-regional office in Dakar also facilitated the humanitarian work of UNFPA.

UNFPA support for maternal health in crisis situations has been included in national and interagency contingency plans.[54] UNFPA maintains a checklist for assessing the utilization of emergency reproductive health kits for reproductive health service delivery during crisis. Field monitoring of support to reproductive health services in humanitarian situations has been included in the UNFPA annual work plan for 2011.

Judgment criterion 5.2

- Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

and

Judgment criterion 5.3

- Accessibility to medical products in emergency and conflict situations

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UNFPA has developed policies and procedures for emergency preparedness, humanitarian response and transition/recovery. The commodities and contraceptives, tools and resources (including rape kits and counseling) that UNFPA provides in emergency and humanitarian settings are not provided by any other agency.

UNFPA has provided MISP trainings for NADMO and health coordinators in several border regions (close to Cote d'Ivoire). The trainings allowed staff from these organizations to incorporate sexual reproductive health issues into humanitarian support in Ghana. Topics covered included basic gender analysis of vulnerability, the integration of gender in humanitarian support and sexual violence against women and girls.[55] Commodities pre-positioned with UNFPA support included condoms (male and female), clean delivery kits, rape treatment kits, oral and injectable contraception, HIV test kits, sexually transmitted infections treatment kits, clinical delivery assurance kits and intra uterine devices.[56] The commodities and contraceptives, tools and resources (including rape kits and counseling) that UNFPA provides in emergency and humanitarian settings are not provided by any other agency.

UNFPA has developed policies and procedures for emergency preparedness, humanitarian response and transition/recovery. These documents cover the three UNFPA mandate areas (reproductive health, population and development and gender) and are further categorized into four areas – emergency preparedness, acute emergency assistance, chronic humanitarian situation and transition and recovery. Major priority activities in each situation, partners and tools and resources are also defined.

At the time of this evaluation, a set of trainings on MISP for the Central Region NADMO and health coordinators was yet to be implemented and no trainings had been carried out for the Ashanti region. However, trainings have been completed for all district coordinators of NADMO in the three northern regions.

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53. UNDAF 2006-11.
54. Interviews with government.
55. Summary of Key Activities for Possible UNFPA Support in four Phases, 2006.
56. Coordination mechanism of UNDAF outcome areas through sector working groups.

4.1.6 Evaluation question 6: Sexual and reproductive health services – family planning

Evaluation question 5

To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?

Judgment criteria	Issues to assess
6.1. Increased capacity within health system for provision of quality family planning services in UNFPA program countries	Are (UNFPA-supported) national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are systems in place to monitor integration and the availability of family planning services in all service delivery points?
	Are the capacity development interventions designed strategically i.e. taking into account national strategies and orientations, supervisory mechanisms, potential for replication?
	Are capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure)?
	What are the mechanisms developed to ensure that training curricula and standards are adopted across the entire country?
	Are the mechanisms promoted/introduced by UNFPA oriented towards ensuring quality service provision? Are these mechanisms adopted at national level with a view to sustain them and to scale them up?
6.2. Increased demand for and utilization of family planning services in UNFPA program countries, particularly among vulnerable groups [57]	How has UNFPA supported community based distribution of family planning commodities translated into sustainable national strategies?
	To what extent communication initiatives aimed at increasing demand for Family planning (undertaken with UNFPA support) are based upon evidence?
	What are the monitoring and evaluation in place to measure the impact of these communication initiatives?
	Are UNFPA supported initiatives contributing to the increase of Family planning utilization among vulnerable groups?
6.3. Improved access to contraceptives (commodity security)	What are the mechanisms in place to monitor and follow up MoH/responsible line ministry supply chain?
	What are the mechanisms in place to sustain actual achievements and governments' commitment to reproductive health commodity security?

57. Approximation of "increased demand", which is difficult to capture.

Judgment criterion 6.1

- Increased capacity within health system for provision of quality family planning services in UNFPA program countries

UNFPA has a long history of support to family planning in Ghana and many important population polices that it helped to establish in the 1980s and 1990s are still in place.

UNFPA Ghana and Pathfinder International jointly supported the MoH/GHS strategy document on family planning (2006-2010).[58] The road map identified gaps in service delivery, research and evaluation, set targets and defined the roles and responsibilities of various agencies and stakeholders. The document presented eight broad strategies, namely policy and advocacy, behavior change communication, institutional coordination and collaboration, human resource development and capacity development and expanding access to family planning services, resource mobilization and research and M&E. The road map had also been supported by the Office of the President and the National Leadership Group on Reproductive Health/Family Planning (an informal grouping of experts and stakeholders).

UNFPA has supported the National Health Information System to update family planning trends on an annual basis. The UNFPA-supported demographic and health surveys (DHS) which helped to track changes contraceptive usage every five years. Family planning usage remains a significant challenge in Ghana, and contraceptive prevalence rate has decreased from 19 per cent in 2005 to 17 per cent in 2010, far short of the 28 per cent that had been proposed by the road map on family planning.

Judgment criterion 6.2

- Increased demand for and utilization of family planning services in UNFPA program countries, particularly among vulnerable groups

UNFPA support to the road map has not changed family planning demand and utilization in Ghana; in fact the situation has worsened since the introduction of the road map. There are persistent gaps in knowledge and use of contraceptives, spatial differences in contraceptive use between rural and urban regions as well as between southern and three northern regions. The unmet need for family planning remains high.

The DHS 2008 showed that in spite of the family planning road map (2006-2010), Ghana had not managed to keep up the momentum of an increasing contraceptive prevalence rate of the 80s and 90s. The broad participation of a variety of stakeholders in the road map has not translated into a strengthened national family planning program. The total fertility rate has not changed significantly and while the maternal mortality ratio (MMR) has been reduced significantly, the current rates (350/100,000 live births) remain high in order to achieve the MDG target of 185 by 2015.

The most significant challenge is the lack of commitment and support for family planning at program budget level, even with the road map in place. This has resulted in a lack of comprehensive education and training on quality family planning services (outside the one week received by midwives) accompanying the road map.[59] Furthermore, the Government has not re-instated family planning, in the way it has antenatal care/postnatal care and EmONC, as a priority within national development strategies and health plans. District assemblies have received little or no training from GHS on promoting and financing family planning. Extending coverage and improving quality of family planning services lags behind all other services related to maternal health and there is high dependency on donors to cover contraceptive security.[60]

58. Re-positioning Family Planning, Road Map, GHS 2006-2010.
59. Interview with NGOs.
60. Interviews with external development partners, NGOs and UNFPA staff.

The National Population Council (which reports to the President) has provided continued support to advocate for repositioning of family planning, with assistance from UNFPA. However, there has been no drive to be more strategic in educational approaches to overcome regional disparities, with birth rates several times higher in some regions than others. The average birth rate per mother in the Northern Region is 7.0 compared to 2.9 in Greater Accra.[61]

Efforts to include family planning in the National Health Insurance Scheme (NHIS) were ongoing at the time of this evaluation. It was foreseen to add family planning to the cost of services charged under the NHIS rather than require a direct payment to the service provider as is currently done. Some discussions have been initiated by USAID, DFID and UNFPA and it is likely that action will be taken before the next election (2012). Studies conducted by the JSI Deliver Project suggest that it will be sustainable and cost efficient for the NHIS to absorb the cost of family planning in Ghana.[62]

Judgment criterion 6.3

- Improved access to contraceptives

In spite of past support for family planning, unmet demand for contraceptives remained at 34 per cent for 2007.[63] The National Family Planning Program in Ghana is only able to meet 43 per cent of the national demand. UNFPA remains the sole UN agency that supports the provision of family planning services by the Ghana Health Service.

As a Stream two country, Ghana has received significant GPRHCS support in the past. However, funding for family planning in Ghana faces structural problems that are beyond the control of UNFPA.[64] UNFPA remains the sole UN agency that supports the provision of family planning services by the Ghana Health Service (GHS) such as training of service providers in long term temporary methods such as IUD and jadelle insertion. Efforts of UNFPA to convince the government to assume more responsibility with regard to ensuring contraceptive security have met with little success.[65]

Since 2011, the MoH has a new Reproductive Health Commodities Security Strategy. It works through the Interagency Coordinating Committee of which UNFPA is an active member.[66] The Committee has expanded beyond contraceptives to include all health commodities. UNFPA, DFID and USAID together provide about four million dollars for contraceptive security, leaving a national funding gap of about 8.5 million dollars per annum. Over the last couple of years, the government pledge to provide about one million dollars per annum to partially fill this gap has not been fulfilled. After the initial launch of Family Planning Week in September 2011, the Minister pledged around three million $ to support contraceptive procurement. UNFPA and partners are following up on this pledge to ensure that it is implemented.[67]

Government, civil society organizations and private companies have continued the drive to distribute contraceptives and education throughout the country. The private sector now sells 54 per cent of contraceptives in Ghana, with civil society organizations and government largely focused on education about the plethora of birth control and sexually transmitted infections prevention options.[68]

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61. Ghana DHS 2008.
62. Interview with external development partner.
63. Maternal Health Survey, MoH, Ghana 2007.
64. Interview with external development partner.
65. Interviews with UNFPA.
66. Interviews with government.
67. Interviews with UNFPA.
68. Ghana trend analysis of family planning based on DHS 1998, 2003, 2008, USAID.

4.1.7 Evaluation question 7: Sexual and reproductive health services – EmONC

Evaluation question 7

To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in program countries?

Judgment criteria	Issues to assess
7.1.Increased access to EmONC services	What elements in UNFPA EmONC support were meant to ensure sustained commitment of the MoH to integrate EmONC services in the national planning and budgeting?
	Did these elements contribute to a (more) sustained commitment of MoH to EmONC?
	Which mechanisms has UNFPA applied to ensure most efficient use of resources of support to EmONC providing facilities?
	How does UNFPA support functioning referral systems from home to tertiary care?
	What are the mechanisms of UNFPA to ensure equitable distribution of EmONC facilities?
	Has UNFPA support improved the equitable distribution of EmONC facilities (affected the planning process for placement of EmONC facilities)
7.2.Increased utilization of EmONC services	What mechanisms is UNFPA utilizing to mobilize the communities to support women in accessing EmONC; and to what effect?
	To what extent does UNFPA support research to evaluate barriers to EmONC?

Judgment criterion 7.1

- Increased access to EmONC services

UNFPA has collaborated with UNICEF on EmONC related advocacy for several years. Since 2007, the two agencies have successfully accelerated collaboration to promote EmONC needs assessment in all ten regions.

UNFPA identified the need to support MoH for a comprehensive national picture of EmONC services and needs. Together, Ghana Health Service (GHS) and UNFPA looked first at surveying the Upper East Region only. UNFPA provided initial funding for this regional survey in 2007. In response to joint advocacy by UNICEF and UNFPA, GHS decided to conduct a nationwide EmONC assessment in 2010. Utilizing funds from the MHTF and with the technical support from AMDD (Averting Maternal Death and Disability), the country office assisted the National Institute of Public Health and Ghana Statistical Service (GSS) to carry out the EmONC assessment. The World Bank and UNICEF provided additional support. Support of the assessment also included the installation of a GIS System to allow the MoH to monitor where EmONC facilities are located and to better target future assistance.[69]

69. Interviews with UNFPA.

Judgment criterion 7.2

- Increased utilization of EmONC services

Recommendations from the National EmONC Assessment report will guide UNFPA next steps in helping GHS to equip facilities and retrain providers as part of an EmONC Improvement Plan. The EmONC assessment itself has been affected by serious delays, due to the priority given to census collection and data analysis in 2010/11.

Data collection for the national census overlapped with the EmONC needs assessment in 2010, resulting in a seven to eight month delay of the EmONC survey and of the formal release of findings. A draft report was ready in the fall of 2011 but had not been disseminated at the time of this evaluation. Fact sheets with key findings had been shared with government stakeholders at the last bi-annual Health Summit in April 2011 and the report was supposed to be distributed in November 2011 (at the second bi-annual Health Summit). The aide memoire associated with the assessment was expected to include a call for an EmONC Improvement Plan.[70]

Socio-cultural change has not kept pace with economic progress in Ghana. This means that de-centralization of the health system and the National EmONC Assessment has contributed to a great extent to addressing Delay Three (receiving adequate care in a facility) but not Delay One and Two (deciding to seek care in an obstetric emergency and reaching an obstetric facility on time). UNFPA was the first to reference the Three Delays model with cultural sensitivity programming and the need to address maternal health, gender issues and cultural practices in tandem (2008).[71] There are good practices of public/private partnership to address Delay Two such as Ghana Private Road Transport Union in the Central Region, but the initiative remains limited to one region.

UNFPA widely disseminated a 2008 study done in collaboration with Ministry of Chieftaincy and Culture that aims to provide guidance on issues, approaches and methodologies in ensuring that reproductive health/maternal health programming such as EmONC Needs Assessment and any improvement plan reflects socio-cultural sensitivities and good practices. This multi-sector analysis includes regional nuances, inter-regional comparisons, concept of family, children place within families and positive aspects of local cultures, community leadership and its relationships to UNFPA issues/mandate areas. No assessment of this socio-cultural intervention has taken place as yet but has been referenced by EmONC needs assessment in 2011.[72]

70. Interviews with UNFPA.
71. Cultural Sensitivity and Programming: The Case of GoG-UNFPA 5th country program 2006-2010.
72. Interviews with UNFPA staff.

4.1.8 Evaluation question 8: Results/evidence orientation of UNFPA maternal health support

Evaluation question 8

To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its program countries?

Judgment criteria[73]	Issues to assess
8.2. Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies	What process have country offices gone through to use lessons from past support for future programming?
	What factors have prevented country offices from using lessons from past programming?
8.3. Results- and evidence based management of individual projects throughout project life	What were main factors that contributed to weak monitoring of most country offices?
	To what extent did UNFPA take into account capacity gaps in M&E among its implementing partners and its own staff when developing its M&E calendars?

Judgment criterion 8.2

- Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies

and

Judgment criterion 8.3

- Results- and evidence based management of individual projects throughout project life

UNFPA has initiated a number of efforts to improve the compilation and analysis of data and information for maternal health planning and programming in Ghana. Its involvement in the M&E sector working group has provided UNFPA with a good opportunity to influence the development of new tools and procedures for monitoring and evaluation. The EmONC assessment, funded in part by the MHTF, is expected to play an important role in the development of an EmONC up scaling plan.

In response to the 2008 mid-term review of the UNDAF, UNFPA promoted the creation of an M&E sector working group to oversee the development and implementation of a comprehensive M&E strategy for the UN framework. The country office has subsequently assumed co-leadership of this group, in cooperation with the National Development Planning Commission (NDPC), allowing UNFPA to anchor health-related M&E provisions in a comprehensive cross-sectoral system. As a result, the NDPC is now able to produce annual maternal and reproductive health progress reports in a timely fashion. UNFPA also supported the development of the Ghana Statistics Development Plan to include reproductive health/maternal health and gender data production.[74] Furthermore, the national, regional and district M&E teams of the monitoring system of the Ghana Health Service (GHS) have been funded by UNFPA through budget support to GHS. The country office has also participated in quarterly meetings led by the National Population Council that have been used to disseminate results-data on reproductive health, gender, and population and development.

73. The previous judgment criterion 8.3 was deleted; the assessment of the operationalization of UNFPA support in annual work plans was put together with the development of UNFPA country strategies (country program document/CPAP).
74. Interview with UNFPA.

Once implemented, the EmONC assessment supported by UNFPA is expected to play an important role in the creation of evidence for maternal health-related planning and programming. In addition, UNFPA has technically and financially supported data collection through macro-level surveys, such as DHS and the national census.[75]

4.1.9 Evaluation question 9: Integrating maternal health into national policies and development frameworks

Evaluation question 9

To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its program countries?

Judgment criteria	Issues to assess
9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process	How coherent are efforts under the different relevant initiatives for maternal health policy making and policy dialogue: CARMMA, Maputo/maternal health road maps and UNFPA participation in SWAp fora?
	What are the principal mechanisms by which UNFPA advocacy and awareness raising campaigns contribute to the development/revision/integration of maternal health issues into national policies?
9.3. Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments	To what extent have M&E tools that were developed with UNFPA support been adopted to monitor national maternal health/sexual reproductive health policies and programmes?
	To what extent are MMH indicators included in the monitoring (and evaluation) systems of national policies?

Judgment criterion 9.2

- Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process

UNFPA has utilized publications and data collection and dissemination to prepare the ground for evidence-based advocacy for maternal health. The bi-annual policy digest, published by the country office, has influenced the treatment of several maternal health related issues by policy makers and has helped to increase awareness in the general public.

The country office has used the publication of brochures, fact sheets and a policy digest to raise awareness on maternal health among policy makers, the media and the Ghanaian public. Among other things, UNFPA has regularly disseminated its bi-annual policy digest (an evidence based tool for advocacy) to key government and planning institutions. The digest has influenced the re-positioning of family planning and also has directed increased national attention to the problem of gender-based violence. The private sector and the media have also been increasingly utilizing the policy as a source of information.[76]

75. Interviews with UNFPA, government partners.
76. Interviews with government.

UNFPA also has provided technical and financial support to the national census, in particular regarding the dissemination of relevant findings to policy and decision makers. The country office has financed the production of census fact sheets and has supported the publication of a special "census edition" of the quarterly Springboard magazine, published originally by UNFPA and now by its implementing partner Curious Minds. UNFPA has also supported the State of Ghana Population Report and the State of Ghana Population Report on Young People.

UNFPA also has facilitated the engagement of youth in policy-making and programming, with the help of its implementing partner Curious Minds and high level journalists organized in the Media Communication and Advocacy Network (MCAN). MCAN was created by UNFPA under the Africa Youth Alliance Project. It has engaged opinion leaders and politicians in maternal health advocacy on radio, television and in newspapers. As a result, the attention of the national media paid to maternal health and population and development has increased over the last few years.[77]

Judgment criterion 9.3

- Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments

The long vacancy of the post of country representative and the vacancy of the post of M&E advisor has made it challenging for the country office to fulfill its M&E-related responsibilities. At the same time, the position of co-chair of the government-led M&E sector working group has provided UNFPA with tremendous opportunities to introduce tools and controlling systems for monitoring national reproductive and maternal health policies and programmes.

Responsibility for monitoring at national level has been shared between the National Population Council (NPC) and the Ministry of Finance and Economic Planning (MoFEP). NPC has served as the technical coordinator while the MoFEP has been responsible for financial management and oversight.

The MoFEP has been using a results-based financial management system and therefore needed data on outcomes of support from development partners. However, the National Population Council has not consistently provided the required information on UNFPA funded activities, also because the country office itself has had difficulties to generate the required information, due to the two-year vacancy of the position of the UNFPA country representative.[78]

The MoFEP and UNFPA used the preparation of the country program as an opportunity to call attention to the need for proper coordination and feedback on UNFPA activities. The position of co-chair of the government-led M&E sector working group has provided UNFPA with tremendous influence in introducing tools and controlling systems for monitoring national reproductive and maternal health policies and programmes. UNFPA involved MoFEP in a workshops and seminars that touched on the need for proper results monitoring and reporting. In August 2011, UNFPA, the government and civil society partners conducted a series of joint monitoring missions to all five of its target regions to look at the progress of program implementation for the past half year. The findings have informed the development of the new "Deliver As One" five- year plan for 2012 to 2016 (UNDAF).

The Ghanaian President Office has put in place its own data collecting system for some key indicators for health and other sectors, instead of using the data collected by GSS[79], leading to the duplication of efforts in monitoring.

77. Interviews with government partners.
78. Interview with government partner (national).
79. Interviews with UNFPA.

4.1.10 Evaluation question 10: Coherence of sexual reproductive health/maternal health support with gender and population and development support

Evaluation question 10

To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other program areas?[80]

Judgment criteria	Issues to assess
10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design	To what extent has UNFPA identified specific gender constraints as affecting and impeding reproductive health program objectives at country level in its planning?
	Have these gender constraints (as described) been adequately addressed by the current government; UNFPA? (reflections on CPAP document, explore gender mainstreaming at policy and program level)
	How have AWPs currently integrated gender constraint findings into the reproductive health component?
	Is the UNFPA adequately addressing the gender-based constraints to access to maternal health services faced by poor and vulnerable women and the most at risk young people?
	How/to what extent has UNFPA addressed constraints in demand for maternal health services through its support; E.g., based on recognition of specific gender-related barriers to maternal health awareness
	Are there concrete examples of how UNFPA is addressing gender constraints which have been reversed and created into opportunities for UNFPA reproductive health objectives or vice versa?
10.2. Integration of monitoring and reporting of UNFPA operations	How has population and development widened the utilization of its data in the last three years by government/UNFPA and other partners in the reproductive health/maternal health interventions?
	To what extent has UNFPA country office utilized current reports from cross program operations at global and regional and country level? Note the most popular ones.

80. Gender (including female genital mutilation/cutting, gender-based violence), HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

Judgment criterion 10.1

- Linkages established between programmes (reproductive health with gender and population and development) established in intervention design

UNFPA in Ghana has supported a number of interventions that have highlighted the linkages between gender and reproductive health. The country office has worked with the Ministry of Women and Children Affairs (MoWAC) to develop gendered data collection instruments for the Demographic and Health Survey (DHS). In 2009, the country office launched a pilot initiative in coherence programming between the three sub-programmes in the Central Region of Ghana. UNFPA planned to replicate the model in other program regions.

UNFPA has worked on a number of initiatives to highlight the linkages between gender and reproductive health. The country office has partnered with the government to ensure adequate and accurate information on contextual influences on maternal health and to address harmful cultural practices (e.g., gender-based violence and female genital cutting). It has also worked with the Federation of Women Lawyers to promote male involvement during pregnancy and delivery and to advocate for women who experience domestic violence. UNFPA supported the passing of the Domestic Violence Act in 2007, formulation of the National Domestic Violence Policy 2009 to 2019 and Action Plan, and the Re-Engineering Action Plan for MoWAC. UNFPA has been a participant in the gender sector quality forum and is participating in MDGs dialogue on gender. However, the country office has not been a member of the sector working group on social protection.

UNFPA has supported the Ministry of Women and Children Affairs (MoWAC) during the last DHS (2008) in the review of data collection instruments and the integration of gender concerns in the survey. The UNFPA-MoWAC partnership led to the inclusion of a module on domestic violence in the DHS 2008. Findings from this module led to the establishment of a Domestic Violence Victim Support Unit in the Ghanaian national police by the Ministry of Interior.[81]

In 2009, UNFPA started to pilot the practice of coherence programming in the Central Region of Ghana. The objective was to bring implementing partners from the three different sub-programmes together to promote information sharing and increase transparency. The formats of the quarterly meetings foresee detailed exercises to jointly discuss program activities. At the time of this evaluation, UNFPA planned to replicate the model in other program regions.[82]

Judgment criterion 10.2

- Integration of Monitoring and Reporting of UNFPA operations

UNFPA has supported Ghana Statistical Service in collecting, processing and analyzing data; and in writing and disseminating reports. The country office has used resources from the population and development sub-program to train government institutions on evidence-based planning. The supported agencies include Ghana Health Service, National Development Planning Commission, National Population Council, Ghana AIDS Commission, ministries, departments, agencies, metropolitan municipalities, district assemblies, local development and health authorities as well as civil society organizations.

UNFPA has made gender disaggregated data available to the government through its support to the Ghana Statistical Service (GSS) to support evidence-based decision making at all stages of policy development, planning, programming, and budgeting. NDPC has provided guidelines that are followed closely by UNFPA and GSS. Civil society organizations that use data from GHS and the National Population Council (NPC) for data are aware of the UNFPA role in collecting and analyzing this information.[83]

81. Interview with government partner.
82. Interviews with UNFPA staff.
83. Interviews with government.

Synergy between UNFPA sub-programmes is also facilitated by the quarterly monitoring meetings under the aegis of NPC. Implementing partners involved in reproductive and maternal health have used these meetings as opportunities to interact with implementing partners in other substantive areas. UNFPA has worked with NPC to disseminate data on gender and maternal health. Both entities realize the importance of being able to share reliable data bi-annually with traditional leaders and community leaders who form part of the District Health Management Team about monitoring.[84]

4.1.11 Evaluation question 11: Coherence between country, regional, global programmes

Evaluation question 11

To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?

Judgment criteria	Issues to assess
11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities	How time consuming was the recruitment of reproductive health expert into country offices? Could all required positions be filled?
	Are gaps in technical reproductive health/maternal health staff capacity remaining that keep country offices from reaching their full potential?
11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level	To what extent has GP guidance for maternal health service up-scaling; midwifery up-scaling been applied at country level/was relevant for programming/ implementation support at country level?
	What are specific contributions of regional programmes to supporting integration of maternal health into national frameworks/health system strengthening?

Judgment criterion 11.2

- Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities

The capacity of the UNFPA country office for strategic planning, sector-coordination, monitoring and evaluation and budgeting has been affected by several human resources related gaps. Most significantly, the country office was without a full-time country representative for two years and, at the time of this evaluation, had not been able to replace the assistant country representative after a six month vacancy.

84. Interview with Regional Health Directorate.

Although the technical staff of UNFPA has been well respected among development partners, the capacity of the country office for policy planning, sector co-ordination and budgeting has been affected by some critical human resources gaps.[85] The most significant shortcoming in this regard has been the absence of a full-time UNFPA country representative for almost two years. Also, at the time of this evaluation, the post of deputy representative had been vacant for six months and no viable candidate had yet been identified. These long-term vacancies affected the ability of the country office to drive the core mandate of the organization at policy, sector and budget level.[86] UNFPA had to be represented by UNDP Resident Coordinator in high-level meetings.[87]

The country office has experienced similar difficulties in the area of M&E. Prior to 2011; M&E had been under the remit of the deputy representative, who had been an expert in the field. With his departure in early 2011, a full-time M&E position was created. However, after an unsuccessful recruitment attempt, the post has remained vacant. Considering the prominent role of UNFPA in supporting the national M&E system, the M&E position is critically important.

The MHTF-funded Country Midwifery Adviser (CMA) has helped to bolster the staff capacity of the country office. Initially, the CMA was supposed to have offices both at the GHS and at UNFPA, however, as GHS did not have the required office space, the CMA joined the staff at the UNFPA office.[88] GHS remains keen to have a full time Country Midwife Adviser based in the Ministry to facilitate a closer co-operation between the government and the ICM sub-regional office in Accra.[89]

Judgment criterion 11.3

- Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

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UNFPA country office has received technical support from the regional office. For example, the Tanzanian Deputy Representative visited Ghana to help with preparation of the 6th country program. The sub-regional office in Dakar has facilitated knowledge sharing.

The sub-regional office has recently developed software that handles all requests from country offices for technical support in a streamlined manner, therefore increasing efficiency. There is now an online form at country level to request technical support from the regional office/sub-regional office and a regular weekly program meeting takes place to formulate these requests. Under certain circumstances, the country office can also request technical support from headquarters. Overall, technical support requests have been fulfilled by the sub-regional office, the regional office and headquarters, provided the country office had submitted the request far enough in advance.[90]

During interviews, country office staff expressed a need for technical support from the sub-regional office on program and financing issues as well as ensuring appropriate linkages between CPAP

85. Interview with government partners.
86. Interview with development partner.
87. Interviews with UNFPA.
88.
89. Interview with government partner.
90. Interview with UNFPA.

4.1.12 Evaluation question 2: Visibility

Evaluation question 12

To what extent did UNFPA maternal health support contribute to UNFPA visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?

Judgment criteria	Issues to assess
12.2. UNFPA leadership of maternal health advocacy campaigns at national level	What approaches has UNFPA used to lead maternal health advocacy vis-á-vis the national governments and the national public? (Based on concrete examples of how UNFPA displays convening power, where, how and who utilize its technical expertise, etc.)?
	What are the top technical assistance products and technical resources from global and regional offices best utilized by the country office? Ask other implementing partners the same question but about the UNFPA country office and visibility/leadership?
	How does UNFPA fill its leadership role in institutional capacity development, advocacy on policy and political level, creation of a critical mass of public support for its program and promoting empowerment (this is a new budget line since 2004).
12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health	What are the tools, information and evidence provided by UNFPA country office that has been utilized in reproductive health/maternal health resource mobilization (non-cash) and fundraising (cash) by partner governments?
	In what way did these tools improve the ability of governments to raise additional funds for maternal health; or the willingness of governments themselves to devote more funds to maternal health?

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

National visibility of UNFPA has been affected by the long-term vacancies of the post for country representative and assistant country representative. However, the work of UNFPA at sub-national level was less affected by these human resources gaps.

Support to the availability of and accessibility to maternal health services in its five focal regions has made UNFPA more visible at sub-national level than at the national level.[91] In the Central Region, for example, UNFPA has been widely acknowledged for its support to the public-private partnership between local authorities and the transport union to reduce

91. Interviews with government.

delays on the way to health centers.[92] At national level, the two year absence of a full-time country representative has affected the presence of UNFPA in national initiatives and has made it difficult to be present in all relevant high level meetings, outside fistula and EmONC.[93]

Nonetheless, UNFPA support of the heavily attended CARMMA launch in 2009 has been widely acknowledged.[94] The CARMMA initiative has been gathering momentum since 2009, also as a result of the UNFPA-supported launches of sub-national initiatives in ten regions of Ghana.[95]

In particular, national initiatives of some of the small implementing partners of UNFPA have garnered national attention, such as the campaign to engage youth in national census activities; the initiative for the prevention of teenage pregnancy, safer sex initiatives for women porters and innovations around condom programming, carried out by Curious Minds and the Society for Women and AIDS Action (SWAA).

Judgment criterion 12.3

- Increased financial commitments of partner governments to sexual reproductive health and maternal health

UNFPA Ghana has used maternal health road maps and the launch of CARMMA to leverage additional financial commitments for maternal health. However, these commitments have not always translated into the actual allocation of resources to maternal health.

Government funding for maternal health has increased fourfold since 2008 in response to the gaps identified in the Maternal Health Survey of 2007, which UNFPA and other agencies had supported. The government also managed to raise additional money for the 2010 census from the private sector after advocacy efforts by two UNFPA implementing partners, Curious Minds and MCAN. Curious Mind has become an important advocate for youth and reproductive and maternal health vis-á-vis the National Population Council.[96]

UNFPA advocacy has helped to solicit the recent government commitment of 3 million dollars for family planning commodities, the largest annual governmental commitment for family planning up to that point. However, at the time of this evaluation, the commitment had not yet translated into an actual budget allocation. In previous years, resources from the family planning budget often had been used to cover shortages in other part of the health budget.[97]

92. Interview with Regional Health Authority.
93. Interview with development partner.
94. Interviews with government.
95. Interviews with UNFPA staff.
96. Interviews with UNFPA.
97. Interview with a development partner.

4.2 Findings related to the Mid-Term Evaluation of MHTF

4.2.1 Evaluation question 1: Relevance

Evaluation question 1

To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria	Issues to assess
1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)	To what extent do the MHTF supported needs assessments consider the needs of the most vulnerable groups in the program countries; and identify the gaps that have prevented the addressing of their needs to that point?
	To what extent are MHTF supported needs assessments (see output two of the MHTF business plan) sufficiently "owned" by national governments to guide the subsequent planning and implementation of national maternal health support?
1.3. National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas	To what extent is the MHTF support targeted to address the identified gaps and needs of the most?

Judgment criterion 1.2

- MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)

The recent national EmONC assessment, funded in part by MHTF, was expected to identify gaps in the provision of EmONC services to poor and disadvantaged groups. The recommendations from the EmONC assessment will also be incorporated into the MAF strategy.

Judgment criteria 1.3

- National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas

MHTF provides support to vulnerable women through the UNFPA fistula awareness campaign that includes advocacy, repair and social re-entry especially in three northern regions, which are both rural and remote and where the need is acutely prevalent.[98] The fistula program has expanded into other regions that have districts with fistula prevalence and high MMR. MHTF funds have been used to educate poor and rural communities on the causes of fistula and on the options for treatment.[99] The country office has also used financing by MHTF to rehabilitate beneficiaries through income generating activities training done by the Non-Formal Education Division of the Ministry of Education. MHTF resources also have helped to support the deployment and retention of midwives in poor and rural areas of the northern regions.[100]

4.2.2 Evaluation question 2: Capacity Development - human resources for health

Evaluation question 2

To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?

Judgment criteria	Issues to assess
2.1. Program countries midwifery education upgraded based upon ICM (International Confederation of Midwives essential competencies through MHTF support	How does the MHTF support improved mechanisms for: long term national midwifery education funding, country wide integration of new curricula and Monitoring of effective uptake of new knowledge/training?
	What follow up mechanisms are instituted by the MHTF to assess the relevance of the training content, the trainers' capacities and the appropriate utilization of the training equipment?
2.2. Strategies and policies developed to ensure the quality of midwifery services provision in program countries through MHTF support	To what extent does the MHTF support the relevant national institutions to address deployment, motivation and retention policies for health care workers (particularly midwives)? (Which activities? what are the changes adopted by the government?)
	How does MHTF support program countries to define the most urgent needs/priorities of midwifery scaling-up within the financial and political constraints? How is it translated in country planning and budgeting process?
2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support	What approaches is the MHTF considering to enabling midwives' associations, to take on the role envisioned in the program (capacity to advocate for and implement the scaling up of midwifery services)?
	Is the skills mix of the MHTF Country Midwifery Advisors optimal to best support countries?

98. MHTF annual report 2008, 2009 and 2010 (this issue will be taken up under evaluation question 19).
99. Interview with UNFPA.
100. Interview with Regional Health Service.

Judgment criterion 2.1

- Program countries midwifery education upgraded based upon ICM essential competencies through MHTF support

The country office has collaborated with ICM to ensure that midwifery curricula for both the diploma midwifery program and the new bachelor degree midwifery program, created largely through UNFPA initiative, are aligned with ICM standards and essential competencies.

The integration of the MHTF supported Midwifery Program in Ghana began in early 2009 and continued in 2010. The ICM sub-regional project office was established the same year in Accra and MHTF supported a detailed desk review and needs assessment and gap analysis to establish a baseline on prevailing standards of midwifery (pre-service and in-service). The needs assessment also revealed that the legislative and regulatory environment for midwifery needed to be updated.[101]

By late 2009, Ghana had updated the existing pre-service national curricula based on WHO/ICM seven essential competencies and had rolled them out to training schools. In 2010, the country saw an increase of 400 midwifery graduates, adding to the 3000 that had existed in 2009. MHTF support began shortly after a formal curriculum review had been completed; however, MHTF resources allowed UNFPA to recommend a number of revisions which were taken on board.[102]

The country office used financing by MHTF to spearhead the development of the curriculum for a four- year Bachelor of Science (BSc) degree at the Kwame Nkrumah University of Science and Technology. This new program was approved by the National Accreditation Board and was officially launched in October 2011. It is intended to attract students and practicing midwives who might otherwise choose a nursing bachelor degree.[103] The government committed itself to sustain all main activities of the BSc. degree that currently are funded by UNFPA. At the time of the evaluation, no financing by MHTF was being used to support the 18-month post graduate midwifery training for community health nurses.[104]

Judgment criterion 2.2

- Strategies and policies developed to ensure the quality of midwifery services provision in program countries through MHTF support

ICM and UNFPA (headquarters) jointly hosted the first inception forum for country midwifery advisors (CMAs) and a capacity development workshop in Accra. This workshop presented a strategic approach to promote and strengthen midwifery services at country level, with a specific focus on midwifery education, regulation and strengthening midwifery associations. The CMA at UNFPA Ghana is fully funded by MHTF.[105]

In order to assist the government in its efforts to strengthen pre-service midwifery training, the country office used MHTF resources to conduct a nationwide needs assessment of all 12 midwifery training schools in 2009 and to carry out an in-depth assessment of the infrastructure and curriculum (pre-service and in-service). As part of this effort, an in-depth assessment was done of the Bolgatanga Training School which is the most deprived midwifery institution and serves the UNFPA program districts of the Northern Region. The Bolgatanga report was catalytic in making MoH and Ministry of Women and Children Affairs take high level action in re-equipping the school. The success of the Bolga Midwifery School project was also showcased.

101. MHTF annual report 2009.
102. Interview with government partners and UNFPA.
103. Interview with ICM sub-regional office, Accra.
104. Interview with UNFPA.
105. Interview with UNFPA.

The country office also utilized financing by MHTF to distribute medical equipment and anatomic models to 14 training schools in 2009. The CMA reported that in six of the schools visited as part of a review, higher passing rate of students indicated the usefulness of the equipment and models. However, not all models were equally used and there was also a lack of comprehensive training of teachers in using these new teaching props.[106] ICM and MHTF hosted a workshop in 2011 with INTEL to discuss expanding capacity development into remote areas through distance learning and use of computer technology; currently it is likely that this technology will be put into place through a UNFPA/ICM/INTEL partnership.[107]

Judgment criterion 2.3

- Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

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Ghana has a Nursing and Midwives Council and the two Midwifery Associations received visits from counterparts in Ethiopia to learn about best practices, networking and advocacy in 2009. At the time of this evaluation, the CMA was helping to mediate tensions between the long-standing Ghana Registered Midwives Association, whose membership is comprised of mostly private sector midwives, and the newer and smaller governmental National Midwives Group, comprised of mostly younger public sector midwives. The goal was to establish one uniformly representative association for midwives.[108] ICM engaged with the two associations to strengthen their regulations in accordance with global guidelines. For the first time in 2011, the two associations jointly celebrated the International Midwives Day.[109]

106. Interview with regional training school.
107. Interview with ICM sub-regional project office.
108. Interview with NGO.
109. Interview with government.

4.2.3 Evaluation question 3: Sexual and reproductive health services – family planning

Evaluation question 3

To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?

Judgment criteria	Issues to assess
3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support	What were the specific family planning activities financed through MHTF?
	To what extent organized family planning training (with MHTF support) responds to identified needs and priorities in comparison to training funded through other UNFPA sources?
	Are the capacity development interventions (supported by MHTF) accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure) in comparison to interventions funded through other UNFPA sources?
3.2. Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups through MHTF support.	What is the rationale of MHTF support to community based family planning distribution interventions and demand creation/communication initiatives?
	Are the monitoring and evaluation mechanisms to measure the appropriateness of the MHTF financed family planning communication initiatives coordinated with the other UNFPA sources of funding?

Judgment criterion 3.1

- Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support

and

Judgment criterion 3.2

- Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups through MHTF support.

The MHTF inception mission to Ghana and the MHTF Needs Assessment identified the shortage of contraceptives and poor quality of integrated family planning services as critical bottlenecks.[110] However, subsequent financing by MHTF focused on midwifery education, regulation, association building and EmONC needs assessment and did not finance activities in family planning.[111] Family planning and commodity security was funded through the GPRHCS.

110. MHTF annual report, 2009.
111. Interview with UNFPA staff.

4.2.4 Evaluation question 4: Sexual and reproductive health services – EmONC

Evaluation question 4

To what extent has the MHTF contributed towards scaling up and utilization of EmONC services in priority countries?

Judgment criteria	Issues to assess
4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support	What mechanisms does the MHTF support to upgrade/ provide continuous EmONC education in remote areas?
	How does the MHTF ensure that its EmONC services quality control mechanisms (including institutionalizing supportive supervision) are adopted by the program countries?
	What mechanisms does the MHTF apply to motivate and sustain the MoH commitment to strengthen and scale up EmONC services based on the bottlenecks identified?
4.2. Utilization and access of EmONC services improved through MHTF support	What are the mechanisms in place to explore the barriers to EmONC services in countries supported by the MHTF?
	What are the mechanisms put in place with MHTF support to address the identified barriers and to increase demand of quality EmONC services (communication activities, social mobilization...)?

Judgment criterion 4.1

- Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support

MHTF has advocated for, helped to design and financially supported the National EmONC Needs Assessment.

UNFPA provided support for basic EmONC services in the 4th and 5th country programs. However, the impetus for a comprehensive EmONC needs assessment was only provided by the MHTF inception mission in 2009. The mapping exercise carried out by H4+ members in 25 countries, including Ghana, also helped to get the Ghanaian MoH on board.

The EmONC Needs Assessment was meant to start in early 2010, but only could be launched and completed with delays, due to overlaps with the national census and a resulting busy schedule for the Ghana Statistical Service. UNFPA, UNICEF and WHO pooled funds and Averting Maternal Death and Disability provided the technical support, funded by the MHTF. [112] At the time of this evaluation, fact sheets on the initial findings were being circulated while the report was still being finalized for submission during the National Health Summit in November 2011 for inclusion in the official Aide Memoire. The needs assessment findings will complement the development of the EmONC Improvement Plan in 2012.

112. Interview with external development partners.

Equipment provided with MHTF money for EmONC services included aspirators, first aid kits, weighing scales, mannequins for fistula repair training, blood pressure equipment, manual vacuum aspiration (MVA) equipment for post abortion complications, labor beds/couches, labor equipment, and blood bank fridges. Funds have also been used for minor facility refurbishments.[113]

MHTF funds were utilized to support two-week in-service lifesaving skills trainings for both public and private sector midwives in several regions, including rural and remote areas. The certification the trainees received provided them with the authorization to administer the core set of interventions which included seven basic EmONC functions. Through the MHTF supported midwifery curriculum, students since 2009 have been introduced to "intervening in emergency situations" and have received additional training on how to take necessary action during pregnancy, labor, delivery and after birth.[114]

Judgment criterion 4.2

- Utilization and access of EmONC services improved through MHTF support

MHTF financing was used to support the implementation of the comprehensive EmONC needs assessment in Ghana. Because of delays in its launch and implementation, MHTF allocations to the assessment for 2010 were not utilized, and the bulk of the resources were carried over to 2011.

Criteria for facilities to be included in the assessment were a minimum of five deliveries per month in most regions, and one birth per month in the three northern regions. The assessment looked at skills and training needs, staff strength, equipment, infrastructure and family planning services. Assessed facilities included teaching hospitals, regional hospitals, district hospitals, health centers, family planning centers and CHPS. Due to delay of the National EmONC Report, fact sheets and checklists for initial improvement have been circulated to facilities.

One of the biggest achievements of the MHTF was to influence the Health Service to pre-position reproductive health commodities, including oxytocin and magnesium sulfate in every CHPS, MVA equipment and other essential EmONC supplies in those facilities where lack of supplies was noted as critical in the assessment.[115] No service quality control mechanisms appear to have been established for EmONC as the needs assessments had yet to be finalized at the time of this evaluation.

113. Interview with regional training center.
114. Interview with Regional Health Directorate staff.
115. Interview with Regional Health Directorate.

4.2.5 Evaluation question 5: Support to health planning, programming and monitoring

Evaluation question 5

To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in program countries?

Judgment criteria	Issues to assess
5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support	How have the advocacy campaigns/activities supported by the MHTF been translated into national policies and strategies (that includes family planning, skilled care in pregnancy and childbirth, emergency obstetric and neonatal care, obstetric fistula and sexual reproductive health and reproductive health/HIV linkage)?
	Do the sexual reproductive health coordination bodies established in countries (facilitated by MHTF) provide a coordination framework to address sexual reproductive health/maternal health issues? What are its main functions?
5.2. National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support	To what extent institutional capacities have been developed through MHTF support to allow systematic and sound costing and budgeting of sexual reproductive health/maternal health interventions/packages? What are the capacity development activities supported by MHTF?
	Do national health budgets include dedicated budget lines for family planning, skilled care during pregnancy and child birth, emergency obstetric and neonatal care and obstetric fistula in MHTF supported countries? What are the prospects for sustainability?
5.3. National and subnational health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages	Are key internationally agreed sexual reproductive health/maternal health indicators integrated in health management information system in MHTF countries and properly measured and used for programming?
	To what extent are the M&E plans and mechanisms (developed with MHTF support) adopted and lessons learnt integrated in sexual reproductive health/maternal health annual programming?

Judgment criterion 5.1

- Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support

and

Judgment criterion 5.2

- National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support

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The bulk of resources from the MHTF have been provided to the Health Service to finance activities in Accra and in the five UNFPA program regions, with a very small amount asigned to the Ministry of Chieftaincy and Culture. Coordination has taken place within the sector working groups.[116]

UNFPA also utilized MHTF resources to provide technical assistance for the costing of Ghana MDG Accelerated Framework (MAF) to Reduce Maternal and Neonatal Mortality. The resulting costing model was being used by the Health Service at the time of this evaluation.[117]

Judgment criterion 5.3

- National and subnational health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages

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The MHTF midwifery needs assessment and gap analysis has helped to develop a data base of all practicing and non-practicing midwives. The Health Service has used the database to plan and monitor recruitment, placement and deployment of midwives. Findings of the midwifery needs assessment also convinced the Health Service to upgrade the systems for the mandatory notification and surveillance of maternal deaths.

The country office used money from the MHTF to assist the government in monitoring the new, expanded reproductive health commodities security strategy that had been developed with input from the National Population Council and civil society.[118] MHTF resources were also used to support the Nursing and Midwifery Council in the development of a strategic plan and monitoring tool to track standards of practice and the application of comprehensive code of ethics.[119]

116. Please see the section on MHTE for details.
117. Interview with external development partner.
118. Interviews with UNFPA.
119. Interview with ICM project office Accra.

4.2.6 Evaluation question 6: Management of MHTF

Evaluation question 6

To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?

Judgment criteria	Issues to assess
6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level	To what extent the needs of country offices in terms of technical guidance and tools (for planning, implementation and monitoring) are responded to (from regional and global level)?
	To what extent country offices MHTF/RHTF planning process is facilitated by the tools provided at global level?

Judgment criterion 6.2

- Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level

While the MHTF Ghana is a separate funding stream, planning, programming, budgeting and reporting has been done in close coordination with the country office and with support from headquarters.

MHTF has provided the country office with a Country Midwifery Advisor (CMA) who has been trained on effective work planning, monitoring and reporting and took part in the mid-term review of the country midwifery program. The CMA who is based at the UNFPA office works closely with the Ministry of Health and the Health Service.[120] The CMA is part of the reproductive health team in the country office and reports to the reproductive health specialist.[121]

MHTF-funded staff at UNFPA headquarters has provided the country office with support in proposal development, reporting, needs assessment and gap analysis for midwifery, the introduction of ICM tools and competencies and technical support for the EmONC National Assessment.[122] The country office also has benefited from a variety of MHTF-financed regional workshops, namely the Inception Forum and capacity development for CMAs, the mid-year progress review, the WHO Regional Meeting and the Core Steering and Program Management Group Meeting. [123]

The country office also utilized MHTF resources to host a variety of country teams to facilitate south-south exchanges of experiences and knowledge. Among other things, staff from the Ministry of Health of Eritrea traveled to Ghana to visit the fistula repair hospital, and to observe its management and the services offered for the rehabilitation and re-integration of clients. The Ethiopian Midwifery Association visited Ghana to learn about midwifery regulations, standards and codes.[124]

120. Interviews with government and UNFPA.
121. UNFPA Ghana, Organogram 2010.
122. MHTF annual report 2009.
123. Interviews with UNFPA.
124. Interviews with UNFPA.

4.2.7 Evaluation question 7: Coordination/coherence

Evaluation question 7

To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA Thematic Funds e.g. the Global Program to Enhance Reproductive Health Commodity Security, the Campaign to End Fistula and the UNFPA-ICM Midwives Program and HIV-PMTCT in order to support maternal health improvements?

Judgment criteria	Issues to assess
7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF	Do MHTF supported countries include obstetric fistula in their advocacy campaign for sexual reproductive health/ maternal health?
	To what extent does MHTF support in promoting sexual reproductive health/maternal health policies, strategies and plans including M&E plans (with specific indicators) allow to integrate obstetric fistula?
7.2. Joint and coordinated planning at country level with GPRHCS	What are the mechanisms in place between GPRHCS and MHTF to harmonize pharmaceuticals, medical supplies and medical equipment lists in program countries?
	To what extent concerted planning seeks an increased synergy between the MHTF and the GPRHCS in countries that are supported by both funds?
7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources	To what extent national and sub national service health delivery plans have an integrated sexual reproductive health/HIV component (with MHTF support)?
	Do the revised midwifery curricula include PMTCT in country with high HIV prevalence supported by MHTF?

Judgment criterion 7.1

- Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF

The Fistula Program started in 2003 with regular funds from UNFPA and is now 100 per cent funded by MHTF. The country office considers that core funding to the Campaign to End Fistula has ended and has been replaced by MHTF, with the intention of eventually having funding taken over by the Ghana Health Service.

Since 2009, the Campaign to End Fistula in Ghana is supported entirely by MHTF. This included a comprehensive advocacy package spearheaded with the participation of Miss Ghana in the Northern Region, Upper East and Upper West as well as expert surgical trainings in 2010.[125] The three main results of the Campaign in 2009-10 were: a) the inclusion of obstetric fistula treatment in the National Health Insurance Scheme (NHIS) and Livelihood Empowerment Against Poverty program to reduce financial barriers and increase possibilities for income generation; b) the establishment of an upgraded fistula center

125. Interviews with UNFPA staff.

of excellence which was officially commissioned by MoH and Ministry of Women and Children Affairs. Key excellence components are: on the supply side - quality assurance, supportive supervision, global partnership for capacity development (International Society of Fistula Surgeons), set up of the Fistula Working Group who in turn developed the standardized competency manual for training and protocol and on the demand side - the utilization of fistula survivors peer group and the NGO SWAA to accelerate community participation in registration with NHIS, rehabilitation and re-integration;[126] and c) south-south collaboration with Ghana hosting Eritrea in fistula repair training.

The MHTF has ensured that UNFPA addresses fistula within the maternal health program in the Accelerated Road Map (MAF). However, no baseline data exists for fistula, and the monitoring framework of the MAF is weak. At the time of this evaluation, the Health Service was contemplating to set up a national fistula task force to develop a national strategy to support treatment and rehabilitation of fistula cases. Due to internal challenges of the Health Service, UNFPA had not yet been able to facilitate and support this and other activities related to fistula that were intended for 2010-11 (such as expanding the number of doctors trained in repair work). As a result, some of the available MHTF resources were not utilized.[127]

Judgment criterion 7.2

- Joint and coordinated planning at country level with GPRHCS

MHTF and GPRHCS have jointly convened the process of peer reviewing the annual work plans in 2010-11 which has facilitated south – south learning and the sharing of good practices. This has resulted in strengthening family planning efforts by supporting favorable policy environment and service delivery.

In synergy with the UNFPA Global Program to Enhance Reproductive Health Commodity Security (GPRHCS), the country office has used MHTF-funds to provide technical assistance to develop capacity in support of re-positioning family planning in Ghana. Key contributions have been: a) joint support to the Ghana Health Services to help integrate family planning logistics (supply chain) into the national logistics system; b) training for family planning service providers in management and logistics to ensure that supplies are delivered on time, directly to facilities c); in-service training for health workers to provide long term family planning methods; and d) general support for M&E in conjunction with the West African Health Organization.[128]

Judgment criterion 7.5

- MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources

The UNFPA reproductive health, gender, population and development specialists attended the Joint Strategic Review Meeting of the Thematic Trust Funds in 2010. This facilitated the strategic integration of the MHTF with funding from other program areas. UNFPA in Ghana also has formulated the first unified budget and joint MHTF and GPRHCS work plans.

Annual planning in Ghana has taken into account core funds, MHTF, GPRHCS and other sources of funding. All planning has been done in conjunction with the respective ministries. Thematic sessions were held on emerging issues, new technologies, scaling up services and M&E.[129] Joint MHTF and GPRHCS plans included results and indicator matrices, outlines for the documentation of good practices, formats for expenditure report and joint annual work plan templates.

126. Interviews with government and NGO.
127. Non-core resources for country program 5, UNFPA Ghana.
128. Interviews with UNFPA staff.
129. Agenda of the Joint Strategic Meeting 2010 and guidelines.

4.2.8 Evaluation question 8: Leveraging and visibility

Evaluation question 8

To what extent did the MHTF increase the visibility of UNFPA sexual reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?

Judgment criteria	Issues to assess
8.1. The MHTF facilitated the presence of UNFPA in global and regional maternal health initiatives	To what extent are the various MHTF supported advocacy and communication efforts translated into higher visibility and additional resources for maternal health?
8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)	How do program countries benefit from regional maternal health related initiatives (conferences, workshops) supported by MHTF?
	What kind of mechanisms are in place to support program countries to increase their efforts to leveraging additional resources with external donors (CARMMA, UN SG initiative, especially Canada, France grants, etc.)?
	To what extent the MHTF support contributed to an increase in the share of external financial commitments earmarked to support maternal health at global, regional level?
	To what extent the MHTF support contributed to an increase in the share of external financial commitments earmarked to support maternal health at country level?
8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health	To what extent program countries governments intended/ committed to allocate additional resources for maternal health with MHTF support?

Judgment criterion 8.1

- The MHTF-facilitated the presence of UNFPA in global and regional maternal health initiatives

MHTF does not have any particular visibility compared to any other non-core earmarked funding. MHTF is however well known to the Ministry of Health and the Ghana Health Service for two reasons: a) participation by influential stakeholders in the Women Deliver Conference and Midwives in Ghana has been featured in an MHTF supported documentary and b) Ghana Health Service receives the bulk of UNFPA non-core resources including MHTF funding. With the MHTF focus on midwifery, fistula and EmONC needs assessment the funding was seen as catalytic and synergistic.

MHTF provided support to high level members of the MoH/GHS and policy makers to attend the Women Deliver Conference in 2010. As a member of the Conference Advisory Committee, UNFPA headquarters facilitated the Ministers and Parliamentarian Forum and Midwifery Symposium where issues, achievements and challenges in midwifery programming in Ghana were featured. The MHTF supported documentary "Ghana Midwives Deliver" has also been broadcasted by BBC,

National Public Radio, CNN, ABC and Al Jazeera and was used by MHTF in political advocacy and donor events throughout the world. UNFPA Ghana, GHS staff and NGOs valued the documentary as an accurate depiction of the achievements of Ghana and the challenges that remain.[130] The trainings in life saving skills were highly appreciated by the Health Directorate in the Central Region but have been noted as supported by direct project funding from UNFPA most probably due to decentralization.[131] Overall, GHS saw MHTF funding as critical and expected that the EmONC needs assessment when made public in December 2011 and utilized as a planning document would help to leverage additional funds.

There is a need for a better strategic vision for using MHTF funds after the first two years of operation. In 2011, MHTF was starting to be used to fill several gaps: EmONC needs assessment, equipment for midwifery training, lifesaving skills, fistula program in the north, CMA salary, support for midwife association conflict resolution, support for startup of bachelor degree midwifery program, some support for JSI DELIVER for contraceptives commodities delivery. All of these were continuing activities from previous years. By the third year of funding, the innovative character of the supported interventions was weakening.[132]

Judgment criterion 8.2

- Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)

and

Judgment criterion 8.3

- Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health

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MHTF has helped UNFPA Ghana and GHS to attract additional resources for MDG 5a and 5b goals, to evaluate services and develop proposals to leverage other funds.

The UNFPA Campaign to End Fistula in Ghana started in 2003. Its goal was to sensitize people about fistula and understand that fistula can be treated and women do not need to be shunned. The MHTF focus on midwifery also helped to sustain the momentum of increased fistula support. The MHTF in Ghana is currently utilized as a strategy for fistula support. The first focus of MHTF was on community awareness; then the program expanded to focus on treatment and rehabilitation. At the time of this evaluation, the Fistula Campaign was ongoing; has affected national policy and continues to identify patients. Women who have been repaired often became active advocates for the program.

MHTF replaced an initial Swedish Midwifery Program at a critical time of its development. It was always intended to include midwifery from the conception phase of the MHTF (see national output 4 in the business plan). The Netherlands provided their funding directly to the MHTF right from the beginning and Ghana was one of the early beneficiaries, together with ten other countries.

GHS has received a loan from the Netherlands and is hoping for an EU grant to supplement funding from UNFPA to strengthen fistula, midwife and EmONC services. The country office considers MHTF as essential for mobilizing additional funding.

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130. Interviews with government and NGO.
131. Interview with Regional Health Directorate.
132. ICM project office.

5. Conclusions

Based on the findings on the issues to assess for each of the evaluation questions, the evaluation team has drawn some cross-cutting conclusions which are presented below. These are country-specific conclusions and are not to be confused with the conclusions of the MHTE/MHTF final reports. The conclusions presented in this section are based on the selective analysis of UNFPA maternal health support in Ghana only, and as such do not provide a judgment on the quality of UNFPA country program in Ghana overall, which would only be provided by a comprehensive country program evaluation. The conclusions cover the overall maternal health interventions of UNFPA in Ghana and also the specific added value of MHTF in the country.

5.1 Conclusions on UNFPA overall maternal health support in Ghana

1. Outside of HIV/AIDS and to some extent in the area of domestic violence, UNFPA does not have a formal working definition for vulnerability within maternal and reproductive health. Nevertheless, its maternal and reproductive health program has addressed maternal health needs of the poor and disadvantaged.[133]

    - The country office works in five of the poorest regions, some of them rural and remote geographic areas; provides most of its support to public health facilities used typically by the poor; gives adequate priority to interventions that promote access to disadvantaged groups in underserved program areas such as fistula, EmONC and family planning, builds capacity of midwives; has expanded its program to include the introduction of MISP in humanitarian settings and its civil society organization/community partnerships target the hard to reach and most at risk population.
    - The country office while selecting operational areas could look into keeping a balance between regions of high need and pockets of extreme poverty outside these regions.

2. UNFPA has contributed to the improved alignment of efforts within the framework of UNDAF at the outcome level and harmonization with government-led sector working groups at the output level. UNFPA has actively provided maternal and reproductive health data and evidence in the development of different road maps and the achievement of milestones within the Maputo Plan-Abuja Call-CARMMA and the MDG Accelerated Framework (MAF). However the position the country office has taken with regard to its role and responsibilities within the health SWAp were contradictory.[134]

    - The country office remained one of the two agencies to fund the health SWAp until 2010 but has not attended a health SWAp meeting in the last two years, there was no notification of its self-imposed absence and neither has it formally withdrawn its membership.
    - UNFPA headquarters policy has not encouraged UNFPA Ghana to go into multi-donor budget support or pool funding. Some of the country office staff was unsure of the effects of the current position of UNFPA on SWAp as participation can still have benefits even without funding; a fact pointed out by two of UNFPA closest sister agencies.
    - The country office is conscious of the fact that UNFPA has to decide sooner than later whether its focus will be more upstream (policy advocacy and influencing budgets) or downstream (support to implementing services). The focus currently is mostly on the latter.
    - The critical and senior positions remaining vacant for a long time affect timely and effective strategic decisions.
    - While UNFPA is sufficiently visible where it matters, greater harmonization and alignment under 'Deliver as One' is expected to affect public visibility of individual agencies such as UNFPA.

133. Based on evaluation question 1, evaluation question 3, evaluation question 4, evaluation question 5, evaluation question 6 and evaluation question 7.
134. Based on evaluation question 2, evaluation question 9, evaluation question 11 and evaluation question 12.

3. Capacity development in reproductive and maternal health, supporting evidence-based programming and establishing multi-sectoral linkages on cross-cutting issues such as gender, population and development were the forte of UNFPA and were central to its support of public sector partners such as MoH/GHS, NPC and MoWAC. Key challenges remain for expanding midwifery school capacity to train more midwives, the tutor qualification requirement at masters' level, the shortage of clinical practicum sites and the recruitment, deployment and retention of midwives in rural and remote areas.[135]

    - The country office has appropiatly recognized the acute human resources shortages in maternal and reproductive health as well as the reality that MoH/GHS will not be able to meet the needs in this area in the short term. The support of UNFPA is still greatly needed for cohesive strategies within GHS to increase the number of qualified midwives, qualified tutors, training sites and clinical sites and to explore new ways to incentivize remote posting, including strategy assessment of how to phase out traditional birth attendants and phase in midwives.
    - UNFPA, however, does not have a seat on the Human Resource for Health Development Directorate and the absence of a country representative and deputy for long periods of time has affected the ability of the country office to influence human resources policy and budgets.
    - Training on gender mainstreaming within maternal and reproductive health are welcomed from a perspective of knowledge enhancement but are not considered sufficiently practical - especially the lack of skill in integrating gender issues and activities at the maternal and reproductive health budget level at the regional/district level.

4. UNFPA focuses on safe birthing practices, especially providing protection to the 15 per cent of high risk pregnancies. The results of the national EmONC needs assessment was eagerly awaited as was the development of the EmONC improvement plan at the district level. However, UNFPA has not managed to focus its attention and funding consistently on the removal of socio-cultural barriers and the primary prevention of high risk and unwanted pregnancy as a program priority in the area of family planning. Nevertheless, the role of UNFPA in the introduction of long term methods was commended.[136]

    - UNFPA has collaborated with UNICEF on EmONC related advocacy for several years. Since 2007, the two agencies have successfully accelerated collaboration to promote EmONC needs assessments in all ten regions and to get EmONC services included in the MAF. MHTF support for the EmONC national needs assessment and UNFPA support for expanding the assessment into a national initiative have had a notable impact on awareness of level of need and momentum for planning improvement at national, regional and district levels.
    - UNFPA support to re-positioning family planning has not positively changed modern contraceptive utilization in Ghana; in fact the situation has worsened with a decrease in the contraceptive prevalence rate between the two DHS (2003 and 2008).
    - For a Stream two country, the threat of contraceptive shortages in the public sector remains a constant possibility and the government is unwilling and/or unable to address the unmeant demand in spite of the best efforts of the country office in advocating for contraceptive security. Recently the MoH has responded by committing resources and asked UNFPA for help in procuring contraceptives.

135. Based on evaluation question 4 and evaluation question 10.
136. Based on evaluation question 6, evaluation question 7 and evaluation question 4.

- The country office does not have an advocacy strategy linked to visibility and milestones in the area of resource mobilization. The concrete added value of the CARMMA Initiative, beyond the Family Planning Week, needs to be documented; e.g. any regularized funding increase by district assemblies' needs propagation or integration of family planning into National Health Insurance Scheme needs acceleration. The UNFPA voice for contraceptive security and youth friendly services may need to be heard through young people and the media to get a groundswell like the 2010 census.

5. The position of UNFPA as the co-chair of the government-led M&E sector working group provides an excellent opportunity for advocacy to introduce tools and controlling macro data systems that have been adopted to monitor national reproductive and maternal health policies and programmes. However, UNFPA has not given sufficient attention and importance to operations, action research, evaluation (outside CCA) or the scaling up of its best practices in strengthening communities.[137]

- The country office dependence on the CCA and the government M&E system has its share of challenges as many of UNFPA special interventions (gender, family planning and culture) and partnerships (civil society organization and private sector involvement) are often not assessed. No operations or action research was brought to the attention of the evaluation team.
- The country office has piloted and demonstrated several good maternal and reproductive health practices in the community; however, while there is recognition of good or best practices there is an inability on the part of country office to scale up or replicate these practices in other regions.

6. UNFPA has no separate or formal strategy on community involvement. The country office supports innovations among communities through several national civil society organizations and regional health directorates. These innovations currently remain limited in scope and scale. The UNFPA – civil society organization partnership has not been independently assessed, however the national civil society organizations are well coordinated under appropriate program component managers in Accra and if necessary under the district health management team. Capacity development of civil society organization is done based on identified need and on request.[138]

- The reasoning within the country office is that the support of UNFPA reflects government policy and program direction. Furthermore, community systems strengthening cannot be in tandem with health systems strengthening especially with the focus of UNDAF shifting more and more towards health system strengthening. This has affected the movement of resources more and more in favor of the public sector.
- While recognizing the importance of increased alignment and harmonization with government priorities, civil society organizations also note how critical it is for UNFPA to keep a balance in funding to civil society organizations. Public health promotion strategies alone cannot shift the socio-cultural change needed to bring down the 30 per cent of deliveries still done by traditional birth attendants or the integration of culturally sensitive and rights based maternal and reproductive health programming to increase demand and utilization. Improving the supply side of service delivery will not accelerate maternal mortality reductions to the extent that is needed in a middle income country that is still highly traditional.

137. Based on evaluation question 3, evaluation question 8, evaluation question 9 and evaluation question 10.
138. Based on evaluation question 3 and evaluation question 1.

5.2 Conclusions on the added value of MHTF in Ghana

7. For the UNFPA Ghana country office, MHTF serves as an umbrella under which UNFPA critical maternal and reproductive health programmes such as midwifery, Campaign to End Fistula and EmONC operate well given the reasonably strong and de-centralized health system in the country. The MHTF is also seen by the MoH/GHS as a dedicated, targeted, earmarked supplementary funding for reducing maternal mortality. One critical bottleneck for MHTF is the shortage of supply of contraceptives and weak family planning services especially in rural areas and among the poor.

    - The MHTF has supported midwifery services in several ways:

        - In launching of midwifery regulatory standards, MHTF is used to ensure that the nursing and midwifery council acts or legislation are reviewed and that global regulatory standards are embodied (just starting);
        - Use of the standard ICM midwifery capacity assessment tool with the two associations;
        - Partnership by country office for feedback on midwifery training curriculum for various levels of training. The MHTF supports strengthening of national curricula for three midwifery training programs (diploma, post basic and bachelor degree);
        - Direct equipment support for midwifery school;
        - The GHS noted that UNFPA had not adhered to prior commitment of posting the country midwifery advisor (CMA) fully in the Ministry and called for greater support in integrating ICM initiatives within maternal health and with greater direct participation by the CMA.

    - The Campaign to End Fistula existed prior to MHTF and core funding is coming to an end. However, the MHTF supports targeting of vulnerable women in high need regions, such as the Northern Region, including those suffering from fistula, and thereby continues to maintain the momentum initiated by the Campaign. Obstetric fistula as it stands within the maternal and reproductive health program and the MAF does not have good indicators. Currently no baseline data exist for the length and breadth of fistula occurrence within the country and GHS is looking to develop a national strategy to support broad treatment and rehabilitation.
    - This small but critical supplemental funding has given a boost to UNFPA position in outcome three (maternal, newborn and child health) within UNDAF, enabled UNFPA to provide technical inputs into the EmONC needs assessment, and ensured that socio-cultural issues that influence the Three Delays are incorporated into the national strategy. The role of the MHTF in spearheading the EmONC Improvement Plan in 2012 is highlighted, as this should play a critical role in evidence-based micro-planning district by district.
    - The initial MHTF needs assessment and gap analysis identified a critical bottleneck in the supply of contraceptives and the weakness of family planning services. However, there has been no effort to strengthen capacity for scale-up and addressing all aspects of comprehensive family planning in spite of the facilitating environment provided by the road map for family planning. The 2011 National EmONC Assessment has included a section on family planning services due to MHTF intervention and the joint strategic peer review with GPRHCS in 2010/11 is a step in the right direction.
    - The MHTF has strengthened costing capacity of GHS through provision of a consultant to guide GHS on costing for the Road Map for maternal health. That costing scale is being used by GHS for other costing activities internally. While the national budget does not have specific budget lines for family planning, skilled birth attendant, EmONC and fistula, UNFPA and its partners are only advocating for dedicated budget lines for contraceptive security and have yet to achieve any success in this. There is some hope with CARMMA and the advocacy by the First Lady in all ten regions in 2011. There has been no independent assessment of the advocacy work of UNFPA.

6. Annexes

6.1 Key data of Ghana

GHANA		
Summary statistics		
Region	2000	Western Africa
Currency	2008	(new)Cedi(GHS)
Surface area (square kilometers)	2008	238539
Population (estimated, 000)	2008	23351
Population density (per square kilometer)	2008	97.9
Largest urban agglomeration (population, 000)	2007	Accra (2121)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	16558
GDP: Gross domestic product (million current US$)	2005	10726
GDP: Growth rate at constant 1990 prices (annual %)	2008	6.7
GDP per capita (current US$)	2008	709.1
GNI: Gross national income per capita (current US$)	2008	698.2
Gross fixed capital formation (% of GDP)	2008	36.0
Exchange rates (national currency per US$)	2008	1.21
Balance of payments, current account (million US$)	2008	-3543

CPI: Consumer price index (2000=100)	2008	387
Agricultural production index (1999-2001=100)	2007	124
Food production index (1999-2001=100)	2007	124
Labor force participation, adult female pop. (%)	2008	71.7
Labor force participation, adult male pop. (%)	2008	73.3
Tourist arrivals at national borders (000)	2007	587 (incl. nationals residing abroad)
Energy production, primary (000 MT oil equivalent)	2007	320
Telephone subscribers, total (per 100 inhabitants)	2008	50.2
Internet users (per 100 inhabitants)	2008	4.3
Exports (million US$)	2008	4032.9
Imports (million US$)	2008	9057.7
Major trading partners (% of exports)	2008	South Africa (44.0), Netherlands (11.7), India (5.3)
Major trading partners (% of imports)	2008	China (11.7), Nigeria (8.7), United States (7.7)
Population growth rate (avg. annual %)	2005-2010	2.1
Social indicators		
Urban population (%)	2007	49.3
Population aged 0-14 years (%)	2009	38.4
Population aged 60+ years (women and men, % of total)	2009	6.0/5.4
Sex ratio (men per 100 women)	2009	102.8
Life expectancy at birth (women and men, years)	2005-2010	57.4/55.6
Infant mortality rate (per 1 000 live births)	2005-2010	73.4

Fertility rate, total (live births per woman)	2005-2010	4.3
Contraceptive prevalence (ages 15-49, %)	2006-2009	23.5
International migrant stock (000 and % of total population)	mid-2010	1851.8/7.6
Refugees and others of concern to UNHCR	end-2008	18696
Education: Government expenditure (% of GDP)	2005-2008	5.4
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	77.3/80.9
Education: Female third-level students (% of total)	2005-2008	34.2
Seats held by women in national parliaments (%)	2009	8.3
Environment		
Threatened species	2009	183
Forested area (% of land area)	2007	23.2
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	9233/0.4
Energy consumption per capita (kilograms oil equivalent)	2007	143.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Ghana

6.2 Data Triangulation

Table 4: Data and methodological triangulation – Maternal Health Thematic Evaluation

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[139]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲ O	▲	▲	▲	▲	Interviews, focus groups, evaluations, project reports, planning documents, etc
2. Harmonization, coordination, partnerships	▲ O	▲ O			▲ O			Interviews, evaluations, project reports, planning documents, etc
3. Community involvement and demand orientation	▲ O	▲	▲ O	▲	▲O	▲	▲	Interviews, evaluations, project reports, planning documents, etc
4. Capacity development – Human Resources in Health (HRH)	▲ O	▲ O	▲ O		▲ O			Interviews, evaluations, project reports, planning documents, etc
5. Maternal health in humanitarian contexts	▲ O	▲	▲		▲ O		▲	Interviews, evaluations, project reports, planning documents, etc
6. Sexual and reproductive health services – family planning	▲ O	▲O	▲	▲	▲	▲	▲	Interviews, evaluations, project reports, planning documents, etc
7. Sexual and reproductive health services – EmONC	▲ O	▲O	▲	▲	▲ O		▲	Interviews, focus groups, evaluations, project reports, planning documents, etc
8. Results/evidence orientation	▲ O	▲ O	▲	▲	▲	▲		Interviews, evaluations, project reports, planning documents, etc
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O	▲	▲	▲ O	▲		Interviews, evaluations, project reports, planning documents, etc
10. Coherence of maternal health support with gender and population and development	▲ O	▲ O		▲	▲	▲O		Interviews, evaluations, project reports, planning documents, etc
11. Coherence between country, regional, global programmes	▲ O	▲				▲		Interviews, evaluations, project reports, planning documents, etc
12. Visibility	▲O	▲	▲	▲	▲	▲		Interviews, evaluations, project reports, planning documents, etc

▲= Primary Sources (Interviews, Focus Groups), O= Secondary Sources (Evaluations, project reports, planning documents, etc.)

139. Other than national government (in particular the Ministry of Health (MoH)) or sub-national governments.

Table 5: Data and methodological triangulation – Mid-Term Evaluation of the MHTF

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[140]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲		▲	▲		Document analysis (strategic and planning documents), interviews
2. Capacity development – HRH	▲ O	▲ O	▲		▲	▲		Document analysis (e.g., progress report, annual report, curricula, strategic documents), interviews
3. Sexual and reproductive health services – family planning	▲ O	▲ O	▲		▲		▲	Document analysis, interviews capital, field visit (focus groups)
4. Sexual and reproductive health services - EmONC	▲ O	▲ O	▲		▲ O		▲	Document analysis, interviews capital, field visit (focus groups)
5. Health planning, programming and monitoring	▲ O		▲ O			▲		Data and document analysis, interviews
6. Management of MHTF	▲ O					▲		Document analysis, interviews
7. Coordination and coherence	▲ O	▲	▲		▲			Document analysis, interviews
8. Leveraging and visibility	▲ O	▲	▲	▲	▲	▲		Document analysis, interviews

▲ = Primary Sources (Interviews, Focus Groups), O= Secondary Sources (Evaluations, project reports, planning documents, etc.)

140. Other than national government (in particular MoH) or sub-national governments.

6.3 Data collection result matrix

Overview evaluation questions MHTE	
Evaluation question 1 To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
Evaluation question 2 To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?	
Judgment criteria	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+[141]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

141. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Evaluation question 3 To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?	
Judgment criteria	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
Evaluation question 4 To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?	
Judgment criteria	4.1. Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs
Evaluation question 5 To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?	
Judgment criteria	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

Evaluation question 6 To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?	
Judgment criteria	6.1.Increased capacity within health system for provision of quality family planning services in UNFPA program countries
	6.2 Increased demand for and utilization of family planning services in UNFPA program countries, particularly among vulnerable groups.
	6.3. Improved access to contraceptives (commodity security)
Evaluation question 7 To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in program countries?	
Judgment criteria	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
Evaluation question 8 To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its program countries?	
Judgment criteria	8.3. Results- and evidence based management of individual interventions throughout project life

Evaluation question 9 To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its program countries?	
Judgment criteria	9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies
	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/maternal health components of national policy framework and development instruments
Evaluation question 10 To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other program areas?[142]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design

142. Gender (including female genital mutilation/cutting, gender-based violence), HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

Evaluation question 11 To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?	
Judgment criteria	11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices
	11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level
Evaluation question 12 To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?	
Judgment criteria	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

Overview evaluation questions MHTF	
Evaluation question 1 To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations
	1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)
	1.3. National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas
Evaluation question 2 To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?	
Judgment criteria	2.1. Program countries midwifery education upgraded based upon International Confederation of Midwives (ICM) essential competencies through MHTF support
	2.2. Strategies and policies developed to ensure the quality of midwifery services provision in program countries through MHTF support
	2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

Evaluation question 4 To what extent has the MHTF contributed towards scaling-up and utilization of EmONC services in priority countries?	
Judgment criteria	4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support
	4.2. Utilization and access of EmONC services improved through MHTF support
Evaluation question 5 To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in program countries?	
Judgment criteria	5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support
	5.2. National plans consider sustainable funding mechanisms for sexual and reproductive health/maternal health through MHTF support
Evaluation question 6 To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?	
Judgment criteria	6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level

Evaluation question 7 To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds e.g. the Global Program on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the UNFPA-ICM[143] Midwives Program and HIV-PMTCT[144] in order to support maternal health improvements?	
Judgment criteria	7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF
	7.2. Joint and coordinated planning at country level with GPRHCS
	7.3.Integration of Midwives Program strategic directions in MHTF plans in countries
Evaluation question 8 To what extent did the MHTF increase the visibility of UNFPA sexual and reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?	
Judgment criteria	8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)
	8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual and reproductive health/maternal health

143. International Confederation of Midwives.
144. Preventing mother-to-child transmission.

6.4 List of documents consulted

TITLE	YEAR	TYPE OF DOCUMENT
EC: Strengthening Community-Based Reproductive Health Services in the Central Region (incl. Monitoring Report 2007)	2004	Assessment Report
GoG: Creating Wealth through Health. The Health Sector Program of Work: 2007-2011	2007	Strategic Document
GoG: ODI/CDD Ghana Joint Evaluation on the Joint Evaluation of Multi-Donor Budget Support to Ghana	2007	Evaluation Report
GoG: Ghana Poverty Reduction Strategy 2003-2005: An Agenda for Growth and Prosperity	2003	Planning Document
GoG/EC/UNFPA: Strengthening Community-Based Reproductive Health Services in the Central Region, Ghana. Final Project Report (incl. Monitoring and Evaluation Report 2008 and Mid-Term Review 2006)	2008	Evaluation Report
GoG/GHS: Accelerated Reduction of Maternal Mortality in Eastern Region: Need for Concerted Effort by all Stakeholders	2011	Presentation
GoG/GHS: 2009 GHS Annual Report	2009	Annual Report
GoG/GHS: A Roadmap for Repositioning Family Planning in Ghana (2006-2010)	2006	Planning Document
GoG/Ministry of Finance and Economic Planning: Ghana AID Policy and Strategy, 2011-2015	2011	Planning Document
GoG/MoH: MDG Acceleration Framework and Country Action Plan – Maternal Health	2011	Planning Document
GoG/MoH: The Health Sector Medium Term Development Plan 2010 – 2013	2010	Planning Document

GoG/MoH: Ghana Health Sector, Common Management Arrangements III	2010	Planning Document
GoG/MoH: Pulling together, achieving more. Independent Review Health Sector Program of Work 2008	2009	Evaluation Report
GoG/MoH: National Health Policy – Creating Wealth through Health	2007	Planning Document
GoG/MoH/GHS/UNFPA: MHTF Success Stories	2009	Report
GoG/MoH/UNFPA/UNICEF: High-Impact Rapid-Delivery Approach for Achieving MDG four and five in Ghana	2005	Strategic Document
GoG/National Development Planning Commission: Growth and Poverty Reduction Strategy (GPRS II) (2006-2009)	2005	Planning Document
GoG/UN: Ghana MDG Report	2010	Report
GoG/UNDP/UNFPA/Ghana Statistical Service: Women and Men In Ghana – A Statistical Compendium	2008	Report
GoG/UNFPA: Annual Work Plan Half Year Joint Monitoring Exercise, Consolidated Report	2011	Monitoring Report
GoG/UNFPA: Country Program 5 in Ghana, Good Practices	2011	Presentation
GoG/UNFPA: Country Program Action Plan (CPAP)	2006-2010	Planning Document
GoG/UNFPA: Country Program Documents	2001-2005, 2006-2010	Planning Document
GoG/UNFPA: 4th Country Program – Mid-Term Review Country Brief	2004	Evaluation Report

HLSP: Final Internal Evaluation of EC-ACP-UNFPA Sexual and Reproductive Health Program	2008	Evaluation Report
Mrisho and Atta Bainson: Evaluation of Northern and Southern Sector Projects. Ghana 4th Country Program, Reproductive Health Sub-Program	2005	Evaluation Report
UN: World Statistics Pocketbook	2009	Report
UN: United Nations Development Assistance Framework 2006-2010. Mid-Term Review	2008	Planning Document
UN: United Nations Development Assistance Framework (UNDAF) 2006-2010	2005	Strategic Document
UNDP: Assessment of Development Results (ADR), UNDP Contribution to the Development of Ghana (2000-2010)	2011	Assessment Report
UNFPA: Impact Assessment of CHAG-UNFPA Project 2006-2010: Improving Maternal Health and Youth Friendly Health Services	2011	Assessment Report
UNFPA: Maternal Health: the National Situation	2011	Presentation
UNFPA: Midwives Program 2009-2011 Annual Work Plans and Monitoring Tool for implementation partners	2011	Planning Document
UNFPA: Annual Work Plans with Implementing Partners	2006-2011	Planning Documents
UNFPA: Summary of all Expenditures in Components reproductive health, population and development and Gender	2009-2011	Management Report
UNFPA: Annual Work Plan for IPs in the reproductive health Component	2010	Planning Document
UNFPA: Country Annual Joint Reporting for the Thematic Funds	2009, 2010	Report

UNFPA: Field Monitoring Reports	2010	Monitoring Report
UNFPA: Final Evaluation Report, 5th Country Program (2006-2010)	2010	Evaluation Report
UNFPA: Review Annual Reports 2009/AWP 2010	2010	Evaluation Report
UNFPA: Country Office Annual Report (COAR)	2004, 2005, 2006, 2007, 2008, 2009	Management Report
UNFPA: Desk Review And Baseline Study Of Midwifery Pre-Service and In-Service Education For Planning Interventions Towards MDGs four, five and six	2009	Review Report
UNFPA: Expenditures Report for Activities Against Thematic Trust Funds	2009	Management Report
UNFPA: MHTF Results Frameworks, Indicators, Baselines and Targets	2009	Management Report
UNFPA: Annual Work Plan Approved 2008 for the UNFPA Midwifery Program	2008	Planning Document
UNFPA: Monitoring And Evaluation Report of UNFPA Project Gha/03/POL: Strengthening Community-Based Reproductive Health Services In The Central Region	2008	Monitoring/Evaluation Report
UNFPA: Analysis of Targeting UNFPA Assistance	2007	Analysis
UNFPA: Investing in Midwives and Others with Midwifery Skills to Accelerate Progress towards MDG5: A Proposal for Three Years	2007	Planning Document
UNFPA: Office Management Plan	2006-2007	Management Report
UNFPA: Program Coordination and Assistance Component Project Document	2007	Management Report

UNFPA: Report of UNFPA Western Cluster Meeting	2007	Management Report
UNFPA: Concept Note – Early Marriages and Childbearing in Ghana	2006	Concept Note
UNFPA: Evaluation of Northern And Southern Sector Projects	2005	Evaluation Report
UNFPA: Project Evaluation GHA/01/P07 Analysis and Utilization of Population Data for Policy Formulation and Implementation	2005	Evaluation Report
UNFPA: Report of the Evaluation of Project GHA/01/P08 Strengthening the Integration of Reproductive Health Services into Private Medical Practice	2005	Evaluation Report
UNFPA: Evaluation of GoG/UN System Program for Promoting Gender Equality in Ghana	2004	Evaluation Report
UNFPA: Project Evaluation Strengthening the Implementation of an Innovative and Culturally Sensitive Integrated Community Based Reproductive Health Service Delivery in the Upper East Region of Ghana	2004	Evaluation Report
UNFPA/Planned Parenthood Association of Ghana: Program Evaluation. Strengthening the Participation of Religious Groups in Reproductive Health	2005	Evaluation Report
WHO: Global Health Observatory Data Repository	2011	Data

6.5 List of people interviewed

Organization/Unit	Name	Position
Abakrampa Health Clinic	Sophia Forson	Midwife
CHAG	Boateng	Program Manager
CHAG	Gilbert Charles Buckle	Executive Director
Coalition of Muslim Organizations	Abdul Manan	Program Officer
Curious Minds	Emmanuel Ashong	Program Officer
District Health Directorate	Gifty Ankra	District Director
District Health Directorate	Eric Ampratwum	Staff Member
District Health Directorate	Mary Boakye	Staff Member
District Health Directorate	Beatrice Essilfie	Staff Member
District Health Directorate	Regina Tagoe	Staff Member
District Hospital (Abura Dunkwaw)	Paulina Amuah	Midwife
District Hospital(Abura Dunkwaw)	Marian Ashun	Midwife
Ghana Health Service (GHS)	Dr. Patrick Aboagye	Family Health Unit
Ghana Health Service	Peace Akormedie	Family Health Unit
Ghana Health Service	Dr. Yaa Osei Asante	Family Health Unit
Ghana Health Service	Dr. Gloria Quansah Asare	Director of Family Health Unit
Ghana Health Service	Claudette Diogo	Family Health Unit
Ghana Health Service	Rejoice Nutakor	Family Health Unit
Ghana Health Service Central Region	Esther Oyinka	Director, Public Education Unit (UNFPA Desk Officer)
Ghana Health Service Central Region	Matthew Ahwireng	Regional Health Promotion Officer

Ghana Health Service Central Region	Kyerematenng	Deputy Regional Director
Ghana Nursing and Midwifery School (Korle Bu, Accra)	Netta Ackon	Program Head
Ghana Nursing and Midwifery School (Korle Bu, Accra)	Gloria Tetteh	Principal
Ghana Registered Midwives Association	Joyce Jetuah	President
Ghana Registered Midwives Association	Gifty Mantey	Treasurer
Ghana Statistical Service (GSS)	Magnus Ebo Duncan	Head of Economics Statistics
Ghana Statistical Service	Sylvester Gyamfi	Head of Programmes
Ghana Statistical Service	Dr. Philomena Nyako	Deputy Government Statistician in charge of Operations and Demography
Ghana Statistical Service	Anthony Pharin	Head of Survey Organisation
Ghana Private Road Transport Union Project	Kofi Osea Addo	Member
Ghana Private Road Transport Union Project	Oheneba Adjei	Member
Ghana Private Road Transport Union Project	Peter Kofi Amoah	Member
Ghana Private Road Transport Union Project	S. K. Amposah	Member
Ghana Private Road Transport Union Project	Mark Appiah	Member
Ghana Private Road Transport Union Project	Francis Bentum	Member
Ghana Private Road Transport Union Project	Adjei Boakye	Member
Ghana Private Road Transport Union Project	Issah Bukari	Member
Ghana Private Road Transport Union Project	Matthias Coffie	Member
Ghana Private Road Transport Union Project	Anthony Ekow Daatse	Member
Ghana Private Road Transport Union Project	Amos Dadzie	Member
Ghana Private Road Transport Union Project	Isaac Kow Eduful	Member
Ghana Private Road Transport Union Project	K. A. Gyasi	Member

Ghana Private Road Transport Union Project	William A. Kporvie	Member
Ghana Private Road Transport Union Project	Kofi Menu	Member
Ghana Private Road Transport Union Project	Matthew Quansah	Member
Ghana Private Road Transport Union Project	Francis Sam	Member
ICM	Dr. Jemimah Dennis-Antwi	Regional Midwives Adviser
Kayayei Youth Association	Mohammed Salifu	Founder Leader
Kayayei Youth Association	Fati Alhassan	Vice Chairperson
Kayayei Youth Association	Ayisha Zakaria	First Trustee
Kayayei Youth Association	Laraba Ibrahim	Branch Leader
Kayayei Youth Association	Jemilah Fuseini	Group Leader
Kayayei Youth Association	Asana Alhassan	Organizer and Collector
Kayayei Youth Association	Ayishetu Alhassan	Organizer
Kayayei Youth Association	Amatu Issakah	Organizer
Kayayei Youth Association	Sumaiya Mohammed	Savings Member
Ministry of Finance and Economic Planning (MoFEP)	Stella Williams	Assistant Director, UN Projects
Ministry of Finance and Economic Planning (MoFEP)	Nana Yaw Yankah	Desk Officer for UNFPA Projects
Ministry of Health (MoH)	Dr. Afisa Zakaria	Director, Programmes, Projects, Monitoring and Evaluation
Ministry of Women and Children Affairs	Efua Anyanful	Director of Research and Economics Statistics
Ministry of Women and Children Affairs	G.K. Kumor	Director 1
Moree Health Centre	Juliana Abban	Midwife
National Youth Authority	Henry Adu	Regional Officer, Central Region

National Population Council	Marian Kpapka	Director, Technical
National Population Council	Dr. Stephen Kwankye	Executive Director
Planned Parenthood Association of Ghana	Albert Odamatey	Director
Society for Women and AIDS Action	Aku Adzraku	National Coordinator
Time With Grandma/Grandpa Project (GHS, CR)	Margaret Awotwie	Grandma/Adviser in Abresea Community
Time With Grandma/Grandpa Project (GHS, CR)	Janet Sakyi	Grandma/Adviser in Abresea Community
Time With Grandma/Grandpa Project (GHS, CR)	Victor Ocran	Teacher/Project Facilitator
Time With Grandma/Grandpa Project (GHS, CR)	-	Group of Youth/Pupils
UNDP	Wolfgang Haas	UN Coordination Specialist
UNDP	Myra Togobo	UN Coordination Associate
UNFPA country office	Dr. Bernard Coquelin	Country Representative
UNFPA country office	Bawa Amadu	Assistant Representative
UNFPA country office	Esther Abaka	Personal Assistant to the CR
UNFPA country office	Esi Awotwe	HIV/AIDS Analyst
UNFPA country office	Doris Mawuse Aglobitse	National Program Office, Adviser RM
UNFPA country office	Mercy Osei-Konadu	National Program Office, Gender
UNFPA country office	Fredrica Hanson	NPP Midwife Adviser
UNFPA country office	Dr. Robert Mensah	reproductive health Specialist
UNFPA country office	Staff	Staff
UNFPA, Northern Region, Tamale Office	Mammah Tenei	Project Officer,Fistula Project
UNICEF	Anirban Chatterjee,	Chief of Health and Nutrition

USAID	Micheal Sossa	Senior Reproductive and Family Health Adviser (West Africa)
USAID	Susan Wright	family planning/maternal, newborn and child health Senior Adviser
WHO	Dr. Charles Fleischer-Djoleto	Country Adviser – Family Health and Population
Youth Assembly Elmina, CR	Salamatu Halidu	Presiding Member
Youth Assembly Elmina, CR	Owura Essel	Member
Youth Assembly Elmina, CR	Sophia Mensah	Member

6.6 Overview of UNFPA interventions in Ghana (2006-2010)

Component of country program	Project/program titles	Volume in US$ (contracted) from UNFPA	Year
Reproductive health	Community Based Reproductive health Services	327,100	2007
Reproductive health	Youth Friendly Services	177,721	2006
Reproductive health	Reproductive health and Rights: Ghana Health Service	2,688,500	2011
Reproductive health	Population and Development: Strengthening Capacity	135,301	2006
Reproductive health	IPs in the Reproductive health Component	5,487,620	2010-2011
Reproductive health	Reproductive Health Commodity Security	2,761,000	2011
Reproductive health	Comprehensive Reproductive health in the Northern Region	265,010	2006-2007
Reproductive health	Comprehensive Reproductive health in the Upper West Region	265,000	2006-2007
Reproductive health	Reproductive health: reproductive and child health Unit	120,000	2007
Reproductive health	Reproductive health: Theatre of Change	40,000	2007
Reproductive health	Comprehensive Reproductive health in the Volta Region	120,000	2006
Reproductive health	Reproductive health: Centre for the Development of People	50,000	2006
Reproductive health	Population and Development: Increased Use of Data on Population and Reproductive Health	1,456,444	2009-2010
Reproductive health	Integrated Community Based adolescent sexual and reproductive health	423,155	2006-2007
	Reproductive health activities in total:	**4611,787**	

Gender	Supporting Gender Strategies for National Development 2006-2010	193,020	2006
Gender	Institutional Capacity for Gender Mainstreaming	427,565	2011
Gender	Gender	965,386	2009-2010
Gender	Gender: Action aid International Ghana	34,064	2006
Gender	Gender: Domestic Violence Victim Support Unit	30,000	2006
Gender	Gender: Oxfam	115,000	2006
Gender	Gender: The Ark Foundation and Families Together	19,300	2006
	Gender Activities in total	**1784,335**	
Population Policy	Strengthening Population Policy Implementation	178,500	2006
National and Local Capacities	Strengthening Capacities of Implementing Agencies	90,000	2006
Midwifery	Midwifery Programmes	180,000	2010
Midwifery	UNFPA Investing in Midwives to Accelerate Progress Towards MDG5	108,850	2009
MHS, Midwifery, Fistula	MHTF Joint AWP: Maternal Health Service, Fistula, Midwifery	1,433,737	2011
MHC	Improving MHC	430,000	2006-2007
Fistula	Obstetric Fistula	220,303	2010

Note: These are not complete expenditures for the mentioned period, but just an indicative overview about the activities within the three components Reproductive health, population and development and Gender, according to the available Annual Work Plans

Source: Annual Work Plans Ghana

Table 6: UNFPA Interventions in Ghana 2004-2010 (based on ATLAS data)

Time period	Project ID	Project Title	Budget	Expenditure
2009 - 2010	GHA5R23A	Access to Reproductive Health Commodity Security	557,148.30	424,990.20
2006 - 2010	GHA5R235	Adolescent sexual and reproductive health	394,736.35	218,285.11
2009 - 2010	GHA5R41A	Availability of quality info	223,516.43	192,380.16
2006 - 2009	GHA5R217	Capacity to manage integrated health	1,392,288.83	1,252,456.44
2008 - 2009	GRP6R21A	Capacity development to integrate maternal heath	144,481.99	74,294.46
2006 - 2010	GHA5R303	Community based youth BCC	173,846.57	48,014.34
2008 - 2010	GHA5G114	Community legal literacy and health	84,420.08	46,685.79
		Community-based reproductive health services	3,984,799.91	2,509,717.47
2007 - 2009	GHA07H03	Comprehensive health sector support	538,063	113,914.66
2007	GHA-07/ H03	Comprehensive health support	0	0
2004 - 2010	GHA01P04	Comprehensive integrated reproductive health	1,190,664	1,210,516.69
2006 - 2009	GHA5R221	Comprehensive reproductive health in the North	433,748.88	253,307.51
2006 - 2010	GHA5R211	Comprehensive reproductive health	438,261.68	219,016.77
2006 - 2010	GHA5R231	Comprehensive reproductive health in the Volta	313,446.22	172,348.54
2004 - 2010	GHA01P03	Comprehensive reproductive health services	968,943	864,040.98

2006 - 2010	GHA5R201	Comprehensive reproductive health services	351,309.59	199,054.03
2010	HUM6R15A	Field emergency support fund	81,605.77	37,844.10
2006 - 2008	GHA5G123	Gender partnerships	372,176.91	337,810.77
2004 - 2007, 2009	GHA00P01	Ghana African Youth Alliance	2,198,985.05	1,690,914.95
2008 - 2010	GHAM0809	Ghana BSB Project	216,1601	1,950,579.39
2006 - 2010	GHA4R107	Ghana fistula project	785,648.58	267,739
2006 - 2010	GHA5R103	Greater involvement of Chiefs	299,637.78	70,742.55
2007 - 2010	GHA5R218	HIV prevention and behavior change	516,217.41	136,032.77
		Improved provision/ availability	3,462,554.05	2,999,683.36
2006 - 2010	GHA5R241	Improving maternal health	417,706.64	325,139.04
2009	GHA5R24A	Increase capacity to integrate maternal health	58,787	47,519.97
2009 - 2010	GHA5G11A	Institutional capacity development for gender mainstreaming	800,566.51	561,247.50
2006 - 2010	GHA5R215	Integrated community-based	407,439.40	199,451.35
2006	GHA01P07	Population data analysis	0	38,478.32
2004	GHA01P05	Population policy	105,720	149,435.51
2007 - 2009	GHA5R238	Promoting legal literacy and VCT	101,779	45,164.44
2009 - 2010	GHA5R42A	Reducing HIV related stigma	114,606.28	76,044.16
2004 - 2010	GHA01P09	Reproductive health delivery	382,715	371,340.17
2007 - 2008	GHA5R212	Reproductive health partnerships	423,692	414,696.66

2008 - 2010	GHA5R258	Scaling up HIV prevention among	1,751,135.96	794,519.75
2004 - 2010	GHA01P08	Reproductive health services integration	238,933	214,983.41
2009 - 2010	GHA5R22A	Strengthened capacity to management	161,821.30	156,292.51
2008 - 2010	GHA5G111	Strengthening capacity to prevention	86,814	52,763.47
2008	GHA5R251	Strengthening fistula prevention	8,000	251.27
2007	GHA5P201	Strengthening population policy	8,000	4,933.03
2008 - 2010	GHA5R336	Supporting choices, creating opportunities	50,972.19	47,827.54
2009 - 2010	GHA5R316	Supporting choices and creating opportunities	0	1,966.27
2007 - 2010	GHA 5R 316	Supporting choices and creating opportunities	44,130.34	28,181.40
2006 - 2010	GHA5G103	Supporting gender strategies	444,473.89	251,992.19
2009 - 2010	GHA5P31A	Timely and reliable disaggregation of data	1,674,299.87	1,369,970.74
		Total	**28,349,693.76**	**20,442,568.74**

Source: ATLAS data