ATTAINING THE MILLENNIUM DEVELOPMENT GOAL 4 OF REDUCING CHILD MORTALITY IN GHANA: THE ROLE OF FOREIGN AID

BY

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(10107246)

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LEGON

JULY, 2013
DECLARATION

I hereby declare that this dissertation is an outcome of an original research conducted by me under the supervision of Professor Ebenezer Laing and that no part of it has been submitted anywhere for any other purpose.

..........................................     ......................................
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(STUDENT)       (SUPERVISOR)

DATE:………………………….          DATE:…………………………..

University of Ghana          http://ugspace.ug.edu.gh
DEDICATION

For my wonderful wife, Mrs. Matilda Naa Korkoi Okoe, for her love, support and dedication.

To make use of the few French phrases I know, I would say, “Je t'aime”.

ii
ACKNOWLEDGEMENTS

I would like to express my profound gratitude to God Almighty for the strength, energy and protection He granted me throughout the duration of the course at LECIAD and particularly in writing this thesis. My thanks go to my supervisor, Professor Ebenezer Laing for his inspiration and constructive comments throughout the period of this research. A special thanks also goes to the Director, lecturers, staff and librarians at LECIAD for their various forms of advice, direction and help they offered me during my time of study.

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And to all the 2013 Class of LECIAD, thanks for the opportunity you bestowed on me as “President”. The role was tough but I must confess it was worth it. A special thanks to Seli for ably assisting me.

To my family, friends and acquaintances, thanks for being there for me.
# LIST OF ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Accra Agenda for Action</td>
</tr>
<tr>
<td>ACSD</td>
<td>Accelerated Child Survival and Development Approach</td>
</tr>
<tr>
<td>AfDB</td>
<td>African Development Bank</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
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<td>AU</td>
<td>African Union</td>
</tr>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BCS</td>
<td>Behaviour Change Support Program</td>
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<td>BMC</td>
<td>Better Medicines for Children</td>
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<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
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<td>CHPS</td>
<td>Community Health Planning and Services</td>
</tr>
<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHMTs</td>
<td>District Health Management Teams</td>
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<tr>
<td>DPs</td>
<td>Development Partners</td>
</tr>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<tr>
<td>ENC</td>
<td>Essential Newborn Care</td>
</tr>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>EU</td>
<td>European Union</td>
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<td>FANC</td>
<td>Focused Antenatal Care</td>
</tr>
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<td>FDA</td>
<td>Food and Drugs Authority</td>
</tr>
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<td>FRHP</td>
<td>Focus Region Health Project</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
</tr>
<tr>
<td>G8</td>
<td>Group of Eight</td>
</tr>
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<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>GES</td>
<td>Ghana Education Service</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
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<td>-----------</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>GHSSP</td>
<td>Ghana Health Sector Support Programme</td>
</tr>
<tr>
<td>G-JAS</td>
<td>Ghana Joint Assistance Strategy</td>
</tr>
<tr>
<td>GSS</td>
<td>Ghana Statistical Service</td>
</tr>
<tr>
<td>GWASH</td>
<td>Ghana Water, Sanitation and Hygiene Project</td>
</tr>
<tr>
<td>HIPC</td>
<td>Highly Indebted Poor Country</td>
</tr>
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<td>HIRD</td>
<td>High Impact Rapid Delivery Approach</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information/Surveillance System</td>
</tr>
<tr>
<td>HP</td>
<td>Health Promotion</td>
</tr>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IMNCI</td>
<td>Integrated Management of Newborn and Childhood Illnesses</td>
</tr>
<tr>
<td>ITNs</td>
<td>Insecticide Treated Bednets</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>JSI</td>
<td>John Snow Incorporated</td>
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<tr>
<td>JSS</td>
<td>Junior Secondary School</td>
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<td>KOICA</td>
<td>Korea International Cooperation Agency</td>
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<td>LECIAD</td>
<td>Legon Centre for International Affairs and Diplomacy</td>
</tr>
<tr>
<td>LLINs</td>
<td>Long Lasting Insecticide Treated Nets</td>
</tr>
<tr>
<td>MDAs</td>
<td>Ministries, Departments and Agencies</td>
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<tr>
<td>MDBS</td>
<td>Multi-Donor Budget Support</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MDRI</td>
<td>Multilateral Debt Relief Initiative</td>
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<td>MICS</td>
<td>Multi Indicator Cluster Survey</td>
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<tr>
<td>MOFA</td>
<td>Ministry of Food and Agriculture</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MWs</td>
<td>Mid Wives</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
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</tr>
<tr>
<td>NCHCB</td>
<td>National Child Health Coordinating Body</td>
</tr>
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<td>NDPC</td>
<td>National Development Planning Commission</td>
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<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
</tr>
<tr>
<td>NMCP</td>
<td>National Malaria Control Programme</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>OFID</td>
<td>OPEC Fund for International Development</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>ProPMT</td>
<td>Promoting Malaria Prevention and Treatment</td>
</tr>
<tr>
<td>RNE</td>
<td>Royal Netherlands Embassy</td>
</tr>
<tr>
<td>SHARPER</td>
<td>Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>SURV</td>
<td>Scaling Up Priority Health Interventions</td>
</tr>
<tr>
<td>SWAps</td>
<td>Sector-Wide Approaches,</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>UCR</td>
<td>University Research Cooperation</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>U5MR</td>
<td>Under-Five Mortality Rate</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration</td>
<td>i</td>
</tr>
<tr>
<td>Dedication</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>List of Abbreviations and Acronyms</td>
<td>iv</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>vii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>x</td>
</tr>
<tr>
<td>Abstract</td>
<td>xi</td>
</tr>
<tr>
<td><strong>CHAPTER 1: RESEARCH DESIGN</strong></td>
<td></td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Problem Statement</td>
<td>2</td>
</tr>
<tr>
<td>1.2 Objectives</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Scope</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Rationale and Justification</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Hypothesis</td>
<td>5</td>
</tr>
<tr>
<td>1.6 Theoretical Framework</td>
<td>5</td>
</tr>
<tr>
<td>1.7 Literature Review</td>
<td>8</td>
</tr>
<tr>
<td>1.8 Definition of Key Concepts</td>
<td>14</td>
</tr>
<tr>
<td>1.9 Methodology and Sources of Data</td>
<td>15</td>
</tr>
<tr>
<td>1.10 Arrangement of Chapters</td>
<td>16</td>
</tr>
<tr>
<td>End Notes</td>
<td>16</td>
</tr>
<tr>
<td><strong>CHAPTER 2: OVERVIEW OF MDGS, CHILD MORTALITY AND FOREIGN AID</strong></td>
<td></td>
</tr>
<tr>
<td>2.0 Introduction</td>
<td>18</td>
</tr>
<tr>
<td>2.1 The MDGs</td>
<td>18</td>
</tr>
</tbody>
</table>
2.1.1 What they are ... ... ... ... ... ... ... ... 18
2.1.2 The various MDGs ... ... ... ... ... ... ... ... 19
2.1.3 Why the Goals Matter ... ... ... ... ... ... ... ... 19
2.1.4 The MDGs for Health ... ... ... ... ... ... ... ... 20
2.2 Child Mortality ... ... ... ... ... ... ... ... 21
  2.2.1 Definition of Child Mortality ... ... ... ... ... ... ... ... 21
  2.2.2 Global Child Mortality Outlook ... ... ... ... ... ... ... ... 22
  2.2.3 Levels/trends of Child Mortality in Ghana ... ... ... ... ... ... ... ... 22
  2.2.4 Causes of Child Mortality in Ghana ... ... ... ... ... ... ... ... 27
2.3 Foreign Aid ... ... ... ... ... ... ... ... 27
  2.3.1 Definition and a Brief History ... ... ... ... ... ... ... ... 27
  2.3.2 History of ODA to Ghana ... ... ... ... ... ... ... ... 29
  2.3.3 Forms and Composition of Aid to Ghana ... ... ... ... ... ... ... ... 30
Endnotes ... ... ... ... ... ... ... ... 31

CHAPTER 3: CHILD HEALTH DEVELOPMENT IN GHANA; AND THE ROLE OF FOREIGN AID IN REDUCING CHILD MORTALITY IN GHANA

3.0 Introduction ... ... ... ... ... ... ... ... 32
3.1 Child Health Development in Ghana ... ... ... ... ... ... ... ... 32
  3.1.1 Strategies for reducing child mortality ... ... ... ... ... ... ... ... 34
3.2 The Role of Foreign Aid in Reducing Child Mortality in Ghana ... ... 41
  3.2.1 Nature of support in reducing child mortality ... ... ... ... 41
  3.2.2 Activities of some DPs in reducing child mortality ... ... ... ... 42
  3.2.3 Relevance of support ... ... ... ... ... ... ... ... 52
  3.2.4 Evaluating the immediate and long term benefits from DPs in reducing child mortality in Ghana ... ... ... ... ... 54
3.3 Progress towards achieving MDG 4 ... ... ... ... ... ... ... ... 60
3.4 Challenges of Reducing Child Mortality 62
Endnotes 63

CHAPTER 4: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.0 Introduction 65
4.1 Summary of Findings 65
4.2 Conclusions 67
4.3 Recommendations 68
Bibliography 72
Appendices 76
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Fig.</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>National U5MR</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>U5MR by Rural/Urban</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>U5MR by Level of Mother’s Education</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>Map of Ghana</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>U5MR by Regional Differences</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>National U5MR</td>
<td>61</td>
</tr>
</tbody>
</table>
ABSTRACT

Children represent an important resource base of every nation and their health therefore becomes an integral part of national development. The quest for the attainment of MDG 4: reducing child mortality by two thirds, is therefore welcome. The increased prominence of foreign aid in developing countries is an established fact and the subsequent calls by G8 members to scale-up aid delivery for the attainment of the MDGs represent the importance of these goals for enhancing development. This work seeks to assess the role of foreign aid in attaining MDG 4 in Ghana. The specific objectives of this study are to examine the health sector development issues of Ghana within the framework of the MDG 4 and to examine whether health aid to Ghana has contributed, if any, to the improvement in reducing child mortality levels/rates. The qualitative research approach was used to gather, analyse, and interpret the data. Primary data was gathered through interviews from the MoH, GHS and DPs such as WHO Ghana, DFID and USAID. Interviews were conducted based on the semi-structured interview format and this data was supported with relevant secondary data. From the research, health sector development concerning child mortality is on the right course as policies and programmes are underway in the bid to achieve MDG 4. The study has further shown that foreign aid has played a significant role in the reduction of child mortality in Ghana through the provision of various forms of support such as budget support, technical assistance, capacity building, healthcare facilities, and equipment. The study also portrayed socio-cultural practices and low economic status as the current challenges inhibiting the attainment of MDG 4 in Ghana.
CHAPTER 1
RESEARCH DESIGN

1.0 Introduction

Health has been part of the development indicators used over the past few years. Child mortality is one of the main indicators under health and remains a major health concern mostly in developing countries. Wagstaff and Claeson indicate that the scale of death and ill health in the world is alarming, with 11 million children dying before their fifth birthday in 2000.\(^1\) The health concerns of a population are an important aspect of the human development of the nation. Nobel laureate Amartya Sen indicated that “health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value”.\(^2\) Badasu further asserts that the shift to a development paradigm that stresses human development as the goal of economic development and human well-being led to a global research interest on the subject.\(^3\) As a result, the health care needs of the population are an important aspect of a country’s commitment in advancing development.

However, in most parts of the developing world, and particularly in Sub-Saharan Africa (SSA), the health and general situation of the population are mostly bleak. There is abject poverty across the continent and in other parts of the developing world. It is the international community’s response to these issues that led to the adoption of the Millennium Development Goals (MDGs). The United Nations Millennium Summit of 2000 saw the adoption of 8 Millennium Development Goals by world leaders, aimed at achieving peace and decent standards of living for all humanity.\(^4\) The goals range from issues of poverty, education, health, and environmental sustainability. Thus, the MDGs are a set of objectives that have been set by the United Nations (UN) as a form of guidelines with timelines to aid in the achievement of development goals for mostly developing countries.
To this end, countries spend much funds on their health sectors and often come out with strategies and programmes aimed at meeting the healthcare needs of their people. In most developing countries, with Ghana being no exception, budgetary allocation to the health sector and other sectors are mostly inadequate to meet the healthcare needs of the population. Such a situation has necessitated the granting of aid by developed countries to augment the budgetary allocations of developing countries. Ghana is not an exception to the world of aid as it receives various forms and amounts of foreign aid which is used to support several aspects of its economy, including the health sector.

Riddell argues that traditionally, aid was provided within the framework of meeting needs. Thus, the fact that most developing countries lack the needed funds to support most aspects of their economies necessitates and justifies the reasons for giving aid. Riddell further points out that more aid was pledged in 2005 at the Group of Eight (G8) Summit in Gleneagles, Scotland to help in the achievement of the objectives of the MDGs that were introduced in 2000. The introduction of the MDGs in 2000 coupled with the subsequent increment of aid to help in the attainment of such goals heightened the interest in seeking to find out how such aid funds are effectively utilized in arriving at the said goals. There have been numerous concerns about the effectiveness of aid given to developing countries. Several studies and impact assessment projects have been instituted and conducted, all in a bid to uncover how aid has helped in bringing relief to its intended beneficiaries.

1.1 Problem Statement

Even though the development paradigm shift has been on human development with health status as a crucial component of human wellbeing, many countries, including Ghana, still have many health concerns to tackle. Meanwhile, Ghana as a developing country has been a major
aid recipient country, receiving such aid to support its budgetary allocations in the areas of infrastructural development, health, education, among others. With the adoption of the MDGs in 2000, there were calls for the scaling up of aid to developing countries and more aid was pledged in 2005 at the G8 Summit in Scotland to help in the achievement of the MDGs.\(^6\)

Since Ghana is a recipient of aid for its health sector, it is of utmost importance that the role of aid in the development of the country and in this regard the health sector be appraised continually. With the time for the achievement of the MDGs fast approaching, the questions worth asking are whether health aid received in Ghana has been contributing to the realization of the said goals. Thus, a more appropriate question to ask will be: “What impact has foreign aid made on the reduction of child mortality since the year 2000?”

With the ever increasing issues regarding aid effectiveness, and more importantly, how aid shapes the development landscape of most developing countries, there is every reason to ascertain how aid affects development in the health sector in general and reducing child mortality in Ghana, in particular. Despite recent reports of an improvement in child mortality within Ghana, there are still concerns regarding the apparent difference between urban and rural areas.\(^7\) The differences that exist between urban and rural areas in terms of child mortality present a daunting task for the country in meeting the MDGs by 2015. The under-five mortality in rural areas is 27% higher than in urban areas. Thus, under-five mortality in the Greater Accra Region stands at 75 per 1,000 live births, whereas that of the Upper West Region is 208 per 1,000 live births. The need, therefore, to ascertain Ghana’s preparedness in reducing child mortality with the help of foreign aid even in the face of a marked difference between urban and rural areas signifies the research problem.
The goal of reducing child mortality in Ghana will be the focus of this thesis as children remain the most important future human resource base of the country. The Ghana Demographic and Health Survey 2008 points out that “infant and child mortality rates are basic indicators of a country’s socio-economic situation and quality of life, as well as specific measures of health status”. As the statement points out, the health of children is an important sign of a country’s socio-economic situation and serves to further illustrate the quality of life of the country. There is every indication that the health of infants and children is crucial to the health of the future generation.

1.2 Objectives

The general objective is to examine the role of foreign aid in the reduction of child mortality in Ghana.

The specific objectives include the following:

1. To examine whether health aid to Ghana has contributed, if any to the improvement in reducing child mortality levels/rates.

2. To examine the health sector development issues of Ghana within the framework of the MDG 4.

1.3 Scope

This study examines the role of foreign aid and the health sector development in Ghana, identifying how aid is actively aiding in the attainment of the health related goals of the MDGs with a precise spotlight on the Goal 4 of Reducing Child Mortality.
1.4 Rationale and Justification

As health is a major component of development and also receives much attention within the aid spectrum, an appraisal of foreign aids’ impact on the health sector is a welcome note. Additionally, with 2015, the year set for the attainment of the MDGs just one and half years away, an assessment of how foreign aid has aided in the realization of such goals, especially the Goal 4 in Ghana is appropriate.

1.5 Hypothesis

Foreign aid has helped in the attainment of the Millennium Development Goal 4 of Reducing Child Mortality in Ghana.

1.6 Theoretical Framework

This paper will employ the theory of international cooperation. The international system exhibits a number of cooperative behaviours among states, both on multilateral and bilateral levels. Milner in her work *International Theories of Cooperation among Nations: Strengths and Weaknesses* observes that a notable feature of the literature on international cooperation is the acceptance of a common definition of the phenomenon. To Robert Keohane, international cooperation “may be defined as the voluntary adjustment by states of their policies so that they manage their differences and reach some mutually beneficial outcome”.

Dougherty and Pfaltzgraff further advocate that “international cooperation encompasses relationships between states and among larger numbers of units known as multilateralism”. In essence, states do cooperate on a one-to-one basis known as bilateralism or in a multiple setting, referred to as multilateralism. Multilateralism mostly manifests in a variety of institutional settings that include international organizations, international regimes and to some
extent international orders. This is seen in Ghana’s membership of international organizations like the United Nations (UN), African Union (AU), Economic Community of West African States (ECOWAS), among others.

Joseph Grieco, in his work *Cooperation Among Nations*, identifies three elements of the concept of international cooperation. The first is the voluntary nature of international cooperation. Secondly, international cooperation comes along with a common or compatible end, thus, mutual gains to which states devote their efforts. The third of such elements is the significance of a longer-term engagement by states in which states seek to pursue a long-term cooperation.¹³ Milner also advocates for two important elements emanating from the concept of cooperation.¹⁴ The first is the assumption that each actor’s behaviour is directed toward some goal(s), which may be different from all actors involved. The second such element identifies cooperation as providing the actors with gains or rewards, even though such gains may not be in the same magnitude or kind for each state. Cooperation therefore hinges on these elements, i.e. “goal-directed behaviour that entails mutual policy adjustments so that all sides end up better off than they will either be.”¹⁵

International cooperation is mainly influenced by two schools of thought: realism and liberal institutionalism or neoliberalism. Some notable proponents of realism include Joseph Grieco, Raymon Aaron, Robert Gilpin and Kenneth Waltz whiles proponents of the liberal institutionalist school of thought are Joseph Nye, Robert Keohane and Robert Axelrod. Both schools of thought are based on certain assumptions. According to Grieco, realism has three basic assumptions. Firstly, states are seen as the major actors in world affairs, and the second assumption is that states are sensitive to costs and therefore behave as unitary-rational agents because the international system penalises states if they fail to protect their interests. Thirdly,
anarchy is the primary force that influences the external preferences of states.\textsuperscript{16} Arising out of these assumptions are the realists’ arguments that states are preoccupied with their security and power and therefore often fail to cooperate even in situations when they have common interests. Another such argument is that international institutions affect the willingness of states to cooperate only marginally.\textsuperscript{17}

Neoliberalism, on the other hand, has very different assumptions about the international system and cooperation. These assumptions are that states are atomistic actors and they make efforts to maximize their individual absolute gains and not the relative gains of other states.\textsuperscript{18} Paramount to the assumptions of neoliberalism is that states are not central actors in the international system, there are specialized international institutions within the international system that can help states overcome the barrier to joint action. These several actors alongside the state bring about plurality and therefore make the international system a decentralized one. The very existence of these institutions and organizations confirm the ability of states to cooperate.

The arguments put forward by neoliberalism in favour of cooperation thus become relevant to this study. The continuous relevance of international institutions, especially the United Nations (UN), in fostering cooperation among various state actors in the international system cannot be ignored. The UN has over the years served as a platform through which global issues have been discussed, resolved and promoted. One of such issues, the MDGs, set out during the Millennium Summit in 2000 calls for the attainment of eight globally accepted development goals. The Goal 8 deals with a global partnership for development, consequently calling for increased cooperation among both developed and developing countries to develop an open
rule-based non-discriminatory trading and financial system as well as deal comprehensively with the debt problems of developing countries to ensure debt sustainability in the long-term. From the discussion so far, relationship that exists between Ghana and its development partners that advance aid packages to it can be explained by the theory of international cooperation. Relationships between Ghana and the development assistance agencies of richer countries are in the purview of cooperation between Ghana and developed countries such as the United Kingdom (UK), the United States of America (USA), among others. There is also the cooperation between Ghana and agencies of international organizations like the UN. International cooperation therefore becomes appropriate for explaining the advancement of aid to Ghana by its development partners in attaining the MDG 4 of Reducing Child Mortality.

1.7 Literature Review

The issue about the effect of foreign aid on the overall development processes in most developing countries has seen debates and reports of varying outcomes. Advocates as well as skeptics of foreign aid have all advanced their positions on the matter, albeit some very entrenched. Over the years, while some have called for the doubling and increment of aid, others have equally called for an end to the granting of aid. Mishra and Newhouse observe that skeptics are of the view that foreign aid has negative impacts on the economies of developing countries by encouraging dependency and reducing incentives to adopt good policies, affect a country’s competitiveness or even the aid being used to ineffectively benefit the political elite.19 Some advocates, on the other hand, argue that aid often results in improved outcomes in poor countries by relaxing resource constraints and thereby improving wider pro-poor conditions.
Roger Riddell in the book *Does Foreign Aid Really Work?* provides a synthesis of the skeptics and advocates views on the role of foreign aid in development. He also points to a polarized view on the issue of aid, with the critics claiming that aid does not work and is therefore not needed, while its supporters are of the view that it works and is therefore necessary and should as well be increased. Citing several impact assessment programmes, Riddell outlines both the effectiveness and ineffectiveness of various aid projects across a wide range of sectors and countries. He points out the weaknesses of aid as including, being channeled into uses that are irrelevant, marginal to poverty reduction or unsustainable, fuelling corruption and the incidence of aid fungibility. Aid in the form of project aid, programme aid, sector-wide approaches (SWAps), budget support, technical assistance, aid for capacity development as well as aid at the country and cross-country levels have all seen some rates and instances of failure.

In her book *Dead Aid*, Dambisa Moyo provides a stark attack on foreign aid, particularly in Africa. In citing several aid critics such as Peter Bauer, William Easterly, and Paul Collier, she contends that the notion that aid can alleviate systemic poverty and has done so is a myth. Peter Bauer argued that aid interfered with development as aid money always ended up in the hands of a small chosen few, while William Easterly provides numerous case studies on the failures of aid policies across the developing world. Aid breeds corruption; weakens social capital; forments conflict; causes economic challenges such as reduction of domestic savings and investment in favour of greater consumption, inflation, chokes off the export sector and presents some difficulty in absorbing such large cash influxes.

Inspite of the numerous critiques of aid, the practice remains very popular within the development arena. Riddell points out that aid could potentially make a difference in the economies of developing countries by contributing significantly to accelerating growth,
enhancing development and reducing poverty.\textsuperscript{24} Aid, he argues further, could help fill some crucial immediate gaps in poor countries that constrains development, help meet some key immediate and urgent needs as well as strengthen capabilities and capacities to enhance sustainability and therefore being referred to as a potential catalyst for development. The different forms of aid including project aid which consists of specific projects in the fields of health, education, rural development, agriculture, transport, housing, water supply, sanitation, human rights among others have succeeded in meeting their immediate objectives. Other forms of aid such as programme aid which also consists of the sector wide approaches have had health, education, and road sector development record successes in Ethiopia, Ghana, Mozambique, Uganda and Zambia while general budget support had seen modest successes.\textsuperscript{25}

Mishra and Newhouse also assert that foreign aid improves health outcomes in developing countries and is often credited with saving lives by providing vaccines, eradicating deadly diseases as well as improving medical services.\textsuperscript{26} They suggest further that despite previous studies failing to find an effect of aid on growth, there is ample evidence to show that aid may improve health outcomes directly with health aid having a discernible effect on infant mortality. Furthermore, the adoption of the MDGs is said to reflect the increased importance attached to aid for poverty reduction, which obviously includes improvement in health outcomes.\textsuperscript{27}

The introduction of the MDGs witnessed the calls for the scaling up of aid to help developing countries meet the targets of the MDGs. Bauclh stresses that in the aftermath of the 2000 Millennium Summit and the 2002 Monterrey Conferences,\textsuperscript{28} various bilateral and multilateral donors committed to increasing the volumes of development assistance to developing countries.\textsuperscript{29} He further asserts that increasing aid volumes to developing countries is not the
only essential means of achieving the MDGs, but rather such increases should be targeted at
countries that need it the most and can effectively utilise such funds.  

Addison et al., wading into the discussion on aid and the MDGs point out that all aid studies
since the late 1990’s have concluded that aid increases economic growth and can therefore be
implied that poverty will be higher in the absence of aid.\textsuperscript{30} In a review of literature, they
conclude that aid increases economic growth and by extension increases public expenditure
including expenditures that are pro-poor in orientation like primary education and basic health
care. Citing several studies undertaken on the issue of aid, they observe that aid works in
countries irrespective of the policy environment even though it works better in countries with
better policy regimes. Aid is also said to contribute to general well-being enhancement.
Drawing on the findings of the various studies cited, they come to the conclusion that growth
in the countries under consideration would have been lower in the absence of aid and so aid
could not be said to have failed those countries.\textsuperscript{31} On aid’s contribution to meeting the MDGs,
they maintain that it is premised on two fundamental assumptions. These assumptions include
the fact that aid raises economic growth which in turn reduces poverty and that aid also relaxes
the budgetary constraints impeding development spending, which includes pro-poor services
and infrastructure.\textsuperscript{32}

Due to these strong debates around the effectiveness of aid, attempts have been made over the
years to make aid effective. The major aid donors recently in conjunction with recipient
countries collectively came up with the Paris Declaration on Aid Effectiveness in Paris on 2\textsuperscript{nd}
March, 2005.\textsuperscript{33} The Paris Declaration on Aid Effectiveness seeks to improve the quality of aid
and its impact on development by taking actions to reform the ways that aid is delivered and
managed to improve economic growth, reduce poverty and attain the MDGs. To achieve these, a number of guiding principles were outlined, some of which include the following:

- **Ownership**: Partner countries exercise effective leadership over their development policies, determine their own development goals, priorities and strategies and co-ordinate development actions.

- **Alignment**: Donors base their overall support on partner countries’ national development strategies, institutions and procedures.

- **Harmonisation**: Donors’ actions are more harmonised, transparent and collectively effective. Donors to adopt common procedures to harmonise aid delivery, including coordinating their actions, simplifying procedures, and using common approaches to aid delivery.

- **Managing for Results**: Donors and partner countries must manage and implement aid in a way that focuses on achieving results. Managing resources and improving decision-making for results as well as measuring results.

- **Mutual Accountability**: Donors and partners are equally accountable for development results and must work together to establish mutually agreed frameworks that provide reliable assessments of performance, transparency and accountability of country systems.\(^3^4\)

Following on the heels of the Paris Declaration on Aid Effectiveness is the Accra Agenda for Action (AAA) which was signed in 2008 in Accra by ministers of developing and donor countries responsible for promoting development and heads of multilateral and bilateral development institutions to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness.\(^3^5\) The AAA stresses the fundamental, independent role of civil society in engaging citizens and therefore redefines the relationship between donors, developing countries and their citizens. It also re-emphasises on the principles outlined in the Paris
Declaration on Aid Effectiveness, stressing on ownership, inclusive partnerships and delivering results.

To ensure aid effectiveness in Ghana, a couple of policies and strategies have been formulated and aligned with various aid effectiveness schemes. These policies and strategies are designed to achieve national and international development targets, including the MDGs. Among such strategies include the Ghana Joint Assistance Strategy (G-JAS), Leveraging Partnerships for Shared Growth and Development (2012-2022), and the Ghana Aid Policy and Strategy (2011-2015). The G-JAS for instance was instituted in 2007 involving 16 of Ghana’s DPs and sought to improve the alignment of development assistance by the various DPs with the government’s agenda of achieving the goals and priorities of the second Ghana Growth and Poverty Reduction Strategy (GPRS II).\(^{36}\) This was to help promote a collective effort by DPs and accelerating progress towards a set of aid effectiveness principles and commitments.

The G-JAS consists of five interlinking elements that contribute to a comprehensive approach on the part of DPs to the aid relationship in Ghana. The second of these five sought a joint description of the major challenges facing Ghana in its quest to achieve the Millennium Development Goals (MDGs) and middle-income status.\(^{37}\) Unfortunately, when the mid-term review of the G-JAS was undertaken in 2009, it was established that the G-JAS has not achieved its overall purpose due to a change of government and a number of economic shocks.\(^{38}\) One of the three elements of the review dwelt on case studies on water, sanitation and health issues. The case study report indicated that much progress has been made between the government of Ghana and its donor partners to make the health sector function effectively, yet with room for improvement. However, one of the achievements outlined in the review is greater harmonisation in aid delivery. It was noted that DPs have made substantial investments
in improving the harmonisation of aid delivery through PBAs, joint projects and common delivery arrangements.

The findings and suggestions of the above writers, whether they support the giving and using of aid or not, as well as the efforts made at making aid effective, guided the writing and discussion of this paper. Due care was taken in ensuring that conclusions and suggestions were not made without critical thinking of the various forms of aid given to support child mortality eradication in Ghana. Thus, whether the process of giving and using aid could encourage corrupt practices by officials, encourage dependency, reduce incentives to adopt good policies, saves lives by providing vaccines, eradicating deadly diseases or improve medical services were all examined.

The information above concerning the debate around aid gave this study an added advantage in contributing to the reasons why aid fail or succeed by examining the processes of giving and the using of aid in reducing child mortality in Ghana.

### 1.8 Definition of Key Concepts

- **Child mortality**: child mortality, or under-five mortality rate (U5MR) is the probability of dying before the age of five, usually expressed per 1,000 live births.

- **Millennium Development Goals (MDGs)**: They are the world’s time-bound and quantified targets for addressing extreme poverty in its many dimensions—income poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education, and environmental sustainability. They are also basic human rights—the rights of each person on the planet to health, education, shelter, and
security as pledged in the Universal Declaration of Human Rights and the UN Millennium Declaration.\(^{39}\)

- **Foreign Aid/ Official Development Assistance**: “consists of all resources – physical goods, skills and technical know-how, financial grants (gifts), or loans (at concessional rates) – transferred by donors to recipients”.\(^{40}\)

- **International cooperation**: it can be defined as the voluntary adjustment by states of their policies so that they manage their differences and reach some mutually beneficial outcome.\(^{41}\)

1.9 **Methodology and Sources of Data**

This research was conducted within the framework of qualitative research approach, using primary and secondary data. The primary data collection methods included interviews, using mainly semi-structured interview guides. The primary sources of data were gathered though interviews with officials from the Ministry of Health (MoH), the Ghana Health Service (GHS) as well as officials of major health development partners (DPs) of Ghana and donor agencies including the United States Agency for International Development (USAID), and Department for International Development (DFID), and the World Health Organization (WHO) Ghana. Where respondents allowed, a radio recorder was used, but in other circumstances, interview notes were taken. These recordings were transcribed and the text was used in the analysis.

Secondary sources of data comprised of the various UN reports on the progress of the MDGs, specifically focusing on the progress of attaining Goal 4. Other sources of secondary data involved reports of studies conducted on the progress of the MDGs, annual and specified reports of donor agencies operating in Ghana, official documents of such agencies, documents from the MoH and the GHS on child health and literature on aid.
1.10 Arrangement of Chapters

The study is divided into four chapters.

Chapter 1 deals with the research design.

Chapter 2 is an overview of MDGs, child mortality and foreign aid.

Chapter 3 focuses on the provision of aid for the health sector and the health sector development aimed at reducing child deaths in Ghana. It will also look specifically at how aid is channelled to help in the reduction of child mortality thereby attaining the Goal 4 of the MDGs.

Chapter 4 provides the summary of findings, conclusion and recommendations of the study.

Endnotes

2 ibid.
6 ibid.
8 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro., Ghana Demographic and Health Survey 2008. (Accra, Ghana: GSS, GHS, and ICF Macro, 2009).
15 ibid. p. 468.
17 ibid.
18 ibid.
The Millennium Summit was a meeting among many world leaders in September 2000 at the United Nations headquarters in New York City. It discussed the role of the United Nations at the turn of the 21st century and world leaders ratified the United Nations Millennium Declaration which set out the Millennium Development Goals.

The 2002 Monterrey Conference, i.e., the United Nations International Conference on Financing for Development was held in Monterrey, Mexico and was attended by over fifty Heads of State and two hundred Ministers of Finance, Foreign Affairs, Development and Trade. New development aid commitments from the United States, the European Union and other countries were made at the conference and countries also reached agreements on other issues, including debt relief, fighting corruption, and policy coherence.

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34 ibid.

35 ibid.


37 ibid.


CHAPTER 2

OVERVIEW OF THE MDGS, CHILD MORTALITY AND FOREIGN AID

2.0 Introduction

This chapter gives an overview of the MDGs, child mortality and foreign aid. The overview of the MDGs shows what the 8 MDGs are and their specific targets, why they are important, and the various MDGs related to health. Overview of child mortality, which is the MDG 4, follows with a definition of the concept, global child mortality outlook, levels, trends, and causes of child mortality in Ghana. Details of foreign aid, comprising definition and a brief history, history of foreign aid to Ghana, and forms and composition of aid to Ghana is then given.

2.1 The MDGs

2.1.1 What they are

The Millennium Development Goals are the world’s time-bound and quantified targets for addressing extreme poverty in its many dimensions—income poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education, and environmental sustainability. They are also basic human rights—the rights of each person on the planet to health, education, shelter, and security as pledged in the Universal Declaration of Human Rights and the UN Millennium Declaration.¹

At the UN Millennium Summit in New York from 6 – 8 September 2000, Heads of State and Government reaffirmed their faith in the organization and its Charter as indispensable foundations of a more peaceful, prosperous, and just world. The world leaders further recognized the importance of forging a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.² Certain fundamental values such as freedom, equality, solidarity, tolerance, respect for nature, and shared responsibility were therefore seen as essential to international relations in the twenty-first century. As a result, there was affirmation for the maintenance of world peace and security.
The Millennium Summit also discussed the over-arching problems of underdevelopment and poverty. To this end, the heads of states and governments indicated their willingness to spare no effort to free men, women and children from the abject and dehumanizing conditions of extreme poverty and further resolved to create an enabling environment, at both the national and global levels which is essential for development and the elimination of poverty. Out of this commitment emerged the MDGs, which have been accepted as a worldwide framework to accelerate the rate of development and help in the effective eradication of poverty in developing countries. 2015 was set as the base year for the attainment of the said goals and the various targets under each goal.

2.1.2 The Various MDGs

Goal 1: Eradicate Extreme Poverty and Hunger.

Goal 2: Achieve Universal Primary Education.

Goal 3: Promote Gender Equality and Empower Women.

Goal 4: Reduce Child Mortality.

Goal 5: Improve Maternal Health.

Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases.

Goal 7: Ensure Environmental Sustainability.

Goal 8: Develop a Global Partnership for Development.

2.1.3 Why the Goals Matter

The MDGs serve as a widely supported, comprehensive and specific poverty reduction targets that the world has identified and therefore very important for all and sundry. Several reasons account for why the MDGs matter and why they are an important aspect of world affairs. First of all, they are said to represent the fulcrum of international development policy through a new
global partnership that is aimed at reducing poverty, improving health, and the promotion of peace, human rights, gender equality and environmental sustainability. This commitment to a global partnership for development was as a result of the recognition that both developed and developing countries need to work together in achieving set objectives. The MDGs recognize that poverty can be reduced only if well designed and well implemented plans to reduce poverty are put in place in developing countries as well as if developed countries increase their support to developing countries substantially.⁵ A key component of the global development partnership is the aspect of developing countries setting their own development targets based on the MDGs and the targets are geared towards meeting local circumstances.⁶

Secondly, the MDGs are seen as the basis to advancing the means to a productive life for the people still living in extreme poverty. The UN Millennium Project best put this in perspective. "For people living in extreme poverty, the Goals are ends unto themselves, directly representing the ambition for a longer, healthier, and more fulfilling life. But they are also "capital inputs"—the means to a productive life, to economic growth, and to further development in the future."⁷

Thirdly, the goals are seen as not only depicting economic targets, global justice and human rights but they are also very critical not only for global security but national stability as well. Poorer countries can easily fall into conflict situations as control over scarce and vital resources like water ways, rivers, land, oil and other minerals could get out of hands.⁸

### 2.1.4 The MDGs for Health

Health is very central to the MDGs. Of the 8 MDGs, three: reduce child mortality; improve maternal health; and combat HIV/AIDS, malaria and other diseases are directly health related
goals. Other goals such as eradicate extreme poverty and hunger, ensure environmental sustainability, and develop a global partnership for development all have outcomes related to health. The prominence of health in the MDGs shows the commitment and concern that the international community attaches to health in the developing world. Also, the central position which health takes within the MDGs is recognition that better health is essential to eradicating poverty globally and also serves as an important measure of human well-being. In effect, health is central to development. Amartya Sen notes that “health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value”. Health therefore represents an indispensable aspect of human well-being and development.

2.2 Child Mortality

2.2.1 Definition of Child Mortality

The Ghana Demographic and Health Survey, 2008 gives a host of descriptions of what constitutes child mortality. These include:

- Neonatal mortality (NN): the probability of dying between birth and the first month of life
- Post-neonatal mortality (PNN): the difference between infant and neonatal mortality
- Infant mortality (1q0): the probability of dying between birth and exact age one
- Child mortality (4q1): the probability of dying between exact age one and five
- Under-five mortality (5q0): the probability of dying between birth and exact age five.

All rates are expressed per 1,000 live births, except child mortality, which is expressed per 1,000 children surviving to age 12 months. However, for the purposes of this paper, child mortality or under-five mortality rate (U5MR) is the probability of dying before the age of five, usually expressed per 1,000 live births.
2.2.2 Global Child Mortality Outlook

Despite the fact that global child mortality rate has fallen leading to progress in reducing child mortality globally, more than 10 million children die each year, most from preventable causes and almost all in poor countries.\(^\text{13}\) 2001 data shows that five countries; India, Nigeria, the Democratic Republic of Congo, Pakistan and China are said to have accounted for about 50% of global under-five deaths.\(^\text{14}\) Additionally, under-five deaths are increasingly concentrated in two regions, sub-Saharan Africa and South Asia, recording 82% of global under-five deaths in 2001, up from 68% in 1990 with sub-Saharan Africa accounting for almost 49% of the global total in 2011. Sub-Saharan Africa also accounts for the highest rate of under-five mortality, with averagely 1 in 9 children dying before age 5.

2.2.3 Levels/Trends of Child Mortality in Ghana

Results from the Ghana Demographic and Health Survey (GDHS) and the Multiple Indicator Cluster Survey (MICS) show a decline in child mortality in Ghana over the past 20 years.\(^\text{15}\) The GDHS from 2003 to 2008 shows that U5MR has reduced from 111 deaths per 1000 live births to 80 deaths per 1000 live births, meaning that one in every thirteen Ghanaian children dies before the fifth birthday whilst infant mortality rate has declined from 64 deaths to 50 deaths during the same period.\(^\text{16}\) Neonatal deaths account for between 40% - 60% of deaths in infancy.
Fig. 1. National U5MR

1998, 2003 & 2008 data taken from GDHS. 2011 data taken from MICS 2011.\(^{17}\)

The figure above indicates that in 1998 U5MR was 110.4, in 2003 it was 111, it fell to 80 in 2008 and was 82 in 2011.

*Mortality by residence: rural/urban*

Over the years, mortality levels in rural areas are consistently higher than those in urban areas. Data spanning ten years from the GDHS 1998, 2003 and 2008 all show mortality levels in urban areas as lower than those in rural areas.
Mortality by mothers’ education

The educational status of mothers also affects the rate of child mortality. Mother’s education is inversely related to a child’s risk of dying. Under-five mortality among children of mothers with no education is substantially higher than under-five mortality among children of women with middle/Junior High School (JHS) level education. The direct association between level of education and under-five mortality is also seen in infant mortality. Children of women with no education are much more likely to die in the first year than children of women with middle/JHS education.
Fig. 3. U5MR by level of mother’s education.


**Mortality by region**

Regional differences in mortality rates are very clear and indicative of where most child mortality rates are recorded in Ghana. Mortality rates are low in the more urbanised Greater Accra Region and very high in the mostly rural Northern and Upper West Regions. The map below shows the regional boundaries of Ghana.

Fig. 4 Map of Ghana
Fig. 5. U5MR by regional differences


Mortality by household wealth status

Wealth status also affects child mortality rates in Ghana. Children in households in the highest wealth quintile have the lowest mortality rates for both child mortality and under-five mortality. Infant mortality is also lowest among children in the second, fourth, and fifth wealth quintiles.\(^\text{18}\)

Mortality by demographics

A number of demographic factors such as sex of child, age of mother at birth, birth order, length of preceding birth interval, and size of child at birth are all associated with child mortality rates in Ghana.\(^\text{19}\) Mortality rates vary for both males and females, U5MR for males at 93 and females at 76 deaths per 1,000 live births with the difference likely due to the higher biological risk during the first month of life of male children. The GDHS 2008 further indicates that births to
young mothers (under age 20 years) and older mothers (35 years and over) are at an elevated risk of dying. The size of a child at birth also influences the child mortality rate. Babies assessed by their mothers as ‘small or very small,’ has infant mortality twice the level observed for babies assessed as ‘average or larger’ at birth.

2.2.4 Causes of Child Mortality in Ghana

The primary causes of newborn deaths are infections, asphyxia, prematurity and low birth weight. Available data estimate that 40% of neonatal deaths occur in the first 24 hours and 75% in the first 7 days of life. The majority of deaths after the newborn period are caused by malaria, pneumonia, dysentery, diarrhoea and malnutrition/ vitamin A deficiency (as contributors to mortality from all causes). Deaths from measles have declined markedly in the last 5 years due to high measles vaccine coverage. Malnutrition remains an important problem. The proportion of children who are stunted – a measure of chronic malnutrition - was estimated to be 22% in 2006, with 18% of children estimated to be underweight. The prevalence of anaemia in women and children also remains high. In 2003, three quarters of children in Ghana were estimated to have some level of anaemia. Forty-five percent of women of child bearing age were anaemic. Maternal mortality also influences the rate of child deaths in Ghana.

2.3 Foreign Aid

2.3.1 Definition and a Brief History

Riddell asserts that in its broadest sense, aid “consists of all resources – physical goods, skills and technical know-how, financial grants (gifts), or loans (at concessional rates) – transferred by donors to recipients”. This definition includes resources to address humanitarian, development and poverty needs in the poorest countries as well as resources provided to further help achieve military aims and objectives.
The Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) named foreign aid as official development assistance (ODA) and defined it as “consisting of flows to developing countries and multilateral institutions provided by official agencies, including state and local governments, or by their executive agencies, each transaction of which meets the following two criteria: (1) it is administered with the promotion of economic development and welfare of developing countries as its main objective, and (2) it is concessional in character and contains a grant element of at least 25 per cent (calculated at a rate of discount of 10 per cent).”

Aid giving precedes the mid 1940s, which is often credited as the era when the modern practice of aid giving is said to have begun. Aid had been provided prior to this time, notably British colonies were provided aid through the 1929 Colonial Act, and the Colonial Development and Welfare Acts of 1940 and 1945. French aid was also provided to French colonies during the 1940s. Post-war aid includes several broad categories, namely the period of the Marshall Plan in the 1950s, the decade of industrialization of the 1960s, the shift towards aid as an answer to poverty in the 1970s, aid as the tool for stabilization and structural adjustment in the 1980s, and aid as a buttress of democracy and governance in the 1990s which has led to the over-reliance on aid by many poor countries. Foreign aid has expanded from the 1950s to become a large and complex enterprise that reaches all corners of the globe, with every country either seen as an aid donor or an aid recipient, and a small number both give and receive aid.

From the 1950s up till now, aid has stood the test of time. Even though foreign aid experienced its sharpest and most prolonged period of contraction as the Cold War drew to an end, aid levels however began to rise again towards the end of the 1990s. More aid was pledged in 2005 during the G8 Summit in Gleneagles, Scotland as a major contribution to achieving the objectives of the MDGs. As such, aid is mostly linked to global poverty reduction and
development. Aid comes in the form of project aid, programme aid (sector-wide approaches, SWApS and budget support), technical assistance, and for capacity development, as well as on bilateral and multilateral levels.

### 2.3.2 History of Foreign Aid to Ghana

Ghana has long been an aid recipient country; receiving aid in the 1960s just after independence and still continues to receive aid. Ghana’s benefit from aid in the late 1980s and early 1990s was influenced primarily by its willingness to pursue structural adjustments. The commitment to the pursuit of democratic governance in the late 1990s, successful transfer of power from one elected government to the other in 2000, the new government’s commitment to the rule of law and democratic governance, to poverty reduction and growth, as well as the new government’s enthusiasm for improvements in corporate governance and private sector led-growth all endeared Ghana to the aid community and therefore saw Ghana’s continuous receipt of aid.

Aid flows to Ghana has been provided by its development partners, both bilateral and multilateral donors. The bilateral donors is made up of traditional donors like Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Italy, Japan, Netherlands, Norway, Spain, Sweden, Switzerland, the UK, and USA. The multilateral donors include: The World Bank, African Development Bank (AfDB), European Union (EU), Nordic Development Fund, Arab Bank for Economic Development in Africa, European Investment Bank, OPEC Fund for International Development (OFID), Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunization (GAVI), and 12 organs/agencies of the United Nations.
2.3.3 Forms and Composition of Aid to Ghana

Aid to Ghana comes in four main categories, which include, (i) Debt Relief funds from the Multilateral Debt Relief Initiative (MDRI) and the Highly Indebted Poor Country (HIPC) Initiative (including exceptional financing from the rescheduling of bilateral debt on more favourable terms); (ii) project support comprising project loans and grants for supporting specific projects and activities; (iii) programme aid in the form of loans and grants for general and sector budget support; and (iv) balance of payments support from the International Monetary Fund (IMF). \(^{31}\) Total project aid to Ghana in 2012 was US$ 107,535,809.20 whilst total programme aid was US$ 127,490,000.00. \(^{32}\) Total grants in 2011 amounted to US$ 1,346,484,000.00, made up of project grants of US$ 811,224,000.00; programme grants of US$ 291,090,000.00; Heavily Indebted Poor Country Initiative (HIPC) assistance (multilaterals) of US$ 133,185,000.00; Multilateral Debt Relief Initiative (MDRI), US$ 110,985,000.00; World Bank support, US$ 100,800,000.00; African Development Bank grant, US$ 10,185,000.00. \(^{33}\)

The bulk of ODA portfolio in Ghana is constituted by project aid, which was about 56% in 2008 and 57.4% in 2009. Programme aid as a percentage of total ODA was pegged at around 38% between 2003 and 2008. General budget support, for instance constituted 32.6% in 2010, and this is attributable to the introduction of the Multi-Donor Budget Support (MDBS) mechanism in 2003 which allows donors to contribute to a common basket to support the national budget. \(^{34}\) The MDBS currently constitute about 30% of donor inflows in Ghana and it is said to have improved commitment and predictability of aid inflows. Overall, aid as a percentage of Gross Domestic Product (GDP) increased from 13.2% in 2003 to 14.6% in 2009 and fell to 12.8% in 2010. \(^{35}\)
Endnotes

3 UN Millennium Project., Investing in Development: A Practical Plan to Achieve the Millennium Development Goals, (New York: UN Millennium Project, 2005).
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12 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro., Ghana Demographic and Health Survey 2008, (Accra, Ghana: GSS, GHS, and ICF Macro, 2009).
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18 ibid.
19 ibid.
21 ibid.
22 ibid
24 ibid.
26 ibid.
28 ibid.
31 ibid.
32 ibid.
35 ibid
CHAPTER 3

CHILD HEALTH DEVELOPMENT IN GHANA; AND THE ROLE OF FOREIGN AID IN REDUCING CHILD MORTALITY IN GHANA

3.0 Introduction

This chapter looks at the policies, programmes and strategies adopted by Ghana to curb Under 5 mortality in the country. It would also present the forms and levels of aid that are received from development partners with regards to reducing child mortality, thus achieving MDG 4 in Ghana. This will outline the role of donor support in reducing child mortality in Ghana. It further outlines the nature of international cooperation that exists between Ghana and its development partners in the aspect of health, and particularly reduction of child mortality. The chapter will conclude with the challenges of reducing child mortality.

3.1 Child Health Development in Ghana

According to Ofosu-Amaah, before 1920, Ghana did not have any organized modern Maternal and Child Health (MCH) services. Since then, hospitals and maternity centres have been established and campaigns against maternal and infant mortality was initiated.\(^1\) Infant mortality has fallen from 360 in 1915 to current average of 82 in 2011.

Ghana as part of its current child health development has developed the Under 5 Child Health Strategy: 2007-2015 and the Under 5 Child Health Policy: 2007-2015. These strategy and policy documents bring together different programme areas, involving maternal and child health, nutrition, immunization, malaria, and HIV/AIDS and emphasises for collaboration among all these sectors.\(^2\) The strategy document contributes to the achievement of the national development framework, sets the reduction of child mortality to 40/1000 live births by 2015 and thereby focused on achieving the MDG 4. It uses a “child centered” approach instead of a
“programme centered” approach in that it focuses on the complete lifecycle of the child from pregnancy through birth, infancy and older childhood.³

The Under 5 Child Health Strategy: 2007-2015 has a total of twelve strategic objectives, four of them describe how newborn and child health interventions are delivered along the continuum of care for the mother and child, including pregnancy, birth and immediate newborn period, neonatal period, infants, and children. The four strategic objectives concerned with the delivery of newborn and child health interventions include: improve coverage of antenatal care interventions; improve coverage of safe delivery interventions; improve coverage of neonatal care interventions; and improve coverage of interventions for children under 5.

The other eight strategic objectives describe programme supports needed to deliver newborn and child health interventions involving: policy, planning and management; community capacity; health promotion and behaviour change; human resources; private sector; financing, monitoring, evaluation and research.⁴ These have been identified to help improve capacity to coordinate, plan and manage activities for child health; improve capacity to implement health promotion and behaviour change activities for child health; improve capacity to implement community level activities for child health; improve availability of human resources for child health; improve health systems for delivering child health interventions; improve capacity of private providers to deliver child health interventions; improve availability of financial resources for child health interventions; improve availability of financial resources for child health; and monitor and evaluate progress in child health.⁵

The strategy further points out that the interventions to improve child health cut across a number of different technical areas and therefore child health interventions may be delivered
by different programmes, almost all of which have available existing strategy documents. The Under 5 Child Health Strategy: 2007-2015 aims to bring all these strategies together for the identification of common approaches to implementation. Child health interventions are defined as treatments, technologies, or key health behaviours that prevent or treat child illness and reduce deaths in children under 5.6

It is important to note that there has not been any review on this programme since it is still running. However, the GHS and the MoH have annual reviews and reports of their progammes and various thematic areas. Analysis on this document is therefore based on the interviews and reports from the MoH, GHS and DPs.

3.1.1 Strategies for Reducing Child Mortality

_Pregnancy_

The strategic objective for reducing child mortality during pregnancy is improving coverage of Focused Antenatal Care (FANC). This involves improving access to FANC and it encompasses delivering refresher training of midwives to provide FANC through outreach. Midwives are allocated to specific communities and encouraged to follow women from pregnancy through delivery and the postnatal period. Community health volunteers are trained to provide elements of FANC, including distribution of iron, folate, and Insecticide Treated bed Nets (ITNs) to pregnant women, and health education on the need for Antenatal Care (ANC). Others include improvement in the quality of FANC, entailing the reviews of essential equipment, medicines and supplies, and action to ensure that these supports are available, and an emphasis on counselling at all opportunities. Key ANC messages identified which are reiterated at all opportunities include visits to a health facility or community-based provider as early as
pregnancy is detected, make at least 4 ANC visits during pregnancy, recognize complications and seek care early when problems arise, and prepare adequately for safe delivery.7

Using the FANC programme as an example for the antenatal care (ANC) intervention, the MoH has exempted fees for four minimum visits per women attending ANC. This initiative has focused on areas such as individualized, comprehensive, private and confidential care, emphasis on birth preparedness and complication preparedness, and continuous care provided by the same provider.8 The benefits of FANC are that it encourages early detection and subsequent treatment of pregnancy complications. As such, key positive outcomes of FANC include enhanced ANC attendance and use of hospital delivery facilities, reduced still birth rates, improved use of postnatal services and improved client provider interaction.9

Birth and immediate newborn period

Strategic objective during this period is improving coverage of skilled delivery interventions. The various strategies consist of improving access to skilled delivery and the GHS has advocated for adequate numbers of trained delivery staff at all levels, develop incentive packages to encourage midwives to remain in rural posts, and advocate increasing postings of midwives to rural settings. Traditional Birth Attendants (TBAs) were also trained to recognize delivery complications and to refer such cases promptly to avoid neonatal deaths.

The second important objective which is observed during birth and immediate newborn period focuses on improvement in the quality of skilled delivery. This includes up-to-date and regular facilitative supervision which includes observation of clinical practice, and entails the reviews of essential equipment, medicines and supplies, and action to ensure that these supports are available, and an emphasis on counselling at all opportunities. Training and support were given
to midwives (MWs), TBAs and community health volunteers to recognize and refer women with delivery complications early, resuscitating newborns needing resuscitation as well as the use of appropriate post-delivery practices which includes early and exclusive breastfeeding and appropriate cord care. On the other hand, harmful practices such as early bathing, and the use of harmful substances such as shea butter and salt on the umbilical stump are discouraged.

Furthermore, improved demand for skilled delivery has been enhanced. There is improvement in the availability of MWs at all levels. The quality of care they provide, incorporate key delivery messages into the materials used by community health workers and volunteers and ensure that they are given at all opportunities. Key messages highlighted include ensuring that deliveries are attended by skilled providers, and encourage communities to plan for referring women and children when necessary.\textsuperscript{10}

Access, quality and demand for skilled delivery has been enhanced in Ghana by the introduction of the free delivery care under the National Health Insurance Scheme (NHIS) which has improved health seeking behaviour of expectant mothers and further boosted the utilization of health care services by scraping significant financial barriers to access.\textsuperscript{11} As a result, the national rate of skilled delivery has continued to improve from 45.6% (2009), 49.5% (2010) to 52.2% (2011).\textsuperscript{12} This service however suffers from the consequences of late disbursement of service funds from the Government of Ghana which delays the majority of essential services offered.

\textit{Neonatal period}

The strategic objective during the neonatal period is to improve coverage of neonatal interventions. The various strategies include improving access to neonatal care. With this, all
newborn services are covered by the National Health Insurance Scheme (NHIS). Postnatal care
(PNC) is promoted at each level, and the PNC for both the newborn and the mother are provided
at the same time. The first PNC service is within 48 hours of delivery and the second within 7
days. Activities to improve access include providing refresher training to midwives to provide
PNC through outreach, and provide training to TBAs and community volunteers to provide
early PNC visits in the home.

Another strategy that is observed during the neonatal period is the improvement in the quality
of care. This involves up-to-date and regular facilitative supervision which includes
observation of clinical practice, and entails the reviews of essential equipment, medicines and
supplies, and action to ensure that these supports are available, and an emphasis on counselling
at all opportunities. Some of the activities to improve quality of neonatal care includes training
and supporting MWs, TBAs and community volunteers to recognize the danger signs for sick
newborns, and refer sick newborns promptly. There has also been improvement in the demand
for neonatal care. This has highlighted health communication and behaviour change on
neonatal care, and will further ensure that community based providers such as TBAs,
community health officers and volunteers provide counselling and support for caregivers to
seek care at recommended times. Key elements of post-delivery care include early and
exclusive breastfeeding and appropriate eye and cord care.13

According to the GHS 2011 Annual Report, GHS is leading a neonatal quality improvement
programme in three hospitals in cooperation with the WHO and the Johns Hopkins University.
Training programme on neonatal resuscitation, neonatal sepsis and kangaroo mother care were
developed, and data on neonatal and infant morbidity and mortality is being collected monthly
in the three hospitals and from the communities through the Demographic Surveillance Surveys being conducted by the Dodowa, Navrongo and Kintampo Health Research Centres.\textsuperscript{14}

\textit{Infants}

The strategic objective covering infant and children is the improvement in the coverage of effective interventions for children under 5. Strategies outlined include improving access to interventions for children under 5. All child services will be covered by the NHIS. Activities that improve access includes scaling up community-based case-management of pneumonia, malaria and diarrhoea, increase the number of baby friendly hospitals, provide refresher training to facility and community-based staff to give preventive and curative service and health education and counselling at all contacts, and provide refresher training for facility-based staff to target outreach to remote or hard to reach communities.

Focus is placed on improving quality of care for children under 5. This is reinforced by the adoption of the national treatment guidelines for children, up-to-date and regular facilitative supervision which includes observation of clinical practice, which entails the reviews of essential equipment’s, medicines and supplies, and action to ensure that these supports are available. Emphasis is also placed on counselling at all opportunities. Some activities to improve quality of care are the scale-up of Community Integrated Management of New born and Childhood Illnesses (IMNCI), scale-up the use of zinc for the management of diarrhoea, and provide training to facility and community-based staff to promote appropriate home care for sick and well children.

Demand for interventions for children under 5 have been improved. This programme emphasize health promotion and behaviour change, ensuring that community based providers
provide appropriate counselling and support. Activities for improving demand for interventions comprise the incorporation of key child care messages in counselling materials for health providers and ensuring that they are given at all contacts, and incorporating key child care messages into education materials for community health workers and volunteers, and ensuring that they are given at all opportunities. Key messages to be highlighted include prevent illness in the home, seek preventive services, appropriate feeding of the child, and recognize when a child is sick and seek care from an appropriate provider.15

A precondition for the achievement of MDG 4 is the availability of essential medicines for children since most of the deaths of children are caused by diseases that could be prevented, treated or managed by access to safe, essential child specific medicines. The Better Medicines for Children (BMC) project takes into consideration an in-depth assessment of the public supply system for the supply of child-specific medicines. As part of the Better Medicines for Children Project, the WHO Pocketbook on Care for sick Children in Hospital is being used in health facilities throughout Ghana. It serves as useful clinical guidelines for practitioners providing care for children on admission and at the outpatient department. This is because an assessment conducted by the BMC project with the MoH on the supply chain assessment of child-specific medicines in Ghana in 2011 revealed that there are no separate structures within the public supply system to ensure access to child-specific medicines, education and training programme to ensure storage, distribution, quality assurance system, quantification, procurement, ordering and selection of products.16

General Child Health Interventions
The Ministry of Health advocates for an integrated approach to planning, implementing and delivering child health intervention strategies in collaboration with other sectors such as the
Ministry of Food and Agriculture (MOFA), Ministry of Gender, Children and Social Protection, Department of Social Welfare, the Ghana Education Service (GES), District Assemblies, and other Ministries, Departments and Agencies (MDAs). Areas that would be focused on include coordination, planning and management; health promotion and behaviour change; community capacity; human resources; health systems; private sector; financing; and monitoring, evaluation and research.\textsuperscript{17}

The Nutrition and Malaria Control for Child Survival Project undertaken by the World Bank, GHS and the government of Ghana is to improve utilization of selected community-based health and nutrition services for children under two and pregnant women. This is an important shift from the curative care system of operation upon which the Ghana health sector has focused on for a long time to the preventive care system.\textsuperscript{18}

The various provisions contained in the Under 5 Child Health Strategy and Policy and the diverse projects being pursued provides a clear commitment on the part of government to deal with the child mortality situation in Ghana. With just one and half years to 2015, Ghana looks unlikely to achieve the target for reducing child mortality looking at the statistics of the birth and death ratio. The Under 5 Child Health Strategy and Policy documents set a target of 40/1000 live births but the recent data from the MICS puts the current mortality ratio at 82/1000 live births. Clearly, more needs to be done for the general wellbeing of the child from pregnancy through delivery to the first couple of years of the child. Even without the MDGs, child health still needs to be adequately catered for.
3.2 The Role of Foreign Aid in Reducing Child Mortality in Ghana

Foreign aid has played a significant role in the development landscape of Ghana for the past 5 decades. It has been used in areas such as general poverty reduction, infrastructure, education, health, business promotion, women empowerment, election support and civic education, human rights, among others with about 40 percent of Ghana’s total budget coming from development partners. The apparent resource-challenged and underdeveloped health sector of Ghana is expected to require some substantial support and technical assistance from development partners.\(^{19}\) As such, aid has played a significant role in the health sector, contributing about 22 percent of the health sector budget.

The United States Agency of International Development (USAID), the Department for International Development (DFID), the Royal Netherlands Embassy (RNE), the Danish International Development Agency (DANIDA), World Bank (WB), the Japan International Cooperation Agency (JICA), the Korea International Cooperation Agency (KOICA), the European Union (EU), UNICEF, United Nations Population Fund (UNFPA) and World Health Organization are the main development partners for the health sector in Ghana.\(^{20}\) The Global Fund and GAVI Alliance have also been very effective in the various forms of support that they give to enhance the Ghanaian health sector.

3.2.1 Nature of Support in Reducing Child Mortality

The various development partners of the health sector in Ghana use diverse approaches in supporting the reduction of child mortality. Generally, support may be identified as either direct or indirect. Direct support is the situation where a development partner directly provides funds or other technical support to a specific area of the health sector or to a particular intervention activity geared towards reducing child mortality. Indirect support on the other
hand is the situation where development partners provide budgetary assistance through the Multi-Donor Budget Support and/or Sector Budget Support for health. This is done through the Ministry of Finance as well as technical support to the Ministry of Health and its various agencies. Some development partners engage in both direct and indirect support strategies.

Most health aid to Ghana comes in the form of budgetary support to the Ministry of Health through the Ministry of Finance and Economic Planning. Total donor budgetary allocation to the Ministry of Health in 2010 was GH₵ 331,536,100.00, 2011 was GH₵ 219,487,125, and 2012 amounted to GH₵ 624,067,874.00.\textsuperscript{21} RNE, DANIDA, DFID and the EU provide Multi-Donor Budget Support and/or Sector Budget Support for health through the Ministry of Finance. USAID on the other hand works through partner institutions for the provision of health services towards poverty reduction in Ghana.

### 3.2.2 Activities of some Development Partners (DPs) in Reducing Child Mortality

**DFID**

The DFID is the international development arm of the United Kingdom (UK), through which it supports development programmes across the world. The United Kingdom remains one of Ghana’s major development partners, contributing immensely to the total development of the country. The UK acknowledges that sustained economic growth and stability have put Ghana on the path to achieve the target of halving poverty by 2015.\textsuperscript{22} It maintains however that more needs to be done in tackling MDGs 3, 4 & 5 as well as scaling up progress to bridge the developmental gap that exists between the southern and northern parts of the country. The UK Government is committed to concentrating its efforts on supporting the achievement of the MDGs and therefore helps reduce inequalities around the world.\textsuperscript{23} Over the years, DFID has
provided both direct and indirect support to the health sector in Ghana and provides funds through the EU, the World Bank, and the UN agencies.

From 2008-2013, the DFID provided £41,166,402.00 to the Ghana Health Sector Support Programme (GHSSP), which was expected to offer improved access to quality healthcare. The components of this support include health policy and administrative management, reproductive healthcare, sexually transmitted disease (STD) control including HIV/AIDS, and medical research. The conditions attached to this GHSSP indicates that release of funds will be dependent on the Government of Ghana’s continued commitment to poverty reduction and making progress towards the health Millennium Development Goals (MDGs) targets, as well as continued improvements in the financial management system of the health sector. Another GHSSP with components of health policy and administrative management, and basic healthcare and earmarked for 2012-2016 has a total budget of £109,305.00 and it is expected to help Ghana develop a sustainable health system addressing equity and quality of care.

DFID provided £10 million from August 2010 to fund the purchase of 2.35 million Long Lasting Insecticide Treated Nets (LLINs) and support social mobilization and communication activities towards the proper hanging and utilization of LLINs. The logistics for this programme was termed ‘the hang up campaign’, aimed at reducing malaria morbidity and mortality in Ghana. DFID channelled the funds through the United Nations Children Fund (UNICEF) to procure the LLINs and other logistics, carry out social mobilization and communication activities for the hang up campaign. The National Malaria Control Programme (NMCP) had oversight responsibility of the campaign in all regions of Ghana and, together with UNICEF, co-ordinated activities of the campaign including training of health workers and volunteers, distribution and hang up of the LLINs, social mobilisation and communication in
all the ten regions of the country. The ‘hang up’ strategy was adopted because evidence from previous campaigns has shown that only a percentage of people who received bed nets actually used them and this under-use was because bed nets were handed to targeted beneficiaries, often still in their packaging. The ‘hang up’ strategy therefore allowed trained volunteers to move from house-to-house to distribute the nets and hang them over identified sleeping places.\textsuperscript{27}

Evidence from previous insecticide treated bed nets distribution campaigns in Ghana had shown positive results contributing to the reduction of over-all mortality in children under 5 falling from 108 in 1998 to 80 per 1,000 live births in 2008. Malaria prevention is entirely consistent with DFID’s global strategy for the achievement of the health Millennium Development Goals (MDGs) and this project was meant to directly contribute to the attainment of MDGs 4 (reduction in child mortality), 5 (maternal mortality) and 6 (reduction in malaria) in Ghana.\textsuperscript{28} These are also in conformity with Government of Ghana’s commitment to reducing child mortality.

\textit{USAID}

USAID provides mainly bilateral assistance to the government of Ghana to support programmes that enhance health, education training and capacity building, agriculture and advocacy. USAIDs cooperation with Ghana is guided by the USAID/Ghana Country Development Cooperation Strategy, which is designed to cover a period of time. At the time of this research, the strategy document in use is the Global Health Initiative Strategy (GHI) 2012-2017. This document outlines the support specifically channelled to the health sector in Ghana by USAID between the stipulated time periods. Unlike other development partners like DFID that provide support through the MDBS for health activities, USAID prefers to use its partners, usually American non-governmental organizations (NGOs) and other organizations.
to implement its initiatives. The various USAID projects, aimed at child mortality reduction and the partner institutions that operate them, are below:

- Focus Region Health Project (FRHP) – John Snow Incorporated (JSI);
- Behaviour Change Support Program (BCS) – Center for Communication Programs, John Hopkins Bloomberg School of Public Health;
- Ghana Water, Sanitation and Hygiene (GWASH) Project – Relief International;
- Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results (SHARPER) – FHI 360; and
- Promoting Malaria Prevention and Treatment (ProPMT) – University Research Cooperation (UCR), the project which ended in March 2013.

USAID acknowledges the integrated nature of the causes of child deaths and therefore gives support to various health and non-health issues that affect child deaths. In the past year, USAID’s funding totalled US$ 65 million and covered the operational areas of USAID. The Ghana GHI indicates the commitment of the USG to expand access to high quality integrated services mainly through increased access to high quality voluntary family planning and reproductive health, improved prevention and management of malaria and other drivers of child mortality, improved health behaviours and demand for key services and strengthened integrated referral system for continuum of care. It also makes provision for other aspects of life beyond health services that affect child mortality, including areas of water and sanitation, provision of LLINs, and nutrition. The implementation of these provisions is executed by partners of USAID within the specified thematic areas. Additionally, it provides direct support to the GHS in terms of provision of equipment and technical support.
The USAID funded FRHP assists the Ministry of Health and the GHS to strengthen access to high quality family planning, maternal, new born and child health services in the Central, Greater Accra and Western regions as well as implementing several programmes of the ministry and GHS. As such, FRHP engages in the supply of health related equipment, refurbishment of surgical theatres to enhance safe delivery of babies, and training of providers of healthcare through capacity building workshops, pre-service and in-service training programmes. Other programmes under the FRHP include support for the proper diagnoses of malaria and subsequent medication, training of licensed chemical sellers to be able to dispense well as they are mostly the first points of call in the communities for healthcare needs, work with pharmaceutical companies and the Food and Drugs Authority (FDA) for the production of standardized drugs, and building of Community Health Planning and Services (CHPS) compounds. FRHP has championed community, health facility and health systems to help reduce child mortality through the essential new born care (ENC), a set of preventive measures including cord care, thermal control, early and exclusive breastfeeding, immunization, prevention and treatment of diarrhoea, pneumonia, malaria, and malnutrition.

The purpose of BCS is to assist the GHS at all levels: national, regional and district levels to support its efforts to achieve the health related MDGs through sustained and consistent social and behaviour change communication (BCC) interventions. BCS aims to increase demand for and usage of commodities and services and create positive behaviours in the areas of: maternal, neonatal and child health; family planning and reproductive health; nutrition; water, sanitation, and hygiene; and malaria prevention and treatment. Most of the work of BCS has been focused on family planning with the production of several documents such as flip charts and other tool kits used by community health workers to explain family planning methods to adults and young adults as well. Television and radio adverts, posters and billboards across the
country are also used to educate the general populace on family planning methods and appropriate healthcare processes for children. BCS also engages in community mobilization to encourage behaviour change in the said communities.

The Ghana Water, Sanitation and Hygiene Project (GWASH), undertaken by Relief International, works to improve rural and peri-urban communities in the areas of health, sanitation and hygiene through close collaboration with communities and government agencies. The provision of improved access to safe and clean drinking water for communities, households and schools will help prevent diarrhoea and other diseases that have negative effects on community health and thereby reduce child deaths. Projects undertaken under the water initiative include construction of boreholes, hand-dug wells, small town piping systems and water kiosks. On the sanitation front, the Ghana WASH Project works very closely with communities to provide improved sanitation facilities for households, schools and health clinics as access to sanitation is seen as a very significant constituent to the health and wellbeing of communities. The hygiene education and promotion initiative motivates individuals and households to adopt positive behaviours for healthier lifestyles.

USAID also funded the Promoting Malaria Prevention and Treatment (ProMPT) project. This project run from 2009 to March 2013, and was executed by UCR in close collaboration with NMCP. The project strengthened malaria prevention and control and expanded successful malaria interventions nationwide. ProMPT aided in the country’s substantial progress towards achieving the national goal of universal coverage of LLINs through door-to-door ‘hang-up’ campaign and led to the distribution of more than 10 million LLINs to primary schools, antenatal care and welfare clinics. The project also helped train health workers on the case management of malaria and community-based agents such as community health officers and
community health volunteers to be able to identify the symptoms and treat malaria in their communities.

**WHO**

The WHO has the WHO Country Cooperation Strategy 2008-2011 for Ghana, with extension to 2013 that guides and defines the medium-term strategy for the work of the WHO at the country level and describes how the three levels of WHO, that is Headquarters, WHO Regional Office for Africa, and Country Office will work to achieve the country’s health sector objectives. The Country Cooperation Strategy (CCS II) is the second such strategy after US$ 16.67 million was provided to implement CCS I from 2002-2005 covering four strategic areas involving health systems strengthening (HSS), health management information/surveillance system (HMIS), scaling up priority health interventions (SURV) and health promotion (HP). The CCS II advocate for the highest quality support to the national health agenda as outlined in the country’s national policies and programmes of work and is guided by the MDGs, WHO resolutions and other regional strategies and resolutions.38

The CCS II has three main strategic priorities with detailed country-specific strategic focus. The first strategic priority is health security and its country-specific strategic focus include: reduce morbidity and mortality linked to priority communicable diseases, HIV/AIDS, tuberculosis and malaria; eradication and elimination of target diseases; improve reproductive health and child survival; strengthen the control of non-communicable diseases, health promotion and nutrition; improved preparedness and response to epidemics and other complex health emergencies. The second strategic objective is health system capacity and performance and the focus is to strengthen health systems for more effective health service delivery. The
last strategic priority is partnerships, governance, gender and equity with a focus on improved health sector partnerships, governance, gender and equity.\textsuperscript{39}

The strategic focus of improving child survival is to support interventions that increase antenatal care coverage, skill attendant at birth, and emergency obstetric care and postnatal care services. The WHO supports integrated interventions targeting neonates, infants and children, which includes coordinated approach to community child survival interventions for pregnancy and new born care, community case management of malaria, diarrhoea and pneumonia, community growth promotion and management of severe malnutrition and immunization and surveillance.\textsuperscript{40} Additionally, the WHO embarks on child health campaigns to increase the uptake of vitamin A, deworming, immunization and insecticide treated nets as well as support improvements in essential new born care, integrated infant and young child feeding counselling, and Integrated Management of Childhood Illnesses (IMCI).\textsuperscript{41}

An officer at the WHO Ghana Country Office in Accra asserts that WHO offers technical as well as financial support in building the country’s capacity to implement some programmes towards the reduction of child mortality in Ghana. She indicated that WHO’s support are in the areas of immunization for polio and measles as well as the introduction of new vaccines into the immunization system, support for the IMCI to improve the quality of care at the first level health facility, working in areas of nutrition and maternal health which all influence the reduction of child mortality.\textsuperscript{42} The IMCI for instance, has three main components which are complementary. These are;

a. Improvement of the case management skills of health workers through the provision of locally adapted guidelines and training activities.
b. Improvement in health systems required for effective case management of childhood illnesses, especially supplies of essential drugs.

c. Improvement in family and community practices in relation to child health.\textsuperscript{43}

As part of the IMCI programme, the Roll Back Malaria (RBM) targets for 2003, which is Improving Management at Household Level, increased from 22\% to 32\% the proportion of children with fever receiving correct home treatment.\textsuperscript{44} In the IMCI documentation on experiences, progress and lessons learnt of 2004, it was concluded that the concept has been embraced very well in the pilot districts with rapid onset of expansion. Suggesting that cascading the expansion to the level where it will be institutionalized will depend on the ability of the programme to attract financial resources. If the Ministry of Health, Ghana Health Services at all levels, partners and District Assemblies could demonstrate renewed commitment and support, the health of children will see a major transformation in Ghana.\textsuperscript{45}

\textit{World Bank}

The World Bank provided the country with a US$ 25 million loan facility in 2007 for the Nutrition and Malaria Control for Child Survival Project which was expected to improve the utilization of particular community-based health and nutrition services for children under the age of two and pregnant women in selected districts.\textsuperscript{46} The project was organized around three main components. Component one is to strengthen institutional capacity for coordination, implementation, and outcomes and its main objective is to develop effective inter-sectoral coordination, ownership, and accountability for nutrition towards the setting up of a coherent national programme as well as reinforce the Ministry of Health and Ghana Health Service to successfully direct execution of the community based health and nutrition programme.
supported by the project. Community-based health and nutrition service delivery is the second component and its objective is to enhance community-based health and nutrition services for children under two and pregnant women. The last component, malaria prevention, has the objective to increase use of Long Lasting Insecticides Mosquito Nets (LLINs) in order to reduce malaria related morbidity and mortality among children under five and pregnant women.\(^47\) In the Jomoro district of the Western region, the LLINs programme has been recorded to reduce malaria cases from 50% in 2011 to 28% in 2012.\(^48\)

**Gavi Alliance**

The Global Alliance for Vaccines and Immunization (GAVI Alliance) on the other hand has provided over US$ 224 million worth of support to the health sector in Ghana from 2001 to March 2013.\(^49\) Support has been in the form of funds, HSS, immunization services support (ISS), injection safety support, measles vaccines, measles-rubella vaccines, meningitis A campaigns, penta, pneumo, rotavirus and yellow fever vaccines.

The above information on the activities of DFID, USAID, WHO and GAVI Alliance shows some of the major forms and levels of foreign aid in reducing child mortality in Ghana. It also explains some of the approaches used in delivering aid. It can be said that each donor employs a medium or technique of execution of its projects or assistance in a manner most convenient for it. Although this may be good for the donors, it may be an inconvenient situation limiting the attainment of the goal of MDG4. This is because almost all the projects being undertaken by the donors do not have a nationwide coverage. Those having a nationwide coverage may not be available in all health centres. Therefore the accessibility of these programmes to all those who may be in need of them is not assured. This situation cannot be fully borne by donors.
alone. The interviews explained that many of these challenges could be minimized if socio-economic and cultural conditions in the Ghanaian society could be dealt with.

Furthermore, it is clearly evident from the above that international cooperation has played a major role in the provision of support for the reduction of child mortality in Ghana by DPs. The various programmes and projects demonstrate that international cooperation exists among states and between states and international organizations. The nature of partnership that informs the various forms of support such as general budget support, multi-donor budget support, sector budget support as well as the numerous bilateral aid and grant facilities given by DFID and USAID to Ghana on behalf of the United Kingdom and the United States of America respectively can be explained by the tenets of cooperation. Cooperation is further seen in the continuous significance of international institutions and organizations in partnering with underdeveloped countries for the provision of support in the form of funds, technical assistance, equipment, and drugs, among others for child mortality reduction interventions. The various kinds of support given by the WHO, the World Bank, and GAVI Alliance as presented in this research confirms the existence of international cooperation between Ghana and these organizations.

3.2.3 Relevance of Support

With the integrated nature of the various interventions geared towards reduction of child deaths, coupled with the varied nature of support given by the numerous projects and programmes undertaken by DPs, it would be difficult to attribute the overall success recorded to a particular intervention. DFID’s support to the MDBS, GHSSP, and the distribution of LLINs; USAID’s support through its partners in the form of behaviour change, ProMPT, distribution of LLINs, and improvement in water, sanitation and hygiene; WHO’s support to
immunization as well as capacity building; World Bank’s facility to improve nutrition and malaria control for child survival; and GAVI Alliance’s support to immunization are just a few of the forms of foreign assistance geared towards attaining MDG 4 in Ghana.

Stating categorically how interventions for child mortality were before and now and the successes attributed to donor funding is very difficult or almost impossible. This became clear when a key respondent from the Ministry of Health explained that donors helping reduce poverty through employment creation, building feeder roads, reducing malaria, encouraging proper nutrition and sanitation are all helping reduce child mortality indirectly. This is supported by the fact that donor funds that come in the form of MDBS through the Ministry of Finance are not allocated to specific or particular child health interventions but rather given to the districts to be used for general health service delivery. Total donor inflows to the health sector amounted to US$ 127,680,000 in 2005, GH₵ 189,000,000 in 2007, GH₵ 126,731,000 in 2008, and GH₵ 183,525,000 in 2009.  

However in a country where a substantial amount of the government’s budgetary allocation to the Ministry of Health comes from donor support, the relevance of foreign aid for the reduction of child mortality cannot be overruled. Thus, donor support helps drive most of the work of the public health sector and its ceasure will therefore have an adverse effect on the operations of the Ministry. But there should be a cause of concern for the government of Ghana as donor funds are likely to dwindle in the next few years because of the country’s elevation into a lower middle income economy coupled with expected proceeds from the oil find. DFID for instance plans to reduce the level of general budget support from £36 million in 2010/11 to around £10 million in 2014/15, even though levels of sector budget support will be maintained.  

This will create a funding gap and efforts by government will have to be enhanced to improve child
health situation in Ghana as child survival goes beyond the 2015 date set for the attainment of the various targets of the MDGs.

3.2.4 Evaluating the Immediate and Long Term Benefits from DPS in Reducing Child Mortality in Ghana.

Immediate help

The assistance from DP’s which may be said to provide immediate help in reducing child mortality from literature and responses in the field include immunization, vitamin A supplement, family planning, bed nets provision to prevent pregnant women and children from malaria and the education of expectant and nursing mothers in areas of good nutrition, sanitation and proper medication to mention a few.

Donor support for immunization against polio, measles and other diseases that cause child deaths could be said to be impacting positively on tackling child mortality in Ghana. This view is supported by the response from the respondent from the MoH that “because of immunization we’ve not recorded any measles death for more than five years, immunization is having the desired effect. Our immunization coverage level has consistently been around over 90 per cent. We are still discussing how we can raise it higher, but it depends. You go to some places and beg them for immunization but they will not do it, some do not do it for religious reasons”.

The statement above depicts the success of immunization and again supports Mishra and Newhouse’s claim that foreign aid improves health outcomes in developing countries by providing vaccines, eradicating deadly diseases and improving medical services. However, although donors would like to see a 100 per cent results, issues such as religion has limited them. Religion is a tough area to work in since it involves intense spirituality and Ghana is known for its strong religious population. In this situation, only strong education and rules or
by-laws with proper enforcement from the state will help save children with parents from such religious backgrounds.

Another form of immediate help realised by Ghana from DPs in relation to child mortality reduction is in the area of provision of bed nets to pregnant women and children for the prevention of the incidence of malaria and the appropriate diagnosis for malaria treatment. DPs have aided in the provision and the actual ‘hang up’ of ITNs and LLINs to most parts of the country. The WHO reports that use of ITNs reduce all-cause child mortality by an average 18% (range 14–29%) in sub-Saharan Africa. DFID also reports that evidence from previous ITNs distribution campaigns in Ghana had contributed to the reduction in Under 5 child mortality from 108 per 1000 live births in 1998 to 80 per 1000 live births in 2008.

Gains from family planning and the education of expectant mothers about the need for good nutrition for their children are some other immediate help from donor support towards the reduction of child mortality in Ghana. A respondent from the MoH confirmed this position by indicating that family planning impacts positively on child health. As such, the USAID funded behaviour change programme that primarily focuses on family planning procedures can be said to have contributed to the reduction of child mortality in Ghana.

In spite of the support given by the donor community, there is the need to tackle the root causes for the challenges being addressed with these immediate help interventions. For instance the provision of bed nets to prevent expectant mothers and children under five from malaria goes down to the problem of poor sanitation and environmental management. This raises the important role of other ministries and government agencies such as the Ministry of Environment, Ministry of Education, District Assemblies, the various waste management
companies and the like in achieving the MDG4. Government institutions must take their work of ensuring a clean environment seriously and do their work as required by the people of Ghana. At the same time, Ghanaians must wake up to the reality that living in a clean environment leads to a good health. The level of risk a person in a clean environment stands to suffer some diseases is far lower than another in a dirty environment. Hence, expectant mothers and nursing mothers must endeavour to live in clean environments if childhood killer diseases such as malaria, diarrhoea, cholera and the like are to be eradicated from amongst us. A respondent from the Ghana Health Service stated that “the health sector can only go half way or a little more and without the other sectors coming on board, I don’t think that we will be able to go far. We first of all want to prevent the situation from happening and these conditions are not favourable so you can’t fully prevent and they will keep coming down with diseases”.  

If the environment would be kept clean and Ghanaians would change their poor sanitation attitude, the efforts of these DP’s would be concentrated in the area of medical supplies. Much impact would then be made by foreign aid in achieving MDG4 than it stands now.

Furthermore, this research uncovered that certain socio-cultural and economic challenges may hamper the effect of foreign aid in positively impacting on the reduction of child mortality. The issue of socio-cultural challenges are seen in some of the traditional values, norms and belief systems of some of the communities in the country. A response from the MoH revealed that in some parts of northern Ghana, pregnant women who deliver in hospitals are considered as weak women so most of them prefer to deliver in the house. In most cases, these women will only be brought to the health facility when there are complications and usually, not much can be done to save the lives of both mother and child.
The various forms of help outlined above point to the fact that foreign aid is contributing very much and in almost all directions necessary to achieve the MDG 4 of reducing child mortality in Ghana. However, there are some of the indirect causes of child mortality which has not yet been covered and these issues stand the chance to erase the efforts chalked in other areas. The government of Ghana therefore needs to bring on board the fight to attain the MDG 4 all ministries and government agencies whose work indirectly affect the fight to stop child mortality in the country. This will help in addressing the root causes of the problem of child mortality, giving a holistic approach in solving the problem. The developed countries today in time past were underdeveloped and had similar problems but solving the immediate and root causes of these problems have made them to totally do away with some of these challenges. Thus, the sustainability of the immediate gains from donor support in reducing child mortality is very critically dependent on the resolution of the root causes as well.

*Long-Term Benefits*

There are certain long-term benefits that donor support presents to the health sector in efforts aimed at reducing child mortality. One of such benefits is in the area of training and capacity building for health care givers of children such as midwives, paediatricians, obstetricians, community health workers and volunteers. The provision of training and capacity building to such care givers obviously improves their service delivery for the care of children from pregnancy through delivery to the immediate periods after birth, which in effect helps reduce the incidence of deaths in infants and children. These trainings have helped improve the expertise of care givers for children in the country to a good extent although more is needed to be done on distribution. Clearly, holistic national achievement from donor support towards reducing child mortality cannot be realised if distribution of health workers across the country is not even. As the respondent from the MoH puts it, “Most of our staff members are found in
the capitals, they are refusing to go to the rural areas and if they don’t go to the rural areas then we don’t have the appropriate staff mix in those places to attend to them, so obviously the mortality will come from there”.\textsuperscript{57}

Another long-term benefit that accrues from donor support is that of the provision of infrastructure and medical equipment. These kinds of supports include building of CHPS compound by USAID, provision of masks for resuscitation of newborns and other medical equipment. The GHS reports that the continued expansion of CHPS and its related services has improved the acceleration of nationwide access to primary healthcare and to especially promote child survival.\textsuperscript{58}

Thirdly, DPs help the country to develop policies and strategies with regards to child health. These strategies and policies in the long-term will ensure standard rules and regulations concerning child health to reduce the risk associated with child bearing complications during pregnancy, delivery and after delivery until age five. The current Under 5 Child Health Strategy and Policy, 2007-2015 for instance had inputs and contributions from the various health development partners of Ghana. The Ghana Joint Assistance Strategy (G-JAS) Mid-Term Review of 2009 indicates DPs level of influence as moderate, with technical input from specialised agencies like UNICEF, UNFPA and WHO very well received.\textsuperscript{59} They are also accepted as having a legitimate voice on policy matters, albeit only one influence among many on national health policy. One of the challenges is to preserve an integrated structure for dialogue among DPs with very different priorities and interests.

One other strategy is the Accelerated Child Survival and Development Approach (ACSD) developed by UNICEF and adopted by the MoH for scaling up child survival interventions
nationwide as well as achieving the child survival MDG. Implemented by the GHS mainly in the Upper East and Northern Regions, the ACSD as supported by UNICEF involved planning and preparatory processes at the regional and district levels which resulted in the development of logical frameworks and work plans; immunization, Vitamin A supplementation and de-worming of children under five years of age; IMCI, including the home management of diarrhoea and malaria, malaria prevention through the use of insecticide treated bed nets (ITNs), promotion of hygiene and breastfeeding; and ANC package consisting of tetanus immunization, prevention of anaemia as well as malaria-prevention through the use of ITNs. Findings from the assessment showed significant improvements in certain child survival indicators and it is further envisaged that ACSD may have contributed close to about 14% reduction in U5MR by raising the coverage levels of key child survival indicators in the regions of operation.

These long term or enduring assistance offered by the DPs further supports the assertion by Mishra and Newhouse that aid may improve health outcomes directly, with health aid having a discernible effect on infant mortality. It again falls in line with the observation by Riddell that programme aid has had successes in health, education and road sector development in Ghana.

Children are an integral part of society and they cannot in any way be done away with and therefore childhood diseases and complications concerning the birth, delivery and growth from childhood to adulthood need to be taken care of. However, most of the programmes and the projects do not last long, which according to the respondent from the WHO are because they are not good but mostly because they are confronted with issues of socio-economic, cultural,
and behavioural challenges. The issue about sustainability of programmes and projects long after foreign aid has ceased therefore comes to the fore.

3.3 Progress towards Achieving MDG 4

On the whole, progress towards the achievement of the global MDG targets has been mixed and varied according to the goals, targets and indicators as well as across regions and sub-regions with SSA and South Asia lagging behind in the attainment of most of the MDGs. Global U5MR for instance has witnessed significant reduction with a decline by a third from 89 deaths to 60 deaths per 1,000 live births between 1990 and 2009 as a result of improved immunization coverage and opportunity for second-dose. SSA and South Asia still remains the sub-regions with the highest rates of child deaths, SSA recording 129 deaths per 1,000 live births in 2009, followed by Southern Asia with 122 deaths per 1,000 live births.

The UNDP Ghana and the National Development Planning Commission reports in the 2010 Ghana MDG Report that Ghana is unlikely to meet the 2015 target of reducing child mortality rates despite the fact that significant progress has been recorded in both infant and U5MR. The Under 5 Child Health Strategy and Policy sets the national target for the reduction of child mortality to 40 per live births. Data from the GDHS 1998, 2003 & 2008 and MICS 2011 all show a decline of infant mortality from 61.2 per 1000 live births in 1998 to 53 live births in 2011, with U5MR also declining from 110.4 per 1000 live births in 1998 to 82 live births in 2011. This is depicted in the graph below.
From the graph above, it is evident that from 20003 to 2011, the level of child mortality has declined from 110.4 to 82. This shows about 26 per cent reduction in the national U5MR. It has taken Ghana 13 years from 1998 to 2011 to get this level of reduction. The 2010 Ghana MDG Report attributes the success in the reduction of child mortality to the implementation of the various interventions under the Child Health Strategy and Child Health Policy which focuses on improving access to, quality of, and demand for essential services. These interventions included the introduction of new technologies such as low osmolarity ORS and zinc for the treatment of diarrhoea, as well as the introduction of new vaccines such as second dose measles vaccine, pneumococcal vaccine and rotavirus vaccine through the national Expanded Programme on Immunization (EPI). Additionally, measles vaccination coverage has shown positive progress with the immunization of under one-year old against measles improving from 68.8 per cent in 1998 to 87.7 per cent in 2010.
3.4 Challenges of Reducing Child Mortality

In spite of the fact that levels of child mortality has reduced over the past 10 years, the reality is that the target set for MDG 4 to be achieved in 2015 cannot be realized. This is as a result of several challenges that child health intervention strategies face. There are direct health sector and non-health sector challenges. Direct health sector challenges include the usual problem of inadequate human resources where there are not enough adequately trained staff to go round the country with most of the skilled staff found in the capitals.\(^{67}\) The poor distribution of health service workers, inappropriate professional behaviours of some of the staff towards child care, and problems with skills of staff to adequately cater for the health needs of the child are also some of the challenges. There are infrastructural problems as well, as most hospitals, especially the district hospitals do not have designated children’s wards so some part of the women’s wards are used for children and this is not always the best because cross infection can occur and have adverse effect on the health of the child. Beyond infrastructure, there are challenges concerning lack of basic and essential equipment for new born care such as oxygen bags and masks used for resuscitation of the child.\(^{68}\)

Aside these, non-health sector challenges come in the form of poor health seeking behaviour of parents and caregivers of children, socio-cultural problems, water and sanitation among others. These are what WHO calls the “social determinants of health”, which are issues that prevent people from getting access to good quality health services. These include poverty, educational background and some other physical barriers.\(^{69}\) The poor health seeking behaviour of parents are mostly influenced by certain socio-cultural practices and belief system of these people as well as physical barriers posed by un-motorable nature of roads in large parts of the country during most part of the year and the inaccessibility of health care facilities due to long distances from communities. Inadequate access to potable water and proper sanitation and
housing services also poses a problem as they are the leading causes of child illnesses and death such as diarrhoea, malaria and acute respiratory infection.

Endnotes

3 ibid.
4 ibid.
5 ibid.
9 ibid.
12 ibid.
20 ibid.
25 ibid.
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CHAPTER 4
SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.0 Introduction

This chapter gives a summary of the findings of the study, gives conclusions and recommendations.

4.1 Summary of Findings

This research focused on the role of foreign aid in the reduction of child mortality in Ghana and the health sector development of Ghana concerning the curtailing of child deaths. The Under 5 Child Health Strategy and Policy outlines the various intervention strategies employed by government and supported by DPs in dealing with the issue of reducing child mortality. It again underscores the importance attached to child survival in the country and the commitment on the part of government and healthcare providers to effectively control the rate of child deaths in Ghana.

The total outcome of aid has affected development in most developing countries. This is evident in the levels and trends of aid flows to developing countries, sometimes about 40% of a country’s entire budgetary allocation. Ghana receives aid from different nations and international organizations it has relations with. The forms of aid to Ghana include debt relief funds from the HIPC initiative, project support consisting of project loans and grants for definite projects and activities, programme aid comprising loans and grants for general and sector budget support including the MDBS, as well as balance of payment support from the IMF. The total amount of aid for the health sector has been increasing with the years under study. Using the highest of GH¢ 219,487,125 of 2011, donor support against the total health
sector budget of GH₵ 987,475,507 of the same year, the total donor support for 2011 may be said to be about 22.2% of the total health sector’s budget.

Approach of support has either been direct or indirect. Direct support usually entailing DPs directly providing funds or other technical support to a specific area of the health sector or to a particular intervention activity geared towards reducing child mortality. The activities of USAID in directly tackling the situation for instance depict forms of direct support. Other DPs like DFID, DANIDA, RNE and the EU however engage in indirect mode of support by providing budgetary assistance in the form of MDBS and/ or SWAps for health through the Ministry of Finance. Technical support is also given to the MoH and its various agencies. Mode of support could either be financial and/ or technical support.

Success gained between 1998, the last survey year before the MDGs were passed until 2011, four years to the end of the stipulated year of 2015. During that period of 13 years, U5MR was reduced by about 26.7%. This percentage of reduction represents an average of 3.5% annual rate of reduction for the 13 year period. Because donor support is given to the entire health sector and the amount given for reducing child mortality is not clearly stated, calculating the percentage of donor support in reducing child mortality is difficult. Despite this difficulty, evidence from the research clearly shows that the various forms of support have been beneficial in the nature of both the immediate and long term benefits. It is clear that donor assistance has provided vaccines, supported immunization against polio, measles and other diseases that causes child deaths. The extent of benefit can be seen in the observation made by this research that Ghana has not recorded any death from measles for the past five years. Apart from immunization, foreign aid has also made provision of ITNs and LLINs to pregnant women and children for the prevention of the incidence of malaria.
The research ascertained further that foreign aid has been beneficial in reducing child mortality through the provision of training and capacity building for health care givers of children such as midwives, paediatricians, community health workers and volunteers. These trainings have contributed to the improvement in the expertise of such care givers for children to a good extent. Donor support in the form of provision of infrastructure and medical equipment have also improved the acceleration of nationwide access to primary healthcare and to particularly promote child survival. The development of policies and strategies for ensuring standard rules and regulations concerning child health and to ultimately halt child deaths are other forms of benefits gained from Ghana’s cooperation with its DPs. Thus, the various DPs of Ghana have supported child mortality reduction over the years.

Despite the gains made in reducing child mortality, there are still some bottlenecks in actually realizing the targets under the MDG4. As it stands now, Ghana is unlikely to meet the MDG target by 2015 as a result of the rate of improvement as well as certain challenges identified by both donors and government. Central themes that run through these challenges are the issues of socio-cultural practices which influence the poor health seeking behaviour of parents and caregivers, inadequate human resources and the poor distribution of health workers, and problems with skills of staff to adequately cater for the health needs of the child. There are also problems associated with inadequate infrastructure and medical equipment as well as the poor access to health facilities mostly in rural and remote areas.

4.2 Conclusions

In chapter 1, it was hypothesised that foreign aid has helped in the attainment of the Millennium Development Goal 4 of reducing child mortality in Ghana. This hypothesis can therefore be accepted because of the numerous forms of support received from DPs in an effort to achieve
MDG 4. Though such supports come in different forms, their overall impact and relevance cannot be denied. This is consistent with what the literature indicates that foreign aid improves health outcomes in developing countries and is often credited with saving lives by providing vaccines, eradicating deadly diseases as well as improving medical services. Furthermore, it resonates parts of the literature which signifies that aid helps meet some key pressing and urgent needs as well as improving health outcomes with a marked effect on infant mortality.

In responding to the objectives of this study, it is observed that child mortality has been adequately addressed by the provisions of the Under 5 Child Health Strategy and Policy documents and in other health related policy guidelines and programmes and projects. It is therefore concluded that foreign aid has contributed to improving child health in Ghana by contributing to efforts in reducing child mortality levels. However, both government agencies and DPs recognize socio-cultural practices and to a lesser extent low economic status as some of the major challenges confronting the attainment of MDG 4 in Ghana.

4.3 Recommendations
The concern about sustainability of work done by donors in helping reduce child mortality comes to the fore when dealing with the effectiveness of foreign aid in tackling MDG 4. The government must work at a sustainable approach to the reduction of child mortality so that even after donors have withdrawn support, the gains made would be maintained. This is because the value of children to a society cannot be quantified as they serve as an invaluable resource base to the country. Children again are vulnerable and are totally dependent on the people around them for survival.
Strong laws and by-laws should be passed by government to protect children. This should be backed with proper enforcement to minimize the incidence of parents denying their children vaccinations and other immunization because of religious and cultural reasons. The government must make immunization and vaccination compulsory through these laws and by-laws which outweighs any religious or cultural reasons, stating clearly the punishment involved for denying any child their right to protection. The police, the Ministry of Gender, Children and Social Protection and hospitals must be made responsible in tracking and processing culprits to face the full rigours of the law when they falter. Software could be developed for monitoring each child’s immunization and vaccination. Each hospital, clinic and health centre must have these computerised system for tracking the vaccination and immunization and total development of each child delivered in their institutions. The telecommunication companies can also support by giving reduced charges for calls made from these health institutions. These calls could be made a week ahead of the immunization or vaccination for care givers to prepare. This will ensure that defaulters have no excuse whatsoever for not bringing the child for treatment. In the rural areas where this computerization may be difficult, the chiefs and elders must be made to take on the responsibility of contacting and reminding the parents and guardians of the children for their vaccinations and immunization.

The level of filth in the cities coupled with the poor disposal system needs governments urgent attention. Government must encourage and charge each DCE and Assemblyman or woman to establish sanitation task force in their communities to ensure that each family or household cleans their gutters and streets daily to prevent the current situation of dirty and chocked gutters. The waste management companies must be tasked to ensure clean public spaces especially the market. These companies must increase their staff and equipment to ensure that rubbish bins
in the various communities are always empty. If there is the need for the citizenry to pay for the disposal of their rubbish, it must be enforced as quickly as possible.

The roads and transport sector should partner with communities without proper roads so they construct feeder roads and train the youth in these communities as to how to maintain them.

I would suggest further that the government of Ghana and the MoH ensure that the staff strength of all professions concerning total child health and care should be improved by encouraging young men and women to go into these professions. Additionally, good incentive packages in the form of free or subsidized accommodation, transportation and the like should be used to entice some of these professionals to rural areas to help bridge the gap between rural and urban differences in child mortality rates in Ghana.

The MoH and other government agencies should enforce proper financial procedures to ensure that funds allocated to each sector affiliated to the alleviation of child mortality in Ghana are used properly. This will ensure that funds allocated to child health issues are used appropriately. This should be enhanced by strong monitoring and evaluation processes to ensure that projects and programmes are adequately assessed so that outcomes will inform policy decisions.

On another hand, religious institutions, groups and their leaders can tackle some of the root causes or challenges confronting the reduction of child mortality such as cleanliness, prevention of teenage pregnancy, seeking proper medical care for pregnant women and children. These can be done through organizing community clean-up exercises within the communities that these religious institutions operate. They can also organize periodic forums
for their congregations and the general public on the issues of cleanliness, teenage pregnancy and proper medical care for pregnant women and children. The religious leaders should encourage their members to aspire to have good economic standing to be able to take good care of the medical/health needs of their children.

Lastly, I would also recommend that DPs continually carry out monitoring and evaluation exercises on programmes and projects that they support and undertake to assess the impacts of these projects and ensure accountability. Such monitoring and evaluation exercises can be carried out in collaboration with the MoH and the GHS.
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### D. Research Papers and Presentations


### E. Interviews

Interview Respondent, Dr. Isabella Sagoe-Moses, Ghana Health Service, 24th June, 2013.

Interview Respondent, Ms Estella Anku, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 16th July, 2013.


Interview Respondents, Mrs. Irene Lartey and Madam Salamatu Futah, USAID Ghana, 16th July, 2013.

Interview Respondent, Dr. Mary Brantuo, WHO Country Office, Ghana, 10th June, 2013.

### F. Internet Sources


**APPENDICES**

**Appendix 1: The MDGs and their targets**

| Goal 1 Eradicate Extreme Poverty and Hunger | TARGET 1 Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day  
TARGET 2 Halve, between 1990 and 2015, the proportion of people who suffer from hunger |
| Goal 2 Achieve Universal Education | TARGET 3 Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling |
| Goal 3 Promote Gender Equality and Empower Women | TARGET 4 Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015 |
| Goal 4 Reduce Child Mortality | TARGET 5 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate |
| Goal 5 Improve Maternal Health | TARGET 6 Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio |
| Goal 6 Combat HIV/AIDS, Malaria, and Other Diseases | TARGET 7 Have halted by 2015 and begun to reverse the spread of HIV/AIDS  
TARGET 8 Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases |
| Goal 7 Ensure Environmental Sustainability | TARGET 9 Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources  
TARGET 10 Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation  
TARGET 11 Have achieved a significant improvement by 2020 in the lives of at least 100 million slum dwellers |
| Goal 8 Develop A Global Partnership For Development | TARGET 12 Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (including a commitment to good governance, development, and poverty reduction, nationally and internationally)  
TARGET 13 Address the special needs of the least developed countries (including tariff- and quota-free access for exports of the least developed countries; enhanced debt relief for heavily indebted poor countries and cancellation of official bilateral debt; and more generous official development assistance for countries committed to reducing poverty)  
TARGET 14 Address the special needs of landlocked countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the 22nd special session of the General Assembly)  
TARGET 15 Deal comprehensively with the debt problems of developing countries through national and international measures to make debt sustainable in the long term |
TARGET 16 In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
TARGET 17 In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
TARGET 18 In cooperation with the private sector, make available the benefits of new technologies, especially information and communication

Excerpted from UN Millennium Project, 2005.

Appendix 2: Interview guides for interviews undertaken

Interview Guide 1

Ministry of Health
- Can you kindly explain the child mortality situation in Ghana
- Any research work on child mortality situation in Ghana and findings?
- Causes of child mortality in Ghana
- Trends of child mortality/ spatial dynamics:
  - rural – urban
  - regional differences
  - rich – poor
- What are the health sector developments of Ghana with regards to reducing child mortality?
- What level of funds does the Government of Ghana commit to child mortality reduction projects/ programmes and what are these programmes
- Major donors and main projects undertaken to reduce child mortality in Ghana
- What are the levels of foreign aid/health aid committed to reducing child mortality?
- What do you think about the role and approach of foreign aid in reducing child mortality in Ghana
- Has foreign aid contributed to reducing child mortality in Ghana?
- If yes, what are the main indicators?
- What are the challenges of reducing child mortality in Ghana?
- What do you think is the future of child mortality in Ghana?

Interview Guide 2

Ghana Health Service
- Can you kindly explain the child mortality situation in Ghana
• Any research work on child mortality situation in Ghana and findings?
• What are the health sector developments of Ghana with regards to reducing child mortality?
• Do you directly undertake programmes geared towards reducing child deaths?
• If yes, what are these programmes and how do you fund them?
• Do you receive any form of foreign aid for your activities?
• What are the challenges of reducing child mortality in Ghana?
• What do you think is the future of child mortality in Ghana?

Interview Guide 3

Development partners/ aid agencies
• What is the nature of your cooperation with Ghana?
• Have you supported the government of Ghana in reducing child mortality?
• If yes, what projects or kinds of support has been given to the government in reducing child mortality since 2000?
• How have these projects fared?
  Have they been fruitful?
  What have been the reports from these projects?
• Reasons for supporting the reduction of child mortality
• How do you see your role in reducing child mortality in Ghana?
• What is the main theory/concept/ideology that underlies/drives your quest to help reduce child mortality?
• Do you have existing frameworks for supporting projects or does the government bring you proposals to be supported?
• How far do you go with your support?
  Do you just give out funds and ideas or do you get practically involved in projects aimed at reducing child mortality?
• Do you think your approach is the best?
• What are the challenges of reducing child mortality?
• What do you think is the future of child mortality in Ghana?