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PERFORMANCE AUDIT REPORT OF THE AUDITOR-GENERAL ON GOVERNMENT EFFORTS IN REDUCING MATERNAL MORTALITY (SDG 3.1) IN GHANA

**This report has been prepared in compliance with
Article 187(2) of the 1992 Constitution of Ghana and
Section 13 (e) of the Audit Service Act, 2000 (Act 584)
for submission to Parliament in accordance with
Section 20 of Act 584**

**Johnson Akuamoah Asiedu
Auditor-General
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18 June 2026**

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TRANSMITTAL LETTER

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PERFORMANCE AUDIT REPORT OF THE AUDITOR-GENERAL ON GOVERNMENT EFFORTS IN REDUCING MATERNAL MORTALITY (SGD 3.1) IN GHANA

I have the honour, in accordance with Article 187(2) of the 1992 Constitution of Ghana and Sections 13 (e) and 16 of the Audit Service Act, 2000 (Act 584), to submit a Performance Audit Report on Government Efforts in Reducing Maternal Mortality (SDG 3.1) in Ghana.

2. Ghana is committed to reducing the maternal mortality ratio (MMR) from 377 deaths per 100,000 live births in 2010 to 125 deaths per 100,000 live births by 2030. Although maternal mortality has generally declined over the years, progress has been slow and inconsistent with the national target.

3. The Government of Ghana and development partners have implemented various maternal healthcare interventions aimed at reducing maternal deaths. However, persistent challenges – including inadequate infrastructure, shortages of skilled health personnel, and limited access to emergency obstetric care – continue to undermine the effectiveness of maternal healthcare delivery.

4. We examined the activities of the Ministry of Health (MoH) and its implementing agencies, including the Ghana Health Service, the Teaching Hospitals, and other relevant organisations, in relation to maternal healthcare service delivery. The audit was carried out in six

regions and covered the period January 2019 to December 2024, focusing on the planning, implementation, and monitoring of interventions toward achieving SDG 3.1.

5. We found that MoH collaborated with key stakeholders to plan maternal health interventions; however, some important partners were not included in the planning process. Additionally, funding arrangements to support the implementation of planned interventions were inadequate.

6. Furthermore, although MoH and its partners implemented maternal health programmes, many health facilities continued to face challenges such as limited space and delivery beds, unreliable electricity and water supply, lack of essential equipment and supplies, and shortages of skilled staff. These constraints negatively affected the performance of the maternal healthcare delivery system and slowed progress toward reducing maternal deaths.

7. We also noted that MoH and the Ghana Health Service established systems to monitor and report on maternal health interventions, but inefficiencies, inconsistencies, and gaps in data management limited the usefulness of the information generated.

8. We have made recommendations to the Ministry of Health, the details of which are contained in the report, to strengthen maternal healthcare delivery and contribute to reducing maternal mortality in Ghana.



JOHNSON AKUAMOAH ASIEDU
AUDITOR-GENERAL

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ABBREVIATIONS

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CCTH	Cape Coast Teaching Hospital
CHAG	Christian Health Association of Ghana
CHOs	Community Health Officers
CHPS	Community-based Health Planning and Services
CSOs	Civil Society Organisations
CTG	Cardiotocograph
DHIMS	District Health Information Management System
DHS	Demographic and Health Surveys
EMRS	Electronic Medical Record System
EmONC	Emergency Obstetric Newborn Care
FHD	Family Health Division
FMHCP	Free Maternal Health Care Policy
GEHIP	Ghana Essential Health Intervention
GES	Ghana Education Service
GHS	Ghana Health Service
GMA	Ghana Medical Association
GoG	Government of Ghana
GSS	Ghana Statistical Service
HoTH	Ho Teaching Hospital
IGF	Internally Generated Fund

IDI	INTOSAI Development Initiatives
ISSAIs	International Standards of Supreme Audit Institutions
INTOSAI	International Organisation of Supreme Audit Institutions
JICA	Japan International Cooperation Agency
KATH	Komfo Anokye Teaching Hospital
KEEA	Komenda Edina Eguafo Aberim
LEAP	Livelihood Empowerment Against Poverty
LNOB	Leaving No One Behind
MDAs	Ministries, Departments and Agencies
MMDAs	Metropolitan, Municipal and District Assemblies
MoH	Ministry of Health
MoE	Ministry of Education
MoFEP	Ministry of Finance and Economic Planning
MoGCSP	Ministry of Gender, Children and Social Protection
MLGCRA	Ministry of Local Government, Chieftaincy and Religious Affairs
MMR	Maternal Mortality Rate
MPDSR	Maternal and Perinatal Death Surveillance and Response
MTDP	Medium Term Development Plan
MWHWR	Ministry for Works, Housing and Water Resources
NDPC	National Development Planning Commission
NHIS	National Health Insurance Scheme
PPAG	Planned Parenthood Association of Ghana
PPH	Postpartum Haemorrhage
PPME	Policy, Planning, Monitoring and Evaluation

RCCs	Regional Coordinating Councils
SDG	Sustainable Development Goals
SHEP	School Health Education Programme
TBAs	Traditional Birth Attendants
TTH	Tamale Teaching Hospital
UCC	University of Cape Coast
UER	Upper East Region
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VNR	Voluntary National Review
WHO	World Health Organisation

EXECUTIVE SUMMARY

Ghana is committed to reducing its maternal mortality ratio (MMR) from 377 deaths per 100,000 live births in 2010 to 125 deaths per 100,000 live births by 2030. Although maternal mortality has generally declined, progress has been slow and inconsistent, with MMR remaining above 200 deaths per 100,000 live births over the past decade.

2. The World Health Organisation (WHO) defines maternal mortality as the death of a woman during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy.

3. To promote sustainable healthcare delivery, the Government of Ghana and development partners implemented several maternal health interventions, including the provision of medical equipment and financial support to strengthen service delivery across the regions. Despite these efforts, persistent challenges continue to undermine maternal health outcomes in Ghana. These include inadequate healthcare infrastructure, shortages of skilled health personnel, delays in accessing emergency obstetric care, disparities between urban and rural health services, and limited coordination and monitoring of interventions.

What we did

4. We examined how the Ministry of Health (MOH) planned, implemented, and monitored interventions aimed at achieving SDG 3.1 during the period 2018-2024, focusing on:

i. Planning

(a) Whether MoH, its agencies, and key stakeholders adequately planned maternal health interventions aimed at reducing maternal mortality,

(b) Whether sustainable funding arrangements existed to support the implementation of maternal health interventions.

ii. Implementation

The extent to which maternal health interventions – such as the Free Maternal Care Policy, emergency obstetric services, and skilled birth attendance – were effectively implemented.

iii. Monitoring

The adequacy of the monitoring framework for tracking progress and generating reliable data on maternal mortality reduction.

What we found

Planning of Maternal Healthcare Interventions

5. MoH collaborated with key stakeholders in planning maternal health interventions. However, some relevant stakeholders were not included in the planning process. In addition, funding arrangements to sustain maternal healthcare interventions were inadequate.

Recommendation

6. We recommended that MoH should:

- a. Conduct a comprehensive stakeholder analysis to identify and involve all relevant stakeholders – including Ghana Water Company Limited, Ministry of Roads and Highways, Drivers' Unions, Ministry of Energy, and others – in planning maternal health interventions; and
- b. Establish a sustainable funding mechanism and create a dedicated budget line for maternal health interventions.

Implementing Maternal Health Interventions

7. The Ministry of Health and its agencies collaborated with stakeholders to implement planned maternal health interventions.

However, significant gaps remained at the facility level, including:

- inadequate infrastructure (limited space and insufficient delivery beds);
- unreliable electricity and water supply;
- inadequate equipment (foetal dopplers, CTG machines, BP apparatus, ultrasound scanners, etc.);
- shortages of essential consumables, medications, and blood products; and
- inadequate numbers of skilled personnel, particularly obstetricians and gynaecologists.

8. These deficiencies undermined Ghana's Leave No One Behind (LNOB) agenda and slowed progress toward reducing maternal mortality.

Recommendations

9. We recommended that MoH management should:

- Collaborate with relevant ministries and agencies to provide adequate, disability-friendly infrastructure and essential amenities across all levels of healthcare facilities; and
- Strengthen supply chain systems to ensure continuous availability of essential drugs, consumables, and prescribed equipment, with priority given to rural health facilities and CHPS compounds.

Monitoring and reporting progress on SDG 3.1 healthcare interventions

10. MoH and the Ghana Health Service (GHS) established a monitoring framework to collect, analyse, and report data on maternal health interventions. However, inefficiencies, inconsistencies, and inadequate data disaggregation affected the effectiveness of the monitoring systems.

Recommendations

11. We recommended that MoH and GHS should:

- Review the monitoring framework for maternal healthcare delivery;
- Standardise monitoring indicators across all data collection systems;
- Harmonise the implementation of monitoring systems; and
- Conduct capacity-needs assessments to address challenges related to ICT infrastructure and staff capacity, particularly at lower-level facilities.

CHAPTER ONE

Introduction

1.1 Reason for the audit

According to the World Health Organisation (WHO), maternal mortality is the death that occurs during pregnancy or within 42 days of the end of pregnancy, regardless of the location and duration of the pregnancy¹.

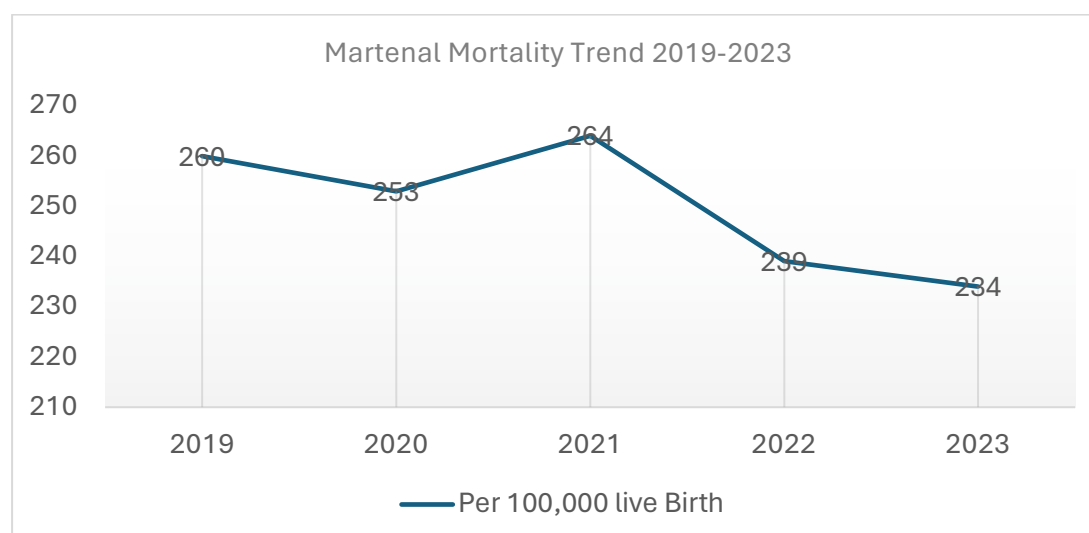
2. Signing onto the Sustainable Development Goals (SDG), the country's average maternal mortality ratio (MMR) over the period 2010 to 2015 ranged from 377 to 339 per 100,000 live births². The Sustainable Development Goal 3, target 3.1, aims to reduce maternal mortality to a global target of 70 deaths per 100,000 live births by 2030. Upon signing onto the SDGs, Ghana's commitment was therefore to reduce its maternal mortality ratio by one-third of the 2010 rate, from 377 to 125 deaths per 100,000 live births.

3. Maternal mortality generally declined from 2019 to 2023 (260 – 234) despite some fluctuations. After a slight reduction between 2019 and 2020, the ratio increased in 2021, indicating a temporary setback, as shown in Figure 1.

¹ <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622>

² <https://www.macrotrends.net/global-metrics/countries/gha/ghana/maternal-mortality-rate>

Figure 1: Ghana's maternal mortality ratio (MMR) from 2019–2023



4. To achieve the national target of 125 deaths per 100,000 live births by 2030, the Government of Ghana has invested in various maternal-related interventions. For instance, from 2019 to 2023, the Government of Ghana, in partnership with the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organisation (WHO), invested approximately GH¢159 million into the Ghana Essential Health Interventions Programme (GEHIP). This intervention aimed to foster effective community engagement at district and sub-district levels to improve maternal and child health outcomes³.

5. In 2024, the Japan International Cooperation Agency (JICA) Ghana, through the Ghana Health Service (GHS), donated equipment valued at US\$150,000 to selected health facilities in the Greater Accra, Ashanti, Volta, and Northern Regions to enhance maternal healthcare services. In addition, the United States Agency for International Development (USAID) committed US\$45 million (GH¢700 million) to improve, among other things, maternal health in Ghana⁴.

³ <https://www.countdown2030.org/publications/analysis-of-reproductive-maternal-newborn-child-and-adolescent-health-indicators-2019-2023-2>

⁴ <https://gh.usembassy.gov/u-s-commits-45-million-to-improve-maternal-newborn-and-child-health-in-ghana/>

6. Despite these interventions, the annual maternal mortality rate remained high. From our trend analysis over the past fifteen years, Ghana's mortality rate has remained above 200 deaths per 100,000 live births. If this trend continues, Ghana is unlikely to achieve its target of 125 deaths per 100,000 live births by 2030. As a result, the Auditor-General, in line with Section 13 (e) of the Audit Service Act, 2000 (Act 584), commissioned a Performance Audit on the Government's efforts in reducing maternal mortality (SDG 3.1).

1.2 Purpose

7. The purpose of the audit was to examine how the Government is planning, implementing, and monitoring maternal health interventions through the Ministry of Health (MoH) to achieve Ghana's SDG target 3.1.

1.3 Scope

8. We examined the activities of the MoH and its implementing agencies, such as GHS and the Teaching Hospitals, in relation to maternal healthcare service delivery aimed at reducing maternal mortality. We also examined the activities of other relevant stakeholders, including the National Development Planning Commission (NDPC), Ghana Statistical Service (GSS), Ministry of Gender, Children and Social Protection (MGCSP), Ministry of Local Government, Chieftaincy and Religious Affairs (MLGCRA), and Christian Health Association of Ghana (CHAG) facilities. This was because, from our stakeholder analysis, these institutions are major actors involved in the implementation of SDG 3.1 interventions. We conducted the audit in the Greater Accra, Upper East, Northern, Ashanti, Central, and Volta Regions and covered the period January 2019 to December 2024.

1.4 Audit Objective

9. The audit objective was to determine whether the Ministry of Health's planning, implementation, and monitoring of maternal healthcare interventions, in collaboration with relevant stakeholders have contributed toward achieving Ghana's target of 125 deaths per 100,000 live births.

1.5 Specific Objectives

10. The specific objectives were to determine whether the MoH:
- i. (a) and its agencies, as well as other key stakeholders, adequately planned maternal healthcare interventions aimed at reducing maternal mortality;
(b) had put in place sustainable funding arrangements to implement maternal health interventions;
 - ii. ensured effective implementation of the maternal healthcare interventions such as the Free Maternal Care Policy, emergency obstetric services, and skilled birth attendance; and
 - iii. implemented a monitoring framework that ensured effective tracking and provided reliable data on progress made towards reducing maternal mortality.

1.6 Audit Questions and Assessment Criteria

The audit questions and the assessment criteria are presented in Table 1:

Table 1: Audit Questions and Assessment Criteria

No.	Audit Question	Assessment Criteria	Source
1.	a. To what extent did MoH, its agencies, and other key stakeholders plan maternal healthcare interventions? b. To what extent has MoH put in place sustainable funding arrangements to implement maternal health interventions?	MoH is required to collaborate with its agencies and other key stakeholders to plan strategies and interventions aimed at reducing maternal mortality. We expected the MoH to have in place a sustainable funding arrangement to implement maternal health interventions.	<i>National Health Policy (2020) (Section 4.4)</i> <i>2021 MoH Guidelines</i> <i>Ghana Health Sector Medium Term Development Plan (2022 – 2025)</i> <i>Public Financial Management Act, 2016 (Act 921), and Best Practices</i>
2.	To what extent did MoH ensure equitable implementation of maternal healthcare interventions?	MDAs/MMDAs are to collaborate with MoH to utilise advantages and resources such as networks of National, Regional, and District offices in the implementation of their programmes.	<i>Guideline for preparing sector and district medium-term development plans (2018-2021; 2022-2025)</i> <i>National Development Planning (System) Act, 1994 (Act 480)</i> <i>NDPC Policy Coordination Framework.</i> <i>MoH Sector-Wide Approach Framework;</i> <i>Health Sector Working Group Terms of Reference</i>

No.	Audit Question	Assessment Criteria	Source
3.	To what extent did MoH implement a monitoring framework that ensured effective tracking to provide reliable data on progress made towards reducing maternal mortality?	MoH, NDPC and GSS are expected to monitor and report on the progress of implemented programmes and activities towards reducing maternal mortality.	<i>MoH Monitoring & Evaluation Framework (Section 6.2)</i> <i>NDPC</i> Monitoring and Evaluation Policy (2024), Chapter 6.2 <i>National Health Policy (Section 4.6)</i>

1.7 Audit Standards

11. We carried out the audit in accordance with the International Standards of Supreme Audit Institutions (ISSAIs) relevant to Performance Auditing. These are: ISSAI 300 – Fundamental Principles of Performance Auditing, ISSAI 3000 – Performance Audit Standards, and the INTOSAI Development Initiatives (IDI) SDG Audit Model (ISAM).

12. These standards require that the audit be planned and performed to obtain sufficient and appropriate evidence to provide a reasonable basis to support the findings and conclusions and answer the audit objectives.

1.8 Sampling

13. The audit was conducted at the National Development Planning Commission (NDPC), Ministry of Health (MoH), Ministry of Finance (MoF), Ghana Health Service (GHS), and relevant MMDAs. The team visited selected hospitals in the Greater Accra Region to understand how maternal health interventions are implemented and monitored; the Upper East and Northern Regions due to difficulties in accessing maternal healthcare and inadequate skilled personnel; the Ashanti

Region, due to its high maternal mortality rate, compared with the steady decline in the Central and Volta Regions.

14. We visited all levels of health facilities (21): Teaching, Regional, District, and CHAG facilities, as well as CHPS zones in the selected regions and districts, to ascertain how maternal health care interventions are implemented and monitored.

1.9 Methodology

15. We used document review, interviews, inspections, and observations to collect data for the audit.

i. Documents review

16. We reviewed documents to understand the efforts MoH had put in place with regard to planning, implementing, and monitoring of SDG 3.1 interventions to reduce maternal mortality. We reviewed the Medium-Term National Development Policy Framework to understand the strategies and programmes adopted to achieve the target and how they were integrated into national, regional, and district plans. We also reviewed documents to understand how agencies collaborated to plan, implement, and monitor programmes and activities towards achieving SDG 3.1. **Appendix 1** presents the list of documents and the reasons for the review.

ii. Interviews

17. We interviewed officers from NDPC (3), MoH (3), GSS (4), CSO (3), and GHS (29), including Regional Health Directorates involved in the planning, implementation, and monitoring of maternal health programmes and activities. We also interviewed obstetricians (15), general physicians (5), midwives (50), and traditional leaders (21) to ascertain how maternal health programmes and activities at regional,

district, and peripheral facilities were implemented and monitored. Pregnant women (30) were also interviewed to ascertain how they access maternal healthcare. Additionally, we interacted with traditional leaders to find out how they encourage pregnant women to attend antenatal (ANC) clinics consistently and mobilise family and husbands to support women during pregnancy. We interacted with the Drivers Union (GPTRU) to ascertain how they transport pregnant women to health facilities. Details of interviewees and their reasons are presented in **Appendix 2.**

iii. Inspection/Observation

18. We visited 30 healthcare facilities in the selected regions and inspected basic tools and equipment used for maternal healthcare to determine their condition and whether they were fit for purpose. These facilities included four Teaching Hospitals, five Regional Hospitals, five District Hospitals, six Health Centres, and 10 CHPS Compounds. We also observed how maternal health activities were carried out at District Hospitals, Health Centres, and CHPS Compounds to understand how the implementation of the activities aimed at reducing maternal mortality had been carried out. The list of selected health facilities inspected is provided in **Appendix 3.**

CHAPTER TWO

Description of Government's effort in reducing Maternal Mortality

2.1 Historical background

19. The fight against maternal mortality dates back to the early 2000s. To reduce maternal mortality, the Government of Ghana (GoG) introduced the Free Maternal Health Care Policy (FMHCP) in 2003 to increase access to maternal healthcare by reducing financial barriers associated with accessing maternal health services. In 2008, the FMHCP was integrated into the already existing National Health Insurance Scheme (NHIS), established in 2005.

20. The FMHCP under the NHIS provides a full maternal benefit package covering a pregnant woman for one year. The package includes six free antenatal care visits, emergency outpatient visits, free facility delivery, including all complicated deliveries, two postnatal visits within six weeks, and waiving the premium and registration fees under the NHIS for the pregnant woman. It also covers the newborn baby for the first three months of life.

21. In 2011, GHS introduced the Skilled Birth Attendance and Emergency Obstetric Newborn Care (EmONC) strategy, aimed at training and deploying midwives, nurses, and community health officers to ensure skilled birth attendance. It also sought to strengthen health facilities with emergency neonatal care services, including blood banks and neonatal intensive care units.

22. Ghana signed onto the 2030 Agenda for Sustainable Development in September 2015 and committed to implementing the Sustainable Development Goals (SDGs), which call for a holistic approach to reducing maternal mortality.

23. The 2022–2025 Health Sector Medium-Term Development Plan indicates that, following Ghana’s adoption of the SDGs, the Ministry of Health (MoH) and its agencies spearheaded initiatives such as strengthening primary healthcare, enhancing maternal health through programmes like the Safe Motherhood Initiative, Community-Based Health Planning and Services (CHPS) Expansions, National Health Insurance Scheme (NHIS), Free Maternal Care, promoting Adolescent Sexual and Reproductive Health (ASRH), and implementing national strategies including the Universal Health Coverage (UHC) Roadmap and Health Financing Strategy. These efforts aim to achieve Universal Health Coverage (UHC) and SDG 3 (Good Health and Well-being) by leveraging partnerships and aligning national plans to deliver integrated, accessible, and quality healthcare services.

2.2 Mandate of MoH

i. Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525)

24. The Ghana Health Service Act, 1996 (Act 525) mandates the Service to provide accessible and comprehensive health services to the people of Ghana.

2.3 Vision

25. To have a healthy and productive population for national development. The health sector aims to continuously improve the health and well-being of Ghanaians by developing a better-coordinated health system that places patients and communities at the centre of quality care.

2.4 Mission

26. To contribute to socio-economic development and the development of a local health industry by promoting health and vitality through access to quality health services for all people in the country, using motivated personnel.

2.5 Functions in Relation to Maternal Health

27. The MoH performs several core functions to achieve its maternal health objectives, often in collaboration with the Ghana Health Service (GHS), by:

- Formulating and coordinating the implementation of sector policies and programmes, such as the *Safe Motherhood Initiative*, the *Free Maternal Care Policy*, and the *National Maternal and Newborn Health Quality of Care Strategy*;
- Setting standards for the delivery of healthcare and providing a regulatory framework for facilities and health professionals, including midwives and Community Health Officers (CHOs),
- Mobilising and allocating financial and human resources (including mobilising funding through the Government, Health Insurance, and International Partners) to all healthcare delivery agencies;
- Providing strategic direction for health services, including implementing and supporting the Community-based Health Planning and Services (CHPS) programme to bridge equity gaps in access, especially in rural areas;
- Monitoring and evaluating the delivery of health services to ensure effectiveness, which includes data gathering, maternal death audits, and using evidence to inform policy and resource allocation;

- Providing a framework for the development and management of human resources for health, including the training and capacity-building of community health officers (CHOs) and midwives to manage pregnancy complications and provide quality antenatal and postnatal care; and
- Promoting community and family activities and values that improve reproductive and maternal health, and engaging women, families, and communities in their care.

2.6 Other Related Laws and Regulations

ii. National Development Planning (System) Act, 1994 (Act 480)

28. Act 480 mandates NDPC to act as the coordinating body of the decentralised development planning system in Ghana.

iii. National Development Planning (System) Regulation, 2016 (L.I. 2232)

29. This regulation mandates MDAs and MMDAs to prepare and implement district development plans based on the National Development Planning Commission's development policy framework and guidelines.

iv. Local Governance Act, 2016 (Act 936)

30. Sections 78 and 79 of the Local Governance Act, 2016 (Act 936), mandate Local Assemblies to provide basic infrastructure and municipal works and services.

2.7 Funding for SDG Target 3.1

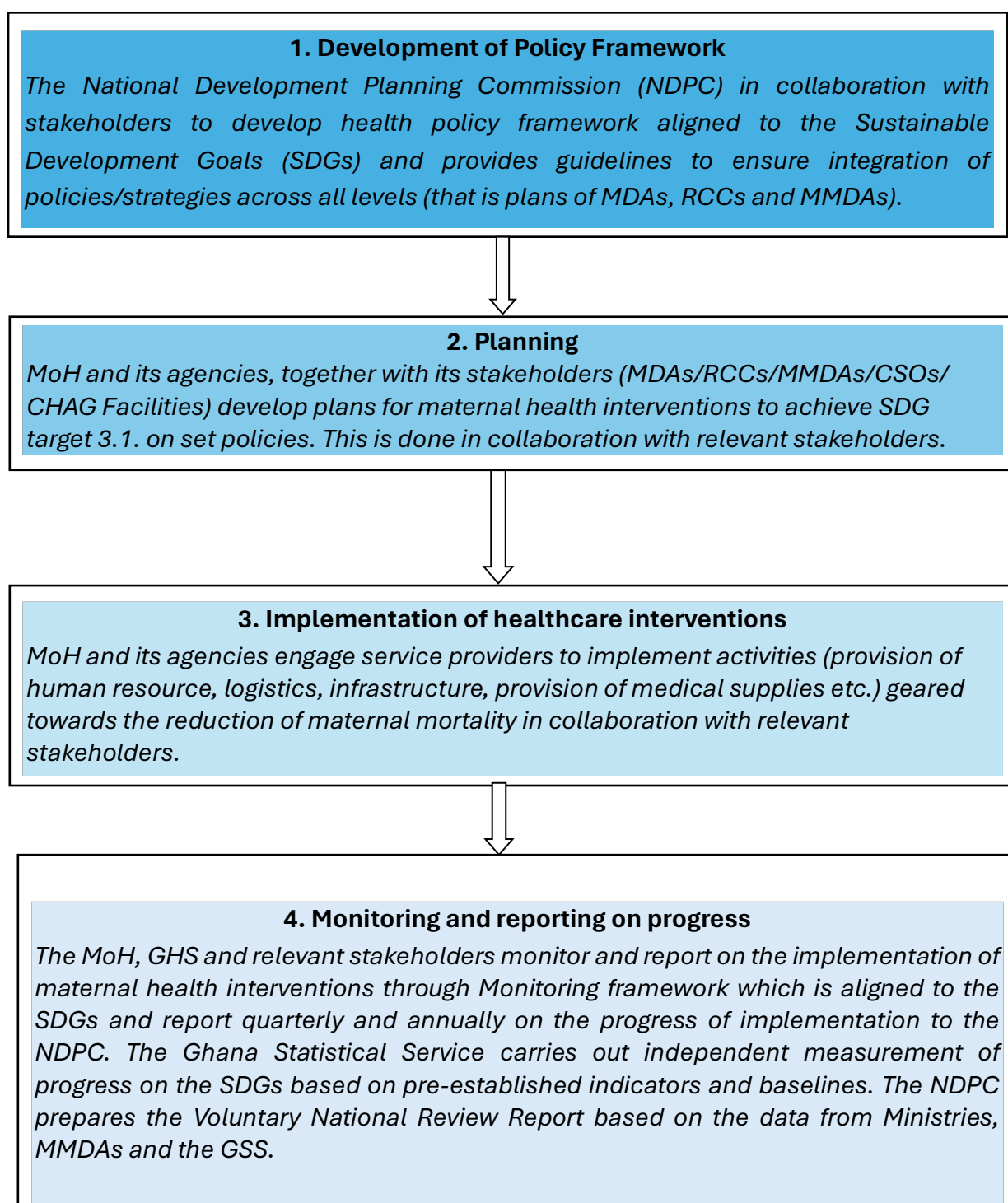
31. The Ministry of Finance is responsible for mobilising and allocating resources for the implementation of the SDGs in Ghana. The Consolidated Fund is the main source of funding for the SDGs activities. The MoH/GHS, through their internally generated funds, and donors provide additional funding for implementing SDG 3.1.

32. In 2019, the Government of Ghana released GH¢4.1 billion to implement Goal 3. In 2021, the Government released approximately GH¢5.3 billion to implement nine targets under the Goal, including target 3.1. Additionally, in 2022, the government released approximately GH¢7.3 million under Goal 3, which included target 3.1. However, the budgets and expenditure for the period under review (2019 to 2024) and releases for 2023 and 2024 were not made available to the team.

2.8 Process Description for Planning, Implementation, and Monitoring of SDG Target 3.1

33. This section presents the system description for implementing the Sustainable Development Goal (SDG) Target 3.1. It shows how the National Development Planning Commission (NDPC) develops guidelines for Ministries, Departments and Agencies (MDAs) and Metropolitan, Municipal and District Assemblies (MMDAs) to implement the SDG Target 3.1 as well as report on its implementation, as shown in Figure 2. The audit focused on the planning, implementation, and monitoring of activities to achieve SDG target 3.1. A detailed description of the process is shown in Appendix 4.

Figure 2: Process diagram for planning, implementation, and monitoring of the SDG Target 3.1



Source: Sustainable Development Goals Indicator Baseline Report, June 2018 / Director General (NDPC)

2.9 Key Players and their Responsibilities

34. The roles and responsibilities of key players involved in the implementation of SDG target 3.1 are shown in Table 2.

Table 2: Key Players and their Responsibilities (Group the stakeholders)

Key Player	Responsibility
National Development Planning Commission	-Provides guidelines to the MMDAs to facilitate the preparation of their development plans. -Ensures that MMDAs align their plans with the SDGs. -Approves and certifies the MTDPs of MMDAs. -Follows up on the implementation of the SDGs. -Harmonises and produces reports at the national level. -Coordinates the activities of all sectors involved in the implementation of SDG targets.
Ministry of Finance	-Allocates and releases funds for the implementation of SDG 3.1. -Collaborates with MoH/GHS to implement strategies that impact maternal health services.
Ghana Health Service (GHS)	-Implements policies and programmes, including antenatal, skilled birth attendants, and postnatal care across facilities, and builds the capacity of health workers to achieve maternal mortality.
Teaching Hospitals	-Serve as a tertiary referral centre and play a critical role in maternal health care. -Provide specialised obstetric and gynaecological services for complicated maternal cases that cannot be managed at lower-level facilities.
CHAG Facilities	-These facilities complement government health services, especially in underserved and rural areas. -Provide essential maternal health services such as antenatal care, skilled birth attendance, and postnatal care. -Provide emergency obstetric services where public facilities are limited. -Collaborate with MoH and GHS to implement maternal health interventions and report progress towards SDG 3.1.
Ministry of Local Government, Chieftaincy and Religious Affairs	-Support the establishment of CHPS and the deployment of community health nurses/midwives to rural and underserved areas
Pregnant Women	-Seek and use maternal health services, work with health providers to ensure safe pregnancy and childbirth.
Community Members /Traditional Leaders	-Advocate for maternal healthcare services and provide culturally sensitive support during pregnancy.
Civil Society Organisations (SEND GHANA, One Love & PPAG)	-Collaborate with all other stakeholders to implement, monitor, and report on interventions to reduce maternal mortality.
Ghana Statistical Service (GSS)	-Collects, analyses, and disseminates data on maternal health and mortality through surveys and census
Ministry of Energy	-Provides critical energy needs of healthcare facilities and reduces environmental health risk for women.
Ghana Water Company Limited	-Provides access to running water at health facilities for sanitising, cleaning, and a safe environment for childbirth.

Key Player	Responsibility
Drivers Unions	-Provide transportation services for pregnant women to health facilities without demanding immediate payment especially in emergency situations.
Ministry of Roads and Highways	-Provides good road infrastructure to reduce transport time to health facilities for obstetric complications.
Ghana Education Service	-Implements the school health education programme (SHEP) to provide health education in schools, including topics on sexual and reproductive health. -Collaborates with the MoH to integrate health education into the pre-tertiary curriculum, aiming to equip students with knowledge on reproductive health and preventive practices. -Conducts health education initiatives such as nutrition, sanitation, and reproductive health campaigns, which indirectly support maternal health by promoting early awareness and health behaviours among adolescents.
Ministry of Gender and Social Protection	-Promotes gender equality and ensures social protection for vulnerable and excluded groups, including pregnant women in deprived communities. -Supports maternal health by advocating for policies and programs that address the needs of women and girls, particularly those at risk of maternal complications due to poverty or social exclusion. -Works with other stakeholders to implement interventions that reduce maternal mortality and improve access to maternal health services for disadvantaged populations.

CHAPTER THREE

Findings, Conclusions, and Recommendations

Introduction

35. This chapter presents the findings, conclusions, and recommendations following our assessment of the government's efforts in reducing maternal mortality to achieve SDG 3.1. The findings are discussed under the following headings:

- Planning maternal healthcare interventions,
- Implementation of maternal healthcare interventions, and
- Monitoring and reporting progress on maternal healthcare interventions.

3.1 Planning of Maternal Healthcare Interventions

36. The 2020 National Health Policy and the 2021 MoH Guidelines require the Ministry of Health (MoH) to collaborate with its agencies and other key stakeholders to plan strategies and interventions aimed at reducing maternal mortality and ensure inclusivity and shared ownership. In line with this, we expected the MoH to conduct stakeholder analysis to identify and collaborate with relevant stakeholders in planning maternal healthcare interventions.

37. We found that MoH identified and involved key stakeholders in the planning of healthcare interventions. The key stakeholders included government agencies such as the Ministries of Finance, Education, Local Government, Gender and Development Partners including World Health Organisation (WHO), United Nations International Children's Emergency Fund (UNICEF), United States Agency for International Development (USAID), World Bank, United Nations Population Fund (UNFPA), Civil Society Organisations (CSOs), Christian Health Association of Ghana (CHAG), Non-Governmental Organisations

(NGOs), Specialists, Consultants, Professional Bodies as well as Vulnerable Groups⁵. Review of correspondence, Holistic Assessment Reports, and minutes of meeting showed that MoH engaged the stakeholders through community engagement, workshops, and technical working groups, and solicited their inputs on proposed maternal healthcare interventions.

38. However, we noted that the Ministry of Energy, the Ministry of Roads and Highways, Drivers Unions, and Ghana Water Company Limited were not involved in the engagement. Health facilities require a constant supply of water and electricity to administer maternal healthcare services. Also, there is a need for good motorable roads and driver education to aid the safe transportation of pregnant women.

39. Table 3 provides excerpts of the MoH's engagements with some of the key stakeholders during their planning of maternal health interventions within the audit period. Details are shown in Appendix 5.

⁵ **Vulnerable Group**

Persons who are disadvantaged because they live in hard-to-reach communities, the youth (teenagers), people with low or no education, and persons with disabilities (PWD)

Table 3: MoH engagement with key stakeholders during planning of healthcare intervention

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagemen ts
2019	National Maternal Child Health and Nutrition. Focused on reducing maternal deaths and child mortality by improving the quality of maternal, newborn and child health services; and addressed anaemia in pregnant women and children through improved interventions.	Accra	Health Sector Development Partners, private health care providers, representatives from MoH, Gender and Education Ministries, District Health Teams, Donor's Partners	Reviewed the national situation for RMNCAH & nutrition, including examination of existing services and persistent gaps in policy and implementation.	
	Stakeholder meeting on nurturing care framework – for early childhood and maternal health. Awareness creation, building consensus and planning practical steps to implement the Nurturing Care Framework in Ghana's maternal, newborn and early childhood programmes.	Accra	Health Sector Development Partners, doctors, midwives, private health care providers, representatives from MoH, district health teams, donor partners, and the vulnerable	To raise awareness about nourishing care and early childhood development among policymakers, frontline health workers and caregivers.	
2020	Nil	Due to COVID 19 pandemic, there was no meeting (engagement?)			

Source: MoH's correspondence with key stakeholders

40. In addition, we found that MoH, in collaboration with donors, CSOs, and other partners, conducted joint strategic planning sessions such as the Health Sector Medium-Term development plan and annual

programme reviews, where technical and policy discussions were held through health sector working groups. The MoH used these sessions to identify key health priorities, set performance indicators and targets, and align partner support with national health objectives. These participatory processes ensured that health sector strategies, including maternal health issues, were harmonised with national development frameworks in line with SDG 3.1.

41. We further noted that MoH engagements with the stakeholders resulted in policies that set broad objectives to increase access to quality and essential health services; reduce avoidable maternal deaths; and strengthen emergency and routine maternal health care. Examples of such policies included the National Health Policy (2020), the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (2020-2025), and the Health Sector Medium-Term Development Plan (2022-2025).

42. Our review of maternal health protocols at the various health facilities we visited showed that the maternal health policies developed at the national level were integrated into management plans of healthcare facilities across Teaching Hospitals, Regional, Municipal, District, Health Centres, and CHPS Compounds. Appendix 6 provides details on maternal healthcare services at the various facility levels.

43. To sustain the interventions, there is a need for a sustainable source of funding and a specific budget line to undertake the planned activities and programmes. We therefore expect the MoH, as part of its planning, to establish funding arrangements to sustain maternal healthcare interventions. However, we noted from review of MoH budgets and interviews with officials that there was no dedicated funding arrangement to undertake maternal health activities. Our interaction with the Director of Finance at Ghana Health Service and

the Administrator at Ho Teaching Hospital indicated that there is no line budget specifically for maternal health activities.

44. As a result of these lapses in budgeting and funding arrangements, we noted that medication and equipment for maternal healthcare were inadequate or not readily available at some of the health facilities at the time of the audit. Table 4 provides details.

Table 4: Analysis on the availability of medication and equipment at selected health facilities because of inadequate funding (September 2025)

No	Name of Facility	Equipment	Medication
1	Tamale Municipal Hospital	Non-availability of Delivery beds and mattresses, oxygen concentrators, foetal dopplers, and an autoclave machine	
2	Bolgatanga Regional Hospital	Non-availability of Vital signs monitors, CTG machines, dopplers, drip stands, delivery beds, oxygen concentrators, ventilators, and suction machines	
3	Kumasi South Regional Hospital	Non-availability of CTG machine, foetal dopplers, BP Apparatus, vacuum aspirator machine	
4	South Suntreso Hospital	Non-availability of delivery beds, dopplers, BP apparatus, monitors, oxygen concentrator, suction machine, CTG	
5	Elmina	Non-availability of adjustable beds, foetal dopplers, mobile scanner, and CTG machine	
6	Knaville Health Centre		Inadequate medication, such as magnesium sulphate
7	Sawua Health Centre	Non-availability of the BP apparatus and thermometer	
8	Namoo Health Centre	Non-availability of delivery sets and autoclave	
9	Nayorigo CHPS		Inadequate medication such as Amoxicillin, oxytocin, and magnesium sulphate
10	Bagble Ando CHPS	Non-availability of Foetal doppler, pulse oximeter, BP apparatus, infantometer	

Source: Audit team's field inspection in September 2025

Conclusion

45. MoH collaborated with its key stakeholders in planning maternal health interventions aimed at reducing maternal mortality. However, we found that some key stakeholders were not involved in the planning process. Also, funding arrangements to sustain maternal healthcare interventions were inadequate.

Recommendation

46. We recommend that MoH should:

- a. Extensively conduct stakeholder analysis to identify and involve relevant stakeholders, including Ghana Water Company Limited, Ministry of Roads and Highways, Drivers' Unions, Ministry of Energy, and others, in the planning of maternal health interventions; and
- b. Establish a sustainable source of funding and have a specific budget line for maternal health interventions.

Management response

47. *Management has taken note of the audit recommendations.*

3.2 Implementing Maternal Health Interventions

48. The National Development Planning Commission (NDPC) guidelines for preparing sector medium-term development plan require MDAs and MMDAs to collaborate and utilise advantages and resources, such as networks of National, Regional, and District offices, in the implementation of their programmes. This provision aims to minimise gaps and avoid duplication of efforts to ensure effective use of resources in programme implementation. We expected the Ministry of Health (MoH) to take advantage of its Regional and District Health Directorates, as well as collaborate with key stakeholders, to implement the planned maternal healthcare interventions. The planned interventions are documented in the following:

- The Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (2020-2025),
- Health Sector Medium-Term Development Plan (2022-2025),
- National Safe Motherhood Service Protocol (since 2008) and
- Maternal Death Surveillance Strategy (since 2014).

49. According to the above documents, the planned interventions are the provision of:

- i. Antenatal, delivery, and postnatal services,*
- ii. Skilled personnel,*
- iii. Provision of infrastructure, and*
- iv. Community-based education.*

50. Regarding maternal healthcare delivery services, MoH is to collaborate with its agencies and stakeholders to:

- Conduct education and create awareness, identify and encourage pregnant women to attend antenatal service; and
- Provide health logistics (infrastructure, tools and equipment, consumables, and skilled personnel at these facilities).

51. We noted from reviews of MoH's Holistic Assessment Reports (2021-2024), interviews with the obstetricians and midwives, and observations that the health facilities were providing maternal healthcare services in collaboration with stakeholders.

52. The healthcare facilities we visited indicated that education and awareness creation activities were conducted. This was to educate:

- ❖ pregnant women when they visit the facility,
- ❖ families and communities during outreaches, and
- ❖ pregnant women through durbars about safe pregnancy, childbirth, and post-natal care.

53. Also, the facilities provided antenatal, delivery, and postnatal services, which included educating pregnant women on nutritional guidance, personal hygiene, danger signs, complications, and risk factors in pregnancy. These services focused on seeking timely healthcare and improved maternal well-being.

3.2.1 Provision of Health Logistics

54. The Public Health Act, 2012 (Act 851), requires the MoH to formulate policies on health infrastructure development, secure Government budget and donor funding, and approve the construction and rehabilitation of health facilities. In doing this, the MoH is to collaborate with the Ministry of Finance and Economic Planning (MoFEP) to provide well-equipped, functional, and disability-friendly infrastructure with consumables for maternal healthcare at Teaching, Regional, and District Hospitals. Also, the MoH is to collaborate with the Ministry of Local Government, Chieftaincy and Religious Affairs (MLGCRA) to ensure that health facilities at the Regional and District levels have basic amenities such as water and electricity to guarantee access to safe maternal healthcare services. Under the provision of logistics, we examined the adequacy of infrastructure, tools and equipment, and medical supplies at the healthcare facilities.

3.2.2 Infrastructure

55. We found that the Teaching, Regional, and District hospitals we visited did not have adequate infrastructure in terms of maternity wards. For instance, at the Bolgatanga Regional and Bongo District hospitals, the maternity wards were crowded, and most of the patients were lying on the floors and in the corridors to receive treatment (See Picture 1). Officials at the hospitals indicated that overcrowding contributed to infections, which were a leading cause of maternal death.

Picture 1: Patients receiving treatment on the floors and corridors of Bolgatanga Regional Hospital and Bongo District Hospital



Patients receiving treatment on the floor at Bolga Regional Hospital



Patients receiving care on the corridor at Bongo District Hospital



Patients receiving healthcare on the floor at Bolga Regional Hospital

Source: Audit team's field inspection at Upper East in August 2025

56. At the Kumasi South Hospital (Ashanti Regional Hospital), we noted from the Annual Reports and an interview with the Hospital Administrator that the facility, which serves as a Regional Hospital, had inadequate space in the maternity wards as one of its major challenges. From our inspection, we found that due to congestion at the maternity wards, the lying-in ward (where pregnant women in labour were kept until delivery) was converted into delivery rooms. According to the midwife in charge, the hospital has a 5-bed capacity delivery ward, which cannot accommodate the large numbers of pregnant women seeking healthcare at the facility.

57. We noted that the Government started the construction of a new maternity block in the year 2000 to expand the capacity of the maternity unit to improve maternal healthcare service delivery. However, at the time of the audit in September 2025, the new maternity block was not completed, and the project had stalled (See Picture 2). According to the Hospital Administrator, the non-completion of the project limited the number of admissions, as some expectant mothers had to be referred to the Komfo Anokye Teaching Hospital (KATH) to seek maternal healthcare.

Picture 2: The stalled maternity block construction project at Kumasi South Hospital



Source: Audit team's field inspection at Kumasi South Hospital in September 2025

58. At the South Suntreso Hospital, we observed that pregnant women had to be wheeled over 300 meters to the general theatre (with a 2-bed capacity), where they had to queue with other patients to undergo caesarean sections when the need arose. The Deputy Chief Nursing Officer at the maternity unit indicated that the situation often led to delays, patient discomfort, and risk of losing mothers during emergencies. We noted that there was a new gynaecology theatre under construction to provide emergency maternity services, but the project also stalled (See Picture 3).

Picture 3: The stalled gynae theatre block at South Suntreso Hospital



Source: Audit team's field inspection in September 2025

59. Again, we noted that health facilities such as Ampenyi CHPS Compound and Yamoransa Health Centre in the Central Region, Navrongo Health Centre in the Upper East Region, Nyashegu CHPS Compound and Kanvilli Health Centre in the Northern Region, did not have disability-friendly infrastructure such as ramps, rails, and safe, independent, and dignified washrooms. Pregnant women with disabilities face challenges in accessing healthcare, increasing the risk of maternal complications among these vulnerable groups.

60. At the Bongo District in the Upper-East region, we found that the district had 58 CHPS⁶ zones comprising 25 compounds⁷ and 33 pavilions⁸. We further noted that there was no constant supply of electricity, and no generator sets at any of the 58 CHPS zones to serve as backup when the national grid went off. The situation compelled

⁶ Community-based Health Planning Services (CHPS)

⁷ CHPS facility with accommodation

⁸ CHPS without accommodation

midwives to use their phones to provide light, which led to poor delivery services.

61. At the Tamale Teaching Hospital (Northern Region), Naylorigo (Upper East Region), and Bagble-Ando (Volta Region) CHPS, we found that the facilities did not have a constant water supply, and patients were compelled to bring in their own water for delivery. Some pregnant women had to go home to wash down after delivery and return to the facility. The nurses at the facilities indicated that these practices often led to infections, which contributed to complications and maternal mortality.

62. The Tamale Teaching Hospital again did not have a regular power supply. The generator set at the Obstetrics and Gynaecology department did not have an automatic switch to ensure a continuous power supply to the theatre during a power outage. According to the Head of the Obstetrics and Gynaecology department, it takes two hours to restore power as switching to the generator set had to be done manually. This puts expectant mothers in danger during delivery, especially during emergency surgeries. An extract of the challenges we identified under the provision of infrastructure is indicated in Table 5, see **Appendix 7** for details.

Table 5: Examples of infrastructure challenges at the selected health facilities (September 2025)

No	Name of Facility	Challenges identify	Effect of challenges	Source
1	Tamale Teaching Hospital (TTH)	Inadequate water and electricity supply, theatre beds, obsolete MRI and oxygen plant.	Delay in delivery service. Quality of service delivery is affected.	Head of Obst. and Gynae. at TTH
2	Ho Municipal Hospital,	ANC unit -inadequate midwives due to change in status (operating as regional hospital) Labor Unit -inadequate midwives (18 out of 22 at post) Gynaecologist/Obstetrician (2 out of 8) at post.	Midwives are overwhelmed. Quality of service delivery is affected.	Principal Nursing Officer Nursing Officer
3	South Suntreso	Inadequate infrastructure, No gynae theatre	Pregnant women had to compete with other patients for emergency surgery.	

63. With regard to collaboration, we noted that the MoH implemented the planned maternal healthcare interventions with its stakeholders. For instance, the Ministry of Education (MoE), through Ghana Education Service (GES), under the School Health Education Programme (SHEP), educated students on sexual health and improved access to information for adolescents to enable them to make informed decisions on reproductive health.

64. Again, MoH, in collaboration with the Ministry of Gender, Children, and Social Protection on the Safety Net Programme under the Livelihood Empowerment Against Poverty (LEAP), identified and provided pregnant adolescents with funding to support them in accessing essential maternal care. The funding assisted them in undergoing safe antenatal, delivery, and post-natal care to minimise the occurrence of maternal deaths. According to the management of MoH, teenagers were always vulnerable, and the collaboration was critical to

prevent them from unsafe abortions since they lacked funding to cater for themselves during pregnancy.

65. Also, we found that Development Partners designed and implemented maternal health programmes to complement the interventions of GHS. For instance, in 2023, UNFPA conducted a safe motherhood campaign aimed at improving maternal health. This provided support for every woman and adolescent girl to have access to maternal healthcare education. In the same year, the WHO/World Bank complemented other activities, such as the Human Reproduction Programme, to support expanded access to quality maternal healthcare consumables.

3.2.3 Tools and Equipment

66. We noted from our assessment of the adequacy of tools and equipment at the facilities we selected that the equipment provided by the MoH/GHS was not adequate. Our interaction with health officers at all the facilities we visited indicated that basic tools and equipment such as dopplers, cardiotocographs (CTG), delivery beds, mobile scanners, manual vacuum aspirators, and pulse oximeters, required to carry out maternal healthcare services, were inadequate.

67. Also, we noted from our review of Annual Reports and our inspection of the selected hospitals that the inadequacy of tools and equipment was a major challenge. For instance, equipment such as ultrasound machines, foetal dopplers, patient monitors, suction machines, cord clamps, BP apparatus, and autoclaves at Tamale Regional, Kumasi South, and South Suntreso Hospitals were non-functional. The Ho Teaching Hospital had five CTG machines but required 13 for labour and antenatal care; seven dopplers instead of 12; and broken-down BP apparatus, hence the use of a manual BP monitor

at the time of the audit. Table 6 gives examples of the inadequacy of tools and equipment. Details are provided in **Appendix 8**.

Table 6: Analysis on adequacy of tools and equipment

Facility	Information on Tools and Equipment	Source	Remarks
Cape Coast Teaching Hospital	Inadequate equipment such as Dialysis machines, Ventilators, anaesthesia machines, Patient monitors, Four dialysis machines are not enough for the teaching hospital.	Annual Reports Medical Director and the CEO	Pregnant women who need dialysis delay in having access.
Elmina Polyclinic Elmina Polyclinic	Maternity unit does not have adequate equipment such as delivery set Episiotomy set B P monitor Foetal dopplers Manual vacuum aspirator Thermometer	Annual Reports	From inspection 4 deliveries set instead of 8, 3 Episiotomy set instead of 8, 2 B P monitor instead of 8, 2 foetal dopplers instead of 6, 1 Manual vacuum aspirator instead of 5, Thermometer 0 instead of 3.
Ho Teaching Hospital	Foetal dopplers CTG	Annual Reports- Regional Health Directorate and facility reports	From inspection, 5 CTG instead of 13, 7 foetal doppler instead of 12.

68. According to the Administrators of the selected health facilities, the supply of essential equipment for maternal healthcare was largely dependent on periodic distributions by the Ministry of Health. The Director of Policy Planning, Monitoring and Evaluation (PPME) at the MoH indicated that there was no dedicated budget line for maternal healthcare, which affected the procurement of equipment needed for the healthcare facilities.

69. Facility Administrators further indicated that, due to delays and gaps in Central Government supply, the facilities frequently relied on Internally Generated Funds (IGF) to procure critical equipment to sustain service delivery. However, the IGF generated by these facilities was not enough to procure the essential equipment needed for maternal healthcare services. The non-functional and inadequate equipment posed a risk to the quality and efficient delivery of healthcare services for pregnant women.

3.2.4 Consumables

70. Consumables are medical supplies used once or over a short period, after which they are discarded or replaced during the care of pregnant women. Consumables such as blood and blood products (platelets, plasma, and albumin), emergency obstetric drugs, disposable gloves, syringes and needles, blood sample tubes, gauze, catheters, are critical for maternal healthcare.

71. We noted from the Store Inventory Register that essential emergency obstetric drugs were frequently out of stock. These drugs were to be readily available at all levels of maternal healthcare service delivery to prevent life-threatening complications during pregnancy, childbirth, and post-partum periods. The drugs included oxytocin/misoprostol for the prevention and treatment of postpartum haemorrhage (PPH); magnesium sulphate for prevention and treatment of eclamptic seizure; ampicillin and gentamicin for obstetric infections.

72. According to the Regional Health Directors, these medications were given freely to pregnant women per the National Health Insurance Scheme (NHIS). The frequent stockout of this medication increased the risk of preventable complications during pregnancy, especially for pregnant women who could not afford to purchase the medication. For instance, Fifty-eight (58) out of the 130 pregnant women interviewed

indicated that they had to purchase medication on the NHIS list that was out of stock. Twelve (12) pregnant women said they relied on the assistance of doctors to buy medication, while the remaining 46 resorted to the medication of traditional birth attendants (TBAs) within their communities. According to Medical Doctors, the use of medication from TBAs is risky since they are unable to determine the type and safety of medication these vulnerable pregnant women receive from the TBAs.

73. Also, we found that the Regional Health facilities and the Teaching Hospitals we visited, which served as referral centres for complex obstetric emergencies, experienced a shortage of blood and blood products during obstetric emergencies. The officials of these referral facilities said they accessed blood from the blood banks of neighbouring health facilities, which were usually delayed and contributed to preventable maternal death caused by obstetric haemorrhage. For instance, the Obstetrician-Gynaecologist and Maternal-Foetal Medicine Specialist at the Cape Coast Teaching Hospital indicated that blood and blood products were not readily available and had to be requested from Korle-Bu Teaching Hospital in Accra, Cape Coast Municipal, and the University Hospitals.

74. Our review of 30 Maternal Death Audit Reports over the audit period from CCTH, HoTH, TTH, KATH, Bolgatanga Regional, Tamale Regional, Kumasi South, and Ho Municipal Hospitals showed that 18 pregnant women died due to the unavailability of blood and blood products. One such blood-related referral case from Tarkwa to CCTH is illustrated in Case Example 1.

Case Example 1

A 39-year-old woman, referred from Premier Hospital in Tarkwa following a Caesarean section complicated by postpartum haemorrhage, arrived at CCTH on 3/7/2024 at 10:30 am in a Taxi. Efforts were made to obtain blood (B+), but there was no blood at CCTH. Arrangements were made for 5 units of blood and 2 units of FFP from University of Cape Coast (UCC) Hospital, but no blood. The patient was declared clinically dead at 4:18 pm. (CCTH Maternal Audit Report 2024)

3.2.5 Skilled Personnel

75. We noted that the Teaching hospitals require multiple specialists due to their mandate for specialist training, research, and management of complex referral cases. The Teaching Hospitals we visited had a total of 66 obstetricians/gynaecologists providing maternal healthcare services. The Teaching Hospital and the number of Obstetricians and Gynaecologists at post at the time of the audit are shown in Table 7.

Table 7: Number of Obstetricians and Gynaecologists at the Teaching Hospitals

Name of Teaching Hospital	Number of Obstetricians / Gynaecologists
Tamale	10
Komfo Anokye	22
Cape Coast	14
Ho	20
Total	66

Source: GHS, Human Resource Department

76. At the Regional Hospitals, we noted that the number of gynaecologists at post was inadequate, except for the Greater Accra Regional Hospital, which had personnel above the minimum required. For instance, Kumasi South had three (3) out of the eight gynaecologists required at the post. In terms of midwives, all the Regional Hospitals we visited had more midwives than required, except at Ho. See Table 8 for details.

Table 8: Analysis of adequacy of skilled personnel at selected Regional Hospitals (August-September 2025)

Hospitals	No. of Gynaecologist /Obstetrician required	No. of Gynaecologist /Obstetrician at post.	No. of Midwives required	No. of midwives at post
Kumasi South	8	3	92	124
Ho Municipal	8	2	92	87
Greater Accra Regional Hospital	8	19	92	284
Tamale West Hospital	8	1	92	138
Upper East Regional	8	3	92	105

Source: GHS, Human Resource Department

77. We noted from the Staff Establishment and interviews with the hospital Administrators at the facilities we visited in the Upper East Region that the entire Region, with a population of 1,301,221, had only three (3) obstetricians/gynaecologists providing maternal healthcare services. Two (2) of the obstetricians/gynaecologists were at the Upper East Regional Hospital, and the other one at the War Memorial Hospital in Navrongo. These specialists were also responsible for providing maternal healthcare services to the North-East and part of the Upper-West regions, with a population of 658,903 and 901,502, respectively. Thus, the three gynaecologists were providing services to a total population of 2,861,626, representing an obstetrician/gynaecologist to population ratio of approximately 1:953,875 instead of the WHO standard ratio of 1:100,000.

78. Also, at the District Hospitals, there were inadequate gynaecologists. For instance, the Bongo District Hospital (in a District with a population of about 130,000) did not have an obstetrician. The District had two medical doctors, who provided general medical

services, including maternal healthcare, without specialist support. Komenda Edina Eguafio Abirem (KEEA) Municipal Health Directorate also had no obstetrician/gynaecologist. As a result, pregnant women had to be referred to the Cape Coast Teaching Hospital (CCTH) in cases of emergency.

79. Our analysis on the adequacy of skilled personnel at the district hospitals we visited showed that the district facilities had more than the required number of midwives, except the Bongo District Hospital. Table 9 provides details.

Table 9: Analysis of adequacy of skilled personnel at selected District Hospitals (August-September 2025)

District Hospitals				
Hospitals	No. of Obst./Gynae. required	No. of Obst./Gynae. at post	No. of Midwives required	No. of midwives at post
South Suntreso	5	2	52	104
Elmina Polyclinic	-	-	11	34
Weija Gbawe	5	2	52	57
Bongo District	5	0	52	47

Source: GHS, Human Resource Department

80. The GHS staffing norm requires a CHPS zone to have one or two midwives at post, while a Health Centre requires two to six midwives. We noted that the Health Centres and CHPS zones had adequate midwives to administer maternal healthcare in the rural communities. For instance, Ampenyi CHPS in the Central Region and Bagble-Ando CHPS in the Volta Region had two midwives each. (Nayorigo) CHPS in the Upper East Region also had two midwives at post. However, we noted that some CHPS zones, such as Kanvilli CHPS, had only one midwife, who was responsible for antenatal care, deliveries, postnatal care and community outreach, resulting in work overload.

81. Despite the relative adequacy of midwives at the lower-level facilities, we found that the absence of specialist support at the district level affected the quality of maternal healthcare. Midwives at CHPS zones and Health Centres indicated that they often had to refer complicated cases to District or Regional Hospitals due to the lack of skilled personnel such as obstetricians, anaesthetists, and physician assistants.

82. According to the 2024-2028 Nurses and Midwifery Strategic Plan, the Ministry of Finance and Economic Planning had not been able to give financial clearance for the recruitment of nurses and midwives, which resulted in a backlog of 60,000 midwives and nurses who were yet to be employed. Employing these midwives and nurses would increase the staff strength and improve the midwife-to-patient ratio, especially at facilities in the deprived areas.

83. Again, the President of the Ghana Medical Association (GMA) indicated that there were over 800 medical officers, including obstetricians and gynaecologists, who had not been posted as of October 2025. Meanwhile, the obstetricians and gynaecologists at Regional and District Hospitals were overwhelmed, compromising the quality and timeliness of maternal healthcare services. The inadequacy of skilled personnel for maternal healthcare at the facilities led to general practitioners (without specialised training) managing maternal cases that required the services of specialists. It also denied many vulnerable⁹ citizens, especially those in hard-to-reach communities,¹⁰ access to good maternal health care. These situations contribute to increased complications leading to maternal mortality.

⁹ women in fertility age in rural communities who face higher health risks or barriers to accessing quality care because of medical, social, economic or geographic factors

¹⁰ living far from health facilities or referral centres, areas with deplorable roads

Conclusion

84. MoH and its agencies collaborated with stakeholders to implement planned maternal healthcare interventions. However, there were inadequacies in the implementation of the interventions at the health facilities in terms of the provision of:

- infrastructure (space and delivery beds at the maternity wards),
- constant electricity and water supply,
- equipment (foetal dopplers, CTG, BP apparatus, scan, etc),
- consumables, medication, and blood and blood products, and
- skilled personnel (obstetrician\gynaecologist).

85. These lapses undermined Ghana's Leave No One Behind (LNOB) agenda and slowed the progress toward reducing maternal mortality.

Recommendations

86. We recommended that management of MoH should:

- collaborate with relevant ministries and agencies to provide adequate and disability friendly infrastructure with required amenities to improve maternal healthcare in facilities at all levels,
- strengthen supply chain systems to ensure that the GHS continuously make essential drugs and other consumables, as well as prescribed equipment, available for effective delivery of maternal healthcare services in the regions and districts, prioritising rural health facilities and CHPS compounds,
- ensure that GHS recruits and deploys adequately skilled personnel to improve maternal health service delivery at all levels, especially in rural communities,

- ensure that GHS improves and enforces existing incentives and posting policies to attract and retain skilled health workers in deprived areas and
- strengthen blood services by improving blood collection and storage systems and ensure timely access to blood products for obstetric emergencies.

Management response

87. *Under infrastructure, management has taken note of the findings and acknowledged that overcrowding remains a major challenge and emphasises the need for infrastructural expansion to improve maternal and child health services.*

88. With regard to tools and equipment, procurement of medical equipment is capital-intensive and therefore requires continued government support to ensure the timely acquisition of essential equipment, particularly for maternal health service delivery. Management acknowledged the need to recruit clinical engineers for the continuous maintenance and repair of equipment.

89. In respect of consumables for maternal healthcare, there is a need to adequately stock the Central Medical Stores with essential drugs and intensify blood donation campaigns through collaboration between the Health Promotion Division and the National Blood Service to improve blood availability for maternal healthcare delivery. With regard to skilled personnel, the Ghana Health Service is working on equity in the redistribution of skilled personnel.

3.3 Monitoring and reporting progress on SDG 3.1 healthcare interventions

90. The National Health Sector Policy, the SDG framework, and Ghana's reporting obligations to the UN require robust monitoring and reporting systems to track progress on reducing maternal mortality (SDG 3.1).

91. National Health Sector Policy requires MoH and GHS to carry out

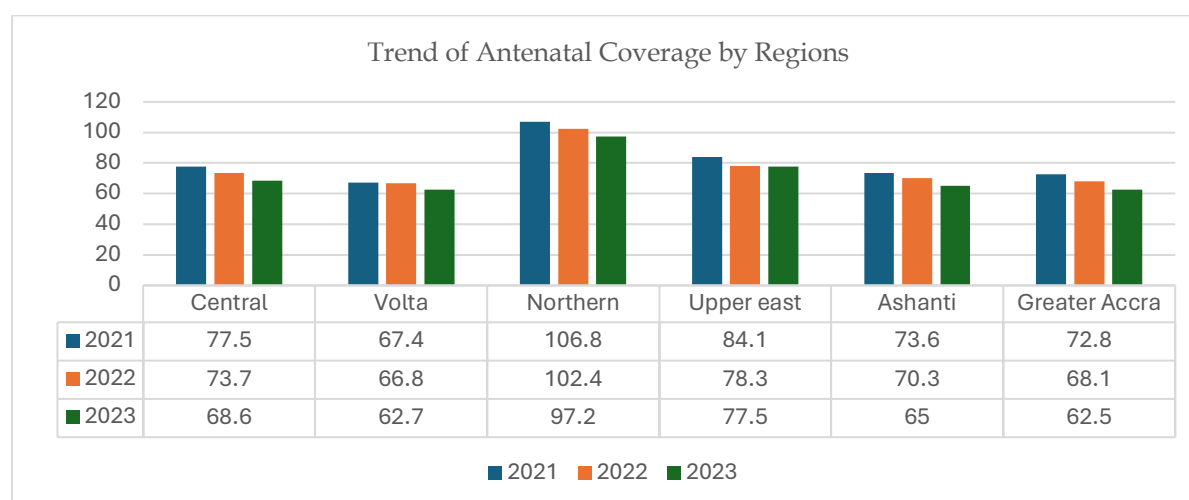
- a. community level monitoring at primary health facility level at health centres,
- b. district-level data validation,
- c. maternal and perinatal death surveillance and response (MPDSR) oversight,
- d. regional analysis and supportive supervision and
- e. Electronic Medical Record System (EMRS) at the Teaching Hospitals and the national-level strategic monitoring, where data was gathered.

92. At all levels, health facilities are required to collect data based on set indicators, review data collected on the indicators, capture data on DHMIS2, analyse the data monthly, and give feedback through reporting. The set indicators are antenatal care coverage, skilled deliveries, danger signs, and causes of maternal deaths. These monitoring mechanisms are to ensure that maternal health performance is tracked continuously for early risk detection and implementation of corrective actions towards reducing maternal mortality.

93. We noted from review of GHS Annual reports, facility reports, MPDSR, and interviews with Regional Health Directors that the selected health facilities we visited collected data on the set indicators on maternal healthcare to track the progress on SDG 3.1. For instance,

GHS monitored, collected, and analysed data and determined antenatal service coverage in the Regions in Ghana as provided in Figure 3. Appendix 9 provides details.

Figure 3: Monitoring of maternal health indicators



Source: 2023 FHD Annual Report

94. However, we noted inefficiencies in the monitoring and reporting processes. For instance, the MPDSR committees are required to hold monthly meetings to review maternal death reports in the regions and come up with action plans to improve the management of maternal healthcare in the facilities. However, we noted that some committees did not hold meetings for several months to review the maternal death reports as required. Additionally, the MPDSR committees in the Northern Region had not convened for over three months at the time of our visit in August 2025, though maternal deaths were recorded. In the Upper East Region, maternal deaths were recorded, but there were no minutes or review reports to show that MPDSR meetings were held.

95. However, in the Ashanti Region, MPDSR committees at KATH, Kumasi South, and South Suntreso hospitals met every month to review reported maternal death cases. They implemented refresher training programmes such as management of postpartum haemorrhage, which was one of the major causes of maternal deaths in the region. Similarly,

in the Central Region, MPDSR meetings were held on a monthly basis with follow-up actions for each maternal death.

96. Also, we noted from review of the DMHIS2 and MPDSR systems for gathering data on maternal health that GHS had inconsistent data on maternal deaths. For instance, in 2019, GHS reported maternal deaths of 2,850 on the DHMIS2, whilst on MPDSR, the reported figure was 2,650 deaths for the same year. Similarly, in the year 2020, GHS reported 2,900 deaths on DHMIS2, whilst the figure was 2,700 deaths on the MPDSR. Table 11 provides for similar disparities in the number of deaths reported on the two systems for the rest of the years under review.

Table 11: Maternal Death Figures from DHIMS2 and MPDSR, (2019–2024)

Year	DHIMS2 Reported Maternal Deaths	MPDSR Reported Deaths	Variance (Approx.)
2019	2,850	2,650	200
2020	2,900	2,700	200
2021	3,050	2,800	250
2022	3,100	2,900	200
2023	3,200	3,000	200
2024	3,250	3,050	200

Source: Ghana Health Service Annual Health Sector Performance Report (2019 – 2023) and MPDSR Annual Reports (2019–2024).

97. According to the Upper East Regional Health Director, monitoring maternal health interventions faced data entry challenges as the district and peripheral facilities' health personnel sometimes input wrong figures into the DHIMS2. For instance, instead of “20 deaths,” personnel may input “200 deaths”. This compromised the integrity of maternal health data, which misinformed decision-making.

98. In addition, the CHiPs and health centres we visited¹¹ had limited access to the internet, trained personnel, and computers for collecting

¹¹ Naylorigo CHPS, Ampenyei CHPS, Namoo Health Centre, Sawuah Health Centre, Yamoransa Health Centre, Kavilli Health Centre, Nyashegu CHPS

data. Others, such as Ho Municipal and South Suntreso hospitals, reported frequent internet fluctuation, which hindered data entry and reporting. According to the Physician Assistants, staff had to enter data multiple times due to system timeouts or failed submissions, which contributed to the errors in data entry.

99. From the Ghana Harmonised Health Facility Assessment Report (2022 to 2023), 28 percent of healthcare facilities had computers with stable internet across the country to enhance maternal health data capturing and reporting. The report again indicated that DHIMS2 did not disaggregate maternal health data by disability status or adolescent motherhood, limiting the ability to assess whether SDG 3.1 interventions are equitably benefiting all population groups. These data gaps contributed to discrimination, particularly among vulnerable groups such as adolescent mothers and women with disabilities, whose specific needs require targeted data for informed decision-making and inclusive maternal health interventions.

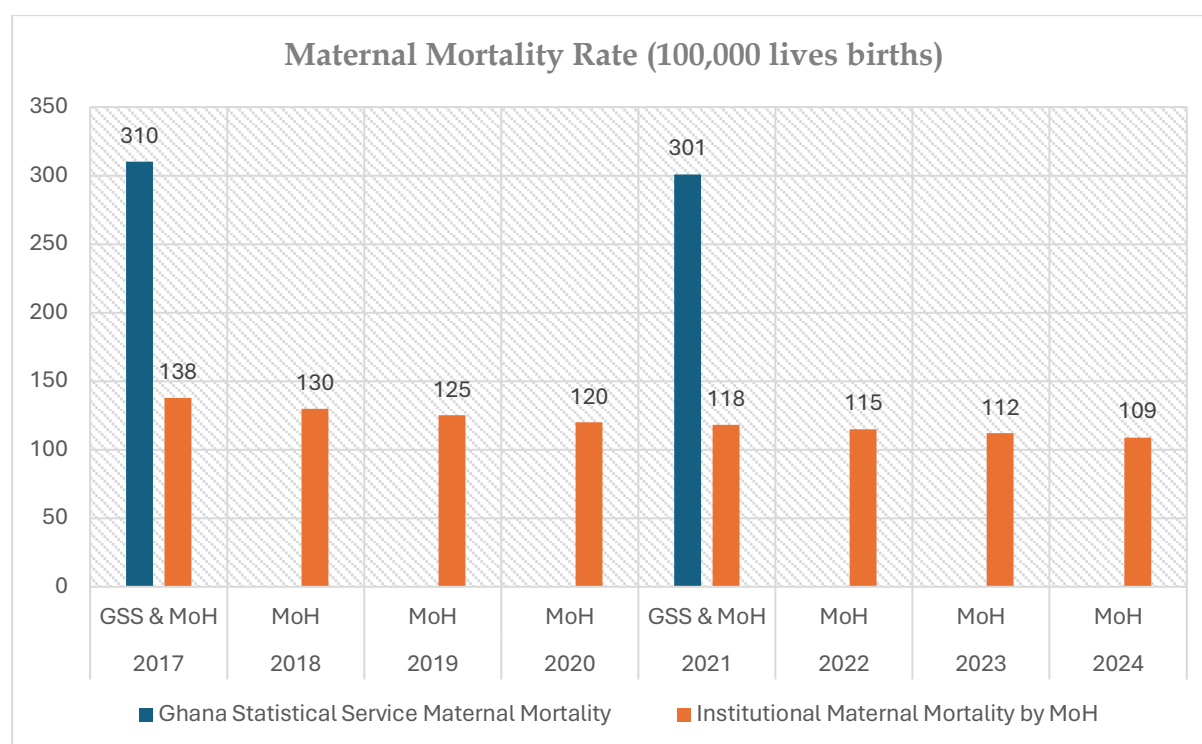
100. Review of Holist Assessment Report, and interviews with Regional and District Health Directors indicated that inconsistency in data was due to incomplete documentation of deaths during transits, delayed reporting, and weak coordination with health facilities. These challenges affected timely decision-making and accountability, as policymakers and programme managers lacked complete and up-to-date maternal health data across all levels of care, particularly data from tertiary and teaching hospitals that manage high-risk maternal cases.

101. Ghana Statistical Service (GSS) is responsible for collecting and disseminating national data, including Maternal Health and Demographic and Health Surveys¹² (DHS), which use indicators that

¹² Not conducted on yearly basis

were different from those of GHS for data gathering on maternal mortality. Whilst MoH classified maternal mortality as the death of a pregnant woman or a woman who dies within 42 days after delivery, the GSS used the death of a pregnant woman from an accident as an additional indicator. The differences in the set indicators for data gathering resulted in the different reportage in maternal mortality rates. For instance, in 2017, GSS reported a maternal mortality ratio of 310 deaths per 100,000 live births, and MOH reported 138 deaths per 100,000 live births, as shown in Figure 4.

Figure 4: Maternal Mortality Rate as reported by GSS and MoH (2017 - 2024)



Source: Ministry of Health /Ghana Health Service

Conclusion

102. The MoH and its implementing agencies, including GHS, had established a monitoring framework to collect, analyse data, and report on the maternal health interventions geared toward the reduction of

maternal mortality. However, there were inefficiencies, inconsistencies, and inadequate data disaggregation in the implementation of the monitoring systems.

Recommendations

103. We recommended that the MoH and GHS should:

- Review the monitoring framework for the maternal healthcare delivery system;
- Standardise the monitoring indicators across all data collection systems;
- Harmonise the implementation of the monitoring systems; and
- Conduct capacity-needs assessments to identify and address the challenges, such as ICT infrastructure and staff capacity at lower-level facilities.

Management response

104. *Ghana Health Service has a Centre for Health Information Management that regularly monitors, verifies, and validates data entered in DHIS2. While human errors may occur, periodic reviews and feedback mechanisms are in place to identify discrepancies and ensure timely corrections at all levels.*

3.4 Overall Conclusion

105. The Ministry of Health (MoH), in collaboration with the Ghana Health Service (GHS) and other stakeholders, had planned, implemented, and monitored maternal healthcare interventions to reduce maternal mortality towards the achievement of SDG 3 target 3.1.

106. However, some key stakeholders were not involved in the planning, and there was an inadequate funding arrangement to sustain the implementation of maternal healthcare interventions. Also, there were inadequacies in the implementation of the interventions at the health facilities in terms of space and delivery beds at the maternity ward, electricity and water supply, equipment, consumables, medication, and blood and blood products, as well as skilled personnel (obstetrician\gynaecology). Furthermore, there were inefficiencies, inconsistencies, and inadequate data disaggregation in the implementation of the monitoring and reporting systems.

107. These lapses undermined the government's efforts, slowing the progress toward reducing maternal mortality.

APPENDICES

Appendix 1

List of documents reviewed and the reasons for review

Name of document	Reason for review
Medium-Term National Development Policy Framework (2022-25)	To know whether the SDGs 3.1 is aligned with the National Medium-Term Policy Framework
Medium-Term Development Plans (MTDP 2018-2021; 2022-2025)	Plans are aligned with target 3.1
Voluntary National Review Report (2019-2022)	The state of implementation of the Sustainable Development Goal Target 3.1
Ghana's SDGs Budget Reports (2019- 2021; 2022-2025)	Allocation of resources to target 3.1
2020 - 2023 Holistic Assessment Report	To ascertain Human Resource development for health regarding Doctor & Midwives to patient ratio
Ghana's Roadmap for Attaining Universal Health Coverage (2020 – 2030)	To know maternal health intervention is implemented.
2020 National Health Policy	To Know whether the policy is responsible to ensuring that no one is indeed, left behind
Guidelines for preparing sector and district medium-term development plans	To understand how MMDAs prepare Sector Medium Terms development plans and policies.
Ghana Harmonised Health Facility Assessment (2022-2023)	To generate information on service availability, readiness and quality of care.
Health Sector Staffing Norm	To understand how MoH is addressing staffing issues using the WHO Population Ratio

Name of document	Reason for review
Ghana Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH&N) Strategic Plan (2020 – 2025)	To ascertain how the strategic plan contributes to significant health gains in the form of overall improvement in maternal and child health.
ISAM, IDI's SDGs Audit Model 2024	To understand how to carry out high quality and high impact audits of the implementation of Sustainable Development Goals (SDGs) based on International Standards of Supreme Audit Institutions (ISSAIs).
National Community Health Planning and Services (CHPS) Policy (2014)	To ascertain whether the policy bridges the equity gaps in access to healthcare and nutrition services and ensure sustainable financing arrangements that protect the poor.
National Monitoring and Evaluation Policy (2024)	To know whether it aligns with current National Development Frameworks
Ghana Health Sector 2021, Programme of Works	To ascertain whether the health sector programmes align with national and global health priorities (SDG target 3.1).
2020-2024 Ghana Health Service Annual Report	To ascertain the progress toward maternal health and international commitments such as SDG 3.1
Ghana Health Sector, Monitoring and Evaluation Framework	To know how maternal death is recorded and monitored.

Appendix 2

List of officers interviewed and the reasons for the interview

Officer and Organisation	Responsibility
Director General, Ghana Health Service	Leads and manages the Service and is responsible for the direction of the work as well as the day-to-day administration of the Service.
Director, Family Health Division	Responsible for developing and implementing health policies, programmes, and budgets for the division. Also oversees the division's activities and departments.
Programme Officer, Family Health Division	Assist the director of FHD in the development and implementation of health policies, programmes, and budgets for the division. Also advocate for funding and support for programmes related to the division's mandate.
Officer, (Doctor) Safe Motherhood	Co-ordinates the programme and ensures the health of women and their newborns.
Programme Manager, Newborn	Responsible for the development and implementation of programmes that support the health of newborns in Ghana
Director, Finance (GHS)	Responsible for managing GHS' financial resources, including ensuring compliance with regulations and policies.
Internal Auditor (GHS)	To understand whether controls and governance mechanism are working properly in relation to maternal healthcare.
Director PPME, MoH	Responsible for the formulation, review and revision of policies aligned with national priorities.
Regional and District Health Directorates	Responsible for providing strategic oversight, coordination, and supervision of health service delivery within their respective regions, including

	policy implementation, human resource management oversight and logistics coordination.
Municipal and District Coordinating Directors	To provide clinical leadership and oversight to ensure safe, high-quality maternal and newborn services across all health facilities within the district, and coordinate with partners to support maternal health programmes
Doctors	Provide quality healthcare services to the people of Ghana.
Midwives	Provide comprehensive reproductive healthcare to women throughout their pregnancy, labour, and postpartum period.
Nurses	Provide healthcare for individuals, families, and communities.
Patients	Provide medical history and any relevant information about their health. They avail themselves to be part of education/awareness creation

List of Health Facilities Visited

Facilities Visited	
Tertiary Hospitals	Cape Coast Teaching Hospital
	Ho Teaching Hospital
	Tamale Teaching Hospital
	Komfo Anokye Teaching Hospital
Regional Hospitals	Bolgatanga Regional Hospital
	Tamale Regional Hospital
	Kumasi South Hospital
District Hospitals	Ho Municipal Hospital
	War Memorial Hospital
	Bongo District Hospital
	South Suntreso Hospital
Health Centres	Yamoransa Health Centre
	Navrongo Health Centre
	Namoo Health Centre
	Kavilli Health Centre
	Sawuah Health Centre
CHPS	Apanyin CHPS
	Gbale-Ando CHPS
	Nayorigo CHPS
	Nyanshegu CHPS

Process Description

Development of Policy Framework for SDGs implementation

1. The National Development Planning Commission (NDPC) develops the National Medium-Term Development Policy Framework comprising national development goals, policy objectives and strategies. This framework is aligned to the Sustainable Development Goals (SDGs). This forms the basis for the preparation of development plans by Ministries, Departments and Agencies (MDAs) and Metropolitan, Municipal and District Assemblies (MMDAs). The Ghana Statistical Service (GSS) provides the baseline status for the SDGs indicators. The NDPC then develops guidelines for preparing the medium-term development sector plans of the MDAs, RCCs and MMDAs.

Planning for SDGs activities

2. The NDPC provides guidelines for preparing the sector medium-term development plans to sector ministries to formulate policies for the departments and agencies under the ministries to achieve their set goals. The MMDAs prepare their medium-term development plans based on the NDPC's guideline and the ministries' policies.

3. The Ministry of Finance (MoF) issues Budget Preparation Guidelines with detailed instructions on the processes and procedures for developing the Budget. The Guidelines have provisional budget ceilings for Ministries, Departments and Agencies (MDAs) and Metropolitan, Municipal and District Assemblies (MMDAs) and these institutions are expected to adhere to the provisional ceilings as in the guideline. In addition, institutions are to consider Government flagship programmes within the ceilings provided. All institutions are to reprioritise their expenditures for efficient utilisation of available

resources. The MDAs/MMDAs are to allocate resources to strategic and critical programmes in their Medium-Term Plans.

4. Additionally, the MMDAs should appropriately budget for Internally Generated Funds (IGFs) and Development Partner (DP) Funds to enable them to use these funds during budget implementation. The MDAs/MMDAs prepare annual budget in line with the guidelines and submit it to the Ministry of Finance.

Approval of plans

5. The NDPC approves the policies and plans of the MDAs, RCCS and MMDAs to ensure that they are consistent and aligned with national development policies and priorities as well as the SDGs.

6. The MoF reviews the MDAs/MMDAs annual budgets to ensure they are in line with their guidelines and approves the budgets and allocates resources to them.

Implementation of activities to achieve SDGs

7. The medium-term plans are aligned to the SDGs and targets. As MDAs/MMDAs implement their plans, they invariably implement the SDGs. Depending on the objective or target to achieve, the institution implements the activities or procures a service provider (consultant, contractor or supplier). The institution monitors, validates, makes payment as well as evaluates the implementation of the target.

Tracking and reporting progress on the SDG achievement

8. At the local level, the MMDAs report on their activities and the progress of the SDGs implementation to the Regional Coordinating Councils (RCCs). There is a two-way accountability arrangement where the decentralised department in the districts report to the MMDAs as well as their respective ministries. The decentralised departments under

the MMDAs also report to the communities and vice-versa on the status of implementation of activities.

9. At the regional level, the RCCs monitor the MMDAs and report the M&E activities to the NDPC and Ministry of Local Government, Chieftaincy and Religious Affairs (MLGCRA).

10. At the National Level, the ministries validate reports and data from MMDAs and then report progress of implementation of the SDGs to the NDPC. The Ghana Statistical Service (GSS) collects data from the MDAs, MMDAs and other stakeholders to track progress on the SDGs. The GSS also collects data from national surveys and partners with other stakeholders to generate data to compute the SDG indicator values and shares this information with the NDPC.

11. The MoF tracks the budget allocations and expenditure made by the government towards the achievement of each of the Goals at the National and Subnational levels. The report also highlights the policy initiatives being undertaken by the government under the various Goals. The Ministry prepares the SDG Budget Report and shares same with the NDPC.

12. The NDPC prepares Voluntary National Review (VNR) report which presents the state of implementation of the SDGs and analysis of key actions in implementing the SDGs, progress made, constraints faced, as well as opportunities to be explored. The NDPC produces the VNR report annually.

Appendix 5

Stakeholder Engagement

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagements
2021	National Maternal Child Health and Nutrition (MCHN). Assessing the impact of COVID-19 on maternal and child health services, sharing lessons and best practices, and planning institutional and system improvements to protect and sustain health outcomes for mothers, newborns, children and adolescents in Ghana.	Accra	Health Sector Development Partners, private healthcare providers, representatives from MoH, district health teams, donor partners	- Improved preparedness and response systems, - Maintained essential RMNCAH services without disruption - Used lessons from COVID-19 to strengthen health infrastructure.	
	Policy validation and stakeholder consultative workshop -Building consensus on proposed policy directions and findings aimed at improving maternal, newborn, child and adolescent health (MNCAH) service delivery.	Accra	MoH and GHS Technical Group, Professional Association	Consensus among government, partners and civil society on policy direction and priorities	
	Multi stakeholder workshop on delivery quality maternal and newborn healthcare – focused on the private sector in delivering quality maternal and newborn healthcare.	Accra	MoH Technical Group, Professional Association, private healthcare providers, representatives from MoH, district health	The workshop produced consensus recommendations for strengthening maternal and newborn care quality, including actionable steps for better public-private collaboration	

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagements
			teams, and donor partners		
2022	National Maternal Child Health and Nutrition- Aimed at improving health systems to ensure quality and accessible service delivery in line with the Sustainable Development Goals (SDGs) and other global commitments bringing together, experts in Reproductive, maternal, newborn, child and adolescent health (RMNCAH).	Accra	Health Sector Development Partners, doctors, midwives, private healthcare providers, representatives from MoH, district health teams, donor partners, and the vulnerable	Strengthened the evidence base for nutrition policy and practise. Showed how maternal nutrition services, adolescent programmes, and child-focused interventions can be scaled and integrated into health systems.	
	Policy validation and stakeholder consultative workshop- Building consensus on proposed policy directions and findings aimed at improving maternal, newborn, child and adolescent health (MNCAH) service delivery.		MoH and GHS Technical Group, Professional Association and donor partners, private sector representatives, civil society, and professional bodies	Identification of priority issues, implementation challenges and recommended actions	
2023	National Maternal Child Health and Nutrition – on integrated Reproductive, Maternal,	Accra	MoH Technical Group, Professional	Reviewed maternal and child health programmes, share	

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagements
	Newborn, Child and Adolescent Health and Nutrition (RMNCAH).		Association, Health Sector Development Partners and related MMDAs	innovations, strengthen partnerships, and generate policy recommendations to improve RMNCAH&N outcomes and accelerate progress toward the SDGs in Ghana.	
	Policy validation and stakeholder consultative workshop- Focused on assessing the relevance, coherence, and feasibility of the draft policy, ensuring it was evidence-based and aligned with national development priorities, sector strategies, and international commitments such as the Sustainable Development Goals and Universal Health Coverage.	Accra	Agencies from MoH and GHS, CHAG facilities, and technical groups	Reviewed, refine and validate key health policy documents, ensuring stakeholder consensus and strengthening the policy framework for improving health service delivery.	
	Annual Health Sector Dialogue – Progress or stagnation in maternal health services, service delivery quality, emergency care, and referral systems.	Rock City Kwahu	Agencies of the MoH, development partners, private sector providers, CSOs and NGOs	Reviewed health sector performance, and produced agreed actions to improve governance, health financing, data systems, commodity supply, and implementation of key health policies.	
	Stakeholder meeting on quality maternal care (Network for improving NMCH)-to discuss	Accra	Health Sector Development	Strengthened coordination among health sector actors and	

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagements
	maternal, newborn and child health quality improvement.		Partners, doctors, midwives, private healthcare providers, related MMDAs, representatives from MoH, district health teams, donor partners, NGOs, CHAG, CSOs and the vulnerable	produced recommendations to improve the quality of maternal and newborn care through strengthened quality improvement systems, better data use, and expansion of the quality-of-care network	
2024	Annual Newborn/Maternal Stakeholder Meetings – Review progress on newborn and maternal health outcomes in Ghana, including the implementation of national strategies to reduce newborn and maternal mortality.	Accra	Agencies of the MoH, midwives, doctors, development partners, private sector providers, CHAG, CSOs and NGOs	Strengthened coordination among health sector stakeholders, reviewed maternal and newborn health performance, and produced recommendations to improve quality of care, and accelerate reductions in maternal and newborn mortality.	
2024	Health Sector Summit- Focused on assessing the performance of the health system and setting strategic direction for improving health service delivery across the	Kempinski, Accra	Agencies of the MoH, midwives, doctors, development	Strengthened national commitment to improving quality healthcare Delivery, strengthening health system	

Date/ Year	Type of Engagements	Location	Stakeholders involved	Outcome of the engagements	Amount spent on engagements
	country, including efforts to advance Universal Health Coverage (UHC) and quality care for all citizens.		partners, private sector providers, CHAG, CSOs and NGOs	governance, improving supply of essential medicines, and accelerating progress toward Universal Health Coverage in Ghana.	

Appendix 6

Level of facility and maternal health services provided

Level of Facility	Maternal Health Services Provided
Community / CHPS	• Health education & counselling (pregnancy, nutrition, danger signs) • Antenatal care (ANC) & referrals • Postnatal care (PNC) & newborn education, Family planning & contraception • Emergency referral support
Sub-District / Health Centre/ Polyclinics	• Routine ANC (risk screening, basic tests) • Normal skilled delivery services. • PNC & post-partum counselling • Basic emergency obstetric care. • Family planning & reproductive health services • Referral of complicated cases.
District Hospital	• Full ANC including risk management • Skilled delivery & labour care • Basic emergency obstetric care (assisted delivery, complications) • Post Natal Care • Family planning • Blood transfusion & basic surgery • Referral for complex cases
Regional Hospital	• Emergency obstetric care including complicated deliveries • Caesarean sections & surgical interventions • Comprehensive emergency obstetric & newborn care (CEmONC) • Specialist prenatal assessment • Supervision of lower-level facilities
Teaching / Tertiary Hospital	• Highly specialised maternal care (high-risk pregnancy management) • Advanced diagnostics & specialist surgeries • Training, research, and clinical leadership • Final referral level for complicated cases

Appendix 7

Infrastructure challenges at the selected health facilities

No	Name of Facility	Challenges identify	Effect of challenges	Source
1.	Tamale Teaching Hospital	Inadequate water and electricity supply.	Delay in delivery service. Quality of service delivery is affected.	Head of Obst. and Gynae at TTH
2.	Bolgatanga Regional Hospital	Inadequate space at the maternity ward.	Poor service delivery; attending to pregnant women on the floor.	Administrator
3.	Nyanshegu CHPS	Inadequate space in the delivery room. Two delivery beds cannot fit in the room.	Poor service delivery	Officer In-charge
4.	Bongo District Hospital	Inadequate space at the maternity ward.	Poor service delivery	Hospital Administrator
5.	South Suntreso	Inadequate infrastructure. No Gynae theatre	Pregnant women had to compete with other patients for emergency surgery.	Nursing Officer
6.	Kumasi South	Inadequate space. Expansion of maternity block stalled	Poor service delivery; attending to pregnant women on the floor.	Obstetrician
7.	Elmina Polyclinic	Inadequate space for 18 beds capacity at labour ward.	Movement in the ward is limited which affected service delivery	Principal Nursing Officer
8.	Bagble Ando CHPS	Inadequate space and water supply	Poor service delivery	Midwife In-charge
9.	Ho Municipal Hospital,	ANC unit -inadequate midwives due to change in status (operating as regional hospital) Labor Unit -inadequate midwives (18 out of 22 at post)	Midwives are overwhelmed. Quality of service delivery is affected.	Principal Nursing Officer Nursing Officer

No	Name of Facility	Challenges identify	Effect of challenges	Source
10.	War Memorial Hospital	Inadequate space in the labour ward.	Quality of service delivery is affected.	Hospital Administrator Obstetrician
11.	Navrongo Health Centre	Inadequate space-one detentions for pregnant women and other patients	Quality of service delivery is affected.	Physician Assistance
12.	Nayoriogo CHPS	Inadequate electricity supply.	Quality of service delivery is affected.	Midwife In-charge

Appendix 8

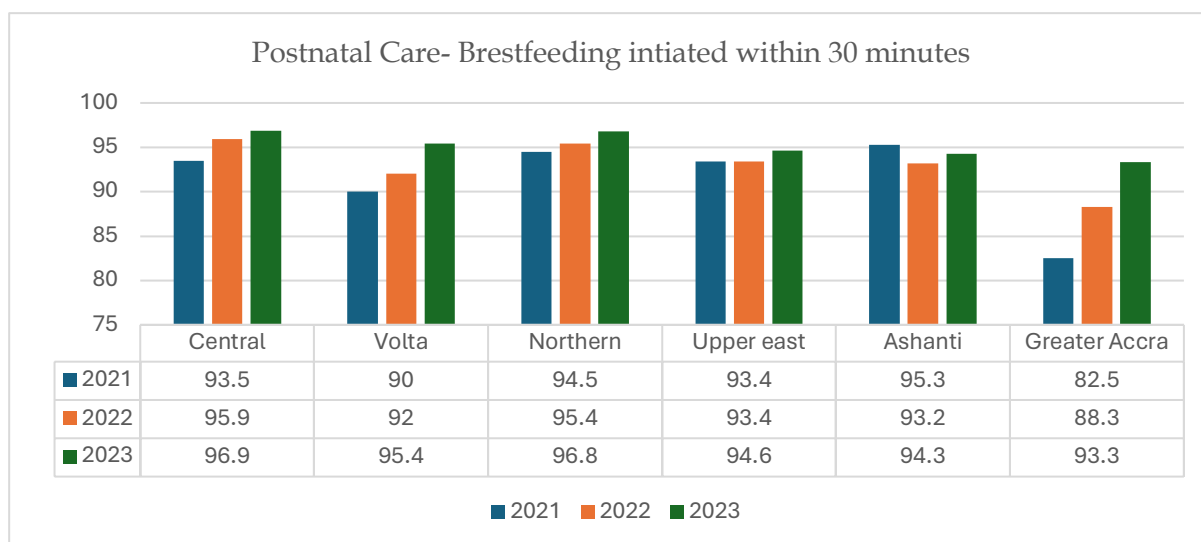
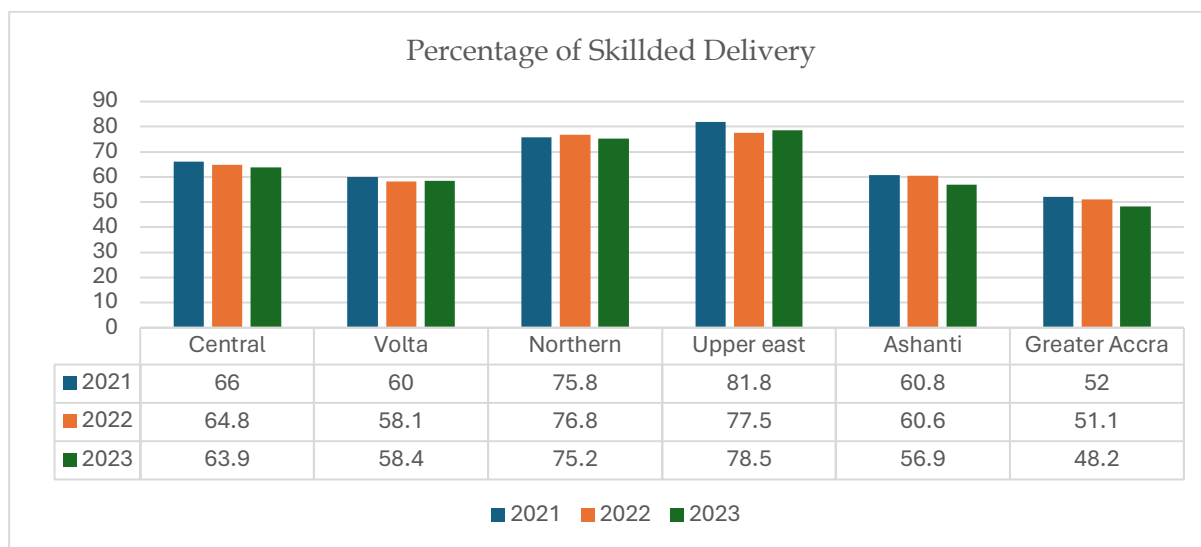
Inadequacy of Tools and Equipment

Facility	Information on Tools and Equipment	Source	Remarks
Cape Coast Teaching Hospital	Inadequate equipment such as: Dialysis machine, Ventilators, Anaesthesia machine, Patient monitors, 4 dialysis machines are not enough for the Teaching Hospital.	Annual Reports Medical director and the CEO	Pregnant women who need dialysis delay in having access.
Elmina Polyclinic	Maternity unit does not have adequate equipment such as delivery set, Episiotomy set, B P monitor, Foetal dopplers, Manual vacuum aspirator, and Thermometer	Annual Reports/ Interview	From inspection 4 deliveries set instead of 8, 3 Episiotomy set instead of 8, 2 B P monitor instead of 8, 2 foetal doppler instead of 6, 1 Manual vacuum aspirator instead of 5, Thermometer 0 instead of 3.
Ho Teaching Hospital	Foetal dopplers CTG	Annual Reports- Regional Health Directorate and facility reports	From inspection, 5 CTG instead of 13, 7 foetal doppler instead of 12.
Tamale Municipal Hospital	Delivery beds and mattresses, oxygen concentrator, foetal dopplers, autoclave machine	Facility reports/Interview	
Bolgatanga Regional Hospital	BP apparatus, CTG machines, dopplers, drip stands, delivery beds, oxygen concentrator, ventilator, suction machines	Facility reports/Interview	

Facility	Information on Tools and Equipment	Source	Remarks
Kumasi South Regional Hospital	CTG machine, foetal dopplers, BP Apparatus, vacuum aspirator machine	Facility reports/Interview	
South Suntreso Hospital	Delivery beds, dopplers, BP apparatus, monitors, oxygen concentrator, suction machine, CTG	Facility reports/Interview	
Elmina Polyclinic	Adjustable beds, foetal dopplers, mobile scanner, CTG machine	Facility reports/Interview	
Sawua Health Centre	BP apparatus and thermometer	Physician Assistance/Interview	
Namoo Health Centre	Delivery sets and auto clave	Physician Assistance/Interview	
Bagble Ando CHPS	Foetal doppler, pulse oximeter, BP apparatus,	Midwife in charge/Interview	

Appendix 9

Monitoring of Maternal Health Indicators



Appendix 10

Auditees' Response (excerpt)

RESPONSE TO AUDIT QUERY ON MATERNAL AND NEONATAL MORTALITY IN GHANA
CHAPTER ONE: INTRODUCTION

1. Reason for the Audit

1. According to the World Health Organization (WHO), maternal mortality refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy¹.

2. Signing onto the Sustainable Development Goal (SDG) the Country's average maternal mortality ratio (MMR) over the period 2010 to 2015 ranged from 377 to 339 per 100,000 live births². Sustainable Development Goal (SDG) 3, Target 3.1, seeks to reduce the global maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030. In line with this commitment, Ghana aimed to reduce its maternal mortality ratio by one-third of the 2010 baseline, from 377 to 125 deaths per 100,000 live births by 2030.

3. Maternal mortality in Ghana generally declined from 2019 to 2023, although fluctuations were observed during the period. Following a slight reduction between 2019 and 2020, the ratio increased in 2021, indicating a temporary setback before declining again through 2022 and 2023, as illustrated in Figure 1.

Figure 1: Ghana's Maternal Mortality Ratio (MMR), 2019–2023

The figure presents a line graph titled "Maternal Mortality Trend 2019–2023," showing maternal mortality ratios per 100,000 live births. The trend indicates values around 260 in 2019, a slight decline in 2020, an increase in 2021, and a gradual decline through 2022 and 2023.

4. To achieve the national target of 125 maternal deaths per 100,000 live births by 2030, the Government of Ghana has implemented several maternal health interventions. Between 2019 and 2023, the Government of Ghana, in partnership with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), invested approximately GH¢159 million in the Ghana Essential Health Interventions Programme (GEHIP). The programme aimed to strengthen community engagement at district and sub-district levels to improve maternal and child health outcomes³.

5. In 2024, the Japan International Cooperation Agency (JICA), through the Ghana Health Service (GHS), donated maternal healthcare equipment valued at approximately US\$150,000 to selected health facilities in the Greater Accra, Ashanti, Volta, and Northern Regions to support quality maternal healthcare delivery. Additionally, government and development partners continue to implement interventions such as free maternal healthcare services under the

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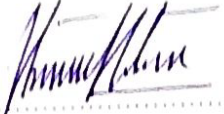
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However, some key stakeholders were not involved in the planning and there was inadequate funding arrangement to sustain implementation of maternal healthcare interventions. Also, there were inadequacies in the implementation of the interventions at the health facilities in terms of space and delivery beds at the maternity ward, electricity and water supply, equipment, consumable, medication and blood and blood products, and skilled personnel (obstetrician/gynecology). Furthermore, there were inefficiency, inconsistency and inadequate data disaggregation in the implementation of the monitoring and reporting systems.

These lapses undermined Government's efforts slowing the progress toward reducing maternal mortality.

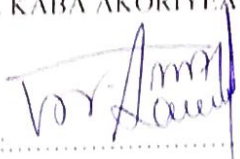
RESPONSE PREPARED BY : DIRECTOR FAMILY HEALTH DIVISION

DR. KENNEDY TETTEY COFFIE BRIGHTSON

SIGNATURE :  DATE 12-05-2026

APPROVED BY : THE DIRECTOR-GENERAL-GHANA HEALTH SERVICE

DR. SAMUEL KABA AKORIYEA

SIGNATURE :  DATE 05/06/26

MISSION STATEMENT

The Ghana Audit Service exists

To Promote

Good governance in the areas of transparency,
accountability and probity in Ghana's Public
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By auditing

to recognised international standards

And

reporting audit results to Parliament