ABSTRACT

The purpose of this study was to examine the dynamics of Ghana's Free Maternal Health Care Policy (FMHCP) from the perspectives of the policymakers and implementers who designed and administered it. Specifically, the study pursued four objectives: to explore how competing coalitions of actors and their belief systems shaped the agenda-setting process of the FMHCP; to explore how policy design choices during the formulation stage and governance constraints influenced subsequent implementation outcomes; to investigate how interactions between the Ministry of Health, Ghana Health Service, and other stakeholders influenced implementation processes and operational performance; and to explore how policy initiators and implementers interpret and negotiate sustainability challenges within the evolving political and financing context of Ghana's health system. The study adopted an interpretivist paradigm and a qualitative case study design. Semi-structured interviews were conducted with sixteen purposively selected senior institutional actors drawn from the Ministry of Health, Ghana Health Service, and National Health Insurance Authority. Thematic analysis, informed by the Advocacy Coalition Framework and Freeman's Stakeholder Theory, guided the generation of four analytical themes corresponding to the study's objectives. Document analysis of policy papers, legislative records, and health reports provided triangulation for participant accounts. Findings established that the FMHCP's agenda was driven by a dominant coalition organized around a coherent three-level belief hierarchy, informed by deliberate comparative policy learning from international models in Zimbabwe and Sweden, and operationally enabled by a diplomatically secured external grant. Ministerial transitions produced recurring implementation disruptions by imposing alternative secondary beliefs without coalition-level deliberation, revealing that in Ghana's strong executive system, individual ministerial authority can function as a single-actor coalition capable of producing policy change, a dynamic that modifies standard assumptions within the Advocacy Coalition Framework. Three formulation- stage design choices were identified as the structural origin of implementation constraints. These were the absence of a facility buffer fund, the lack of a formal feasibility assessment, and the failure to embed the policy in primary legislation. They produced four governance constraints: fragmented institutional accountability, a structural GHS-NHIA power asymmetry, donor dependence, and exposure to ministerial discretion. All four were embedded at the formulation stage and persisted throughout the policy's implementation history. A definitive power asymmetry between the Ghana Health Service and the National Health Insurance Authority was identified as the primary driver of operational failures, redirecting the reform agenda from capacity building to governance accountability. Participants across all institutional levels conceptualised sustainability as a politically negotiated condition and proposed a convergent reform agenda centred on statutory entrenchment, parliamentary financing, and enhanced accountability mechanisms. The study makes three original contributions to knowledge. It extends the Advocacy Coalition Framework to maternal health reform in Ghana and identifies the contextual modification required for its application in strong executive systems. It reframes sustainability as a secondary belief deficit rather than a fiscal deficiency, offering a new explanatory mechanism for policy fragility in low-income settings. It applies stakeholder salience analysis to reveal the institutional power asymmetry driving FMHCP operational failures, providing a theoretically grounded reform lever for policymakers and practitioners.