MEETING REPORT

Implications of the 2014 DHS Findings for Family Planning Programming in Ghana

La Palm Royal Beach Hotel, 7th July 2015

DAY OF DIALOGUE

ON

FAMILY PLANNING IN GHANA

Contents

APPENDICES

July 2015

LIST OF ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
CSO	Civil Society Organization
CHPS	Community-based Health Planning and Service
CMS	Central Medical Stores
CPR	Contraceptive Prevalence Rate
DD	Demographic Dividend
DP	Development Partner
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GNFPP	Ghana National Family Planning Programme
MAF	MDG5 Acceleration Framework
MOH	Ministry of Health
MSI	Marie Stopes International
NCCE	National Commission for Civic Education
NDPC	National Development Planning Commission
NPC	National Population Council
PPAG	Planned Parenthood Association of Ghana
PHC	Population and Housing Census
PMA	Performance Monitoring Assessment
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization

1.0 INTRODUCTION

Ghana has long prioritized Family Planning (FP) as a key strategy for addressing the country's health, social and economic issues. Ghana's first organized efforts towards scaling up FP started in 1969 when an advisory team on population affairs led by Prof. Fred T. Sai helped to establish the Family Planning Council at the Ministry of Finance and Economic Planning. Ghana developed its first population policy in 1969, which aimed primarily at reducing the high rate of population growth to facilitate sustainable socio-economic development. The Ghana National Family Planning Programme (GNFPP) was launched the following year to implement the plans as outlined in the 1969 population policy. The GNFPP achieved limited success due to a number of factors including poor institutional coordination, shortage of trained personnel, insufficient institutional support and inadequate government funding.

The policy was first revised in 1994 and emphasized a systematic integration of population variables into development planning, with a renewed emphasis on fertility reduction through family planning programmes. An important goal of the revised policy was to reduce the total fertility rate (TFR) from 5.5 to 5.0 by the year 2000, to 4.0 by 2010, and to 3.0 by 2020 through increased contraceptive use.

Evidence from data since 1988 paints a picture of both gains and stagnation in FP programming. On one hand, knowledge of any contraceptive method is almost universal in Ghana, with 98% of all women and 99% of all men knowing at least one method of contraception. Modern methods of contraception are widely known and available including IUD, condoms, the oral pill, implants, sterilisation, injectables and emergency contraception. Between 1988 and 2014, the use of modern methods of contraception almost doubled (from 13% to 22%).

On the other hand, while TFR declined from 6.4 in 1988 to 4.0 in 2008, preliminary results from the 2014 Ghana Demographic and Health Survey (GDHS) report indicate that TFR has increased over the last six years to 4.2. Use of FP methods has been less than desired, despite the almost universal knowledge and awareness. Contraceptive Prevalence Rate (CPR) for modern methods has fluctuated from 19% in 2003, decreasing to 17% in 2008 and increasing to 22% in 2014, an indication that even after a decade, still less than a quarter of married women are current users of modern contraception in Ghana. Yet, 30% of married women in Ghana have an unmet need for family planning.

Over the past decade, heavy investments have been made by government and several stakeholders to improve FP uptake in Ghana. There have been investments in the areas of training service providers to increase access and quality of FP service delivery, procurement and distribution of contraceptives, demand creation activities, and

health systems strengthening including supply chain management and the scaling up of the Community-based Health Planning and Service (CHPS) initiative with support from a myriad of development partners. In spite of these investments, the country has been unable to register any marked and sustained improvements in its FP indicators. At best, the gains made can be described as being sluggish, fluctuating and below expectations.

In order to galvanize multiple stakeholder support for improving FP indicators, the Ministry of Health/Ghana Health Service, in partnership with UNFPA convened a 'Day of Dialogue on FP' in Ghana to: (a) critically review the current FP trends, (b) brainstorm and identify the underlying causes of the sluggish performance and (c) make recommendations for the way forward. The meeting brought together a broad range of stakeholders within the FP fraternity including the academia, government agencies and institutions (including regulatory bodies), civil society organizations, the private sector, professional associations, the media and development partners.

1.1 Specific Objectives of the Dialogue

The specific objectives of the dialogue were to;

- Brainstorm on the factors behind the recent trends in modern FP uptake in Ghana and identify some of the underlying causes of sluggish performance;
- Forge consensus on the main challenges to effective FP programming in Ghana and what needs to be done to overcome them; and
- Put forward key recommendations on specific actions for significantly increasing FP uptake in Ghana in the next five to seven years.

1.2 Underlying Principles Considered at the Dialogue

As a means to drive the discussions on critical FP issues in a holistic and well-coordinated manner, the meeting participants considered three well established principles as follows;

- Extensive use of modern contraception is the main determinant of sustained fertility decline in developing countries including Ghana,
- Significant increases in the use of modern contraception rarely occur without large-scale FP programmes.
- Huge and rapid increases in contraceptive prevalence (85% - 300% in 5-7 years) are achievable in African settings.

2.0 CRITICAL FP ISSUES IN GHANA

The meeting participants engaged in stimulating discussions on issues surrounding the FP trends, the policy perspectives that shape FP programming, FP

service delivery and the social marketing of FP commodities. Other areas that generated interest included the socio-cultural factors influencing demand for FP and the role of development partners and civil society in FP programming. Highlights of the discussions are presented below:

2.1 FP Indicators and Trends

Participants deliberated on the trends in selected FP indicators from two groups of nationally representative population-based surveys; the GDHS (1988 to 2014) and the Performance Monitoring and Accountability Survey (PMA 2013 and 2014). The discussions centered mainly on the findings regarding the CPR and TFR. The findings revealed the CPR figures for modern methods remained almost the same for both sets of surveys; 16.6% (GDHS, 2008), 19.5% (PMA, 2013-R1), 21.4% (PMA, 2014-R3) and 22% (GDHS, 2014). Whereas, for example, the 2008 and 2014 DHS findings indicated TFR of around 4.0, the 2013 (R1) and 2014 (R3) surveys showed a slight decline in the TFR with figures of 3.6 and 3.7 respectively. Notwithstanding the slight decline observed from the PMA and G DHS surveys; the observed trends in fertility transition, the CPR and the dynamics of Ghana's population raise concerns regarding the country's quest to reap the benefits of the demographic dividend.

Some viewpoints suggested that while it is evident that the country has not had a drastic decline in the CPR and the consequent TFR in the past twenty years; data collection constraint s may account for the low contraceptive use recorded over the years. The clandestine use of modern contraceptives (due to socio-cultural pressures and the value that is placed on having children) by some survey respondents may hinder them from providing affirmative responses. A study conducted by the Navrongo Health Research Centre in the early 1990s revealed that about 42% of respondents who initially indicated they were not using Norplant were actually using the method. Participants agreed on the need to go beyond traditional methods of quantitative data collection to elicit the true picture on FP indicators in Ghana.

"...the no.1 priority of every nation should be on FP ...it appears the population is growing faster than the economy can handle..."
Dr. Appiah Denkyira, Director General, Ghana Health Service.

2.2 Policy Perspectives on FP in Ghana

Following Ghana's development of its first population policy in 1969, a number of programmes were implemented. These included the contraceptive social marketing and the family planning and health programmes. A situational analysis of the 1969 policy revealed inadequate resources and a lack of political commitment were critical constraints to the implementation of the policy. No priority was given to population programmes at the time, particularly in situations where donor funds were dwindling.

The non-existence of a Legislative Instrument (LI) to support the policy also contributed to the abysmal performance of the national population programme.

The revision of the policy in 1994 informed the setting of targets on CPR and TFR. Disturbing trends, including the stagnation of the TFR and CPR ten years after the revision of the policy, necessitated the implementation of a comprehensive strategy to reposition FP services in Ghana. In this regard, a roadmap was developed in 2005 to facilitate the effective integration of FP into the various service components of reproductive health for a more vibrant service delivery within a five-year period. Several policy and programmatic steps were initiated and are currently underway to facilitate increased availability, accessibility and wider acceptance and utilization of FP methods. These include the development of a costed implementation plan to harmonize all interventions and ensure that relevant stakeholders work towards the achievement of concrete and specific goals aligned to the national FP programme. In addition, the 1994 Population Policy and the 2004 Adolescent Reproductive Health (ARH) Policy are currently under revision. While acknowledging that fertility targets and population growth rates have not seen much improvement, several exchanges at the forum suggested that some gains have been made in the policy environment. These include achievements regarding some factors that affect fertility targets, especially around women's empowerment and girls' education. Such deliberations drew the participants' attention to the importance of giving due consideration to other factors and indicators beyond the TFR, CPR and unmet need for FP when measuring the performance of the policy environment.

"...if we're looking at how we progress in terms of fertility, it might be disappointing, but if we look at how we have progressed in terms of other factors that affect fertility in terms of women's education and girls' empowerment, those two have made significant strides... at the end of the day we want to see our fertility come down... but we have made some gains also with the policy environment..."

Marian Kpakpah, Acting Executive Director, National Population Council

Participants at the forum repeatedly expressed their concern on the noticeably minimal commitment from the highest levels of government and the heavy dependence on international donor support for FP. The forum agreed on the need to intensify advocacy efforts to increase and sustain government ownership and investment in FP as a highly cost- effective socio-economic development intervention. In view of the inadequate financial support for FP by government over the years observed by stakeholders in the FP/MH/SRH fraternity, there was a suggestion to consider investing in areas where there is more value, assuming the current inadequate quantum of resources for FP programming remains the same.

The forum participants also agreed on the need to have an integrated and coordinated FP program to improve upon the targets. Other suggestions at the forum included a critical assessment of the strategies that work, setting of realistic targets, and the institutionalization of a multi-sectoral management arrangement to facilitate the effective implementation of the plan.

2.3 Service Delivery and Commodity Supply

The Ghana Health Service (GHS) continues to provide leadership in ensuring that FP becomes the pivot for strengthening and advancing reproductive health care and rights.

The GHS currently operates about 2,000 facilities, with about 91% of GHS facilities providing those services. However, about 84% of the facilities do not offer permanent FP methods as indicated in the EmONC assessment conducted in 2011. Respectively, about 33% and 29% of the private sector and mission hospitals offer FP services. CSOs such as the Planned Parenthood Association of Ghana (PPAG), Marie Stopes International (MSI), Population Council, Willows Foundation and IPAS provide community-based complementary FP service delivery and capacity building to varying degrees. Undocumented observations also suggest that community pharmacists provide vital complementary assistance to clients in underserved areas.

The CHPS initiative was introduced to among other objectives; improve the reach of FP service delivery to the marginalized and underserved communities. However, quality and timely service delivery to the marginalized, rural and underserved target groups, including adolescents remains a challenge. The 2010 MAF Action Plan identified *capacity* and *commodity security* issues as the two broad gaps affecting FP service delivery. High staff attrition rates account for the observed capacity gaps, as the related service personnel posted to

rural areas where needs are greatest, continue to seek educational advancement and other employment opportunities in less remote areas. As such, some facilities are unable to offer full range of FP services at a point in time, in view of the absence of qualified personnel.

In the areas where FP services are available, the skills and competencies of the personnel at post determines the type of methods and kind of services provided. The transfer of trained personnel to non-FP related units/departments of health facilities also contribute to the human resource constraints affecting FP service delivery. USAID provides technical assistance to the GHS on strengthening logistics, management and information system for RH commodities, including forecasting and quantification of commodities. Financing of contraceptives and RH commodities still remains heavily skewed towards donor support. Over 85% of currently procured contraceptives in Ghana are from three major donors - UNFPA, USAID and DFID, and, more recently, WAHO. In addition, FP commodities distribution and logistics remain a challenge. The recent fire outbreak at the Central Medical Stores (CMS) created some gaps in supply of commodities. However, the timely intervention of DPs in providing emergency FP supplies enabled the re-distribution of commodities to avert any mishaps that could have risen from FP commodity shortages. Notwithstanding the efforts to ensure the availability of commodities at the national level, commodity shortages have been reported at the decentralized levels. Such situations occur when FP commodities at the regional levels are not supplied to the service delivery points at the district and periphery levels on time.

The GHS, with support from DPs, has responded to the 2011 MAF assessment findings by initiating steps to address the observed financing, capacity and commodity security gaps. A RHCS survey is currently underway to assess, among others, the extent to which the staff attrition rates and commodity supply line issues contribute to the unmet needs for FP and to explore diversification of funding sources and increase overall funding for contraceptives. Training of service personnel on long-term FP methods have been scaled up. Currently, about 2,000 Community Health Nurses have benefitted from Implant training sessions following task shifting. FP integration with other maternal and child health programmes is ongoing at selected facilities. However, more effort is required in order to advance both strategies. Considering the benefits that the community pharmacists could facilitate, the registration and documentation of their services as well as the provision of the necessary referral linkages are being explored.

"we've been attempting an integration for a long time... we are looking at proper integration with child welfare programmes... and how best we can move to reduce the missed opportunities that we have..."

Dr. Patrick Aboagye, Director, Family Health Division
Ghana Health Service

A key concern regarding the capacity development drive is the focus on formal and residential trainings, leading to the absence of the relevant service personnel from their respective duty posts.

Participants acknowledged a need to focus more attention on on-the-job trainings to enable the continuous offering of FP services at the facilities. Improving community-level service delivery with emphasis on quality FP counseling, particularly at the CHPS zones, was also recognized by the forum participants as an essential requirement for extending the reach of FP service delivery to the underserved communities.

The meeting participants agreed on the intensification of the task shifting and FP/child welfare integration efforts.

The privatization or out-sourcing of commodity distribution was also underscored as an option to address the gaps observed with the supply chain.

2.4 Demand Generation

2.4.1 Socio-cultural Factors Influencing Demand for FP

Ghana's dynamic and changing cultures have impacted the values, beliefs and attitudes relating to fertility. High infant mortality and family lineage interests were contributory factors driving high fertility and childbearing in the pre- and immediate post-colonial era. Various developmental agenda in the country have influenced the social indicators that relate to education, urbanization, religion and marriage. Census figures indicate the proportion of the population in urban areas increased from 23% in 1960 to about 51% in 2010. The percentage of the population that never attended school declined from 73 in 1960 to 23.5 in 2010. Likewise, the proportion of Ghanaians engaged in traditional religion and polygamous unions declined from 38% to 5% and 35% to 18% in 1960 and 2010 respectively. Infant mortality, a core factor that supported high fertility also declined from 274 in 1960 to 90 in 2010.

Ghana's changing demographics demonstrate a gradual breakdown of the rigid values and traditional structures that support high fertility. Currently, the economic and social factors that shape prolific childbearing have weakened considerably within several Ghanaian cultures. Marriage is no longer universal as construed by age-old cultural norms. The extended family support system which promoted high fertility is gradually being displaced by an increase in nuclear households. Such changing values, beliefs and

attitudes regarding fertility and childbearing offer opportunities for promoting greater acceptance and use of modern contraceptives. While acknowledging these opportunities, participants were cognizant of the fact that faith and religion still wield great influence on FP.

Recognizing that the Ghanaian society is currently highly differentiated in terms of socio-economic indicators, values, beliefs and attitudes, the forum participants agreed on a need to explore innovative culturally sensitive approaches for more diversified populations.

The participants laid emphasis on intensifying male involvement and participation in FP uptake, given the traditionally dominant role of men in determining fertility and family size issues.

> *"...the new phenomenon...means we have to come up with very innovative culturally sensitive strategies and programs for more diversified populations. We have to identify the underserved areas and groups; adolescents, the slum dwellers... the illiterate in the remote areas, etc. We need to use modern tools, the media, IT and so forth to penetrate areas we could not enter before".*
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> *Prof. A. F. Aryee. Regional Institute of Population Studies (RIPS), Legon*

2.4.2 Social Mobilization and Marketing of FP Commodities

Social mobilization and marketing are critical approaches to enabling a better understanding, wider acceptance and practice of FP by individuals and families as a responsible health behaviour. DKT International and other NGOs including PPAG, MSI, Willows Foundation and IPAS employ multiple communication and marketing techniques to reach different segments of the Ghanaian society with information, education and products that address the concerns, fears and rumors surrounding FP.

Social marketing of FP commodities in Ghana has not been as intensive as expected. Duties and taxes on commodities range from 8% to 43%; and such costs eventually get transferred to the end-user. Notwithstanding that the marketing of commodities creates a significant amount of awareness, certain restrictions from the Food and Drugs Authority (FDA) prevent the advertising of some clinical methods, namely IUD, injectables and implants; hence requiring one-on-one engagement with target groups. There is a high dependence on donor supported social marketing programmes which affects continuity in promoting and distributing branded products particularly when these donor-funded programmes end. The current energy crisis

has also impacted negatively on commodity distribution in view of a reduction in sales in the evenings. In addition, the current currency depreciation creates difficulties in selling commodities at sustainable prices.

Participants agreed on the need to employ advocacy and related approaches to reduce the duties on FP commodities at the ports and to promote and build economically sustainable brands. Other viewpoints suggested increased private sector engagement in advocating and advertising FP as part of corporate social responsibility. There were also proposals on creating FP demand by demystifying commodities and underscoring not only fertility but most importantly, the economic benefits of FP.

Of much concern is the seemingly competitive approaches employed by CSOs in the delivery of social mobilization programmes. The quest of CSOs to mobilize donor resources result in the implementation of fragmented and ad hoc programs by CSOs, leading to a potential loss of focus and misalignment with the priorities of the GHS. The forum participants agreed that harmonized CSO interventions and partnerships with government agencies such as the National Commission for Civic Education (NCCE) could help sustain the country's FP agenda.

2.4.3 Comprehensive Sexuality Education and Services

Comprehensive sexuality education (CSE), as a channel for information and ASRH services for young people in and out of school and other vulnerable groups, remains inadequate. Certain Ghana Education Service (GES) policies prevent the provision of comprehensive reproductive health information and contraceptive services to young people in-school. The bulk of information on reproductive health education in primary schools is mainly on the negative impact of teenage pregnancy.

The most comprehensive adolescent reproductive health education syllabus does not involve all basic school pupils as the subject is offered only for a small cohort that enroll in the Home Economics course.

Participants expressed concern on the gaps in CSE and RH service provision, including access to contraceptives, to young people within the school and community settings. In recognition that the high unmet need (42%) for FP among sexually active unmarried women include young girls in and out of school, the forum participants proposed the refocusing of strategies on CSE and contraceptive services to address the needs of young people in and out of school.

"...in a country where we have got something like 13-14% of maternal mortality due to abortions.....If there is such a demand for abortion...there is a need for FP and that need should be turned into a demand..."

Prof. F.T Sai, pioneer of FP promotion.

3.0 KEY RECOMMENDATIONS

Participants built consensus on several recommendations that could facilitate marked improvements in the FP indicators within the next five to seven years. The forum acknowledged that some of the strategies were not new, as they were already noted in previous documents such as the repositioning FP roadmap that was formulated in 2005.

The recommendations provided are broad strategies that are expected to reinforce ongoing efforts at addressing the imbalances in the quality and quantum of FP services currently available to the different segments of the Ghanaian population.

3.1 Strategic Information and Knowledge Management

- Institute a critical measurement system through research and dissemination on the trends and dynamics of FP indicators.
- Explore the inclusion of qualitative research in population-based studies for deeper explanations of FP trends and dynamics.
- Ensure strict monitoring and evaluation, performance and accountability of the national FP programme.

3.2 Policy Perspectives

- Position FP as a broad development issue (through NDPC) within the context of the Demographic Dividend and the long-term development planning agenda.
- Ensure the effective coordination of FP programmes by MOH/GHS and NPC.
- Consider an inter-sectoral review of the reposition FP document in conjunction with the meeting's outputs.
- Follow-up on the implementation of the inclusion of FP commodities in the national health insurance scheme.
- Conduct a cost-benefit analysis on FP to enable strategic advocacy on the economic gains from FP with political leaders.
- Engage political leaders and parties to champion FP issues and commit to investment in FP programming in the country.

3.3 Service Delivery and Commodity Supply

- Strengthen CHPS compounds to provide quality counseling and regular FP services.
- Expand alternate approaches to service delivery at the facility level, such as door-to-door interventions, particularly for underserved and hard-to-reach communities.
- Encourage facility-level and step-down trainings to reduce training costs.
- Advocate for the adoption of certification for on-the-job trainings by professional associations.
- Encourage the transfer of knowledge on FP service provision at the facility level.
- Scale up task-shifting and innovative integration efforts.
- Establish a flexible career progression programme to address the issue of staff attrition.
- Advocate with the Ministry of Finance on the inclusion of a budget line for the procurement of contraceptive commodities.
- Consider the outsourcing of FP commodity distribution to the facilities at the periphery levels.

3.4 Demand Generation

Intensify the engagement of local authorities, men as partners, traditional and religious groups in promoting culturally sensitive innovative approaches on FP uptake.

- Advocate for a waiver or reduction of duties on FP commodities imported by the private sector.
- Intensify quality assurance on FP commodities to reduce the existence of expired and unregistered products on the market.
- Engage with media and telecommunication companies for free airtime to advocate and educate the public on FP.
- Engage GES, Parent-Teacher Associations (PTA) and School Management Committees (SMC) on the need to expand the basic school curriculum to include details of ASRH.
- Review existing SRH curriculum for in and out of school youth to include more age-appropriate details about sex, contraceptives and family life education.
- Strengthen coordination and harmonization of CSO social mobilization interventions to facilitate programme coherence.

"If Ethiopia, Malawi... have done it, why not Ghana, which is the black star of Africa? Many of these countries came to learn from Ghana... we have taught them, they are using the theories, and the theories are still with us, and we are lagging behind".

Prof. S.O Kwankye, Regional Institute of Population Studies, Legon

4.0 CONCLUSION AND NEXT STEPS

The forum brought together all the 'brains' from diverse backgrounds in the FP environment. It provided a platform for the participants to build consensus on how to re-orient FP interventions to address the gaps observed and change the trajectory of FP uptake in Ghana. Several recommendations were made to strengthen or complement ongoing efforts at influencing increased FP uptake at policy, knowledge management, service delivery, commodity supply and demand generation levels within the next five to seven years. A key commitment by the GHS was to revisit and review the recommendations quarterly or biannually. This commitment will require regular and ongoing meetings, information exchange and collaborative actions, using the existing robust structures for interagency engagements on FP.

> *"...what gives us hope is the fact that the situation in Ghana can be rapidly transformed... that we can significantly increase modern contraceptive uptake..."*
>
> *Babatunde Ahonsi. UNFPA Ghana Representative*

APPENDICES

A. AGENDA: DAY OF DIALOGUE ON FP IN GHANA

VENUE: La Palm Royal Beach Hotel

DATE: 7TH JULY, 2015

TIME	ACTIVITY	RESPONSIBLE PERSON
08:30 – 09:00	Arrival & Registration	Abigail Sackar
09:00 – 09:30	Welcome & Opening Remarks	MoH/GHS
	Brief Remarks by Moderator	Prof. S. Kwankye
	Opening Remarks –Chairman	Dr. Ebenezer Appiah Denkyirah, Director General, Ghana Health Service
9:30 – 10:00	Day of Dialogue in FP-Overview	Dr. Babatunde Ahonsi, UNFPA Country Representative
10:00 - 10:30	Highlights of Family Planning in Ghana	Dr. Easmon Otupiri, Dean, School of Public Health KNUST
10:30 – 10:45	**SNACK BREAK**	
10:45 – 12:45	Panel Discussion & Open Forum	Discussants: Dr. Patrick Aboagye, Director, Family Health Div. GHS Representative of USAID Ms. Marian Kpakpah, NPC Prof. A.F Aryee Mr. Kevin Hudson, DKT International Mrs. Amma Oforiwaa Sam, PPAG
12:45 - 1:15	Reflections on the Way Forward	Professor Fred Sai
1:15 – 2:00	Table Discussions: Formulation of recommendations/action points	Table moderator and rapporteur
2.00- 2:30	Group feedback: Action and responsible party	Moderator
02:30	**LUNCH & DEPARTURE**	

B. PARTICIPANTS LIST

NAME	ORGANIZATION	EMAIL
Pearl Allotey	IPAS	allotey@ipas.org
Olivia Aglah Doste	USAID Systems for Health	oadotsecurc-chs.com
Nicholas Kanlisi	USAID Systems for Health	nskanlisi@gmail.com
Richard Adanu	SPH – Univ. of Ghana	rmadanu@ug.edu.gh
William Tackie	First Digital	w.tackie@yahoo.com
Paulina Siaw-Akoto Debrah	GRMA	linalivsa08@yahoo.com
Sharron Kyei-Mensah	GRMA	ghanamidwives@yahoo.com
Leslie MacCarthy	MCAN /First Digital TV	lesmac1969@yahoo.com
Marian Kpakpah	NPC	mkpakpah@npc.gov.gh
Ebenezer Appiah Denkyira	Ghana Health Service	appiahd@yahoo.co.uk
James Addy	MCAN	James1addy@yahoo.com
Irene Agyemang	USAID/Deliver Project	ireneagyemang@gmail.com
Anita Nyako	Ghanaian Times	lindywayn@yahoo.com
Dorcas Aryeh	Ghanaian Times	daryeh@hotmail.com
S. K. Antobam	IPAS	antobams@ipas.org
Stephen Ntim	DKT	Stephen_ntim@dktghana.org
Evelyn A. Manful	National Association of Regional Midwives	mvash200@yahoo.com
Kevin Hudson	DKT International	kevin@dklinterantional.org
Claudette Diogo	FHD/GHS	ahliba@gmail.com
Henry Safori	FHD/GHS	hensaf205@gmail.com
Patrick Aboagye	FHD/GHS	yaboagye2003@yahoo.com
A.F Aryee	RIPS, Legon	afaryee@ug.edu.gh
Yaa Asante	FHD/GHS	yaanyameye@gmail.com
Leonard Gobah	MSIG	Leonard.gobah@mariestopes.org.gh
Nyaaba Nsarma Gertrude	Population Council	gnyaaba@popcouncil.org
Vandana Stapleton	USAID	vstapleton@usaid.gov
Nora Maresh	USAID	nmaresh@usaid.gov
Salamatu Futa	USAID	sfuta@usaid.gov
S. O. Kwankye	RIPS	kwankyes@ug.edu.gh
Joseph Amuzu	PPAG	jamuzu@ppag.gh.org
Holley Stewart	Population Reference Bureau (PRB)	hstewart@prb.org
Philomina Woolley	Nursing and Midwifery	philo_woolley@yahoo.com
Gloria Quansah-Asare	Ghana Health Service	Gloria.quansahaswe@ghsmail.org
Hanna Nkrumah	Ghanaian Times	hannkrumah@yahoo.co.uk
Seth Adjei	FHD/ GHS	sethofms@yahoo.co.uk
Gifty Korantema Koranteng	GRMA	ghanamidwives@yahoo.com
Rizwana Hawa Amoako-Agyei	National Association of Registered Midwives Gh.	
Zana Somda	Palladium Group/ NPC	zana.somda@palladuimgroup.com
Mary Mpereh	NDPC	mmpereh@yahoo.com
Jerry Yem	MSD	Jeremiah.yem@merck.com
Amanda Baedua Sam	National Association of Registered Midwives Gh.	kofmandy@yahoo.com
Jasper Sablah	Consultant, Futures Group	jasablah@gmail.com
Isaac Nyampong	FHD/ GHS	Kofiamoah20@yahoo.com

Akosua K. Adu	**University of Kentucky**	**akosuaadu@uky.edu**
Fred Sai	**Leading FP advocate**	**Saiakora43@gmail.com**
Selina Esantsi	**Population Council**	**sesantsi@popcouncil.org**
Richard Dzikunu	**Metro TV**	**richardodee@gmail.com**
Babatunde Ahonsi	**UNFPA**	**bahonsi@unfpa.org**
Lucas Mensah	**Metro TV**	**lucasmensah@gmail.com**
Ayaga A. Bawah	**Columbia University/ University of Ghana**	**aabawa@gmail.com**
Kwaku Osei	**Ghana AIDS Commission**	**kosei@ghanaids.gov.gh**
Patience Boni	**Willows Foundation**	**pboni@popcouncil.org**
Nicole Raatgever	**Marie Stopes**	**Nicole.raatgever@mariestopes.gh.org**
Josephine Gyawu	**USAID**	**jggawu@usaid.gov**
Kofi Awus abo-Asare	**UCC**	**k.awusabo-asare@ucc.edu.gh**
Nana Amma Oforiwaa Sam	**PPAG**	**oforiwaasam@ppag.gh.org**
Fidel Leviel	**GHS**	**levielfidel@gmail.com**
Placide Tapsoba	**Population Council**	**ptapsoba@popcouncil.org**
Dennia Gayle	**UNFPA**	**gayle@unfpa.org**
Easmon Otupiri	**KNUST**	**easmono@yahoo.com**
Terence Adda-Balini	**Population Council**	**taddabalinia@popcouncil.org**