Introduction

As many countries embark on substantial structural and financial change to their health sectors, there is mounting concern that planning for change does not employ priority-setting mechanisms that are suited to recognizing or taking account of the needs and priorities of sexual and reproductive health (SRH) services. There is a call for a new approach to priority-setting to better reflect reproductive health rather than disease, because many SRH interventions do not fall within the disease-model on which the traditional burden of disease and cost-effectiveness tools were developed.

The main aim of this research was to assess the sensitivity of the priority-setting tools and mechanisms used in the development of the health sector reforms in Ghana, to the needs and priorities of SRH services, and to consider how priority-setting mechanisms could be improved.

Methods

This research was qualitative and exploratory in nature and sought to understand the process of and influences on priority-setting in three distinct but interconnected reform components: decentralization, essential package and sector-wide approach (SWAp).
We used two main methods for data collection: key informant interviews and document analysis. Thirty-five key informant interviews were held between April and June 2003 with: Ministry of Health (MOH) officials from different divisions and units; non-government organizations (NGOs); professional interest groups; donors; and district and regional health management team members. We also drew on a further 98 interviews (from the same levels and types of key informant) that were conducted in earlier work between 1996–98 (see Mayhew et al. 2000; Mayhew 2002, 2003), to gain an historical perspective on reform processes and the involvement of different actors. For both data collection periods, the regional and district data came from the Upper East Region, which is considered to be representative of poor, rural, Ghana – the focus of policies to improve reproductive health and development.

Extensive document analysis was conducted of MOH reports and documents from national, regional and district levels, donor reports and documents, and relevant independent research papers. These documents spanned a period of about 10 years: 1992–2003.

The guiding framework for our interviews and analysis were a series of research questions:

(1) What priority-setting tools and mechanisms were used at different levels of the Ministry of Health during the reform process, and who were the key actors involved?
(2) How far are SRH priorities reflected in the reform indicators, whose priorities are reflected, and how do they compare with Cairo?
(3) How important is it for SRH actors to be involved in priority-setting processes?
(4) Can priority-setting mechanisms and tools be developed that are sensitive to the needs and priorities of SRH services?

**Health sector restructuring and SRH: policy development and priority setting**

Family planning has been supported by USAID and UNFPA since the late 1960s/early 1970s in Ghana, and safe motherhood has been supported since the 1980s. UNFPA and USAID worked closely with the Reproductive, Maternal and Child Health (RMCH) Unit of the Ministry of Health to establish a strong network of clinics and specialized staff. The National Council on Population was established as a dedicated, and transparent, channel for donor funds for population activities, and was responsible for developing the 1996 National Population Policy. The RMCH clinic network and its reporting and monitoring system remains strong today, and represents the biggest network of public health facilities available; the RMCH Unit produces the most comprehensive Annual Report of any in the Ministry.

Health sector reforms in Ghana began a decade later in the mid to late 1980s when a group of dissatisfied middle-rank directors in the Ministry of Health agitated for major reform to improve the functioning of the system (interviews, Ministry of Health officials 2003; Gyapong et al. 1998). De-concentration began with support through DANIDA’s Strengthening Sub-District Health Systems initiative and later from the World Bank and the UK Department for International Development (DFID) (interviews, senior Ministry of Health officials; Gyapong et al. 1998; Mayhew 1999). The sector’s reforms were consolidated in the early 1990s with two high-profile meetings at which the need to streamline inefficient and bureaucratic vertical structures and reporting systems was discussed (GMOH 1991, 1992; Cassels and Janovsky 1992; Gyapong et al. 1998).

Following these meetings, a MOH Steering Group of five key reformers was established, and working groups were set up to consider different components – essential package, mortality/ morbidity, decentralization etc. (Senior GHS official 2003). Two World Health Organization (WHO) consultants were invited to advise, and, making health sector restructuring a condition for its Second Health and Population Programme Loan, the World Bank offered substantial support to the restructuring as part of wide-ranging public administration and civil service reforms involving the Ministries of Finance, Local Government and others.

This was a period of incremental change, with planning and budgetary responsibility gradually shifting from the centre, through regions and finally to the districts and other quasi-independent ‘Budget Management Centres’ (including teaching hospitals and sub-district health teams) (GMOH 2002a). An Essential Package of Health Services was developed based on WHO’s Burden of Disease measures and World Bank cost-efficiency measures, though lack of data meant calculations for priority-setting were rudimentary, relying on clinical records and available disease-specific surveys (interviews MOH officials, 2003):

“Cost-effectiveness data were not easily available. Decision-making was done largely on the extent of morbidity and mortality . . . we said this is the pattern of diseases – we didn’t rank them, but selected diseases which covered most of the problems and then allocated resources to disease patterns.” (Senior GHS Official, 2003)

Reliance on disease-based clinical records of morbidity and mortality does not capture preventive services such as family planning, though this is long established as a cost-effective long-term means for promoting smaller families and increasing their economic benefits and health. The dangers of over-emphasis by planners on bio-medical, clinical records for priority-setting are exemplified in early experiences of the sector-wide planning in Ghana in which a budget line for condoms was omitted, despite this being central both to reproductive health and the fight against HIV (Mayhew 2002).

The essential package was incorporated into the first 5-year Programme of Work and the first phase of the SWAp was finalized (GMOH 1996). These were consolidated in 1996 with strong support from the World Bank, DFID and a handful of other European donors: the Ghana Health Service was established as an executing agency for the MOH, which
was to concentrate on policy. During this period of change a series of high-level consultation meetings was held with Ministry Divisions and donors, but according to officials who were involved, the decision-making and priority-setting mechanisms for the essential package and related decentralization priorities were ad hoc and tended to rely on the involvement of enthusiastic or interested individuals, leaving room for individual bias:

“We don’t have any priority-setting tools as such . . . there is no framework which is prioritizing items.” (Senior Ministry of Health official, 2003)

“There were no clear priority-setting arrangements – it was more a question of those interested in RH, raise their hands!” (Senior Ghana Health Service Official, 2003)

“There is flexibility for political and individual priorities . . . Advocacy is very important, otherwise you will be surprised that priorities slip away.” (Ministry of Health Official, 2003)

Previous research noted problems with the inclusiveness of the consultation process (Gyapong et al. 1998). In our research it was significant that the reproductive health actors tended to remain outside the priority-setting negotiations to the detriment of the SRH programme:

“In the early versions of the Programme of Work, reproductive health was not there at all. HIV was there but even safe motherhood had been left out . . . The RMCH Unit is not part of the Ministry of Health systems group, so it was completely out of the loop.” (SRH donor, 2003)

Perhaps this was partly because the mid-1990s were a time of significant policy and programme development for SRH itself, independently of health system changes. Post-1994 in particular was a pivotal period for reproductive health, 1994 being the year of ICPD, which expanded the mandate of family planning to encompass a whole range of SRH components. In particular, Ghana took up management of sexually transmitted infections and adolescent reproductive health. 1996 saw the first draft of a comprehensive SRH policy/guidelines document which was finalized in 2003 and covered the broad range of Cairo components including gender-based violence, female genital mutilation, cancers and male sexual health. This was developed primarily through negotiation by the RMCH unit with representatives of the main SRH funders: USAID and UNFPA (Mayhew 1999, 2000). The range of actors now involved in SRH included UNAIDS and the National AIDS Control Programme of the Ministry of Health (who collaborated on training family planning staff in management of sexually transmitted diseases), UNICEF and a wide range of NGOs. This expansion of the SRH programme did not happen in isolation from the system-level changes, and by the mid-1990s, the SRH donors had streamlined their 5-year Country Programmes to harmonize with the MOH’s own 5-year Programme of Work.

Meanwhile, a Steering Committee within the MOH was established in 2000 to review the first Programme of Work and SWAp. Teams of stakeholders analyzed progress, recommended changes for the Second Programme of Work and SWAp, and revised the essential package and Programme of Work indicators. UNFPA, USAID and other SRH actors were engaged at some level in this process, but it is striking that their involvement had little significant impact on the reform process in terms of resulting in a greater profile for SRH issues. The resulting review document The Health of the Nation, for example, does not contain a single mention of the family planning programme, despite the presence of an eminent population advocate as Chair of the Steering Group (GMOH 2001). One high-profile family planning organization, which theoretically also sat on the Steering Committee, did not know what the SWAp was when asked in 2003, and said they had not been officially involved in the process. When questioned further they said they had been invited to meetings at the MOH but were never very clear as to their purpose. Earlier research noted that: ‘Very few people understood what the reforms were about. Much misinterpretation and misinformation abounded’ (Gyapong et al. 1998, p. 33). Our findings suggested a lack of understanding on the part of key SRH actors as to the nature of the reforms or their significance for SRH services delivery and organization, resulting in a degree of isolation from both the reform development and the recent reform review processes:

“During the Health Summit review process, USAID was never invited to be part of the Steering Group so they couldn’t ever feel part of the process . . . reproductive health has the support and undivided attention of USAID – this has really isolated them from the SWAp.” (SWAp donor, 2003)

The lack of involvement of technical programmes like SRH is a common feature of reforms; the strong donor-funded vertical SRH programme in Ghana, however, meant SRH programme personnel, in particular, may not have felt the need to engage with other health system actors. Clearly the lack of active involvement by SRH actors in reform negotiations must affect the status of SRH in reform indicators. The following section considers to what extent SRH priorities feature in the reform indicators, and whose priorities these indicators reflect.

**SRH in reform indicators: whose priorities?**

### SRH in reforms

Table 1 illustrates priority indicators for the decentralization, Essential Package and SWAp reforms.

The Essential Package contains seven priority areas, of which two are related to SRH: HIV, which is given prominence as a separate indicator, and ‘Reproductive Maternal and Child Health’ which includes maternal mortality (a Millennium Development Goal) and focuses primarily on safe motherhood (antenatal care, emergency obstetric care), family planning and child health services. Adolescent reproductive health services and screening/management of cervical
cancers are included in the description of the package, but are not reflected in the four indicators that are given.

The priority areas for decentralization, set out in the 2002–06 5-year Programme of Work, are systems-orientated strategic areas (GMOH 2002b). Broad descriptive strategies are set out in the Programme of Work but no specific indicators have been defined to measure targets for ‘access’, ‘efficiency’ and so on. With the emergence of the SW Ap, the ‘sector wide’ indicators developed for this were taken up by the Programme of Work and are now used as the main monitoring measures for decentralization.

The SWAp indicators are a combination of the previous two with 23 specific indicators reflecting both the essential package and effectiveness/efficiency measures that are grouped according to the five strategic pillars of decentralization. There are seven specific indicators relating to SRH: five on safe motherhood, one on HIV and one on family planning. The family planning indicator is ‘% acceptors’, which is considered inadequate by SRH donors since it does not capture the importance of long-term methods (e.g. you only have one sterilization; you only go for Norplant once every 5 years). Contraceptive prevalence rate would be a more accurate indicator.

Thus, the different components of reform attempt to marry disease-specific indicators with cross-cutting, systems-focused priorities. These indicators, developed during the ad hoc priority-setting processes described earlier, are used for accountability purposes. Notwithstanding the fact that every indicator cannot be included, criticisms have been made. First, that the traditional ‘burden of disease’ type ranking used by the Ministry does not adequately reflect the long-term nature of interventions like family planning or their importance for quality of life. Interestingly this is something that was recognized by Directors in the frontline of trying to deliver health services to rural communities:

“Burden of disease data measure palpable outcomes – mortality and morbidity – but reproductive health is about health and development. When reproductive health is good, the positive outcomes are not captured – there is no measurement for the freedom that family planning brings to women.” (District director, 2003)

Secondly, the systems indicators are too broad to be meaningful; strategic aims such as access and efficiency need to have identified measures linked to specific technical programme needs. For example, there is little point procuring anti-retroviral drugs if there is no HIV-testing and counselling service available.

Whose priorities?

The ICPD declaration provided the definitive interpretation of ‘sexual and reproductive health’ and all its component parts. Table 2 charts the priorities of key reform and reproductive health actors against the SRH priorities identified at Cairo.

On the left are the three Cairo indicators that are included in the reforms (HIV, maternal mortality rate and family planning); on the right are all the other Cairo indicators that are not included in the reform indicators. We have marked ‘Y’ (yes) against each actor where their official documents explicitly state a commitment to the priority; we have marked ‘P’ (partial) where there is a stated commitment but this is not reflected in the associated actions and strategies (because of lack of resources, capacity, low down the priority list and so on) – these issues are dealt with further under the section on process measures below.

What comes across quite clearly is that the key actors involved in the reform processes (World Bank, DFID, Government/MOH headquarters) reflect only the two main reform indicators on SRH (HIV, MMR). Most disturbingly, family planning barely appears as a priority of reform actors. The MOH states its commitment to family planning, but pays it little attention, manifest in the omission of family planning from national and district reports (GMOH 2001; Kassena Nankana 2002). This may be because family planning is considered the mandate of the SRH programme, which is supported by donors outside the SWAp, whereas maternal mortality and HIV, having been defined as Millennium Development Goals, are also of concern to the main reform

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**Table 1. Reform priority performance indicators 2003**

<table>
<thead>
<tr>
<th>Essential package</th>
<th>Decentralization (5-Year Programme of Work)</th>
<th>Sector-wide approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 priority areas including:</td>
<td>5 ‘strategic pillars’:</td>
<td>5 strategic pillars + 20–44 specific indicators including 7 on SRH:</td>
</tr>
<tr>
<td>- HIV/AIDS/STI</td>
<td></td>
<td>- HIV prevalence</td>
</tr>
<tr>
<td>- Reproductive, maternal and child health (antenatal care, family planning, supervised deliveries and maternal/infant mortality rates)</td>
<td>- Quality</td>
<td>- maternal mortality rate</td>
</tr>
<tr>
<td></td>
<td>- Efficiency</td>
<td>- % maternal audits to maternal deaths</td>
</tr>
<tr>
<td></td>
<td>- Collaboration</td>
<td>- % family planning acceptors</td>
</tr>
<tr>
<td></td>
<td>- Resources</td>
<td>- % antenatal care coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- % postnatal care coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- % supervised deliveries</td>
</tr>
</tbody>
</table>

Sources: GMOH 2002a, 2002b.
Table 2. Reform and Cairo indicators on sexual and reproductive health by supporting health sector actor

<table>
<thead>
<tr>
<th>Actor</th>
<th>Reform indicators on SRH</th>
<th>Additional Cairo indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV/ Gon&lt;sup&gt;a&lt;/sup&gt;</td>
<td>MMR/ SM&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>MOH/Ghana Health Service</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>World Bank</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>DFID</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MOH: NACP&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MOH: RMCH&lt;sup&gt;k&lt;/sup&gt; Unit</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>USAID</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>UNFPA</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>District 1</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>District 2</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Y = yes; appear in policy documents and recorded activities; P = partial: appear in policy documents only.

<sup>a</sup> HIV/Gon = HIV/gonorrhoea;  
<sup>b</sup> MMR/SM = maternal mortality rate/safe motherhood;  
<sup>c</sup> FP = family planning;  
<sup>d</sup> STI = sexually transmitted infections;  
<sup>e</sup> ARH = adolescent reproductive health;  
<sup>f</sup> FGM/GBV = female genital mutilation/gender based violence;  
<sup>g</sup> Rep cancers = reproductive cancers;  
<sup>h</sup> Abortion/PAC = abortion/post-abortion care;  
<sup>i</sup> Rep rights = reproductive rights;  
<sup>j</sup> NACP = National AIDS Control Program;  
<sup>k</sup> RMCH = Reproductive, Maternal and Child Health.


actors who support the SWAp. As one SWAp donor quite candidly admitted:

“We don’t really have a position on SRH any more because it isn’t the SWAp approach. Maternal mortality is a concern because of the Millennium Development Goals.” (SWAp donor, 2003)

The additional Cairo indicators (not included in the reform priorities) are, as expected, reflected by the main SRH actors – RMCH unit, UNFPA and USAID – who were, as we have seen, not part of the reform process. Even the SRH stakeholders, however, are only partially addressing many of the Cairo priorities. This is partly a resource issue, but also a reflection of the international preoccupation with the Millennium Development Goals – this issue is discussed further in the ‘political measures’ section below.

Thus, one interpretation of why safe motherhood and HIV in particular appear in reform indicators is because they are Millennium Development Goals to which the key sector-reform donors subscribe at present. Family planning is also mentioned because of its long-standing association with development. One might ask, however, does it matter if the only SRH indicators reflected in reforms are those that are also Millennium Development Goal indicators? If the SRH programme is strong, why does it need to be involved in negotiations on restructuring the health system? It is to these questions that we now turn.

**SRH is a strong programme; why should it engage with reform processes?**

Ghana has a strong and well-functioning SRH programme that has developed independently of sectoral changes and reflects the diversity of Cairo that is not readily apparent in reform indicators and strategies. The challenge is whether the SRH programme should continue to operate more independently of the main health sector, or does it need to become a more integral part of a decentralized, sector-wide approach? If so, how does it maintain its current strength within this structure?

Programmes supported by donors independently of the system are not sustainable

During earlier research on reproductive health policies and programmes in Ghana, several government officials described a view of sustainability as ‘sustaining donor funding’ (Mayhew 1999), but this cannot be a viable long-term solution. While international funding to developing country governments will undoubtedly continue in some form, it is clear that traditional programme support is unlikely to be the main source of finance in the medium- to long-term future. Furthermore, the decline in international financial commitment to SRH has been noted for a number of years (PAI 1999; Potts et al. 2000). We are likely to see an increasing diversification of sources of funding and resource transfer (involving the private sector, philanthropic organizations, international trade agreements and financing institutions), as well as shifts to less earmarked (less ‘paternalistic’) funding for sectors and governments (Mayhew 2002). Therefore, programmes like SRH that rely exclusively, or largely, on donor funds must ultimately be unsustainable, a fact recognized by key SRH donors themselves. As one commented, “There’s the contraceptive security issue, we’re not funding this forever” (interview, 2003).

If the SRH programme continues to be funded largely outside the mainstream ‘system’, it runs the risk of being ‘forgotten’ by health sector personnel who have not been
used to planning for it in the way that they do for other health issues that appear in the Sector priorities. One donor reflected on the early budget planning for the SWAp when condoms were left out because they were then fully funded by USAID and UNFPA; hence, they were not considered to be a ‘system’ issue despite being a critical component of public health services (Mayhew 2002). This can also be seen in districts where external earmarked ‘programme’ funds are not forthcoming, and the view of reproductive health as a distinct donor-funded programme means that districts do not allocate extra resources or priority status to it because they think of it as already taken care of, particularly if SRH issues do not have the support of the district officer:

“The district officer who does not ‘like’ HIV or reproductive health, he will not allocate sufficient funds . . . It happens more with some programmes, especially those which have external funding like reproductive health . . . [because] they see reproductive health as belonging to another programme.” (Senior MOH Official, 2003)

Furthermore, even if district decision-makers are interested in SRH, they must first respond to those priorities identified in the Sector’s Programme of Work since these must be reported:

“When it comes to reproductive health, we are constrained because you don’t receive funds for reproductive health – it competes with all the other problems: malaria, diarrhoea, upper respiratory tract infections and childhood diseases. These are the top killers and therefore the concern is on them.” (District director, 2003)

There are strong tensions here between the desire to keep earmarked programme funding in order to safeguard SRH activities as a district priority, and the effect of distinct programme funding in creating strong donor-dependence that is of questionable sustainability and may, when earmarked funding ceases, result in the non-reporting of SRH indicators that do not appear as sector indicators.

**Systems improvements, on which SRH services rely, depend on interaction with technical programmes**

Ghana’s SRH programme, while strong with a high degree of independent funding, is nevertheless delivered through the public health system. The documented lack of involvement of technical programmes in the planning and priority-setting of the reform processes and indicators may lead to an unsustainable polarization of programmes and systems, and ultimately to a weakening of the system itself.

At national and district levels, the parallel existence of programmes and a sector-wide system essentially disrupt the system and weaken its ability to plan in a sector-wide manner, since ‘independent’ programmes may be left out of planning (as the previous section illustrated). Conversely, the programmes have no ‘big picture’ about what is happening to them within the wider system. Reform donors maintain that there are benefits of the cross-sector view and service integration, but they recognize that “the technical programmes tend to get lost” (SWAp donor, 2003), and the benefits of the sectoral vision will not be achieved while knowledge of technical programme requirements is lacking. There is growing concern among the reform donors that “The sector needs to get it right . . . We need to reflect the disease and programme priorities” (reform donor, 2003), but programme knowledge will not be shared as long as SRH advocates are not integrated in reform negotiation and monitoring processes:

“If we don’t get this technical feedback then we have a problem . . . Because programmes operate in a stand-alone way, we don’t know what they are doing, so the SWAp doesn’t benefit . . . One way of getting RH up the agenda is to share what they are doing.” (SWAp donor, 2003)

In the past, SRH donors, notably USAID, have intervened at critical points in the reform developments – for example, to contest the indicators for the first Programme of Work – but have not often demanded to be invited to the negotiating table. Some SWAp donors now seem to be extending the hand and USAID was invited to present at a health partners meeting in 2003, which one SWAp donor remarked “was quite an eye opener for some of us” to see how active the reproductive health donors are in their own field. There are further signs of collaboration in efforts such as the Community-based Health Planning and Services Strategy (CHPS), which started off as a community-based family planning initiative supported by USAID and other SRH donors and has now become part of the decentralized sector-wide approach.

The core challenge appears to be how one adapts the system, and the current reforms, to accommodate and safeguard technical SRH programme needs and funding within the health system as a whole. Unless programme specialists are involved in priority-setting decisions, resource and planning allocation priorities will reflect needs and priorities of reform donors and policy makers, who may not understand priorities of particular health issues. A new approach to priority-setting could be critical here.

**Can future priority-setting in Ghana better reflect SRH goals?**

In this section we examine briefly whether it is possible to develop priority-setting processes and tools that better reflect SRH in reform processes and indicators at local, national and international levels. We apply a framework developed by Laura Reichenbach (2002), who argues that there are three types of measures that determine priority-setting for SRH: direct attention measures (what is known empirically?); process attention measures (what is occurring to support the issue?); and political attention measures (what is the level of commitment to the issue?). The following sections examine each of these factors and highlight how they could contribute to priority-setting for SRH in Ghana.
Direct measures: what do we know about SRH priorities?

Consideration of direct attention measures allows us to assess the extent to which national indicators reflect actual SRH needs. Table 3 provides data available on the range of SRH components indicated at Cairo. SRH data have improved over the years and are generated in several departments of the Ghana health service and the university system. However, what is apparent in Table 3 is the lack of information about the indicators that are not national priorities. The sketchy data available are provided largely by research institutions and small-scale surveys. There are no accurate data on reproductive cancers, infertility, gender-based violence or, surprisingly, on sexually transmitted infections. Despite widespread initiatives in the mid-1990s to train family planning nurses in syndromic management of sexually transmitted infections, this is reported neither by the RMCH unit nor the National AIDS Control Programme Annual Reports, and data are not routinely collected. Sentinel surveillance of sexually transmitted infections could be included in the HIV sentinel surveillance system if political will and resources were committed. Female genital mutilation is known to be widespread in some regions, but data are difficult to obtain (Adongo et al. 1998a; Mbacke et al. 1998); the research centre at Navrongo provides most available data.

Nevertheless, the data available can tell us some things. Indicators on prevalence of family planning use have improved slowly over the last decade but remain low, somewhat surprisingly given the reduction of the total fertility rate in

Table 3. Direct attention measures for SRH in Ghana

<table>
<thead>
<tr>
<th>Cairo SRH component indicators</th>
<th>Incidence/prevalence/coverage data</th>
<th>Reference population, date and source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning (FP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>4.5</td>
<td>National, GSS 1999</td>
</tr>
<tr>
<td>CPR (% modern; among currently married women)</td>
<td>13</td>
<td>National, GSS 1999</td>
</tr>
<tr>
<td>Couple Years Protection (CYP) short term</td>
<td>642,508</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td>CYP long term</td>
<td>354,671</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td><strong>Safe motherhood:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% antenatal care coverage</td>
<td>98</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td>% skilled delivery</td>
<td>45</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td>% postnatal care coverage</td>
<td>54.2</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– institutional</td>
<td>204/100,000</td>
<td>National, RCH Unit 2002</td>
</tr>
<tr>
<td>– population</td>
<td>c.740/100,000</td>
<td>National, GMOH 1999</td>
</tr>
<tr>
<td><strong>Abortion:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion ratio</td>
<td>270/100,000</td>
<td>4 regions, Ahiaideke 2001</td>
</tr>
<tr>
<td>Unsafe abortion</td>
<td>n/a, est. 20–30% MMR</td>
<td>National teaching hospitals, RCH Unit 2002</td>
</tr>
<tr>
<td>Post-abortion care</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td><strong>HIV:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% HIV prevalence</td>
<td>4</td>
<td>National, NACP 2002</td>
</tr>
<tr>
<td>% knowledge of at least one means of HIV prevention</td>
<td>80</td>
<td>Women only, national, GSS 1998</td>
</tr>
<tr>
<td><strong>STI:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>Not routinely collected</td>
<td>–</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>n/a</td>
<td>NACP, 2002</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Not routinely collected</td>
<td>–</td>
</tr>
<tr>
<td>Urethritis in men</td>
<td>Not routinely collected</td>
<td>–</td>
</tr>
<tr>
<td><strong>Adolescent reproductive health:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% unmet FP need 15–19 yrs</td>
<td>27</td>
<td>National, GSS 1999</td>
</tr>
<tr>
<td>% unmet FP need 20–24 yrs</td>
<td>22</td>
<td>National, GSS 1999</td>
</tr>
<tr>
<td><strong>Reproductive cancers:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer incidence</td>
<td>30/100,000</td>
<td>Regional figures from WHO</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>43/100,000</td>
<td>data, Shibuya et al. 2002</td>
</tr>
<tr>
<td>Prostate incidence</td>
<td>45/100,000</td>
<td></td>
</tr>
<tr>
<td><strong>Infertility:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% women</td>
<td>12</td>
<td>2179 sample, rural, Geelhoed et al. 2002</td>
</tr>
<tr>
<td>% men</td>
<td>15</td>
<td>–</td>
</tr>
<tr>
<td>Gender based violence</td>
<td>n/a</td>
<td>Known to be widespread</td>
</tr>
<tr>
<td><strong>Female genital mutilation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National prevalence (% women)</td>
<td>9–12 (est.)</td>
<td>National, Mbacke et al. 1998</td>
</tr>
<tr>
<td>Upper East Region (% women)</td>
<td>77</td>
<td>Upper East Region, UNFPA/Odoi-Agyarko 2002</td>
</tr>
</tbody>
</table>
recent years; reproductive health specialists consider abortion to play an important role in reducing fertility (personal communication, USAID 2003). Reasons for the continuing lack of uptake of family planning are not well understood, though could include socio-cultural factors, poor access for adolescents and unmarried women, and continuing quality of care issues (Adongo et al. 1997; Adongo et al. 1998b; Parr 2002):

“We are killing ourselves over this [family planning] and 30 years later we are not there yet. The counselling is very poor, the methods are not really there, post-partum FP is non-existent – it’s about quality of care, that’s the whole issue.” (SRH donor, 2003)

There are more data relating to safe motherhood. Antenatal care levels are good in Ghana (RCHU 2002) and are important for ensuring a healthy mother and pregnancy. Maternal mortality rate is notably high in Ghana, which may reflect the lower rates of supervised delivery and access to good emergency obstetric services. In a welcome move, prompted partly by the concern of reform donors like DFID with the maternal mortality Millennium Development Goal, maternal audits were introduced in the reform indicators to try to better understand the causes (GMOH 2002b; GMOH/GHS 2003). Apart from the clinical causes (haemorrhage, hypertension, eclampsia etc.), research increasingly suggests that high rates of abortion may also contribute.

Research in three northern regions recorded an institutional maternal death ratio of 348/100 000, but population-based estimate of 500–600/100 000. Of the institutional maternal deaths recorded, 19% were due to abortion (USAID 2001). A number of studies done at Legon University and Korle-Bu Teaching Hospitals estimate that between 20–30% of maternal mortality is attributable to unsafe abortion (RCHU 2002). Ghana has a relatively liberal abortion policy (DESA-UN 2003), but this is not widely known, and accessible, safe, legal abortions are therefore not widely practised in the public sector. The incidence of unsafe abortion is thought to be high; a recent study in four regions found an abortion ratio of 27 per 100 live births (Ahiadeke 2001). The public sector response is to promote family planning to prevent the need for abortion and to provide post-abortion care if it goes wrong (RCHU 2002; GMOH/GHS 2003). We have noted the limitations of family planning however, and availability of post-abortion care services is unknown.

Adolescent reproductive health is a particular cause for concern. The 1998 Ghana Demographic and Health Survey (GDHS) estimates a 22–27% unmet need for family planning among young people (GSS 1999). This is corroborated by data from Korle-Bu Teaching Hospital, which indicate that maternal deaths through septic abortion were 25 times higher among adolescents (RCHU 2002). Adolescent reproductive health is a programme goal of the Reproductive and Child Health Unit, but the primary focus is on counselling of young people and promotion of abstinence.

Despite its shortcomings, the available SRH data suggest that while continuing promotion of family planning, understanding causes of maternal mortality and responding to slowly increasing levels of HIV are very important, there are additional needs not currently reflected in national priorities. These are the provision of dedicated adolescent reproductive health services, accessible safe abortion and post-abortion care. These issues may have been neglected because the policy actors who take national priority decisions in Ghana do not have ready access to SRH data or the inclination to address those SRH issues that are not Millennium Development Goals. SRH stakeholders have also been slow to grapple with these more controversial topics. Nevertheless, data do exist and more will emerge, particularly if prominence is given to non-statistical measures of SRH which give policy makers a more informed range of information on which to act (Singh et al. 2004). SRH stakeholders have a critical role to play in highlighting key SRH needs that do not necessarily appear in disability-adjusted life year (DALY) or cost-effectiveness oriented measures. For example, donors and NGOs can support research on areas for which little information currently exists (cancers, female genital mutilation) or where recent data suggest more research is needed (link between unsafe abortion and maternal mortality). For data to be used effectively in priority-setting, MOH planners should ensure that the existing Health Management Information System includes the widest possible range of health needs in its monitoring, and that regular review procedures are established to allow reform indicators to be updated to respond to emerging and underlying issues as data become available. Quality control would ensure reporting is accurate; currently, for example, many incomplete abortions seen at hospitals are recorded as gynaecological or obstetric complications.

**Process measures: what is happening to support SRH?**

Present commitment to SRH components in terms of provision of facilities, programme goals, guidelines and training is shown in Table 4. The only two areas that are not explicit SRH programme goals are provision of safe abortions and infertility treatment/counselling. Management of sexually transmitted infections seems to be of little active priority, and measures for post-abortion care and female genital mutilation are limited. Activities have increased markedly over the last few years to address reproductive cancers, gender-based violence and adolescent reproductive health, although facilities are as yet extremely limited. Most activity is evident for family planning, safe motherhood and HIV, reflecting the international Millennium Development Goals.

The data surveyed in the previous section highlighted areas of SRH need not reflected in the reform priorities: adolescent reproductive health services (especially contraceptives) and access to safe abortion and post-abortion care. Table 4 indicates that these are not reflected in process measures either. By contrast, the extent of activity for HIV-related issues seems disproportionate, notwithstanding the reality that HIV is spreading in Ghana. In particular, the focus on expensive anti-retroviral provision and training of nurses in prevention of mother-to-child-transmission in rural regions, where there
are neither tests to confirm whether a woman is positive nor drugs to treat her even if there were, seem misguided. This tension between scaling-up HIV treatment activities at the expense of other less expensive and more pressing SRH needs was starkly indicated by one of the leading SRH donors:

“My battle here in this office is not to let HIV cloud everything – yes, it’s an important issue, but abortion and malaria kill more people here than HIV.” (SRH donor, 2003)

The other critical issue is funding. The SWAp and changes in Ministry financing and reporting mean that it is virtually impossible to disaggregate SRH costs and spending (GMOH 2003; IPPF/DSW 2003). What we can say is that there are absolute deficiencies in SWAp/government funding and the prospects of moving from a sector-wide funding basket to full budget support (donors financing direct to the treasury) caused alarm among many:

“All funding to districts has decreased – we are getting about 10% of what we previously got. So the programmes have suffered.” (District Director, 2003)

“We have annual plans of action which break down into quarterly plans, but we are not able to follow them because the funds don’t come in time. It is now [mid June] that I have only just had the first and second quarter disbursements, which is only about one-tenth of what we requested. The only way we can continue activities in the first 6 months is if we have donor funds left – moving to budget support will cripple the system.” (Regional MOH official, 2003)
And from others a more pragmatic view:

“If we get the processes right and things are flowing how they are supposed to flow, then it makes sense to channel money centrally – but then it assumes all allocation procedures, etc., are perfect, but it doesn’t happen that way so the earmarked funds are still useful. They should continue to be allocated for some time.” (Senior regional MOH official, 2003)

There is a need to ensure that process measures reflect key needs both at national level (in goals and guidelines) and at district level (in facilities and resources). From this review it appears that process measures tend to predominantly reflect safe motherhood and HIV rather than the issues we suggest are equally, or more, important: adolescent reproductive health, family planning and safe abortion. Further, the limited funding available through the SWAp, coupled with severe and continuing constraints in the government’s financial disbursement processes, mean that many districts are still forced to rely on earmarked donor funds to implement their basic plans. This suggests the need for some incorporation of targeted programme funding within the sector-wide programme.

**Political measures: commitment to the problem**

Finally, we have seen that while direct measures suggest a need for focus on adolescent reproductive health (especially access to contraceptives) and safe abortion services, the process measures are more weighted towards HIV and safe motherhood activities. These can be explained by the level and nature of political commitment.

We have noted, throughout this paper, the ongoing bias of the government and SWAp donors, and to some extent the SRH donors, towards the Millennium Development Goals of (reducing) HIV and maternal mortality. While there are real maternal health issues to be addressed in Ghana, and the political safety it is assured through its presence in the Millennium Development Goals is to be welcomed, the dominance of HIV, especially expensive treatment aspects, is not so welcome. HIV prevalence is currently relatively low, suggesting a need for preventive rather than treatment interventions; moreover, the policy favour currently afforded HIV/AIDS tends to obscure the family planning and wider reproductive health goals that are critical for Ghana to improve SRH and the status of women (and through them reduce HIV):

“No, we cannot take the risk that something goes wrong in the country because of the AIDS. The SWAp is being diverted to focus on the disease.” (District Director, 2003)

“Reproductive health activities are so quiet you don’t see them – they yield fruit in 5 years, so it is difficult to ignore issues that make political noise . . . Our priorities are determined by politics and funding . . . HIV and disease control activities like polio are the ones getting funding. We are spending disproportionate amounts on these relative to gains. Reproductive health should be the soul of the programme. We need to make priorities clear.” (District Director, 2003)

The influence of politics in determining priorities at a particular time is explored in detail by Reichenbach, who shows how breast cancer in Ghana was taken up as an issue in the mid-1990s because of the involvement of high level political figures, at a time when cervical cancer was actually more prevalent and had more cost-effective screening and treatments available (Reichenbach 2002). Similarly, it would appear now that HIV has gained significant political ‘cool’ among Millennium Development Goal and SWAp donors at the expense of more controversial issues like adolescent contraceptive services and safe abortion, despite evidence that these are equally pressing SRH needs in Ghana at the present time than HIV. Particularly damaging is the right-wing stance of the present United States administration, which is now impeding the activities of USAID, arguably Ghana’s most powerful SRH advocate, in precisely these areas of need.

A number of research institutions and NGOs are addressing wider SRH issues, like female genital mutilation, gender based violence, unsafe abortion and reproductive cancers, but their work is not widely aired and these groups are traditionally little involved in advocacy. As a leading SRH donor points out:

“You really need an advocate for reproductive health in this process . . . At every opportunity you have to say, ‘what about family planning?’ We need to network to get people to take up reproductive health.” (SRH donor, 2003)

Political measures are somewhat intangible and therefore often ignored (Reichenbach 2002). Nevertheless, it is these that often explain the discrepancy between the apparent empirical needs (direct measures) and the actual process activities of goals formulation, training and resource allocation. Political will of donors and powerful national bodies is critical for securing committed action on an issue. The power of HIV and other quantifiable, clinical, disease-oriented interventions overshadows the ‘quiet’, long-term, health-oriented goals of SRH. If resource allocation and priority-setting mechanisms of donors and governments are not to be swayed by current political trends, but are to keep focused on real programme needs, advocacy by SRH actors during priority-setting negotiations is of paramount importance.

**Conclusions**

The development of the health sector reforms in Ghana was driven by a small group of key actors. Priority setting involved the basic ranking of diseases and ad hoc, iterative negotiations with interested stakeholders who did not usually include representatives of technical programmes. SRH actors, the focus of this study, were involved in an inconsistent manner in these negotiation processes, neither being invited to be part of detailed formulation meetings nor often
demanding to be invited. This lack of involvement by SRH actors in reform negotiations was partly because of a desire to safeguard the relative independence of the donor-supported SRH programme from being ‘threatened’ by the sector-wide approach, but this has perpetuated a lack of awareness of the implications of reforms for the long-term functioning of the SRH programme.

In Ghana’s case it is tempting for the strong, well-functioning SRH programme to want to remain semi-independent, retaining its own earmarked funding and specialized staff cadre. There may be grounds for retaining this status quo in the short and perhaps even medium term; however, questions should be raised about the long-term sustainability of such an arrangement. We conclude that investing technical programme expertise in the development and strengthening of a well-functioning system may be a more desirable long-term goal. The involvement of technical programme specialists in negotiations on resource allocations and planning indicators is critical. Without their involvement, allocations and indicators will reflect the priorities of donors and policymakers with interest in health systems who may not understand the specialist priorities of particular programmes that are delivered through that system. The challenges for SRH, and other technical programmes, within a decentralized or SWAp-type system are how to keep their specialist needs visible within a more integrated health systems structure. Primarily this requires that SRH advocates be proactively involved in priority setting and strategic planning of systems reforms, while reform actors should be willing to incorporate flexibility and inclusiveness into their decision-making processes.

Through application of a three-fold approach to priority setting, we suggest a number of ways in which this could be achieved. SRH stakeholders should monitor and make use of data on a range of SRH needs. MOH planners can assist by ensuring adequate monitoring systems are in place and information, particularly of controversial or low-priority conditions (incomplete abortion, cervical cancer), is properly recorded. Donors can further assist by financing research in areas where small-scale research indicates there may be a national problem (e.g. unsafe abortion and maternal mortality). Priority-setting mechanisms then need to be flexible enough to regularly review key programme indicators to reflect any emerging data. Strategic system and process indicators are important and need to explicitly reflect key programme needs and goals (e.g. planning for condom procurement and distribution). Serious negotiation about incorporating targeted programme support within a broader sector-wide approach is needed; this implies ‘sector’ people taking programmes into account in their planning, and ‘programme’ people being prepared to meet and plan with sector managers. The importance of advocacy on SRH, to keep political discourse focused on SRH needs rather than political trends, cannot be under-estimated.

Finally, and perhaps most importantly, the SRH community, in collaboration with the wider development community, needs to challenge current priority-setting mechanisms and the long-held view that traditional disease-ranking and cost-effectiveness measures are necessarily the best, most accurate way to measure health priorities. As Amartya Sen has noted, the measurement of ‘poverty’ is not just a deprivation measure, but also requires some attempt of measuring conditions such as ‘voicelessness’ and ‘vulnerability’. The World Bank has tried in recent years to address these issues. In the health field, there needs to be wider recognition that traditional priority-setting tools like cost-effectiveness measures or DALYs do not adequately reflect the long-term benefits of preventive interventions such as family planning, and are therefore not an adequate reflection of holistic health sector planning needs. In response to this, there needs to be greater commitment from the international development and research communities to: (1) support multi-sector collaboration between economists, epidemiologists, social scientists and reproductive health specialists to develop better measures for the effectiveness and impact of SRH services; and (2) in the interim, accept proxies for priority-setting which may include small-scale, qualitative research data combined with priorities identified by SRH specialists. This is no easy challenge but it is the challenge facing SRH, which has difficult gender and power issues at its heart, perhaps more than any other programme.

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Accra: Ministry of Health.


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Susannah Mayhew was born in Ghana and has been involved in research with Dr Adjei and others in the Ghana Ministry of Health since 1996. She also works elsewhere in sub-Saharan Africa and in South East Asia on research projects spanning sexual and reproductive policy and rights issues and the interface between sexual and reproductive health and health sector development. She is currently a lecturer in health policy and reproductive health at the Centre for Population Studies, London School of Hygiene and Tropical Medicine.

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