Healthy Experiments
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A Report of the
CSIS TASK FORCE ON WOMEN’S AND FAMILY HEALTH
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Executive Summary

In late May 2016, a delegation from the CSIS Task Force on Women’s and Family Health traveled to Ghana to examine U.S.-Ghana bilateral cooperation on reproductive, maternal, neonatal, and child health (RMNCH) issues, as well as the ways in which U.S. bilateral assistance on immunization programs complement support provided to Ghana by Gavi, the Vaccine Alliance.

The task force chose to examine U.S. engagement in Ghana for several reasons. First, there is a long history of U.S.-Ghana cooperation on health, and Ghana is one of 24 priority countries for U.S. engagement on MCH, as well as family planning. Second, Ghana’s ongoing economic growth and transition to lower-middle-income country (LMIC) status has implications for the country’s continued eligibility for some forms of health-related development assistance, including from Gavi, and the task force members believed that there might be lessons from Ghana that could be relevant for other LMICs where the United States is engaged on RMNCH. Third, the United States has developed a robust government-to-government engagement in Ghana, with direct financial support for sub-national government entities, as well as the country’s National Health Insurance Scheme (NHIS), and the task force felt it could be helpful to examine that experience and consider how it might be sustained and scaled up in Ghana, and implemented in other countries.

Over five days in the capital city, Accra, and in Ghana’s Northern Region—a historically underdeveloped and largely rural area to which the United States and other bilateral partners

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1 Katherine E. Bliss is a senior associate with the CSIS Global Health Policy Center. Cathryn Streifel is associate director of the CSIS Global Health Policy Center. The authors are grateful to staff at the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), Peace Corps, and the U.S. Embassy in Accra, as well as the World Health Organization (WHO) Country Office, the Ghana Ministry of Health, Ghana Health Service, the Northern Regional Coordinating Council, Systems for Health, Global Communities, University Research Company (URC), and Gavi, the Vaccine Alliance, for their assistance in scheduling meetings and site visits during the delegation’s visit. Jen Kates, Adam Wexler, and Stephanie Oum at the Kaiser Family Foundation provided a helpful analysis of U.S. health-related spending in Ghana, as well.

2 The delegation included task force members Representative Barbara Lee (D-CA), U.S. House of Representatives, and Afaf I. Meleis, University of Pennsylvania, as well as M.A. Keifer, Office of Representative Barbara Lee, U.S. House of Representatives, and Alison Jarus, Office of Representative Mike Quigley (D-IL), U.S. House of Representatives. It also included the authors.
have begun shifting their focus because of lagging progress compared to the south—the
delegation spoke with government officials and visited health care centers at the community,
district, and regional levels. Each meeting and site visit offered an opportunity to analyze
RMNCH programs within the context of the United States’ bilateral health assistance; assess
current opportunities and challenges related to direct government-to-government funding;
and consider how the United States can better partner with Ghana as Ghanaian officials plan
for the financial requirements associated with progress toward universal health coverage, the
upcoming transition from Gavi support, and increasing women’s access to voluntary family
planning services in the neediest and most impoverished areas of the country.

Recommendations

- **Immunizations and the Gavi Transition:** Since 2001, Ghana and Gavi have had a strong
  partnership, with Ghana taking on seven new and underutilized vaccines with Gavi
  support. But because it has passed the Gavi eligibility threshold of annual gross national
  income (GNI) per capita of $1,580, in 2017 Ghana will enter the Gavi “accelerated
  transition phase.” By 2022 Ghana will assume full self-financing for all vaccines currently
  procured with assistance from Gavi. Given the number of Gavi-supported vaccines Ghana
  has introduced, as well as the uncertainty about long-term public funding for
  immunizations, there is a risk that by the end of the transition period Ghana could
  struggle to allocate sufficient resources to sustain current high immunization coverage
  rates. This could lead to several negative scenarios: that the high immunization coverage
  for key vaccines achieved with Gavi support could decrease; that the Expanded Program
  on Immunizations (EPI) could be compelled to drop some vaccines from the program in
  order to continue paying for others; or that the government could decide not to adopt
  new, comparatively expensive, and critically important vaccines, such as the HPV vaccine,
  because of concerns that it could not mobilize sufficient resources to continue providing
  them once Gavi support ends. **As Ghana moves toward full self-financing for all
  vaccines currently procured with support from Gavi, the United States should
  reinforce its operational and technical support for Ghana’s immunization and child
  health programs; use its role on the Gavi Board to advocate for extending the period
  of time during which transitioning LMICs, like Ghana, have access to Gavi prices
  following the transition; and facilitate discussions about how Ghana and other
  LMICs can introduce and sustain new (and expensive) vaccines once Gavi support is
  phased out.**

- **RMNCH within Health Systems Strengthening:** Ghana has dedicated considerable effort
  to strengthening the delivery of health services at the community level, largely through
  the extension of the Community-based Health Planning and Services (CHPS) Initiative
  model, which places paid public health nurses in village-level compounds, where they
  provide “preventive and curative maternal, newborn and child health care while residing
  within the community.”

3 Emma Sacks, Soumya Alva, Sophia Magalona, and Linda Vessel, “Examining domains of community health nurse
satisfaction and motivation: results from a mixed-methods baseline evaluation in rural Ghana,” *Human Resources
through the National Health Insurance Scheme (NHIS). The United States assists Ghana’s efforts to improve the provision of community-based health services, including RMNCH services, by supporting the construction of some CHPS compounds, by providing technical assistance to improve quality of care at the CHPS compounds, and through programs focused on strengthening the health system at all levels. The United States has also supported Ghana’s movement toward universal health coverage by funding a study to determine the feasibility of incorporating coverage for family planning services into the NHIS benefits package, and by providing technical assistance to the NHIS to perform clinical audits and carry out monitoring and evaluation to better analyze claims. The delegation was impressed by what it learned about the role U.S. support has played in extending health services to a greater percentage of Ghanaians and felt that a sharpened focus on the training, employment, and retention of a highly qualified cadre of community-based nurses, midwives, and health workers dedicated to women’s and children’s health could amplify this impact. **The United States should couple its support for the extension and strengthening of health services at the community level with reinforced emphasis on activities that increase the access of women and children to RMNCH services at all levels of care. The United States should also continue to support the integration of family planning services into the NHIS, which has been approved but has not yet been implemented.**

- **Integrating and Extending Family Planning Services:** Given the low contraceptive prevalence rates in Ghana, high rates of maternal mortality, and Ghana’s stated goals of increasing access to and uptake of family planning by 2020, bilateral support for family planning services to address unmet need for contraception, and to improve maternal and newborn health outcomes, is well targeted. In Ghana, the United States supports a number of important family planning and reproductive health activities, including the purchase of family planning commodities, technical assistance regarding management of the family planning commodity supply chain, social marketing to raise the availability and quality of contraceptive products in the private sector, and workshops to train health workers to administer long-acting reversible contraceptives (LARCs). While “increased access to integrated health services” is one of the United States’ development objective indicators for the health sector, and while some of these technical assistance and training activities are integrated into broader U.S.-supported health systems strengthening initiatives, the delegation left Ghana with the impression that family planning programs in the country are frequently segregated and isolated from other health initiatives.  

The delegation observed that some U.S.-funded vertical programs, such as the President’s Malaria Initiative (PMI) and President’s Emergency Plan for AIDS Relief (PEPFAR), are serving as platforms for addressing a broader range of RMNCH challenges in Ghana. For example, Ghana is a PMI focus country, and PMI-supported activities, 

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4 A high-level panel has recently recommended that NHIS cover a basic package of primary health care services for all Ghanaians, regardless of whether they are registered with NHIS or carry an NHIS card; see Godwin A. Allotey, “NHIS must cover CHPS, protect patients - Review c’ttee,” June 22, 2016, http://citifmonline.com/2016/06/22/nhis-must-cover-chps-protect-patients-review-cttee/.

including training midwives to address malaria in pregnant women and teaching clinic staff to more accurately diagnose and treat malaria in children, have helped strengthen maternal and child health services more generally. And other national programs, such as immunization activities, are successfully reaching remote populations and could be usefully integrated with family planning services to extend those programs to populations in hard-to-reach areas. Lessons learned from the successful integration of HIV/AIDS, immunizations, nutrition, or malaria services with maternal and child health activities should be shared with—and extended to—other sectors, particularly reproductive health and family planning.

- Documenting and Monitoring the Benefits and Challenges of Government-to-Government Support for Health: Innovative U.S. government-to-sub-national government support for health and nutrition activities in Ghana reflects the strength of the U.S.-Ghana partnership on health and food security and represents an important opportunity to build the capacity of local government agencies to address the health needs of their citizens over the long term. The delegation was inspired by what it learned in Ghana’s Northern Region regarding the ways in which U.S.-supported activities focused on small-scale agriculture, financial management, and nutrition, as well as water, sanitation and hygiene (WASH), are helping to empower women; improve the health of women of reproductive age, as well as their children; and build the capacity for district-level officials to meet the needs of their population through improved governance, resource mobilization, and accountability. As U.S. government-to-government support for health and nutrition in Ghana moves forward, the United States should carefully document and analyze the financial, administrative, and human resource requirements of the government-to-government programs, paying particular attention to ensuring adequate oversight by U.S. and Ghanaian officials regarding how the funds are used and accounted for, and should use the experience in Ghana as a model for government-to-government, multisectoral engagement in other contexts.

Ghana’s Health System

In 1957 Ghana secured independence from the United Kingdom amid dreams of pan-African nationalism and continental political unity. But several years of political strife and economic instability linked to failed industrialization schemes and fluctuating global prices for export crops, such as cocoa, led to a series of military coups starting in 1979. In 1992 Ghanaians approved a new constitution, and Ghana returned to democratic rule in 1993. Decentralization and the transfer of power from central to regional and local government authorities have characterized Ghana’s development policy since the political reforms in the early 1990s.6 The country is divided into 10 administrative regions, which are subdivided into political districts. Historically, the southern regions of the country have presented more positive social and economic indicators, reflecting long-term political neglect of, and more limited development in, the northern part of the country. The current population estimate for

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Ghana is 28 million, and the president, John Dramani Mahama, assumed the position in 2012, when his predecessor, John Atta Mills, died in office. Mahama was subsequently elected to a four-year term, and a new round of elections is scheduled for later this year.

Ghana’s Ministry of Health, which was reorganized following the country’s return to democracy in 1993, oversees and regulates the health sector; the ministry has responsibility for developing policy guidance, managing resources, and monitoring and evaluating programs related to health. Since 1996 the Ghana Health Service (GHS), which is part of the ministry, has provided public health services, with an emphasis on primary care. The GHS oversees the Expanded Program on Immunization (EPI), originally launched in 1978 in order to coordinate and enhance the government’s efforts to protect children against vaccine-preventable diseases by providing immunizations free of charge. The GHS offers health services, including routine immunizations, through facilities at the sub-district, district, and regional levels. The Community-based Health and Planning Services (CHPS) compounds provide the most basic level of care, with a focus on MCH services; for more comprehensive services, patients must visit a district hospital or a regional hospital. Ghana also has numerous private hospitals and teaching hospitals, which are outside the public health system.

In 2004 Ghana launched the National Health Insurance Scheme (NHIS), which provides an estimated 40 percent of the population with insurance to pay for health services. Through fees collected under Ghana’s value added tax (VAT), as well as funds contributed through Social Security programs, the NHIS covers services for subscribers at a range of credentialed private and public facilities. Children, pregnant women, and the indigent are among the groups covered by the NHIS free of charge. The NHIS covers such RMNCH services as antenatal care, as well as labor and delivery, but family planning services are not yet covered; however, civil society and advocacy groups have been pressuring the National Health Insurance Authority to incorporate them into the scheme. The Ministry of Health has also requested that the National Health Insurance Authority (NHIA) incorporate family planning into its benefits package but “has yet to provide the policy directive and implementation guidelines necessary to make these methods part of the NHIS package, in practice.”

Beyond the NHIS, public spending on health comprised 59.8 percent of Ghana’s total expenditure on health in 2014, down from a high of 74.4 percent in 2011. Per capita spending on health, which increased steadily between 2002 and 2012, dropped from a high of $85 in 2012 to $58 in 2014. In the last two decades, Ghana’s dependency on external

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support for health has grown. In 2014 15.4 percent of total resources for health were from external sources, up from 7.8 percent in 1995.\(^{12}\) Since 2001, Gavi has provided more than $240 million to Ghana to support the introduction of new and underutilized vaccines, as well as to support health system strengthening activities.\(^{13}\) Civil society groups report that the government of Ghana routinely fails to meet its Abuja Declaration commitment to spend 15 percent of the total national budget on health.\(^{14}\) After relatively consistent spending of between 13 percent and 16 percent between 2004 and 2011, Ghana’s government spending on health as a percentage of total government spending has declined to 6.82 percent in 2014 (see Figure 1).\(^{15}\)

According to the 2014 Demographic and Health Survey (DHS), women in Ghana bear an average of 4.2 children, down from 6.4 in 1988. Fertility rates are lower in the capital, Accra (2.8), than in more remote regions. The overall national contraceptive prevalence rate is low, with only 27 percent of women using any method of family planning; the rate is lowest in Northern Region, where only 11 percent are using contraception.\(^{16}\) Injectable hormonal methods, as well as long-acting, reversible methods, such as IUDs and implants, are the most popular contraceptives in Ghana, but for several years the long-acting reversible contraceptives (LARCs) have been difficult for women to access, as only licensed midwives have been able to administer them. However, in 2014 GHS announced that community health nurses would now be authorized to place implants, opening up opportunities for women seeking contraceptives to secure them at a local facility rather than traveling to a site where a more highly trained midwife is working.\(^{17}\) Assuming the CHPS compounds are able to hire and retain qualified community health nurses—a challenge, considering the frustration some care providers report regarding limited opportunities for career advancement, poor pay, and insufficient resources to effectively do their jobs—this policy change represents an important shift in access for women unable to travel to higher-level facilities for consultations.\(^{18}\)

\(^{12}\) World Bank, “External resources for health (% of total expenditure on health),” http://data.worldbank.org/indicator/SH.XPD.EXTR.ZS. The top donors for health-related assistance in Ghana are the United States; the United Kingdom; the Global Fund to Fight AIDS, Tuberculosis and Malaria; Gavi, the Vaccine Alliance; Canada, Denmark, Japan, Korea, and the Netherlands; and the World Bank, Kaiser Family Foundation, “Ghana: Funding Analysis,” May 2016, provided to CSIS by the Kaiser Family Foundation.


Despite some progress in reducing the maternal mortality ratio between 1990 and 2015, Ghana did not meet its MDG target of 190 deaths per 100,000 live births. The leading cause of maternal death in Ghana is postpartum hemorrhage. A majority of pregnant women do attend at least one antenatal care visit, and at least 68 percent of women deliver their babies in a health facility, assisted by a skilled provider. But, as with access to family planning services, regional disparities characterize women’s access to and use of skilled attendants; their use is “most common in Greater Accra (92%) and least common in Northern Region (36%),” according to the 2014 DHS.

Forty-seven percent of Ghanaian children under the age of 5 who die are newborns, with prematurity, asphyxia and sepsis primary causes of death. Among older children, malaria is a leading cause of death, with pneumonia, diarrhea and malnutrition, as well as anemia, important contributors to child mortality, as well. Since 1990 Ghana has increased its immunization coverage for diptheria-tetanus-pertussis (DTP) and with Gavi support simultaneously incorporated rotavirus and pneumococcal vaccines into its national immunization portfolio in 2012. Underweight and stunting prevalence have decreased, but

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20 Ibid.
23 Ibid.
24 Countdown to the MDGs, “Ghana Health Data: 2015 Profile.”
in 2014 nearly one-fifth of all children under the age of 5 were considered short for their age.\textsuperscript{25}

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**National Health Insurance Scheme (NHIS)**

The National Health Insurance Authority implements Ghana’s National Health Insurance Scheme (NHIS). The NHIS was established in 2004 to improve on earlier approaches to health coverage, including the Community-Based Health Insurance plans and the “cash and carry” system. At the time authorities launched the NHIS, they envisioned that within five years, every resident of Ghana would belong to a health insurance scheme “that would guarantee equitable healthcare access and adequately cover him or her against catastrophic expenditure.”\textsuperscript{1}

The National Health Insurance Scheme is financed through a combination of a 2.5 percent addition to the value added tax (VAT), pension contributions of formal sector workers, contributions from informal sector workers and Parliament, as well as other voluntary donations. Several groups, including those who already contribute to the social security fund, people under the age of 19 and over the age 70, as well as pregnant women and the indigent, are exempt from paying the membership premium.

Over the past decade, Ghana’s National Health Insurance Scheme has made significant progress in expanding financial risk protection for residents of Ghana. As of November 2015, the National Health Insurance Scheme covers 40.2 percent of the population. The benefits package covers 95 percent of the disease burden, with expenditures on malaria accounting for 40 percent of spending and expenditures on maternal, neonatal, and child health accounting for another 20 percent. A range of services that are not currently covered as part of the benefits package include treatment for breast and cervical cancer, as well as tuberculosis, immunizations, and family planning services.

The NHIS faces several important implementation challenges including: weak mechanisms to manage fraud; providers experiencing delays receiving payment due to a funding gap; an urgent need for long-term strategic planning to accommodate a rise in noncommunicable diseases and an aging population; difficulties maintaining a pro-poor focus; and concerns related to financial sustainability as the benefits package is expanded and enrollment increases.\textsuperscript{2}

To address these challenges, a presidential technical committee was formed in September 2015 to review the NHIS. It made several recommendations including that the NHIS should provide universal primary, maternal, and child health coverage for all, with only those seeking secondary and tertiary healthcare needing a NHIS card. This will allow residents to access health at all community-based health planning and services (CHPS) compounds. The committee also recommended that an independent Patient Protection Council be established to protect the rights of the patients and promote a high quality of care and for the NHIA to find innovative ways of securing funding from the private sector.\textsuperscript{3}

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2. Interview with Nat Otoo, CEO, National Health Insurance Agency, June 23, 2016.
Figure 2. Ghana Maternal Mortality Ratio per 100,000 Live Births, 2000–2015


Figure 3: Ghana Under-Five Mortality Rate per 1,000 Births, 2000–2015

In recent years, the Ministry of Health has endorsed a series of plans and strategies intended to improve maternal, neonatal, and child health. Through the “Under 5 Child Health Strategy,” which covered the period from 2007 to 2015, the government developed 12 strategic objectives intended to help reduce under-5 mortality from 111/1,000 live births in 2006 to 40/1,000 live births in 2015 (see Figure 3). The strategy’s text noted that “the majority of child deaths in Ghana are caused by conditions that are preventable or treatable with simple, low-cost interventions,” and the plan prioritized health care delivery for mothers and newborns, quality of care, monitoring and evaluation of progress toward targets, as well as financing.26

Recognizing that deaths among newborns comprise an ever-greater percentage of deaths among children under the age of 5 in Ghana, in 2014 the Ministry of Health released the Newborn Health Strategy and Action Plan (2014–2018). The plan is aligned with the global Every Newborn Action Plan and set a goal to “reduce the neonatal mortality rate from 32 per 1000 live births in 2011 to 21 per 1000 live births in 2018 (a 5% decrease per year) and to reduce the institutional neonatal mortality by at least 35% by 2018.”27 The plan has 14 distinct strategies, and the government estimates reaching the goals will cost roughly US$81 million.

The Ghana Family Planning Costed Implementation Plan 2016–2020 (CIP) was developed to realize Ghana’s goal to increase the modern contraceptive prevalence rate to “30 per cent amongst married and 40 per cent amongst unmarried, sexually active women by 2020.”28 Recognizing that improving the use of family planning services is “not only a health and rights issue” but also an issue of economic development, the plan centers around six thematic areas—demand creation, service delivery, contraceptive security, the policy and enabling environment, financing, and stewardship, management, and accountability—to increase the number of women in Ghana using modern contraception from 1.5 million in 2015 to 1.9 million in 2020.29

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29 Ibid.
U.S.-Ghana Cooperation on Health

The United States and Ghana have had diplomatic relations since Ghana’s independence in 1957. U.S. agencies supporting health-related activities in Ghana include USAID, the U.S. Centers for Disease Control and Prevention (CDC), and the Peace Corps, as well as the Department of Defense. Funding for health is a significant component of overall U.S. foreign assistance to Ghana. Between 2006 and 2015 the United States “provided over half a billion ($592 million) in funding to support a range of global health activities in Ghana,” and global health currently accounts for more than 50 percent of total U.S. foreign assistance in Ghana. In FY15, total bilateral funding for health was $78.3 million, with more than 30 percent of the funds supporting work on malaria, 19 percent going toward family planning and reproductive health, and just 10 percent for maternal and child health.

USAID is the principal agency supporting work on health in Ghana, where the agency established a mission in 1961. For the first few decades after Ghana secured independence, USAID activities were focused on promoting agricultural production, infrastructure.

Source: Kaiser Family Foundation, received directly from KFF, May 9, 2016.

30 Kaiser Family Foundation, “Ghana: Funding Analysis,” May 2016, provided to CSIS by the Kaiser Family Foundation.
31 Ibid.
development, and macroeconomic reforms. By the late 1980s, USAID’s work encompassed activities related to maternal and child health, nutrition, and family planning. Following Ghana’s return to democratic rule in the early 1990s, the USAID health portfolio in Ghana further expanded to include an emphasis on HIV/AIDS prevention and, later, neglected tropical diseases. Within the 2013–2017 Country Development Strategy, health is one of five areas of focus, with an emphasis on “service delivery at the community level, with a secondary focus on strengthening the health systems—human resources, finances, information, and logistics—on which quality services rely.”

In 2016, USAID priorities in Ghana are malaria, family planning and reproductive health, nutrition, HIV/AIDS, and health systems strengthening. USAID has also supported efforts to strengthen the country’s immunization cold chain. According to a fact sheet from May 2016, “over the next five years, USAID will support Ghana’s efforts to expand coverage and quality of health services through scaling up interventions to: reduce unintended pregnancy; reduce maternal mortality; reduce newborn and under-five mortality; improve nutritional status; and reduce the spread of HIV among the most-at-risk populations.”

One key initiative is the Systems for Health program, which is implemented by URC and began in 2014. Its goals include “ending preventable child and maternal deaths; reducing unmet need for family planning; reducing childhood mortality and morbidity from malaria; improving nutritional status of children under five and pregnant women; increasing gender equity; [and] preventing the spread of Ebola and other infectious diseases,” by building the management and leadership capacity of Ghanaian health institutions, as well as by providing technical assistance related to supply chain management, health financing, and information system strengthening. The Systems for Health activities have also included renovating the family planning unit at Tamale Teaching Hospital and plans for introducing postpartum family planning counseling at U.S.-supported facilities.

Through USAID’s flagship Maternal and Child Survival Program, which is implemented in Ghana by Jhpiego and R4D, USAID is supporting work on HIV, malaria, nutrition, and family planning, as well as maternal, newborn, and child health services. The initiative builds on the earlier Maternal and Child Health Integrated Program (MCHIP) Jhpiego implemented to support the Ministry of Health and Ghana Health Services in providing pre-service training to midwives and nurses. MCSP is also charged with training providers to implement national family planning policies at all levels of the health system, from district hospitals to the CHPS compounds, in five key regions.

Two programs, Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING), implemented by JSI, Inc., and Resiliency in Northern Ghana (RING), supported by Global Communities, draw on funding from USAID’s Global Health Initiative and Feed the

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Future Initiative. Both programs target Ghana’s Northern Region, which is a Feed the Future focus area. The five-year SPRING project provides technical assistance related to promoting breastfeeding and improving water, sanitation, and hygiene (WASH) practices, and works with pregnant women and children age two years and younger. RING is also a five-year program (2014–2019) that targets women of reproductive age and children under the age of five and supports activities in three areas: livelihoods, nutrition and WASH, and governance. In particular, the program works with the Northern Region Coordinating Council (NRCC) and District Assemblies (DA) to “overcome the institutional challenges to creating the synergies across nutrition, agriculture, and livelihoods activities necessary to promote a healthy, thriving, productive population.”

USAID has also directly supported the government of Ghana through its work with the NHIS. USAID previously funded a study to determine the feasibility of integrating family planning services into the scheme and is currently supporting the NHIS’s efforts to conduct clinical audits and to implement a capitation process to determine how best to manage reimbursements to providers.

At the embassy level, USAID, CDC, Peace Corps, and the Department of Defense coordinate on health-related activities in Ghana. Since 2008, CDC activities in Ghana have supported work on HIV/AIDS prevention and treatment, malaria control, and influenza surveillance. Most of the agency’s activities in Ghana are funded through the President’s Emergency Plan for AIDS Relief (PEPFAR), but the agency also maintains a resident malaria adviser to contribute to the President’s Malaria Initiative, of which Ghana is a focus country. CDC supports laboratory strengthening activities to improve Ghana’s capacities in disease surveillance and response, for diagnosis and disease surveillance, as well as initiatives related to indoor residual spraying for malaria control. CDC has also provided technical support to Ghana’s national immunization program. The U.S. Department of Defense, through Naval Medical Research Unit 3 (NAMRU 3) in Cairo, maintains a small detachment in Accra that is connected to Noguchi Memorial Institute for Medical Research; the collaboration focuses on building research and surveillance capabilities related to diseases of concern in West Africa. Peace Corps volunteers in Ghana develop programs related to health within their

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40 U.S. Centers for Disease Control and Prevention, “CDC in Ghana,” http://www.cdc.gov/globalhealth/countries/ghana/pdf/ghana_factsheet.pdf. In 2003, CDC supported a Field Epidemiology and Laboratory Training Program (FELTP) in Ghana, and since 2007 the government has overseen the activity.
development and sustainability of the country's immunization programs. In recent years Ghana has had trouble making its Gavi cofinancing payments on time; however, having passed the Gavi eligibility threshold of annual GNI per capita of $1,580, in 2017 Ghana will soon begin moving through the five-year Gavi “accelerated transition” process. Assuming Ghana’s annual GNI per capita does not drop back below the eligibility threshold, by 2022, the government will be expected to “fully self-finance” all vaccines currently procured with Gavi support. Because Ghana has introduced so many of the Gavi-supported vaccines, the country is facing a significant increase in spending on immunization programs over the next five years. The cost to the government to procure Gavi-supported vaccines in 2016, before Ghana enters the accelerated transition phase, will be $3.2 million. But by 2022, when Ghana will be expected to self-finance all vaccines currently procured with Gavi support, the government will need to pay an estimated $24.3 million.43

Ghana has begun developing a strong transition plan, in collaboration with Gavi and other domestic and international partners. However, during the CSIS delegation’s meeting with representatives of the GHS and the EPI, as well as the WHO Country Office, UNICEF, and the Coalition of NGOs, we heard about several looming challenges. One of particular interest to

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43 Communication from Lissy Moskowitz, senior manager, Gavi, May 24, 2016.
the delegation was the government’s reluctance to apply for Gavi support to introduce the human papillomavirus (HPV) vaccine, despite a successful Gavi-supported demonstration project that introduced the HPV vaccine to a small cohort of adolescent girls in 2013–2014.

While the quality of data regarding HPV and cervical cancer in Ghana is a challenge, information from the Kumasi Cancer Registry suggests that HPV infection is prevalent in Ghana and that cervical cancer is a leading cause of cancer among women.\textsuperscript{44} During our meeting, EPI officials noted that scaling up the HPV vaccine could have an important impact on the health of women in the longer term. But they acknowledged that the government is reluctant to apply for funding from Gavi, despite its remaining eligible this year to do so, because of concerns about committing Ghana to paying full price for this comparatively expensive product at the end of the transition period.

The United States has made a significant investment in Gavi at the global level, with nearly $1.5 billion contributed to date. The Gavi transition process requiring countries to phase out of assistance as they grow economically represents a critical factor in the partnership’s support for developing countries in mobilizing sufficient domestic resources for, and sustaining, successful immunization programs. Given the United States’ global engagement with Gavi and bilateral emphasis on supporting Ghana’s effort to improve RMNCH services, including immunization services, it makes sense for the United States to complement its global support for Gavi, and for countries undergoing a transition from Gavi support, with continued operational and technical support for Ghana’s national immunization program.

RMNCH within Health Systems Strengthening

The U.S. emphasis on helping Ghana bolster the quality and availability of health services at the community level, while improving the population’s access to services through health system strengthening programs, resonates with the government of Ghana’s health objectives and represents an important aspect of the bilateral relationship on health. The delegation was impressed by what it learned about U.S.-supported programs to improve the quality of maternal, newborn, and child health care through activities designed to facilitate data collection and management, streamline the procurement and distribution of medical commodities, enhance emergency management and triage protocols, and improve the organization and administration of health care facilities.

Through several meetings and visits to health care facilities in Accra and Tamale, in Ghana’s Northern Region, we also learned about the ways in which U.S.-supported training for nurses and midwives is improving RMNCH services. For example, pre-service training for midwives regarding emergency newborn care, and workshops that teach community-level nurses to administer long-acting reversible contraceptives, help bring essential RMNCH services to facilities at the local level and reduce the time and effort women and families must make to seek health care and advice. We were inspired by the effort to help make the CHPS compounds focal points for antenatal care, family planning services, and, in some cases, labor and delivery, particularly when we learned that higher-level facilities are frequently

overwhelmed by late-arriving laboring women whose uncomplicated deliveries could have been handled at the community level. Yet the delegation was discouraged to learn that there is, on the one hand, a glut of health workers and on the other, a shortage of trained nurses available and willing to work in the most remote CHPS compounds. The shortage stems in part from there being no housing for them, because they are concerned about professional advancement opportunities, and because they feel that they are not adequately compensated for their efforts. The United States is currently supporting the construction of several dozen CHPS compounds, including housing for health staff, which may help alleviate some of the community workers’ concerns. Finding ways to support the continued training and advancement of health workers while attracting highly qualified personnel to the CHPS, and retaining them, will be an important aspect of ongoing bilateral work to improve RMNCH.

Integrating Family Planning with Other Services

Given the low contraceptive prevalence rates in Ghana, persistent high rates of maternal mortality, and Ghana’s stated goals of increasing access to and uptake of family planning by 2020, bilateral support for family planning services to address unmet demand for contraception, as well as to improve maternal and newborn health outcomes, is well targeted. In Ghana, the United States supports a number of important family planning activities, including the purchase of family planning commodities, technical assistance regarding management of the family planning commodity supply chain, social marketing programs to increase the availability and quality of family planning products within the private sector, and workshops to train community health nurses to administer LARCs.

The delegation was impressed to learn about the effort to train community health workers to administer LARCs and appreciated the focus on family planning services within U.S. health systems strengthening approaches, but noted that family planning activities appeared to be less connected to other health programs, such as immunizations, which are successfully reaching remote populations. At hospital site visits in Accra and Tamale, for example, we observed that family planning services were situated in buildings segregated from many other clinical services, leading the delegation to conclude that there may be missed opportunities to link family planning to postnatal services, to well-child and immunization visits, and to other routine health activities. Yet integrated services could reduce the time women might spend waiting to see diverse caregivers on a clinic visit and offer women fearful of stigma associated with contraception an opportunity to seek information and procure services in a more neutral setting.45 We also heard from providers that where doors or curtains have been installed to create a greater sense of privacy, women are more comfortable seeking family planning counseling. The effort to support Ghana’s ambitious family planning goals by facilitating women’s access to a broad range of integrated services while improving the confidentiality of those services will need to be carefully managed.

The delegation observed that U.S.-supported vertical programs, such as the President’s Malaria Initiative (PMI) and the President’s Emergency Plan for AIDS Relief (PEPFAR), are addressing important RMNCH issues and also serve as platforms for strengthening and integrating other health areas. In Ghana, PEPFAR funds are focused largely on key populations with the highest burden of HIV. Yet PEPFAR has also supported programs to strengthen laboratory services in Ghana, enhancing the country’s ability to detect and respond to outbreaks of infectious disease for a much broader segment of the population. In addition, at the Tamale Public Health Lab, which serves as a reference laboratory for the northern part of the country, the CDC, using PEPFAR funds, has helped technicians strengthen their ability to perform early infant diagnosis of HIV; the close collaboration between CDC and the lab led to cooperation earlier this year in the effort to detect and respond to an outbreak of bacterial meningitis in the Northern Region.

Malaria is the number-one cause of mortality among children under the age of five in Ghana and is a key cause of maternal and newborn health complications, as well. Ghana is a PMI focus country, and PMI-supported activities, including training midwives to address malaria in pregnant women and teaching clinic staff to more accurately diagnose and treat malaria in children, have directly strengthened maternal and child health services. Maternal and child health has been indirectly strengthened through PMI support for health and data system strengthening. We also learned how PMI-supported indoor residual spraying (IRS) complements training for health care providers to incorporate malaria awareness and prophylaxis into antenatal care visits, as well as assessments and treatment of febrile illness in young children.

Strengthening bilateral support for Ghana’s progress toward its ambitious family planning and reproductive health goals while identifying opportunities to better integrate those services with programs focused on maternal and child health, nutrition, and immunizations, not to mention HIV/AIDS and malaria, should be a U.S. diplomatic and development priority.

Documenting the Benefits and Challenges of Government-to-Government Support for Health

Innovative U.S. government-to-government support for health and nutrition activities in Ghana reflects the strength of the U.S.-Ghana partnership on health and represents an important opportunity to build the capacity of local government agencies to address the health needs of their citizens. While on the ground, the delegation learned that an estimated 33 percent of all USAID-funded government-to-government work is being conducted in Ghana, with work on health an important component. The delegation was encouraged by what members learned about the decision of the United States, along with other donors, to refocus efforts toward northern Ghana, where social and health indicators have historically lagged behind those in the South. The integration of U.S. global health and food security funding streams and programmatic objectives in northern Ghana is impressive. And delegates were interested to learn how the USAID mission in Ghana has embraced the vision of USAID Forward and the emphasis it places on building local institutional capacity.

Through meetings with representatives of the Northern Regional Coordinating Council (NRCC), as well as the Tolon District Assembly, the delegates heard from local officials about the positive impact such direct government support, embodied largely through RING, has made in their communities. Health and nutrition officials reported feeling more empowered to design programs to address local needs. But U.S. and Ghanaian officials, alike, were quick to note that government-to-government support is time-consuming and resource-intensive because of the oversight and monitoring required. As RING got underway in 2014–2015, USAID officials worked with Northern Region counterparts to undertake financial assessments of the region’s districts to determine which ones had the capacity to receive direct funding. And USAID maintains an office in Tamale and officers routinely travel to Tamale from Accra to assess program progress. Nine of 17 districts in Northern Region now receive direct funding transfers that make up an estimated 25 percent of the district budgets, with the other eight districts working with the NGO Global Communities to build their financial management capacity.47 In 2017 USAID plans to directly fund an additional five districts.

The delegation felt the potential for building sub-national government capacity to originate and execute health and nutrition programs to benefit women and children is important and that lessons from direct government funding to sub-national groups may offer guidance about what will work in other contexts. But the delegation also understood that this kind of program requires considerable administrative commitment—on the part of both USAID and the national government—and felt that it is important to ensure sufficient resources are allocated from the beginning to sustain critical supervision and mentoring. The delegation also worried about what will happen once the RING program ends in 2019 and wondered if five years is sufficient to develop and solidify the governance and budgeting skills necessary to replace and manage the funding currently provided by the United States. How the RING model might be extended to other parts of the country and scaled up to the national level are other important issues to consider.

Recommendations

- As Ghana moves toward full self-financing for all vaccines currently procured with funds from Gavi, the United States should reinforce its support for Ghana’s immunization programs; use its role on the Gavi Board to advocate for extending the period of time during which countries have access to Gavi prices following the transition; and facilitate discussions about ways for the government to take on new and expensive vaccines once Gavi support is phased out.

- The United States should couple its support for the extension and strengthening of RMNCH services at the community level with a reinforced emphasis on supporting the training and professional development of RMNCH care providers and continued support for the access of women and children to all health services through the NHIS and other mechanisms. The United States should continue to support research and advocacy.

regarding the incorporation of family planning services into the NHIS, which has been approved by the government but not yet implemented.

- Given the low contraceptive prevalence rates in Ghana, high rates of maternal mortality, and Ghana’s stated goals of increasing access to and uptake of family planning by 2020, it is important to maintain a special focus on family planning to address unmet need, as well as to improve maternal and newborn health outcomes. In addition, lessons learned from the successful integration of other programs, such as HIV/AIDS or malaria services with maternal and child health activities, should be shared with—and extended to—other sectors, particularly reproductive health and family planning.

- As government-to-government work in Ghana moves forward, the United States should carefully document and analyze the financial and human resource costs of the programs, consider what approaches are most likely to lead to sustainable programs in the long term, and use the experience with government-to-government work in Ghana as a model for engagement in other contexts.

Conclusions

Ghana is a small, lower-middle-income country in West Africa with a vibrant health sector. Ambitious national plans and concrete strategies in the areas of newborn health, family planning, and child health have made reproductive, maternal, newborn, and child health topics of national importance and high-level political attention. Ghana’s NHIS has made health care an aspect of popular, everyday discussion, and through it, Ghana has become a model for other countries advancing toward ensuring universal health coverage for their citizens.

Despite progress on RMNCH in recent years, Ghana still faces considerable challenges when it comes to protecting women’s and children’s health. Thanks, in part, to support from Gavi, the Vaccine Alliance, Ghana has enjoyed success in reducing child mortality because of its strong immunization program, but over the next five years Ghana will need to assume full financing for those vaccine purchases. And despite impressive national policy commitments, in the vast, impoverished Northern Region, where many communities are dispersed, reaching women and children with lifesaving services at the community level is often not a reality.

As the United States considers the future of its own health assistance, in Ghana and in other LMICs like Ghana, the country’s experience with the Gavi transition, the U.S.-Ghana experiment with government-to-government financing at the sub-national level, the challenge of extending health services, including family planning services, to the community level, and the U.S. emphasis on building capacity for maternal and child health through health systems strengthening will offer important lessons for continued work in other contexts.
Appendix A: Delegation Members

Dr. Katherine E. Bliss, Senior Associate, CSIS Global Health Policy Center
Ms. M.A. Keifer, Legislative Assistant, Office of Representative Barbara Lee
Ms. Allison Jarus, Senior Policy Adviser, Office of Representative Mike Quigley
Representative Barbara Lee, U.S. House of Representatives (D-CA)
Dr. Afaf I. Meleis, Professor of Nursing and Sociology, University of Pennsylvania
Ms. Cathryn Streifel, Associate Director, CSIS Global Health Policy Center
Appendix B: Delegation Agenda

CSIS Global Health Policy Center
Task Force on Women’s and Family Health
Delegation to Ghana
May 29–June 2, 2016

Sunday, May 29, 2016: Accra

Lecture and tour of Accra’s Agbogbloshie slum and conversation with female migrants and porters (kayayei) to learn about history, politics, and social challenges related to migration, access to services, and economic development in Ghana’s capital. Participants: Mr. Nat Nuno-Amarteifio, former mayor of Accra (1994–1998); Mr. Farouk Braimah, Representative, Slum Dwellers International

Working lunch: overview of U.S.-supported health activities in Ghana. Participants: Mr. Andrew Karas, Mission Director, USAID Ghana; Ms. Akua Kwateng-Addo, Health Office Director, USAID Ghana; Dr. Philip Ricks, Resident Malaria Adviser, CDC

Working dinner: overview of health in the context of Ghanaian politics, economy, society. Participants: Dr. Peter Lamptey, President Emeritus, FHI360; Dr. Irene Ayepong, Public Health Specialist, Ghana Health Service Research and Development Division; Mr. William Adjabui, Manager Branch, Imperial Health Sciences; Dr. Ebenezer Nikoi, Lecturer in Geography, University of Ghana

Monday, May 30, 2016: Accra and Tamale

Site visit: La General Hospital in greater Accra

Roundtable on Gavi, the Vaccine Alliance, support for immunizations in Ghana. Participants: UNICEF, WHO, USAID, the World Bank, Ghana’s Expanded Program on Immunization, Ghana Ministry of Health, Ghana Health Service; the Coalition of Health NGOs

Meeting to learn about food security, nutrition, and health challenges in the region and how the Resiliency in Northern Ghana (RING) project that brings together the capacity of communities and governments to work together to help vulnerable families address their livelihoods, finance, and water, sanitation and hygiene (WASH) needs. Participants: representatives of Northern Region Coordinating Council

Working dinner: Discussion of reproductive, maternal, neonatal, and child health challenges and opportunities in Northern Region. Participants: Mr. Muhammad Ali, Programmes Manager of Health, Catholic Relief Services (CRS); Ms. Vandana Stapleton, Deputy Director, Health, Population, and Nutrition Office, USAID Ghana; Dr. Felix Osei-Sarpong, Public Health Specialist, USAID Ghana; Mr. Joseph Ashong, Field Interviewer, USAID; Dr. Phillip Ricks, Resident Malaria Adviser, CDC; Dr. Edward Bonku, Chief of Party, SPRING, John Snow International (JSI); Mr. Philippe LeMay, Chief of Party, RING, Global Communities; Mr. Yunus
Abdulai, Deputy Chief of Party/Agriculture & Livelihoods Specialist, RING, Global Communities; Ms. Kristin Kappos, Nutrition Manager, RING, Global Communities; Mr. Alberto Wilde, Country Director, Global Communities

Tuesday, May 31, 2016: Tamale

Site visit: Cheshegu Community-based Health and Planning Services (CHPS) site to learn about provision of reproductive, maternal, and neonatal health services at the local level

Site visit: SPRING-supported Nyankpala Health Center to learn about options for labor and delivery with a skilled attendant at the district level and services to monitor child health and improve nutrition in Tolon district

Meeting to learn about the impact of U.S. support for health and nutrition in Ghana’s Northern Region and opportunities for enhanced cooperation and effectiveness. Participants: District Assembly members (District Chief Executive, District Coordinating Director, Planning officer, District Agriculture Director, Director of Health, Environmental Health Director and Budget officer)

Site visit: Meet with Village Savings and Loan Association (VSLA) soybean women’s group, organized by USAID Resiliency in Northern Ghana (RING) project

Site visit: Indoor Residual Spraying (IRS) site in Kumbungu to learn about efforts to prevent and control malaria through the African Indoor Residual Spraying Project/USAID/ President’s Malaria Initiative (PMI).

Working dinner: Peace Corps volunteers to discuss opportunities to improve health outcomes at the community level in Northern Region

Wednesday, June 1, 2016: Tamale and Accra

Site visit: Tamale Central Hospital to examine integration of services to address malaria, reproductive health and family planning, antenatal care, deliveries, postnatal/newborn care services, and immunizations, as well as nutrition

Site visit: Tamale Public Health Lab to learn about PEPFAR/CDC support for building capacity in the three Northern Regions with respect to disease surveillance and early infant diagnosis of HIV, as well as diagnosis of meningitis

Site visit: Tamale Teaching Hospital to learn about options at the tertiary level for emergency and comprehensive obstetric and newborn care in Northern Region

Delegation lunch and report discussion

Working dinner: options for improving maternal and newborn health in Ghana. Participants: Mr. Hari Banskota, Health Specialist, UNICEF; Dr. Christabel Enweronu, Senior Lecturer Department of Child Health, University of Ghana Medical School; Dr. Aisha Awumbila,
Thursday, June 2, 2016: Accra

Briefing at National Health Insurance Agency on health financing in Ghana and progress toward universal health coverage in Ghana. Participants: Mr. Nathaniel Otoo, Acting Chief Executive, National Health Insurance Agency; Mr. Francois Xavier Adndoh-Adjei, Director, Research, Policy, Monitoring and Evaluation, National Health Insurance Agency; Ms. Lydia Baaba Dsane-Selby, Director Claims, National Health Insurance Agency

Working lunch: discussion of delegation observations. Participant: Mr. Andrew Karas, USAID/Ghana Mission Director

Meeting: Mr. Alex Segbefia, Minister of Health

Meeting: Outbrief discussion to share delegation’s observations, insights, preliminary recommendations, and questions. Participants: Ms. Melinda Tabler-Stone, Deputy Chief of Mission; Ms. Akua Kwateng-Addo, Health Office Director, USAID Ghana; Dr. Philip Ricks, CDC Resident Malaria Adviser
Healthy Experiments

Innovative Approaches to U.S. Support for RMNCH in Ghana

A Report of the
CSIS TASK FORCE ON WOMEN’S AND FAMILY HEALTH

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