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The political economy of maternal healthcare in Ghana

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Abstract

Despite substantial improvements in access to health services in Ghana during the last two decades, there has been limited progress in improving maternal health, and the country as a whole was unable to meet the Millennium Development Goal (MDG 5) in relation to maternal mortality. However, some administrative regions have made significant progress, with the Upper East, one of Ghana's most impoverished regions, surprisingly recording the most dramatic progress in the reduction of maternal mortality during the last decade. This paper explains Ghana's limited progress in reducing maternal mortality as a product of the country's 'political settlement', in which ruling elites are characterised by a perennial threat of losing power to other powerful excluded elites in tightly fought elections, incentivising those in power to direct public investments to policy measures that contribute to their short-term political survival. Competitive clientelist political pressures have contributed to greater elite commitment towards health sector investments with visual impact, while weakening elite incentives for dedicating sufficient public resources and providing consistent oversight over other essential, but less visible, interventions that are necessary for enhancing the quality of maternal health. In the absence of system-wide drivers of improved performance, sub-national variations in the quality of maternal health services are strongly shaped by the capacity and commitment of regional and district health authorities in enforcing human resource management norms within the Ghanaian health sector, thus ensuring the accountability of health workers. In the largely impoverished Upper East Region, incentives for health workers' performance are particularly driven by a hybrid form of accountability that combines top-down pressures from the Regional Health Directorate with horizontal forms of accountability among various health facilities.

Keywords: politics, political economy, political settlements, competitive clientelism, maternal health, Ghana.

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1. Introduction

In recent years, political settlements analysis has gained ground as an increasingly useful approach for improving our understanding of the politics of development. This paper investigates the effects of a type of political settlement which scholars refer to as *competitive clientelism* on health service delivery in Ghana, with a particular focus on maternal health issues. A competitive clientelist political settlement is one where the coalition in power faces strong excluded elite coalitions contesting its hold on power, as well as having strong lower-level factions within the ruling coalition. Together, this renders political elites vulnerable when in power, resulting 'in a ruling coalition with short time horizons and weak implementation and enforcement capabilities' (Khan, 2010: 69). We focus specifically on Ghana because of its recognition as a typical example of competitive clientelism (Hirvi and Whitfield, 2015; Abdulai and Hickey, 2016). Although Ghana has recently joined the ranks of lower-middle-income countries and is generally recognised as one of Africa's best governed polities, most development indicators normally associated with middle-income countries are absent. In particular, although access to health services has improved significantly during the last decade, there is broad acknowledgment that 'the quality of care remains problematic' (Saleh, 2013: 27; see also Ghana Universal Access to Health Care Campaign, 2012: 3), especially when compared to other countries with similar income and health spending levels.

Maternal health care has improved in Ghana over the past 20 years, although at such a slow pace that the country was unable to meet the MDG 5 in relation to the reduction of maternal mortality. Between 2000 and 2010, Ghana reduced its maternal mortality ratio (MMR) at an annual rate of 4.5 percent, compared to 8.7 percent in Rwanda, 6.9 percent in Ethiopia, 6.7 percent in Angola, and 5.1 percent in Uganda (WHO and UNICEF, 2013). Progress in reducing under-five mortality rates has equally been 'worryingly slow' (UNICEF, 2013: 71), such that Ghana's neonatal mortality rate 'has not improved over the past 10 years' (Ministry of Health, 2015a: 11). Importantly, however, some administrative regions and districts have made good progress, the most notable of which is the Upper East. Although one of the most impoverished regions of the country, with one of the worst doctor–population ratios and health infrastructures, the Upper East region exhibits the most enviable record in the reduction of maternal mortality in Ghana today.

At the national level, the disappointing maternal health outcomes have persisted despite dramatic increases in the number of health facilities in the country, the implementation of several measures aimed at reducing maternal deaths (MoH et al., 2011), and the expression of commitment to improving maternal health at the highest of level of government. In November 2013, the government announced a 10 percent voluntary pay cut from the president's salary and that of other members of the executive, with the objective of constructing special health facilities aimed at enhancing maternal and neonatal health (Republic of Ghana, 2013: 5). Such levels of elite commitment to maternal health issues are not new, as with the previous government's declaration of maternal mortality as a 'national emergency' in 2008,

and its subsequent launch of a free health insurance policy for pregnant women. So why does progress towards improved maternal health remain limited? How have political settlements dynamics shaped health policy reforms in Ghana, and with what implications for quality health service delivery in general, and for improving maternal health in particular? How have some relatively disadvantaged regions managed to emerge as 'pockets of effectiveness' in quality health service delivery in Ghana? Evidence for the paper is drawn from over 60 key informant interviews conducted at the national, regional and district levels. Our interviewees included senior bureaucrats at the Ministry of Health, the Ghana Health Service, regional and district health directors, donor agencies, NGOs, as well as medical superintendents, nurses and midwives. The paper also benefited from the author's participation in a two-day conference on maternal health and newborn care, which brought together health workers and administrators in the Upper East region to share experiences relating to the promotion of maternal and child health.¹

The paper proceeds in five broad parts. Section 2 discusses the politics of service delivery from a political settlements perspective, before turning to discuss the nature of the national-level political settlement in Ghana. Section 3 discusses Ghana's sectoral political settlement in health, while Section 4 explores the impact of these political settlement dynamics on health service delivery. This is followed by an investigation of the drivers of interregional variations in maternal health outcomes in Section 5, focusing specifically on the contrasting experiences of the Volta and Upper East regions. Section 6 concludes and highlights lessons and policy implications.

2. Competitive clientelism and the politics of service delivery

Defined as 'the balance or distribution of power between contending social groups and classes, on which any state is based' (Di John and Putzel, 2009: 4), political settlement theory pushes development thinking beyond an institutionalist approach by focusing on the underlying power arrangements that underpin the emergence, stability and performance of institutions.

An important contribution of this concept is the primacy it accords informal institutions for understanding governance and development outcomes in developing countries 'where so much happens informally' (Khan, 2012: 37). Khan (2010) argues that the distributional power inherited by ruling political coalitions in developing countries cannot be supported by the income created by formal institutions alone, primarily because of the limited size of the formal productive economy. Therefore, 'informal institutions play a vitally important role in all developing countries because informal institutions are the only feasible mechanism for sustaining economic benefits for powerful groups...' (Khan, 2010: 26). Developing countries are therefore characterised by 'clientelist political settlements' (Khan, 2010), in that the exercise of power is significantly based on informal organisations, typically patron–client networks of different kinds.

¹ Organised by the Upper East Regional Health Directorate with support from UNICEF, this conference coincided with the field work for this research

This paper is particularly interested in understanding the effect of a type of clientelist political settlement which Khan refers to as *competitive clientelist*. This type of political settlement is both *clientelist* and *competitive* because ruling elite coalitions are not entrenched, but instead compete for electoral power against similarly powerful excluded coalitions of clientelist networks. Here, the coalition in power faces strong excluded coalitions contesting its hold on power, as well as having strong lower-level coalitions. While the latter provides the ruling coalition with significant organisational power, it can also constrain the resource allocation decisions of the leadership (Khan, 2010). Ruling elites are therefore faced with a credible threat of losing power to excluded powerful coalitions through competitive elections, incentivising them to focus on public investments and broader policy reforms that contribute to their short-term political survival. Here, and precisely because ruling political elites are credibly at risk of electoral loss, 'political elites within the ruling coalition continually manoeuvre to sustain stability and to assure the continuing loyalty of clients' (Levy, 2014: 49).

One result is that the time horizons of political leaders tend to be shorter, and the calculated political return of public investment decisions are shaped by how visible a good is (Batley and Mcloughlin, 2015), rather than what holds the greatest promise in improving the welfare of the wider citizenry. As Levy (2014: 35) expresses it, a competitive clientelist political settlement is based on a credible prospect of power alternation, such that 'whichever faction is in power is likely to have a short time horizon'. In this respect, ruling elites' incentives are geared towards addressing localised development problems that require visible solutions, particularly around election time, so as to please voters. It is this preoccupation with regime survival that helps explain why competitive clientelist political settlements are generally characterised by 'weak implementation and enforcement capabilities' (Khan 2010: 68), especially around reforms that take a long time to bear fruit, and which require the cooperation of several 'principals' within the ruling coalition. Moreover, the threat of being removed from power implies that there is often 'little incentive for political leaders to invest in the long-term task of building bureaucratic capability' (Levy, 2014: 40).

In such contexts, countries are likely to experience 'a growing disconnect between a rapid expansion in the provision of resources for service provision and corresponding expansion in access to services, but continuing shortfalls in service quality and results' (Levy, 2014: 139). This explains why public service delivery in most competitive clientelist settings is 'typically of low quality' (Levy and Walton, 2013: 18), a problem that is likely to persist until incentives within the dominant coalition shift away from the impersonalised use of public institutions in pursuit of short-term gains. As Kelsall and Heng (2016: 251) recently note in the case of Cambodia:

'deeper-seated problems in service provision are unlikely to be resolved until the settlement's dominant tendency shifts from winning votes through predation-fuelled patronage, to programmatic public goods supply; and this

shift is unlikely to take place until the dominant coalition senses that the existing way of governing cannot be sustained.’

In the absence of such significant shifts, the best that can perhaps be hoped for is the emergence of ‘islands’ or ‘pockets’ of effectiveness (Leonard, 2010; Roll, 2013). Pockets of effectiveness (PoEs), as noted by Michael Roll, are:

‘public organizations that are surprisingly effective in delivering the public goods and services they are officially supposed to deliver in politico-administrative environments in which gross ineffectiveness in public service delivery is the norm’ (Roll, 2013: 3; see also Roll, 2014).

Based on a synthesis of a large number of cases, David Leonard identifies leadership, personnel management, resource mobilisation and organisational adaptation as prerequisites for the rise and persistence of pockets of effectiveness (Leonard, 2010).

Levy and Walton (2013) predict that multi-stakeholder governance arrangements² may hold the greatest promise for the emergence of PoEs in competitive clientelist settings. This approach requires participation in the governance of frontline service provision facilities by multi-stakeholder groups that include service recipients and others (e.g. donors, NGOs, community leaders, etc.) with a stake in the efficiency and effectiveness of service provision (Levy, 2014: 148). The logic here is that, given the dispersed nature of power among several principals in competitive clientelist settings, a focus on ‘nurturing commitments among equals’ through multi-stakeholder oversight offers a better route to improving service provision than hierarchical approaches that focus on addressing principal-agent problems. However, and as Levy (2014) emphasises, an effective multi-stakeholder governance approach does not happen automatically; instead, ‘it takes leadership to set a cooperative endeavour in motion’ (p.189).

The political settlements approach represents a significant advance in our understanding of the politics of service delivery, particularly when compared to previous influential approaches such as the ‘accountability framework’ outlined in the *World Development Report 2004*, which usefully distinguishes between a ‘long-route of accountability’ of service providers and an alternative ‘short-route’ (World Bank, 2003). While the ‘short-route’ comprises the interactions between providers and their ‘clients’, the long route is based on two broad sets of links: ‘voice’, which links citizens to politicians, and thence to policy makers, and a ‘compact’ that links policy makers and service providers. While this framework represents an important corrective to the narrowly technocratic preoccupation of many public-sector

² They define ‘multi-stakeholder governance’ as a situation in which, ‘there is a politically salient coalition of external stakeholders that is working in concert with an organisation’s management (whether through proactivity of the organisation’s leaders or social pressures on the leadership) with a mutual interest in pursuing the organisation’s goals’ (Levy and Walton, 2013).

reformers, Levy and Walton (2013) remind us that competitive clientelist settings are characterised by many more complexities and ambiguities than is implied by both the 'long' and 'short' routes of accountability. Here, where several powerful factions exist within ruling coalitions, the likelihood of significant contestation around rule-setting processes is high, and implementation of agreed decisions is 'likely to be subject to weaknesses in both monitoring, and in sanctions for non-compliance' (Levy, 2014: 149).

There is broad agreement that the nature of the political settlement in Ghana since the return to multiparty democracy in 1992 has been characterised by 'competitive clientelism' (Abdulai and Hickey, 2016; Hirvi and Whitfield, 2015), where ruling political elites have become increasingly vulnerable due to intense electoral competition. Ghana transitioned from decades of political instability in the immediate post-independence era to a decade of a stable quasi-military experiment (1982-1992) and then to a stable multi-party democratic rule from 1993 to date. Although several parties have contested all six sets of elections held during 1992-2012, elections are primarily a two-horse race between the New Patriotic Party (NPP) and the National Democratic Congress (NDC). Electoral competition between these parties has become increasingly intense; in 2008, it took three rounds of presidential elections to determine the winner, by a narrow margin of less than 0.5 percent of total valid votes cast, and the NDC won the elections held in 2012 by less than 3 percent of the votes (Table 1).

Table 1: Presidential election results, 1992-2012

Year	NDC (%)	NPP (%)	Other parties (%)	Margin of victory (%) – NDC & NPP
1992	58.40	30.29	11.4	28.11
1996	57.37	39.67	3.0	17.7
2000	43.10	56.90	6.7	13.8
2004	44.64	52.45	2.92	7.81
2008	50.23	49.77	2.91	0.46
2012	50.63	47.81	1.56	2.82

Source: Author, based on Electoral Commission of Ghana, Accra.

Despite this equal strength, the party that wins elections monopolises power and state resources, irrespective of the margin of its electoral victory. Consequently, each ruling coalition is characterised by a high degree of vulnerability in power, leading to the politicisation of public institutions and the allocation of public goods according to an electoral logic (Abdulai and Hulme, 2015; Abdulai and Hickey, 2016; Abdulai, 2016a). These competitive clientelistic tendencies have been exacerbated by growing levels of vertical power within each ruling coalition, particularly the influential

'party foot soldiers', who play crucial roles in vote-mobilisation efforts for their parties, and are also often deployed as party polling agents to protect their parties' interest on election day at the polling. In a move that testified to the growing political influence of foot soldiers in Ghana, the late President J. A. Mills issued a public directive in 2010, instructing all of his appointees to cater to the needs of the party's foot soldiers. As Khan (2010) reminds us, such lower-level factions of ruling coalitions are particularly powerful in competitive clientelist settings, where their significance in winning elections puts them in a position to be able to block or limit the implementation of reforms should dominant ruling elites fail to meet their demands (p.65). As we will see, the Ghanaian health sector is not immune from these tendencies, with foot soldiers becoming increasingly powerful in informing appointments to the upper echelons of health sector bureaucrats.

We now turn to explore the question of how these political settlement dynamics have shaped health policy reforms in Ghana, and their implications for quality health service delivery. Before this, however, it is important to discuss the nature of the political settlement within the Ghanaian health sector itself.

3. The political settlement in the Ghanaian health sector

Political settlement analysis focuses on powerful *actors*, *interests* and *institutions*, both formal and informal. The power relationships between various actors dictate the actual functioning of institutions, and also determine whose interests are translated into policy and practice. This section discusses the nature of the political settlement within the Ghanaian health sector, focusing on an understanding of the key actors and how their differential levels of 'holding power' have shaped major health sector reforms. The health system in Ghana, at least on paper, follows a highly decentralised governance structure. The Ministry of Health (MoH) is the central government institution responsible for sector-wide policy development, financing, regulation, monitoring and evaluation, using its various agencies, including the Ghana Health Service (GHS). Regional and district medical matters fall under the jurisdiction of regional and district health management teams.

At the regional level, GHS' Regional Health Administration (RHA) offices provide secondary hospital care through regional hospitals, and coordinate the districts' health activities and planning, as well as providing supervision and management support to the districts and sub-districts within each region.³ Each RHA is headed by a regional director of health services (RDHS), who is supported by a regional health service administrator, a senior medical officer in charge of public health, a pharmacist, public health nurse, a regional director in charge of nursing services, and an accountant. It is this group that forms the regional health management teams (RHMTs) in each region. At the district level, health services are managed by a district health management team (DHMT), headed by a district director of health services (DDHS), who is responsible to the RDHS. Overall planning, organising and monitoring of health outcomes within the district are vested in the DHMTs. The

³ See: <http://www.ghanahealthservice.org/>

DHMTs are responsible for the supervision of all health services at the district level, as well as the implementation of plans and policies.

While this administrative structure gives the impression of a highly decentralised system, in which power is dispersed among different actors, it masks the actual distribution of power that governs the health sector. Bossert and Buauvais (2002) characterise the Ghanaian health system as one of 'decentralised centralism', in which much power is concentrated in the hands of politicians, particularly the minister of health and the president. The GHS itself, while deconcentrated, has a centralised governance structure. Its national governing council and director-general are appointed by the president on advice of the Council of State, many members of whom are themselves presidential appointees. Moreover, while the formal governance arrangements entrust health policy making in the hands of senior bureaucrats within the MoH, in reality, party/government interests often override technocratic views in policy making and implementation (Asante and Zwi, 2009). One senior bureaucrat within the MoH expressed this sentiment, stating that:

'At times, we will be there and then from a higher [political] office, you get a call to do certain things. That is there as a limiting factor, and there is little we can do. At times, you want to effect some changes, but because of the political terrain you are called to halt certain moves. These are the strong hands that move things around'.⁴

The wide dispersion of power within the health sector is also evident in the increasingly influential role of party foot soldiers in public appointments to the upper echelons of Ghana's health bureaucracy. One recent example occurred in February 2015, when foot soldiers of the ruling NDC successfully halted a handing over ceremony in which Dr Kofi Issah was to take over as the newly appointed regional health director to the Northern region. Dr Issah's appointment was based on a series of competency-based examinations and interviews conducted by the Public Services Commission and approved by the governing council of the GHS. However, a dramatic twist occurred when the minister of health, Dr Kwaku Agyemang-Mensah, halted Dr Issah's posting to the Northern region, following a protest march by foot soldiers insisting that Dr Issah was not their preferred candidate. In a blatant disregard for the decision of the Public Services Commission, the preferred candidate of the foot soldiers (i.e. Dr Jacob Mahama) was asked to take over the Northern regional directorate as the acting regional director. These manipulations prompted response from the Ghana Coalition of NGOs in Health, which called on the president to reverse these decisions, in order to protect and promote professionalism and the institutional integrity of the GHS.⁵

⁴ Interview, MoH official, 8 July 2015.

⁵ For further details on this, see *Daily Guide* (13 February 2015), '[NDC foot soldiers stop handing over](#)'. Available at: <http://www.peacefmonline.com/pages/politics/politics/201502/232402.php> (accessed 22 October 2018). Aberinga, M. (2015), 'Upper East NDC youth threaten massive defection'. Available at: <http://www.newsghana.com.gh/upper-east-ndc-youth-threaten-massive->

These observations reflect wider problems within the national-level political settlement, where short-term political calculations dictate the appointment of senior officials within the public bureaucracy. Here, as vulnerable ruling politicians have become increasingly preoccupied with the maintenance of power, top-level bureaucratic positions 'are typically appointed by presidential fiat, largely on the basis of partisan political criteria rather than merit' (Gyimah-Boadi and Yakah, 2012). Within the health sector, such short-term political calculations also explain the rapid changes of ministers and accompanying changes of some key bureaucrats in the sector. Indeed, between 2009 and 2015, Ghana has had seven different ministers of health,⁶ implying an average of less than one year per minister. Key informants note that such frequent changes have played a major role in undermining quality health outcomes in Ghana in various ways, including leading to a 'flight of ideas and policies'.⁷

3.1 Influence and limits of donors

The Ghanaian health sector enjoys substantial support from over 30 development partners: DFID, DANIDA and Global Fund are the largest contributors to the health sector budget, collectively accounting for over 86 percent of total donor receipts in 2014 (MoH, 2015b: 24). Donor proliferation in the sector from the early 1990s onwards necessitated the adoption of a sector-wide approach (SWAPs) in 1997 to address the problems of parallel donor systems and increased aid transaction costs (Pallas et al., 2015). The SWAPs created institutional arrangements whereby the MoH, donors and other stakeholders negotiate national health priorities and allocate financial resources to implement them. To this end, donors gained some agenda-setting powers in the health sector, as they used financial support as leverage (Koduah et al., 2015). Although the Ghanaian health sector remains predominantly publicly financed, the cost of salaries is dominating the budget, with over 98 percent of government allocations to the MoH spent on salaries alone in 2013 (MoH, 2015b). Consequently, the health sector remains significantly dependent on donor funds for capital expenditures. In 2012, donor funds accounted for 57 percent of health sector capital expenditures, increasing further to 78 percent in 2014 (Table 2).

So, given the magnitude of their inputs in proportional terms, to what extent have donors either individually or collectively influenced the nature or direction of reforms? Addressing a related question in the 1990s, Cassels (1996: 11) noted that 'it is hard to make the case that donors have had a great deal of influence or have imposed reforms on unwilling recipients of their aid'.⁸ As an example, he cites government's

[defection/](#) (accessed 24 April 2016); *The Chronicle* (24 April 2015), 'NGO challenges transfer of Dr Awoonor-Williams. Available at:

<https://www.ghanaweb.com/GhanaHomePage/regional/NGO-challenges-transfer-of-Dr-Awoonor-Williams-355918> (accessed 24 April 2016).

⁶ These have included George Sipa-Adjah Yankey, Benjamin Kunbuor, Joseph Yieleh Chireh, Alban Bagbin, Hanny-Sherry Ayitey, Kwaku Agyemang-Mensah, and currently Alex Segbefia

⁷ Interview, senior official, regional health directorate, 5 August 2015.

⁸ One notable exception Cassels (1996) cites was the World Bank's pressure on the GoG to raise health user fees in 1987 as part of the structural adjustment reforms.

Table 2: Contributions to health sector capital expenditure (in million GH¢)

Year	GoG	Donors	IGF	*ABFA	Total
2012	29.23	132.49	71.89	0.00	233.61
2013	2.99	155.57	211.17	29.90	399.63
2014	15.44	625.01	159.25	0.00	799.70
2015	1.00	570.22	570.22	43.55	1185.00

Source: GoG annual budget statement, various years.

*The ABFA (Annual Budget Funding Amount) is the proportion of oil revenues allocated to specific key sectors determined by the minister of finance.

successful resistance to the introduction of the UNICEF-inspired Bamako Initiative, which would have had the effect of establishing a parallel cost recovery system in the health sector. An example of the continuous resistance to donor policy preferences that are not in line with domestic elites' interests relates to the adoption of a National Health Insurance Scheme (NHIS) in 2003. Debates about Ghana's adoption of the NHIS were characterised, at least initially, by an 'open disagreement between [the government of] Ghana and development partners' (Embassy of Denmark in Ghana, 2015: 8). Many key health sector donors were sceptical of the government's NHIS reform plans, and accordingly opposed the NHIS bill on grounds of the fiscal soundness of the proposal, the proposed timeframe for rolling out the programme, the lack of external technical assistance for the reform, as well as inadequate governance and institutional arrangements to ensure successful implementation (Rajkotia, 2007; Assensoh and Wahab, 2008; Carbone, 2011; 2012). While DANIDA, a major health partner, initially advocated a community-based scheme with national oversight and a slower more sustainable model for moving towards universal insurance coverage as a better option, it soon 'acknowledged that it could not continue its opposition to the government's policy and changed its strategy to support the NHIS' (Bjerrum, 2016: 23). During the 2003 annual health summit, development partners collectively cautioned government against migrating too quickly to a national social health insurance scheme. However, as the NPP political elites were determined to fulfil a major election campaign promise (see next section), 'the development partners... were generally side-lined' in the reform process (ibid), and went on to commence implementation of the NHIS.

This said, it is important to note that access to donor funding has played a major role in explaining the increasing government commitment to the reduction of maternal mortality in Ghana. In September 2003, the MoH introduced an exemption policy directed at making delivery care free in Ghana's four most deprived administrative regions, the cost of which was paid from HIPC funds (Abdulai and Hulme, 2015). The December 2004 presidential elections presented an opportunity for policy actors to modify existing policies, putting maternal fee exemption back on the agenda. At the December 2004 health summit meetings, the MoH and stakeholders argued that a national maternal mortality rate of 503 per 100,000 live births was high, and that there were pockets of extreme poverty across the country beyond the four most deprived regions. A national user fee exemption for antenatal, delivery and postnatal

services was therefore proposed by the MoH and stakeholders to help reduce maternal mortality. Politically, this idea was approved by the government, and in 2005, 30 billion cedis (3.4 million US\$) from HIPC grants was budgeted and allocated to implement the policy nationwide. However, as HIPC resources began to dwindle substantially by 2007, funding to reimburse health facilities for delivery fee exemptions ran out, and pregnant women who were not enrolled in the NHIS had to pay fees for delivery services.

Evidence presented at the health sector performance review in 2008 suggested that the suspended maternal user fee exemption policy contributed to worsening maternal mortality indicators. Here again, donor efforts in reversing the trend were highly evident through their contributions to new ideas and the provision of resources. In particular, the UK government's Department for International Development (DFID) submitted a brief to the presidency through the MoH, suggesting that all pregnant women be given functional NHIS membership cards to assure access to maternal healthcare and improve the performance of MDGs 4 and 5 (Koduah et al., 2015). When the NPP government subsequently announced its free maternal healthcare policy in July 2008, it did so with secured funding from DFID through the health sector budget support.

Other donors have contributed to the growing government commitment to the reduction of maternal mortality, both by increasingly earmarking their funding contributions for maternal health interventions, and by tying funding disbursements to triggers based on performance of agreed indicators. Since 2011, the European Union has been earmarking its health sector budget support towards the implementation of the Ghana MDG Acceleration Framework (MAF) Action Plan – an initiative designed by government and development partners to combat maternal mortality through improvements in skilled birth attendance, family planning measures and investments in emergency obstetric and newborn care. In 2014, DANIDA also earmarked its sector budget support to MAF, justifying it on grounds of 'the continued high maternal mortality' (Bjerrum, 2016: 31). This discussion suggests that donors do wield some influence over the Ghanaian health sector, but with ultimate policy decisions still resting largely with politicians.

4. The political settlement and healthcare in Ghana

This section explores the impact of Ghana's competitive clientelist political settlements in shaping health sector investments and how these in turn shape health outcomes in the country. Specifically, we highlight: (1) how electoral cycles have shaped health sector reforms; (2) the role of electoral pressures in skewing health sector investments towards high visibility projects; and (3) weaknesses in the enforcement of accountability mechanisms.

4.1 Electoral cycles and health policy reforms

One important manifestation of the politicisation of the Ghanaian health sector relates to the ways in which electoral cycles influence major policy reforms. A typical

example is the adoption of the National Health Insurance Scheme (NHIS). In the 2000 elections, 'Cash and Carry', or payment for healthcare at the point of service delivery, assumed a political dimension. While in opposition, the NPP attacked the cash-and-carry system as 'iniquitous', 'notoriously callous and inhuman', and promised to replace it with a more equitable insurance scheme (NPP, 1996; NPP, 2000).⁴⁰ However, the party also knew that a single national health insurance scheme was not feasible, due mainly to the low percentage (10-15 percent) of people employed in the formal sector. Its 2000 election manifesto therefore pledged to encourage various segments of society (workers, employers, private health companies, etc.) to establish their own insurance schemes, with government retaining a regulatory and monitoring role (NPP, 2000).

After coming to office, however, and as the 2004 elections approached, 'the NPP government was on the lookout for highly visible measures it could showcase in seeking a new mandate' (Carbone, 2012), and accordingly felt the need to go beyond its own election pledges. Therefore, as the work of a committee set up in 2001 with the task of designing a new health insurance reform appeared to slow down because of technical concerns, its composition was changed to better reflect the political priorities and the haste of the executive (Rajkotia, 2007; Carbone, 2011). In the process,

'the health minister made a series of new appointments aimed at realigning the position of key ministerial personnel with the political imperatives and the policy goals of the executive. With political nominees rapidly taking a decisive role in the policymaking process, the traditionally strong role played by the technocrats at the Ministry of Health was *de facto* downsized' (Carbone, 2012: 168).

To further minimise the risk that the passing of the NHI bill would be slowed down – or even halted – and the political objective of having it enacted prior to the election undermined, the government rushed the bill through parliament with very limited time for debate (Rajkotia, 2007; Carbone, 2011). The opposition NDC accused the executive of too hastily introducing the new policy, only to fulfil a campaign promise, and accordingly boycotted parliamentary debates on the bill.

The increasing connection between elections and health policy reforms in Ghana is also evident in President Kufuor's announcement of a free maternal healthcare initiative that was to be implemented through the NHIS. Under this initiative, pregnant women obtained the right to join the NHIS for one year without a waiting period and without paying a registration and processing fee. In what was largely seen as 'a political initiative' (Witter et al., 2013: 9) aimed at attracting votes in the December 2008 elections, the president announced this policy in May 2008, and its implementation started nationwide only six weeks thereafter. The extraordinary speed at which the initiative was rolled out became a major source of problems at the level of implementation. Among others, prior costing and budgeting of the policy was not done, and questions about who would pay for the production and distribution of

Insurance cards for the newly registered pregnant women, as well as who would undertake the registration when a woman presented in labour at a health facility far away from an insurance office, were not thought through.

Unsurprisingly, recent qualitative evaluations of the free maternal health policy suggest that, whereas the policy led to the increased utilisation of health services by pregnant women, this has not significantly translated into access to quality maternal services (HERA and Health Partners Ghana, 2013). Indeed, on the contrary, the initiative led to increased pressure on existing human resources, which in turn 'affected quality of care negatively' (Witter et al., 2013: 8).

Our interviews with healthcare workers and hospital administrators at both the national and regional levels reveal that low tariffs for maternal health services and delayed claim payments have continued to undermine the effective implementation of the NHIS in general, and the free maternal care component of the scheme in particular. As one district medical superintendent explained:

'The NHIS is making life very difficult for us. Most of the time, the claim will pile up for several months. (...) We don't have a lot of non-insured drugs and even the insured ones, because the money is not there to procure these drugs. We are most of the time short of most drug consumables. There are times that you have an emergency and you have to give a prescription to a patient's relatives to go and search for the medicine for you because the facility doesn't have it in stock'⁹.

Such long delays in reimbursements have driven 'some hospitals to the brink of insolvency' (HERA and Health Partners Ghana, 2013: 41), resulting in the now 'widespread practice' of requiring patients to purchase supplies that should be part of the basic service package for pre-and post-partum care (ibid., p.2). The combined results have been that, barely three years after the policy's introduction, many health facilities had either stopped providing free maternal health services (Kodua et al., 2015), or engaged in what may be regarded as 'informal' charges as a way of redressing the delays in government funding: 'Insurance was helping free maternal health, but unfortunately they stopped paying several months ago. (...) So if they [pregnant women] come now, they will pay because government hasn't paid.'¹⁰

By the end of 2013, the National Health Insurance Levy due from the finance ministry stood at GH¢332.21 million (National Health Insurance Authority, 2014: 12), and the financial sustainability of the NHIS is now widely acknowledged as 'an emergency' (MoH, 2015b: 5). Importantly, rather than focus on addressing this long-term sustainability issue, reform efforts seem to continue to focus on a further broadening of the scheme's coverage, especially around election years. One example was an announcement by the health minister in March 2012 that government would soon

⁹ Interview, DHA official, 29 July 2015.

¹⁰ Interview, GHS official, 10 July 2015.

include free family planning services among NHIS benefits. From the perspective of health sector bureaucrats, one way of sustaining the NHIS within the context of currently limited resources, is to restrict its benefits to the poorest segments of society. Such a restriction holds a promise not only of enhancing the sustainability of the scheme, but also of enhancing its original pro-poor orientation.¹¹

‘So we are also telling government to restrict it to primary health care ...and to the SADA areas [referring to the poorer Northern regions] because even government studies show that this is where the poor are concentrated (...) But it’s the matter of who makes the decision. That’s why we are trying to get the politicians to get the full grips [of the problem].’¹²

However, the political benefits associated with universal coverage imply that reforms that consider restricting NHIS benefits to certain parts of the country, or to specific segments of society, remain an unappealing option to ruling political elites. These observations are reflective of broader patterns of public spending in the Ghanaian health sector. Although key policy documents frequently demonstrate a clear intent to shift resources to more deprived areas (e.g. MoH, 2007; 2005; 2003), the criterion for resource allocation significantly ignores variations in health needs across jurisdictions (Asante and Zwi, 2009; Saleh, 2013). Instead, a considerable proportion of the health budget is simply divided equally across the board among regions, districts and facilities, without any regard for differential needs. Such resource allocation criteria, which have the tendency of deepening interregional inequities, are driven primarily by the logic of electoral politics: the increasing need to court votes countrywide means that politicians prefer to spread resources thinly to reach as many potential voters as possible, rather than narrowly targeting more deprived areas in the interest of geographically equalising outcomes (Abdulai, 2012). These observations are fully consistent with the logic of competitive clientelism, where the effective implementation of policy decisions requires ‘the distribution of rents to many or all lower-level factions to ensure their cooperation’ (Khan, 2010: 23).

4.2 Prioritisation of quantity over quality

The discussion in Section 2 shows that in competitive clientelist political settlements, the persistent threat of losing power to excluded powerful coalitions means that ruling elites are likely be inclined towards immediate and ‘visible’ policy outcomes that contribute to their short-term political survival. In terms of the politics of service delivery, this implies that elite incentives are steered towards the production of ‘visible hardware, or easily imagined and quantified expansions in access ... over

¹¹ In its current state, the NHIS is not sufficiently pro-poor as those in the upper and middle income brackets are more able to afford the NHIS premiums while many poor people are unable to afford health care services. The differences are striking, with 20 percent of the upper wealth quintile men having NHIS cards, compared to only 10 percent in the lower wealth quintile. For women, the comparable percentages are 29 percent for the top wealth quintile as against 17 percent for the lowest wealth quintile

¹² Interview, senior GHS official, 10 July 2015.

backroom, quality-improving functions' (Batley and Mcloughlin, 2015: 278). One major impact of competitive clientelism in Ghana relates to the ways in which ruling politicians are incentivised to focus health sector investments on the *quantitative* provisioning of visible infrastructure. Budget disbursements in the sector often focus disproportionately on the provision of infrastructure, while funds for actual quality service delivery attract the 'least priority' (Bjerrum, 2016: 33). This problem was acknowledged in a 2006 joint MoH–Development Partners aide-memoire, which bemoaned government's 'progressive expansion of services beyond the limits of available human resources and operating budget' (MoH, 2006: 5).

Since the early 2000s, health policy reforms have focused heavily on the implementation of the NHIS and the expansion of the Community Health-Based Planning Services (CHPS) strategy. The CHPS are designed to bring health services closer to the doorstep of households, and this involves subdividing sub-districts into smaller zones, assigning trained health workers, and providing them with the logistics to deliver basic preventative and curative care services. Although the CHPS programme has the capacity to contribute to improved maternal and quality healthcare in general, its implementation has taken a dimension that focuses on the construction of CHPS compounds, at the expense of equipping these compounds to be able to perform their basic functions. Consequently, whereas the number of CHPS compounds has increased in recent years – from just 39 in 2002 to 2,948 by 2014 (Ghana Health Service, 2012: 55; MoH, 2015b: 10), a 2010 national survey shows that 57 percent of CHPS compounds had no midwife, while most health centres (57 percent), clinics (61 percent) and maternity homes (55 percent) had only one midwife.¹³

Many health sector technocrats argue that the route to improved health outcomes in Ghana 'is not about building more hospitals', but more about equipping existing health facilities and ensuring the effective supervision of health sector workers.¹⁴ Yet, various governments have continued to prioritise the quantitative provisioning of health facilities at the expense of the quality of the services provided. In 2012, an important election year, the Ministry of Health exceeded its target of expanding CHPS coverage by over 50 new compounds (MoH, 2013: 34), while apparently failing to enhance the capacity of existing CHPS compounds to contribute to quality healthcare delivery. Although the CHPS operational policy prescribes a package of equipment and logistics to enable CHPS officers to function effectively, it is acknowledged that inadequate funding, poor human resource base, and 'poor supervision ... have contributed to the poor performance of the CHPS programme' (MoH, 2013: 34).

At both the national and regional levels, several key informants noted that, although the basic idea behind the CHPS was the training and strategic placement of health officers providing basic public health services at the community level, the political

¹³ See the 2010 assessment of emergency obstetric and newborn care report (MoH, 2011a).

¹⁴ MoH official, 10 July 2015; MoH official, 8 July 2015.

imperative of winning elections has meant that the CHPS programme has now increasingly lost its original focus on public health orientation to that of building CHPS compounds that remain poorly equipped. A senior policymaker at the health ministry recalled how one health minister recently diverted some donor funds meant for various health sector interventions towards the construction of CHPS compounds, and explained this in terms of the electoral calculus of politicians:

‘The politicians’ view is that create the structures so that they [voters] see the structures as our performance in improving health services. So for a politician, a CHPS compound is very important. But for me as technocrat, the public health aspect of CHPS is more important than the CHPS compound....They [politicians] want the facility there so they can label it as their performance; they would not see the idea that a public health nurse riding on a motorbike with a vaccine career as more of addressing the needs of the community than the CHPS compound.’¹⁵

Importantly, as the building of CHPS has become a major priority for political elites, the performance of health ministers tends to be measured, not so much in terms of their overall contribution to quality health outcomes, but more importantly by the quantity of CHPS compounds they construct:

‘So the minister comes here and one of the ways of measuring his performance is how many CHPS compounds have been built. These are some of the things that distort the focus. So any money that comes in ... the first is always how many CHPS can we build, so that in the first place I am seen to be performing as a minister and also to support the government to meet his objectives.’¹⁶

These observations need to be understood within the context of the competitive character of clientelist politics in Ghana, where the calculated political return of investment decisions is shaped strongly by the visibility of the good in question. In this context, the provision of physical buildings and infrastructure gets prioritised because ‘the potential political returns from responding to visible problems and producing visible outputs are greater than those from tackling lower profile challenges or improving systems and processes that are obscured from public view’ (Batley and Mcloughlin, 2015: 278). One senior health policy maker argued that a major challenge to improved quality healthcare delivery in Ghana has been a ‘disconnect between the strategic objectives that we set for ourselves and the activities that we implement’.¹⁷ He cited the example of the recent government’s heavy investments in the provision of ambulance services as a way of improving maternal health, while at the same time showing little commitment in equipping emergency rooms in hospitals. Such patterns of investments have failed to make the

¹⁵ MoH official, 10 July 2015.

¹⁶ MoH official, 10 July 2015.

¹⁷ Interview, MoH official, 10 July 2015.

desired impact on improved maternal health outcomes because, as this respondent explained:

'Ambulance services and emergency services are two different things. Yet we are focusing on ambulance services, expecting that we are going to address the emergency service. But when they take a patient ... to the hospital, 80 percent of the patient's survival needs are taken care of in the emergency room, and we are not investing in the emergency rooms. (...) We have always discussed these things, saying instead of focusing on ambulance services, why don't we focus on emergency services.'¹⁸

Unsurprisingly, and based on a series of monitoring visits to selected health facilities aimed at understanding the causes of the limited progress in enhancing maternal health in the country, another report by the health ministry also found the emergency preparedness of 'most' health facilities to be 'weak' (MoH, 2012: 5). One recent assessment of emergency obstetric and neonatal care in Ghana also highlighted major deficits in the capacity of existing health facilities to provide assisted deliveries (MoH, 2011a). Based on a survey of some 1,268 health facilities, the assessment reveals that only 33 percent of pregnant women in the country requiring emergency care actually receive it. Existing gaps highlighted ranged from inadequate equipment and drugs, to limited and inequitable distribution of human resources (*ibid*).

These observations seem characteristic of most competitive clientelist political settlements, whereby ruling elites may make broad programmatic policy promises, while in practice prioritising the implementation of measures that hold the greatest promise to attract votes. As Booth and Therkildsen (2012) note, there is often a high 'tendency of competitive clientelism, especially in its democratic form, to generate policy incoherence – bold policy gestures that are neither followed up with implementation nor accompanied by the necessary complementary measures' (p.18).

4.3 Weak enforcement of accountability mechanisms

One salient feature of countries characterised by competitive clientelism is the weak enforcement capabilities of ruling coalitions, not least as the existence of multiple strong factions, both within and outside of the ruling coalition, means that the enforcement of policy decisions 'requires much greater collective action' (Khan, 2010: 65) that is difficult to achieve. Recent work on service delivery within different types of political settlements also suggest that top-down reforms within competitive clientelist settings are more prone to capture by agency management and coordination failures. Here, service delivery sectors tend to be driven by multiple goals and principals, with no clarification over respective roles leading to poor implementation outcomes (Levy and Walton, 2013). These observations appear very characteristic of the Ghanaian healthcare system, where weak accountability mechanisms and poor coordination remain a major obstacle to quality healthcare delivery.

¹⁸ Interview with senior bureaucrat, MoH, 10 July 2015.

Although various regulatory agencies exist, ‘accountability in the health sector remains weak’ (Saleh, 2013: 18), with the result that many health workers are performing well below standard (ibid., p.5). Significant lapses in the functionality of oversight and accountability mechanisms are evident across the entire health sector, ranging from the national to district levels. One example relates to the relationship between the GHS and the MoH. With the passage of the Teaching Hospitals and the Ghana Health Service Act in 1996 (Act 525, 1996), performance contracts were required to be established not only between operational BMCs (Budget Management Centres) and their supervising BMCs (Couttolenc, 2012), but also between the MoH, on the one hand, and the GHS and teaching hospitals, on the other; the latter were expected to be accountable for performance according to established performance indicators (Adjei, 2003). However, the introduction of such accountability mechanisms had been characterised by feet-dragging for well over a decade,¹⁹ and it was only in 2012 that the health ministry began signing performance contracts with the three teaching hospitals and the GHS (MoH, 2013: 22).

Although various regional health directors are also now required (since 2013) to sign performance contracts with the director general of the GHS,²⁰ our field research evidence shows that these agreements are not enforced. As one regional health director rhetorically asked:

‘Have I been ever called and asked, Director, this is your contract with me what have you done? No! There is no follow through. You sign, and you take pictures and they sign, but then what else? Nothing!’²¹

Thus, while a number of performance appraisal mechanisms do exist in the sector, these are generally not applied in such a way as to elicit high performance or penalise poor performance (Lievens et al., 2011: 50; MoH, 2009: 32). Moreover, rather than based on good performance, promotion in the health sector is mostly granted on the basis of ‘patronage’²² or ‘personal networks’ (MoH, 2009: 32); as well as length of service. Some insiders refer to the existence of ‘a culture of automatic promotion’ in the Ghanaian health sector (Asabir et al., 2013: 66).

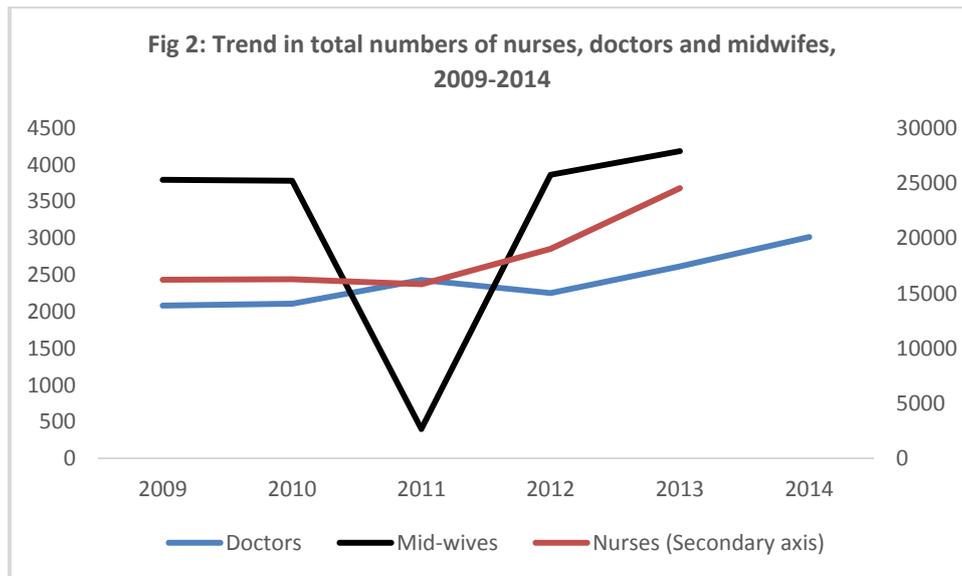
These problems have meant that recent significant improvements in the production of various health professionals (Figure 2) and a corresponding improvement in the population to health professional ratios (Table 3) have failed to reflect in improved maternal health outcomes. In particular, there have been significant improvements in the production of nurses and midwives, leading to population-to-nurses-and-midwife ratios that are now better than world standards. One recent review report observes

¹⁹ As recently as 2011, the GHS was ‘still working with MOH to create accountability through the introduction of the performance contract’ (GHS, 2012: 18).

²⁰ Interview, Regional Health Administration (RHA) official, 5 August 2015.

²¹ Interview, RHA official, 5 August 2015.

²² Interview, RHA official, 5 August 2015.



Source: Author, based on MoH annual health sector review reports, various years.

Table 3: Trends in population to skilled health professional ratios, 2009-2012

Years	Population to doctor	Population to nurse	Population to midwife
2009	11,649	1,494	
2010	11,698	1,516	
2011	10,217	1,599	1,505
2012	11,515	1,362	1,611
2013	10,170	1,084	1,525
2014	9,043	959	1,374

Source: Compiled from MoH annual health sector review reports, various years.

that based on WHO's standard of 175 deliveries per midwife per year, there are now 'more than enough midwives' in Ghana, and goes on to caution that sustaining the current levels of production of midwives could lead to inefficiencies in the system (MoH, 2015a: 17-18). Yet weaknesses in oversight and accountability mechanisms have meant that absenteeism among public sector health workers remains 'commonplace' (Lievens et al 2011: 45), resulting mostly from moonlighting among medical doctors and senior nurses in urban areas (ibid). Moonlighting and dual practice are noted to have significant adverse consequences for health worker productivity and quality healthcare delivery; some health workers deliberately scale down their (primary) clinical public work to provide better services in their (secondary) professional private facilities (ibid).

Thus, altogether, health administration office and facility managers in Ghana are not held accountable to results in a significant way. One senior health official from the Volta region blamed this problem on local Ghanaian culture that makes it difficult to discipline staff. Referring specifically to the attitude of certain influential actors in Ghanaian society, he argued that once a process to discipline a non-performing health worker commences,

‘a chief will send somebody to come and beg you and if that fails, your pastor will come and knock on your door. It will go up and up till it gets to a stage that you can’t do anything about it but to give in. So our culture, cultural norms are unhealthy to the system of accountability.’²³

Yet, this culturalist interpretation is questionable, not least because of the significant variations in terms of the functionality of accountability mechanisms between public and private health facilities and the ways these in turn shape health worker productivity in the public and private sectors. Recent qualitative research contrasts the problem of absenteeism in the public sector with the experience in private health facilities, where ‘absenteeism ... is not tolerated and is typically sanctioned’ (Lievens et al 2011: 45), suggesting that there are no deterministic cultural norms that undermine health sector worker accountability across the board. Therefore, to the extent that local chiefs and church leaders may have a role in weakening the enforcement of disciplinary measures in the public health sector, this has to be understood in terms of their influence within Ghana’s competitive clientelist political settlement, especially through their control over large voting populations (Oduro et al. 2014; Abdulai, 2016b).

That weaknesses in accountability in the Ghanaian health sector are more of a political than a cultural problem is also evident in the nature of accountability arrangements and how this has in turn undermined the implementation of disciplinary measures. First, and in line with evidence in other countries characterised by competitive clientelism (e.g. see O’Neil and Cammack, 2014; Booth and Cammack, 2013), the Ghanaian health sector is characterised by ‘blurred or unclear lines of authority and accountability’ in ways that undermine the enforcement of disciplinary measures (Couttolenc, 2012:49). Second, the important management authority to hold health workers accountable for their performance (including the responsibility to carry out formal performance appraisals or to fire health workers) is not decentralised to facility level (Asabir et al., 2013: 80), with some adverse implications for the effectiveness of accountability mechanisms. While both regional- and district-level staff have long emphasised the need to have more authority on staff management, hiring and firing is not under the authority of the district level. Most decisions on disciplinary action are therefore referred upwards in the system, where firing staff remains ‘very exceptional’ (MoH, 2011b: 16).

Another important factor that helps explain the disconnect between improvements in the production of health workers, on the one hand, and quality health outcomes in Ghana, on the other, relates to the geographical distribution of the health workforce. Although health policies have long emphasised the need for a redistribution of critical human resources as a way of improving the equitable provisioning of quality health-care, interregional variations in the availability of medical doctors have not only persisted, but have widened over time. In 2013, more than half of Ghana’s medical doctors (53 percent) were concentrated in Greater Accra, compared to 40 percent in

²³ Interview, RHA official, 15 July 2015.

2009. A comparison of the doctor-to-population ratios for 2006 and 2013 also shows that these inequities are widening. In 2013, of the 25 government hospitals that did not have a single doctor, eight were found in the Northern Region alone (MoH, 2013: 18). These distributional inequalities have persisted, despite the official policy rhetoric of bridging the gaps, and the implementation of several measures aimed at enhancing the reallocation of human resources to deprived areas.²⁴

One crucial factor that explains this problem has been the centralisation of the doctors' payroll, with one key informant insisting that 'until hiring and firing of staff is decentralised, these things won't change'.²⁵ In particular, it is argued that a more decentralised salary regime would ensure that doctors registered with the Ghana Medical Association (GMA) would be more closely monitored and supervised by the local representatives of the people that they serve. With the current system, where salaries are paid by the central government in Accra, no such effective supervision is feasible.²⁶ Moreover, the virtual appointment and payment of doctors by the central government has sometimes meant that appointed staff who fail to report on duty can continue to receive their salaries. Indeed, between 2007 and 2009, only one of 13 doctors posted to the Upper East region actually reported in the region, even though all the 13 remained on the government's payroll (MoH, 2009: 32). Although a new proposal by the MoH is to withdraw the salary of staff who do not take their post, it is acknowledged that this is not being implemented, so that 'currently... health workers can collect their pay despite never taking up their post' (MoH, 2015b: 19; see also MoH, 2010: 67). However, health sector decentralisation in Ghana has faced a number of challenges, including a legal framework that is both 'confusing' and 'contradictory' (Couttloenc, 2012: 40). Moreover, discussions of having local governments control physicians' salaries have often faced significant resistance from the Ghana Medical Association (GMA). These observations draw attention to how the dispersed distribution of power within the Ghanaian health sector has undermined progressive reforms and, by extension, the quality of healthcare delivery.

5. The politics of sub-national variations in health service delivery in Ghana

As noted earlier, although improvements in maternal health indicators in Ghana remain generally disappointing, there are significant sub-national variations in these outcomes. This section explores the drivers of interregional variations in maternal health outcomes, focusing specifically on the contrasting experiences of the Volta and Upper East regions of Ghana. We chose these cases purposively from the extremes of good and bad performing regions in terms of maternal health outcomes: the Upper East is the high-performing region, and Volta is the low performer. Following Faguet and Ali (2009), we focused on these two extremes of performance

²⁴ For example in 2004, the MoH established the Deprived Districts Incentive Scheme to help attract doctors to deprived localities. An inter-agency committee was also established in 2006 to oversee the equitable distribution of newly graduated health professionals.

²⁵ Interview, senior official, regional health directorate, 15 July 2015.

²⁶ Interview, senior MoH official, 8 July 2015.

with the hope of gaining analytical richness and insight into the causes of good and bad social development outcomes.

It is well known that the northern savannah belt of Ghana, comprising the Northern, Upper West and Upper East regions, has historically been the poorest throughout the country's postcolonial history. The Ghana Living Standards Survey (GLSS 2012/13) estimates levels of extreme poverty in the Northern, Upper East and Upper West regions at 22.8 percent, 21.3 percent and 45.1 percent, respectively, compared to just 8.4 percent at the national level, 1.5 percent in Greater Accra, 2.9 percent in Ashanti, and 9 percent in Volta (Ghana Statistical Service, 2014: 15). Presently, the Upper East region has the highest level of under-weight children in Ghana (Ghana Statistical Service and Ghana Health Service, 2015: 26), the highest primary school class sizes (Ministry of Education, Science and Sports, 2008: 111), and the lowest proportion of trained teachers in both primary and junior secondary schools (World Bank, 2010: 68, 111).

Surprisingly, the Upper East consistently recorded the highest average of antenatal visits, and the highest number of skilled deliveries in Ghana during 2011-2013. In 2013, skilled delivery coverage in the region was 70 percent, compared to a national average of 55 percent (Table 4), with a recent MoH report suggesting the need 'to look to Upper East Region for best practices in supervised delivery coverage' (Ministry of Health, 2013: 16). In contrast, the Volta region has consistently been the lowest performer with regards to supervised delivery during 2010-2013 (MoH, 2014: 10), recording the worst infant mortality rate in recent national surveys (MoH, 2013: 27). Based on a set of six health indicators,²⁷ the MoH has been conducting a simplified holistic assessment to identify performing and non-performing regions since 2010.²⁸ While the Upper East has consistently been highlighted as a 'region of excellence' in these assessments, the Volta region has almost always been characterised as 'a region requiring attention'.

Table 4: Selected maternal health indicators, 2011-2013

Years	Skilled delivery rate			Maternal mortality rate			Antenatal 4+ visits			Postnatal care coverage (%)		
	UER	VR	Ghana	UER	VR	Ghana	UER	VR	Ghana	UER	VR	Ghana
2011	64.6	40.8	49.1	127	201	174	92.1	74.0	75.2	78.7	58.2	65.3
2012	68.6	44.9	55.0	136	174	152	94.5	74.3	77.0	77.0	53.4	62.7
2013	67.5	43.4	55.3	108	161	155	87.5	67.7	72.6	76.6	55.1	64.1

Source: MoH 2013 and 2014 annual review reports; ANC visits from GHS, 2014: 11.

A recent sectorial review report described Volta as 'an outlier', and recommended the need to conduct an in-depth study to help unravel the surprisingly poor health

²⁷ This includes those directly related to maternal and child health such as ANC 4+ visits, skilled delivery, family planning acceptor rates and institutional maternal mortality rates,

²⁸ The indicators include ANC 4+, skilled delivery, family planning acceptor rates and institutional maternal mortality rates.

outcomes in the region (MoH, 2013). This is because the region's average human resource availability not only compares favourably to the national average; it has also generally been more resourced in terms of the availability of health facilities. For example, whereas 53.8 percent of districts in the Upper East were covered by the distribution of National Ambulance Services in 2013, the corresponding figure for the Volta region was 64 percent (MoH, 2014: 58). Here again, whereas one doctor was serving a little over 23,000 people in 2013, the comparative figure for the Upper East was almost 34,000. These contrasting experiences prompt us to ask: how has the Upper East region emerged as a 'pocket of effectiveness' in health service delivery in Ghana, and what accounts for the surprisingly poor health outcomes in Volta? Does the character of regional and district health management teams play any role in explaining these varied outcomes?

5.1 Leadership and the emergence of pockets of effectiveness in health service delivery.

The literature on PoEs suggests that depending on the capacity and commitment of subnational leaders and front-line managers to devise and enforce problem-solving solutions to local problems, as well as enforce accountability measures on service providers, it is possible for bureaucratic units to function effectively even in contexts where gross ineffectiveness in service delivery is the norm (Leonard, 2010; Roll, 2013). The potential role that sub-national leadership can play in the emergence of PoEs is clearly demonstrated by the case of health service delivery in the Upper East region, where a dynamic regional health director (RHD), Dr Koku Awoonor-Williams, has been able to inspire health workers through his vision and conduct. Indeed, whether at the national, regional or district level, many key informants repeatedly referred to the 'effective', 'exemplary', and 'visionary' leadership of the RHD when explaining the relatively good maternal health outcomes in the Upper East:

'We have a leader who is very interested in whatever happens and takes action, and just by observing or looking at the way he does his business, we are all copying his example.'²⁹

'The regional director is ... someone who wants to achieve results and that trickles down to the district directors as well. He is an exemplary leader and everyone knows that.'³⁰

'The bedrock behind this is leadership, I mean effective leadership. We are blessed to have a leadership that has a lot of vision and that seeks to push people to come out with innovative ideas.'³¹

Our research particularly highlights the crucial role of leadership in the production and retention of critical human resources, and in instituting accountability

²⁹ Interview, official, regional health directorate, 23 July 2015.

³⁰ Disease control officer, 28 July 2015.

³¹ Disease control officer, 25 July 2015.

mechanisms that have helped in driving up health worker commitment and productivity. We discuss these points below in comparison with the experience of the poorly performing Volta region.

5.1.1 The production and deployment of human resources

One clear example where leadership has played a central role in accounting for the relatively good maternal health outcomes in the Upper East relates to the ways in which the regional health administration (RHA) has managed to address the human resource challenges in the region. For a long time, healthcare delivery in the Upper East (and the northern part of Ghana as a whole) was hampered largely by the paucity of qualified medical staff, as most health workers refused postings to the region because of its highly deprived status. For example, of some 13 doctors posted to the Upper East between 2006 and 2008, only one reported on duty (MoH, 2009: 32).³² This problem persisted for a long time because doctors who failed to turn up remained on the government's payroll (*ibid*). Following the assumption of office by a new regional director in 2008, the RHA took some concrete steps that ensured an increased production of health workers (specifically nurses and midwives) and also contributed to their retention and equitable distribution across districts.

To increase the production and retention of health workers, each district was given annual quotas to sponsor the training of community health nurses and midwives who were then required (under bonds) to serve the district for a minimum of three years before they could move out of the region. In collaboration with the GHS headquarters, those who left without serving their three-year bond periods had their salaries blocked. These strategies have made a significant difference in ensuring the availability of needed human resources that is central to understanding the relatively good health outcomes in the Upper East:

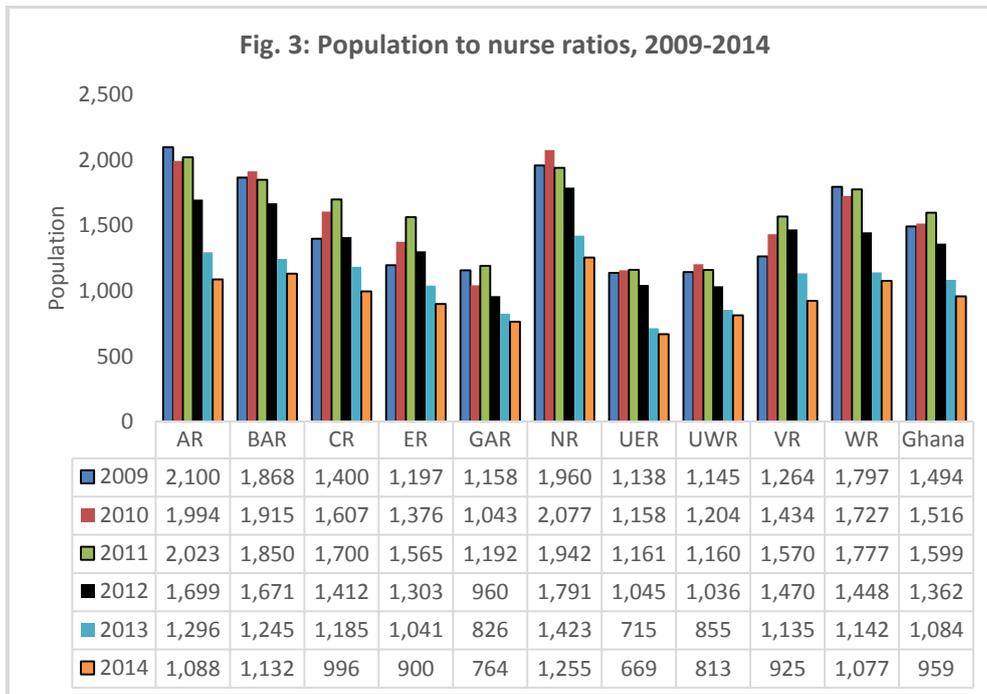
'So when we train them, they sign bonds with us to work for three years with the region before they can go to their various regions. (...) We let them know about the bond before they even start their studies. (...) If after the three years, we think there are no replacements, we do not release them. And if we do not release them, they cannot work in any other region because no one will pay them. Those who leave on their own always come back. For this region, we religiously obey the protocols that have been laid down. (...) Because of this, most of our CHPS zone facilities have most of the requisite staff, especially the midwives. Even though we are still short of midwives, we are better than other regions.'³³

'We are a deprived region and even though staff want to leave, the internal policies that have been put in place at least help in retaining some staff for a

³² This problem remains prevalent in all the three poorer regions in the northern part of the country. For example, in 2008, none of the ten doctors posted to the Northern region reported on duty. Eleven pharmacists were posted to the region in the same year, out of whom only one reported (MoH, 2009: 32).

³³ Senior official, regional health directorate, 22 July 2015.

while. For instance, he [the regional director] says that if you are from elsewhere and you have decided to come to Upper East to be trained as a nurse or as a midwife for three years, it is just fair that you serve the people when you complete for a number of years and then you can leave. (...) So we have this kind of arrangement and it is working. That also makes our human resource base good. I mean, if you look at the nurse-population ratio, we have the good numbers and it is all because of this kind of arrangement.³⁴



Source: Author, based on MoH annual review reports, various years.

These narratives are supported by the evidence in Figure 3, which shows that the Upper East recorded the best nurse-to-population ratios in both 2013 and 2014. To the extent that the Upper East had the worst nurse-to-population ratio in Ghana in 2007, one recent review report on the health sector describes its recent improvement as ‘dramatic’ (MoH, 2014: 10).³⁵

Two important caveats are worth noting here, however. First, the initiatives that led to these significant human resource capacities are not necessarily new ideas introduced by the leadership in the region, but are the product of the region’s ability to enforce nation-wide staff posting guidelines that allow regional health directorates to retain a proportion of newly trained staff in their regions.³⁶ Second, these measures are not always strictly enforced in the region because, as one respondent acknowledged:

³⁴ Interview, senior health official, regional health directorate 23 July 2015.

³⁵ In 2013, the region had one nurse per 715 persons, which is well above the WHO target of one nurse per 1,000 (MoH, 2014: 10).

³⁶ As with GHS guidelines, regions with a tertiary health facility are allowed to retain up to 90 percent of all newly trained staff, while those without tertiary facilities can retain up to a maximum of 70 percent.

‘Sometimes, the politicians interfere with our work. You will be there and they will just send you emails or phone calls to release so, so and so person. And we have no option but to release them, but sometimes we refuse to give in. If it is critical that the person should stay, we talk with the person pressuring us.’³⁷

One respondent corroborated this narrative, citing examples of how the regional director has occasionally rejected demands from close relatives and his own district health directors on posting patterns – decisions that have contributed to making him both popular and unpopular.³⁸

Moreover, unlike the poorly performing Volta region where midwives remain largely ‘mal-distributed’ (MoH, 2015b: 33), our field interviews also point to some conscious efforts aimed at ensuring the equitable distribution of health workers across districts in the region, whereby no additional staff are posted to areas where a significant proportion of the region’s skilled workforce is already concentrated. It is the implementation of these measures that helps explain the significant regional variations in skilled delivery coverage, in which the Upper East outperforms the nation as a whole. Based on analysis of data for 2014, a recent MoH report concludes that ‘the probability for a woman in Volta Region to deliver at a health facility is 45 percent compared to 74 percent in Upper East Region’ (MoH, 2015b: 33). A major reason for this also relates to the training and deployment of midwives to CHPS compounds that assist in supervised deliveries at the community level.³⁹ Evidence in a recent MoH review report shows that in the Upper East Region where about 30 percent of CHPS compounds have midwives, 47 percent of deliveries occur in sub-district clinics and CHPS compounds. This compares favourably not only to the lowest rate of 11 percent in Volta, but also to the national average of 20 percent (MoH, 2015b: 14).

5.1.2 Incentives and supervision

In addition to the enforcement of the staff posting norms discussed above, the RHA succeeds in retaining nurses and midwives in a highly deprived region like the Upper East through the provision of incentives (e.g. the provision of TV sets in remote CHPS compounds), the frequent rotation of staff across cities and rural communities, and the regular supervision of health workers. One health administrator noted that the Upper East is

‘not a region where you are thrown to one [remote] place and left there forever. If you go to other regions, you are thrown there and nobody remembers you. But for this region, there is constant reshuffling, [whereby] if I am at a village today within the next year, I can find myself in the city.’⁴⁰

³⁷ Senior official, regional health directorate, 22 July 2015.

³⁸ Interview, regional health administration official, 5 August 2015.

³⁹ Interview, senior official, regional health directorate, 5 August 2015.

⁴⁰ Disease control officer, 25 July 2015.

Importantly, the prospect of moving to a city is not based on how long you stay in a remote community, but, more importantly, how hard you are deemed to be working under more difficult circumstances.

There is also the practice of recognising hardworking staff through periodic awards of performance certificates and letters of recognition that are circulated to every single district health facility in the region. This approach has contributed to promoting a sense of competition among health workers who strive for the prestige attached to the award of certificates of merit. In particular, the widely circulated letters of appreciation directly bear the names of the identified good performers for any given year in ways that serve as motivation for others to follow. After all, as one respondent asked:

‘Who wouldn’t want to be part? (...) Once I am a health worker in a facility and they give me a copy of a letter where my colleague’s name has been mentioned, I wish the next letter that will come, my name should be there.’⁴¹

These types of motivation packages are combined with a relatively effective monitoring and supervision of lower-level health workers that also contribute to driving up performance. As noted in Section 3, the Ghanaian health system is structured in a way that places the delivery of primary healthcare services on district and sub-district health management structures. In this context, whether the CHPS strategy succeeds in improving maternal health outcomes ‘depends on the performances of DHMTs and SDHTs in terms of facilitative supervision’ (Aikins et al., 2013: 7). So how effective are district and sub-district teams and structures in supervising primary health workers in the Volta and Upper East regions, and how does this explain the differing maternal health outcomes in these regions?

In a recent study that involved a survey of some 122 health workers in the Upper East, a vast majority of respondents (80 percent) reported having been supervised within the last month, while only five respondents (or 4.1 percent) indicated that they had never been supervised by any member from the DHMTs (Frimpong et al., 2011: 1230). These ‘frequent’ supervisions were noted to have contributed significantly to the productivity of primary healthcare workers at the CHPS level. Many of our key informants also stated that health workers in remote CHPS compounds are frequently being visited in the region, not only by members of the DHMTs, but also by staff at the regional health directorate.⁴² One respondent noted that he worked in a remote rural community in the Upper East for a period of four years without travelling to his home region, and that what motivated him was essentially the constant visits and calls he got from the regional level:

⁴¹ Disease control officer, 25 July 2015.

⁴² Some respondents noted that frequent supervision is somewhat facilitated by the relatively small size of the Upper East region.

I saw constant visits of the regional team to my facility and when they come, they tap at your back and say “ooh you are doing well; keep on doing what you are doing”. (...) I was motivated by the calls I received, by the visits I got. I mean, when they come and review your documents, whatever you are not doing well, they try to correct you and also when you go for meetings at the district level, they mention that this guy is doing well.’⁴³

One senior health administrator corroborated this narrative, attributing the relatively high level of commitment among rural health workers to a combination of incentives and regular supervision:

‘When we go there, we ask them what their problems or challenges are. Sometimes they themselves can solve the problems but they just don’t know how to go about it. So when we show them how, they become happy. Sometimes just a pat at the back that “you are doing very well in this bush” is enough to motivate them.’⁴⁴

Observers have noted that this ‘supportive’ type of supervision which emphasises joint problem solving is significantly more effective in stimulating health worker productivity than ‘traditional’ forms of supervision that focus on inspection and fault-finding among frontline officials (Rowe et al., 2005; Frimpong et al., 2011; Aikins et al., 2013).

These observations are in stark contrast with the experience of the Volta region, where the supervision of primary healthcare workers remains ‘very poor’.⁴⁵ Here, a recent monitoring visit by the health ministry showed that some DHMTs have ‘never visited their CHPS zones’ (MoH, 2015b: 77). During our field interviews, both regional- and district-level health officials readily acknowledged this problem, often blaming it on inadequate transport facilities. Several key informants explained that most districts either lack functional vehicles or are unable to afford the cost of fuel for monitoring visits:

‘If you go to districts such as Krachi Nchumoro, districts such as Krachi East, their communities are such that when staff are posted there, [...] it is very difficult to supervise them, and this is due to lack of resources. Even as we speak now, the district health directorate of Krachi Nchumoro has not got a single vehicle, I mean a single vehicle.’⁴⁶

Community health workers are very much aware of the irregular nature of monitoring visits to their facilities, enabling them to absent themselves from work, ‘sometimes even without asking for permission’.⁴⁷ This seems to have been a long-standing

⁴³ Disease control officer, 25 July 2015.

⁴⁴ Senior official, regional health directorate, 22 July 2015.

⁴⁵ Senior hospital administrator, 4 November 2015.

⁴⁶ DHMT official in Volta region, 24 July 2015.

⁴⁷ Senior official, Volta regional health directorate, 15 July 2015.

problem in the region, with little evidence of significant improvements over time. During the region's 2012 annual health review meeting,⁴⁸ the regional director of health services acknowledged that poor supervision of health workers was such a significant challenge in the region that 'simple immunisation practices were not adhered to by staff at the lower levels'.⁴⁹ In the absence of effective field visits, the supervision of lower-level health workers remain heavily dependent on self-completed forms by frontline officials in various health facilities: 'We use the monthly reports that come from the various facilities to monitor them and then the appraisal forms as well'.⁵⁰ The frequently mentioned challenge of transport facilities not only undermines supervisory efforts, but has also had adverse implications for emergency referrals in the region. During interviews, we heard stories that sub-district level health officials were unable to ensure successful referrals of complicated cases to higher-level facilities, due to lack of transport facilities:

'We transferred a woman to another facility and she didn't go because that time we were not having ambulance to compel her to go.... So we advised that they should go with the taxi that brought them. Later, we were told that they didn't go; they went home to pray to take care of the woman [and she died].'⁵¹

The relatively poor supervision of lower-level health facilities thus appears central to our understanding of why the Volta region has remained a negative 'outlier' (MoH, 2014: 73) in the health sector.

Importantly, while the issue of emergency referrals remains a national problem in Ghana, the Upper East regional health directorate has managed to significantly overcome the emergency referral challenges through the innovative deployment of the 'motor king ambulance system' in some districts. With support from the US-based Doris Duke Charitable Foundation and Comic Relief of UK, this initiative introduced a customised module of the three-legged vehicle well known as motor-king alongside a mobile communication plan for community volunteers (who serve as drivers) and health workers in underserved communities. Several of our respondents mentioned that the motor king ambulance system has contributed significantly to saving the lives of many newborn babies and mothers.⁵² Unsurprisingly, the GHS has now adopted

⁴⁸ This meeting was held under the theme 'The role of supervision in productivity'

⁴⁹ See Ghana News Agency, 4 September 2012, 'Volta Regional GHS cautions non-performing districts'. Available at: <http://www.ghanaweb.com/GhanaHomePage/regional/Volta-Regional-GHS-cautions-non-performing-districts-249532> (accessed 4 October 2018).

⁵⁰ DHMT official, Afadzato South District 27 July 2017.

⁵¹ Health information officer, 5 November 2015.

⁵² See also 'GHS adopts Motor-King ambulance to save lives'. Available at: <https://www.newsghana.com.gh/ghs-adopts-motor-king-ambulance-save-lives/> (accessed 22 October 2018).

this customised ambulance system as a national programme aimed at helping to improve emergency health referral in rural Ghana.

5.1.3 Accountability measures and staff commitment

Although the accountability of street-level service providers has long been recognised as critical for improving health system performance (Brinkerhoff, 2004), there remain important debates as to the relative effectiveness of top-down and bottom-up accountability measures in enhancing quality service delivery. The literature which approaches service provision from a bottom-up perspective has been concerned mainly with direct accountability relations between service providers and consumers or clients (Batley et al. 2012; Joshi and Houtzager, 2012) – what the *World Development Report 2004* refers to as the ‘short-route’ to accountability (World Bank, 2003). Until recently, much emphasis was placed on this ‘demand-side’ of accountability, in which reform efforts focused largely on the mobilisation of voters and service users and their proxies in civil society to generate bottom-up performance pressures on providers as a way of improving service delivery (e.g. World Bank, 2003). However, there is now growing recognition that citizen-centred accountability mechanisms cannot be an adequate source of pressure for better service performance unless they are accompanied by strong top-down, supply-side pressure from political leaders and senior officials (Fox, 2007). Indeed, some observers have gone as far as to claim that bottom-up pressures in most African democracies often tend to strengthen ‘clientelist pressures, not performance pressures’ (Booth, 2012: 166). Drawing on outputs from the Africa Power and Politics research programme, Booth and Cammack (2013) similarly argue that what accounts for variations in maternal health outcomes in Africa ‘relate[s] directly to the presence or absence of strong upward accountability mechanisms, *not* to the presence or absence of downward accountability to health service users’ (p.62). This emerging insight suggests that ‘top-down pressures for performance in public services can be effective even where bottom-up pressures are weak’ (Batley et al., 2012: 141).

There is a strong perception among health workers in the region that the regional health director is a highly ‘maternal mortality conscious person’ who ‘express a lot of pain’ about maternal deaths. This consciousness is evident in the institutionalisation of specific accountability mechanisms that put additional pressures on both health sector administrators and hospital managers towards improved maternal health outcomes. Following the Upper East region’s declaration of ‘zero tolerance for maternal mortality’⁵³ in 2012, the RHA instituted biannual maternal mortality conferences, and district-level midwife review meetings on a quarterly basis. These conferences serve as platforms where health workers share experiences, examine successes and challenges, and explore ways of improving maternal and child health

⁵³ See Regional News of 23 October 2012, ‘Zero tolerance for maternal mortality declared In Upper East region’ [by Mathias Aboba]. Available at: <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=254017> (accessed 4 October 2018). See also News Ghana, 23 April 2014, ‘Midwives declare zero tolerance for maternal mortality’. Available at: <http://newsghana.com.gh/midwives-declare-zero-tolerance-maternal-mortality/> (accessed 4 October 2018).

in the region.⁵⁴ These frequent review programmes have played a major role in eliciting health workers' commitment to their duties, in part because of what one medical superintendent referred to as 'the personalisation of results' during such reviews:

'If a woman dies here, everyone will say Dr Azzika did not take good care of her; she died in the hands of Azzika. So Azzika does not want anybody to die in his hands. But Azzika wants to make sure that as much as possible, they survive.'⁵⁵

This respondent equated the periodic performance reviews to 'peer review mechanisms', in that heads of various district health facilities are required to recount their specific achievements on maternal and child health outcomes. The specific causal mechanisms through which these review meetings contribute to eliciting staff commitment and productivity was elaborated further by another district medical superintendent in the region:

'Most of the time, the staff seem to be serious so far as maternal mortality is concerned. So they put in so much effort trying to get the so-called zero maternal mortality ratio. (...) For instance, somewhere in May when we had not yet recorded any maternal mortality case, everybody was putting in much effort so that we can cross to June because they wanted to record zero maternal mortality case for the mid-year [review]. So when we finally crossed the six months, the other headache was how we can maintain a clean record for the entire year.'⁵⁶

In general, the seriousness which the RHA attaches to maternal deaths contributes to putting additional pressure on all health workers to do their utmost best in reducing maternal mortality in the region. Speaking specifically of the regional director for health, one respondent elaborated:

'He ensures that we have a conference with midwives to deliberate on some of the reasons why we are getting those deaths and I mean he doesn't mince words; he just tells them if these are the things we could have done to prevent what happened, [why couldn't you do it?]. So coming to a conference to listen to such sad stories and knowing that you are a contributory factor to it, when you get back home you are compelled to sit up and examine yourself and then see what you can do to improve upon these things.'⁵⁷

Incentives for performance among health workers in the Upper East are thus driven not solely by direct top-down pressures from the RHA, but rather by 'hybrid

⁵⁴ Fieldwork for this study coincided with a full-day conference on maternal mortality, followed by another conference on newborn care.

⁵⁵ Interview, medical superintendent, 26 July 2015.

⁵⁶ Interview, medical superintendent, 29 July 2015.

⁵⁷ Interview, official. regional health directorate, 23 July 2015.

combinations of vertical and horizontal oversight, involving direct citizen engagement within state institutions' (Fox, 2015: 347).

These hybrid accountability mechanisms are complemented by the enforcement of performance contracts between the regional director and his district directors. Respondents at both the regional and district levels noted that the terms of such contracts are determined largely by the regional director, with lots of emphasis on indicators pertaining to maternal and child health. Although not very frequently used, there is evidence of the application of sanctions in the case of non-performance, and health officials remain conscious that they can lose their jobs due to non-performance: 'We look up to the leader...because if you don't do that, they can change you and nobody wants to be disgraced. (...) All these are as a result of the leader. The way he is, and the way he is pushing us to work.'⁵⁸ Other interviewees drew attention to how some two district directors lost their jobs during the past six years due to unsatisfactory performance. One senior health administrator noted how the 'director will [often] call a meeting and give it to us', explaining further that:

'For all the years I have been here, if we take you through a programme and you are lazing about with it, you will be sanctioned by the director. Even the regional director will sanction a district director for collapsing a programme.'⁵⁹

In the case of the Volta region, we found no evidence of specific top-down accountability mechanisms geared towards improved maternal health outcomes. One innovative means of improving service delivery which was repeatedly cited by respondents in the region was the institutionalisation of a peer review system in 2010. Under this system, a team of assessors with a set of indicators visits hospitals to assess various aspects of healthcare. This initiative, which was extended to cover health centres in 2015, has not been an effective way of driving up health workers' performance; some key informants explained that some health facilities present temporarily borrowed logistics or, in some cases, create a façade of compliance, in order to score high marks during the peer review. A major factor that potentially exacerbates this is the general absence of performance-driven indicators for measuring health workers' output. Like most regions in Ghana, health workers are mostly appraised only when they are due for promotion.

Another problem relates to the absence of contractual obligations between district directors and sub-district-level health workers. One district director of health explained that the absence of contractual agreements at lower levels means that district and sub-district-level health workers 'don't have any image to preserve', incentivising them to 'do anything they want'. Unsurprisingly, recent official government reports identify 'poor staff attitude' as a major challenge to improved health outcomes in the Volta region (MoH, 2015b: 34), including recurrent allegations

⁵⁸ Disease control officer, 28 July 2015.

⁵⁹ Senior official, regional health directorate, 22 July 2015.

of large-scale fraudulent activities by hospital administrators.⁶⁰ These problems exist in part because of the weak enforcement of disciplinary mechanisms beyond mere cases of verbal queries. In August 2008, the Daily Graphic reported a 'general breakdown of discipline' at the Volta regional hospital, whereby most doctors were working for only between one and two hours a day (instead of eight hours) and thereafter handed over to nurses to write prescriptions for patients.⁶¹ One respondent blamed the relatively high maternal mortality rates in the region to limited ANC visits by pregnant women, acknowledging, however, that 'staff attitude is one thing that is sending the people away'.⁶²

In the absence of strong top-down accountability pressures, service users in some communities seem to rely on 'rude' forms of accountability – 'the informal pressures used by citizens to claim public services and to sanction service failures' (Hossain, 2010: 907). One example is the work of Queen Mothers in the Asogli traditional area within the Ho municipality. For quite some time, the Ho municipal hospital in the Volta region was regarded as a 'death camp'⁶³ for expectant mothers; an average of two or more women and/or their babies died at the hospital every week.⁶⁴ As part of a project implemented by the Global Action for Women Empowerment (GLOWA) – a local NGO that seeks to help reduce maternal and neonatal mortality through multi-stakeholder action,⁶⁵ chiefs and queen mothers were engaged to ensure that all pregnant women and mothers attended ANC and child welfare clinics on a monthly basis, while selected radio stations were engaged to report on healthcare errors and best practices from the Ho municipal and regional hospitals. Through the project, queen mothers in the area also instituted an award scheme for health workers, and hardworking workers are identified through a publicly broadcasted telephone call-in programme (using a local radio station), in which women who deliver at the hospital gave accounts of their satisfaction or otherwise with the nurses, midwives and doctors who attended to them. This project is widely acknowledged to be making a difference, such that for the first time, the Ho municipal hospital recorded zero maternal death for one full year (from June 2013 to June 2014), down from 14 deaths

⁶⁰ See Daily Graphic, 14 March 2013, 'Investigate Volta regional hospital – opinion leaders'. Available at: <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/Investigate-Volta-Regional-Hospital-Opinion-leaders-267649> (accessed 4 October 2018).

⁶¹ See Modern Ghana News, 23 December 2008, 'Indiscipline at Volta regional hospital'. Available at: <http://www.modernghana.com/news/196132/1/indiscipline-at-volta-regional-hospital.html> (accessed 4 October 2018).

⁶² Deputy health director, 24 July 2015.

⁶³ See Peace FM online news, 22 July 2014, 'Ho municipal hospital records zero maternal deaths'. See <http://www.peacefmonline.com/pages/local/health/201407/207936.php>

⁶⁴ See Ghana News Agency, 16 July 2014, 'Asogli Queenmothers honour midwives'. Available at: <https://www.modernghana.com/news/556597/asogli-queenmothers-honour-midwives.html> (accessed 22 October 2018).

⁶⁵ The project was implemented by Global Action for Women Empowerment (GLOWA), a local NGO formed in 1999 in response to the health and socio-economic needs of women, youth and children in the Volta and Eastern regions of Ghana.

in 2012 alone.⁶⁶ These outcomes prompted queen mothers in the area to organise an award ceremony in honour of some selected midwives and other health officials at the hospital in July 2014. These observations suggest that, in the absence of strong top-down accountability pressures, well designed top-down accountability mechanisms can play a major role in driving up health worker performance and improving the quality of service delivery.

6. Conclusions and implications

This paper set to out to: 1) explain Ghana's mixed records in health service delivery, whereby despite dramatic increases in the number of health facilities, the quality of health – and particularly maternal health – has seen very modest improvements during the past two decades; and 2) investigate the drivers of sub-national variations in quality healthcare delivery, paying particular attention to how one of Ghana's historically deprived regions has successfully emerged as an island of effectiveness in improving maternal health within the context of a largely dysfunctional healthcare system at the centre. Our analyses focused on maternal health issues, with particular emphasis on maternal mortality.

The findings show that central to understanding Ghana's limited progress in reducing maternal mortality has been the competitive character of its political settlements, in which two political parties compete vigorously for votes in tightly fought elections. In this political environment, ruling elites are characterised by a perennial threat of losing power to other powerful excluded elites, incentivising those in power to direct public investments to immediate and 'visible' policy outcomes that contribute to their short-term political survival. Such competitive clientelist pressures have contributed to greater elite commitment towards health sector investments with visual impact, while weakening elite incentives for dedicating sufficient public resources and providing consistent oversight over other essential, but less visible interventions that are necessary for enhancing the quality of maternal health.

In particular, governments across the political divide have focused heavily on investing in the construction of the highly visible CHPS compounds, while paying limited attention to the everyday management of these primary care facilities and the personnel working at them. Short-term electoral calculus remains the primary driver of health sector investments, with ruling elites introducing a variety of populist policies around elections, often without thinking through the complementary measures (including the availability of resources) that are required for their effective implementation. This is most strongly illustrated by the introduction of the free maternal health policy in 2008. Motivated largely by the imminent 2008 elections, the extraordinary speed at which the initiative was rolled out became a major source of problems at the level of implementation, leading to the reintroduction of unofficial user fees in many health facilities today. Moreover, an initiative to expand the

⁶⁶ See Ghana News Agency, 7 July 2015, 'Asogli Queenmothers honour midwives'. Available at <http://www.ghananewsagency.org/health/asogli-queenmothers-honour-midwives-77248> (accessed 4 October 2018).

number of ambulances in the country has not been matched by resources to equip emergency rooms – confirming the problem of ‘policy incoherence’ that is characteristic of most competitive political settlements in Africa (Booth and Therkildsen, 2010; Booth and Cammack, 2013).

In their recent study of the extent to which the nature of different public services affects political commitment, Batley and Mcloughlin (2015) note that less visible outputs like human capacity building attract poor political commitment because they are hard for citizens to observe, at least in comparison to physical buildings and infrastructure that are inherently ‘noisier signals’ of political effort (p.278). The evidence in this paper shows that even where sufficient human resources are produced, the problem of ‘weak enforcement capabilities’ that is characteristic of competitive clientelist countries (Khan, 2010) would remain a significant impediment to the effective delivery of quality healthcare. Although large numbers of health staff have been trained recently in Ghana, a long-standing problem of maldistribution means that many facilities remain chronically understaffed. In general, performance-related rewards and sanctions are rarely enforced, and promotion depends largely on patronage rather than performance. Some doctors who have never shown up at their official place of work remain on the central payroll, with schemes to remedy this problem, such as putting salaries under the control of local government officials, vigorously resisted by the Ghana Medical Association. These observations are typical of countries characterised by competitive clientelist political settlements, where intense electoral competition and the resultant vulnerability of ruling elites give rise to a number of political ‘principals’ to whom lower-level bureaucrats may be answerable (Levy, 2014).

In the absence of system-wide drivers of improved performance, sub-national variations in the quality of (maternal) health services are strongly shaped by the capacity and commitment of regional and district health management teams in addressing three key challenges in the Ghanaian health sector: human resource capacity management; the enforcement of accountability mechanisms on health workers; and the effectiveness of multistakeholder governance arrangements. Our findings draw attention to how a dynamic regional health director has been able to create an island of effectiveness in the Upper East region, which was once the worst staffed in terms of population-per-nurse ratio,⁶⁷ and one of the worst performing regions in quality healthcare delivery but now has an enviable record in the reduction of maternal mortality.

Much of this turnaround is explained by the ability of a new regional director for health, who has been able to create a highly motivated workforce and nurture some successful multistakeholder alliances, for example through the motor king ambulance scheme that contributed to zero maternal mortality rates in some districts within the Upper East region. To address the human resource challenges, the region strictly enforces a ‘bond system’, under which health workers who are trained in the region

⁶⁷ Note that the region still has the worst population-per-doctor ratio to date.

are required to serve the region for a minimum of three years, and those who defy this arrangement have their salaries blocked at the centre. Staff are deployed to areas of greatest need, often remote locations, and are frequently visited by senior officials and praised for their hard work. All health workers are aware that the RHD treats every maternal death as a preventable tragedy, and are motivated accordingly. The region makes use of personalised letters of commendation for good work, and holds regular meetings in which the performance of health facilities is compared. Together, this results in a competitive spirit among staff, driving better performance.

In the Upper East region of Ghana, where ‘high levels of poverty militate against community participation’ (Upper East Regional Health Administration, 2005: 9), our findings support the primacy of top-down accountability mechanisms over bottom-up pressures in explaining better performance. Nevertheless, it is not only top-down pressures that are responsible. Our evidence points to a more nuanced picture, in which incentives for health workers’ performance in the Upper East are underpinned by a hybrid form of accountability that combines top-down pressures from the RHA with horizontal forms of accountability among various health facilities – what has been referred to as diagonal accountability (see Goetz and Jenkins, 2001; Fox, 2015).

This experience is in sharp contrast with that of the Volta region, which is relatively well resourced in terms of health facilities and personnel, but exhibits much poorer performance indicators in relation to maternal health. Our findings show that the surprisingly poor health outcomes in Volta are explained mainly by the weak enforcement of staffing norms, which results in the maldistribution of health workers, as well as the weak supervision of health facilities by regional and district health management teams. Together, these twin problems result in a poor staff attitude in most health facilities that in turn discourages the use of maternal health services, explaining why the Volta region has the lowest rate (11 percent) of supervised deliveries in sub-district clinics and CHPS compounds in Ghana (MoH, 2015b: 14).⁶⁸ Even here, however, a local NGO multistakeholder initiative, in which traditional queenmothers⁶⁹ have been enrolled in raising awareness about maternal health and imposing some ‘rude’ forms of accountability on health workers, has begun to produce good results in one of the region’s hospitals that was noted for its high records of maternal deaths. Unlike the case of the Upper East, this experience suggests that even in the absence of strong top-down accountability pressures, well-designed bottom-up mechanisms that involve traditional leaders can play a major role in driving up health worker performance and improving the overall quality of health service delivery.

These findings point to three crucial lessons for reformers, particularly donors. First, our work reinforces recent observations that donor efforts towards progressive

⁶⁸ The comparative rate for the Upper East is 47 percent, compared to 20 percent at the national level.

⁶⁹ Queenmothers are female traditional leaders who wield significant social power and influence among certain ethnic groups in Ghana.

reforms in developing countries will have the greatest impact if their policy strategies are seen to be 'a good fit' for the nature of the political settlements in which they work (Kelsall et al. 2016: 26). Our discussion of the influence of donors in the Ghanaian health sector shows that political elites embrace donor policies that are seen to enhance their prospects for winning and maintaining political power. In contrast, where donor preferences are seen to have the potential to threaten regime survival, they will most likely be resisted. Donors' advice about the need for a free maternal health policy in advancing the attainment of the MDGs 4 and 5 was quickly embraced because ruling elites saw this as an extremely popular policy with the Ghanaian electorate. Yet, as we saw, the same set of donors were effectively 'sidelined' in their collective advocacy against the government's rapid adoption of the highly populist NHIS policy in the early 2000s.

Second, given the entrenched nature of competitive clientelism in Ghana, and the extent to which the country's governance problems flow from the constraints that its political settlement places on ruling elites, external interventions that focus on system-wide reforms at the centre are unlikely to yield desired results. Instead, a more realistic agenda would require donor agencies to redirect their efforts towards supporting the emergence and sustenance of pockets of effectiveness. This could take the form of nurturing multistakeholder governance arrangements or developmental coalitions at the regional and district levels. Third, and finally, the contrasting experiences of the Volta and Upper East regions suggest the need for reformers to go beyond the binary distinctions regarding the usefulness of top-down versus bottom-up accountability measures and focus on building more effective and legitimate forms of accountability that run both top-down and bottom-up.

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