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POLICY BARRIERS TO LONG-ACTING AND PERMANENT METHOD USE IN GHANA

SEPTEMBER 2010
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EXECUTIVE SUMMARY

Ghana's population is growing rapidly, and if it continues to grow at the current rate of 2.7 percent, it will double in 26 years (NPC, 2006). The total fertility rate has declined from 6.4 children per woman in 1993 to 4.0 children per woman in 2007, reaching the lowest level in West Africa (ICF Macro, 2010). Fertility has declined despite low and declining use of modern family planning (FP) methods. Use of long-acting and permanent methods (LAPMs) rose slowly from 1988 to 2003 and then declined from 3.8 percent of married women of reproductive age (MWRA) in 2003 to 2.7 percent of MWRA in 2008. Thirty-six percent of Ghanaian MWRA have an unmet need for family planning, 23 percent want to wait at least two years before their next birth, and 13 percent do not want any more children. Stakeholders are concerned about the role that unmet need for FP plays in maternal deaths. Although Ghana has made progress in reducing maternal mortality from an estimated 540 maternal deaths per 100,000 live births in 2000 to 451 per 100,000 live births in 2007 (PRB, 2010), much more needs to be done. Increases in FP use, especially use of more cost-effective LAPMs, will enable Ghanaian women to reach their desired level of fertility and significantly improve maternal health.

USAID/Ghana and the Family Health Department (FHD) of the Ghana Health Service (GHS) requested that the USAID | Health Policy Initiative, Task Order 1 identify the policy and operational barriers to increasing LAPM use in Ghana. The Health Policy Initiative conducted a desk review and consulted key stakeholders, including policymakers, implementing partners, and service providers to learn their perspectives on expanding access to LAPMs. The project also surveyed GHS regional and district-level officials to determine their views on strategies for increasing use of FP and LAPMs, in particular.

Recommendations for Policy Reform to Increase LAPM Use

Reduce cost barriers to the use of LAPMs by including coverage of services in the National Health Insurance Scheme (NHIS). Stakeholders identified included coverage of LAPM services in the NHIS as a priority in increasing use. Stakeholders also observed that careful consideration must be taken in implementing this new benefit in order to maximize its impact on both reducing unmet need for FP and providing cost savings to the NHIS.

Conduct research to determine the potential impact of reducing both costs for services and opportunity costs associated with obtaining services on demand for LAPMs. The GHS and key stakeholders have identified reducing costs of using LAPMs as an immediate priority. Costs include both user fees for obtaining services, as well as opportunity costs, such as transportation and time required to obtain services. Strong evidence exists that eliminating costs to users for services and reducing opportunity costs by expanding the provider pool and broadening the mix of methods available at the community level will improve use of LAPMs. Research also needs to be done to understand fully the impact of reducing fees collected on the sale of contraceptives on operations at each level of the health system. The FHD is especially interested in understanding the potential impact at the regional and district levels of eliminating return-to-project funds and the system of accounting for them. This research should also identify needed changes in reporting and tracking of contraceptive inventories that will improve the efficiency of the contraceptive distribution system and reduce stockouts.

Support integration of contraceptive commodities into the procurement and logistics system for essential health medicines. The GHS is working closely with the USAID | DELIVER Project to improve the current contraceptive procurement and logistics systems as an important component of the repositioning FP effort. Support needs to be given to this effort to improve all components of the system, including projecting contraceptive needs, advocating for and coordinating

Government of Ghana and donor funding and support, and strengthening systems for reporting and managing inventories and monitoring performance.

Increase funding and support for behavior change communication and efforts to improve counseling on LAPM. Increased funding and support for behavior change communication campaigns that promote smaller family size, present benefits of LAPM, address misconceptions concerning the health consequences of long-acting methods, and present testimonials from satisfied users of LAPM can significantly increase use. The messages in these campaigns should coordinate and complement information provided by health providers during group counseling and one-on-one counseling sessions provided at health facilities. Training to improve providers' counseling skills and update their knowledge of LAPMs is also needed.

Increase availability of trained personnel by revising service delivery standards so that community health nurses can be authorized and trained to insert and remove intrauterine devices and implants. Stakeholders at the central, regional, and district levels supported revising the role of community health nurses. For this change truly to have an impact, pre-service and in-service training curricula need to be revised, as do systems for supervision and performance monitoring.

Increase support for continuous training, facilitative supervision, and performance monitoring. These support systems are essential to ensuring high-quality service delivery that will increase use of LAPM.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BCC	behavior change communication
CHN	community health nurse
CHO	community health officer
CPR	contraceptive prevalence rate
CPT	contraceptive procurement tables
CYP	couple-years of protection
DELIVER	USAID | DELIVER Project
DHS	Demographic and Health Survey
FHD	Family Health Department, Ghana Health Service
FP	family planning
GEMI	Ghana Essential Medicines Initiative
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS II	Ghana Poverty Reduction Strategy II
HIV	human immunodeficiency virus
IUD	intrauterine contraceptive device
IPPF	International Planned Parenthood Federation
LA	long-acting method
LAPM	long-acting and permanent method
MDG	Millennium Development Goals
MMR	maternal mortality ratio
MOF	Ministry of Finance
MOH	Ministry of Health
MWRA	married women of reproductive age
NHIA	National Health Insurance Authority of Ghana
NHIS	National Health Insurance Scheme
NPC	National Population Council of Ghana
PPME	Planning, Performance, Monitoring and Evaluation Department, Ghana Health Service
QHP	Quality Health Partners Project of USAID/Ghana
RH	reproductive health
R3M	Reducing Maternal Morbidity and Mortality (project)
STI	sexually transmitted infection
TFR	total fertility rate
USAID	United States Agency for International Development
WHO	World Health Organization

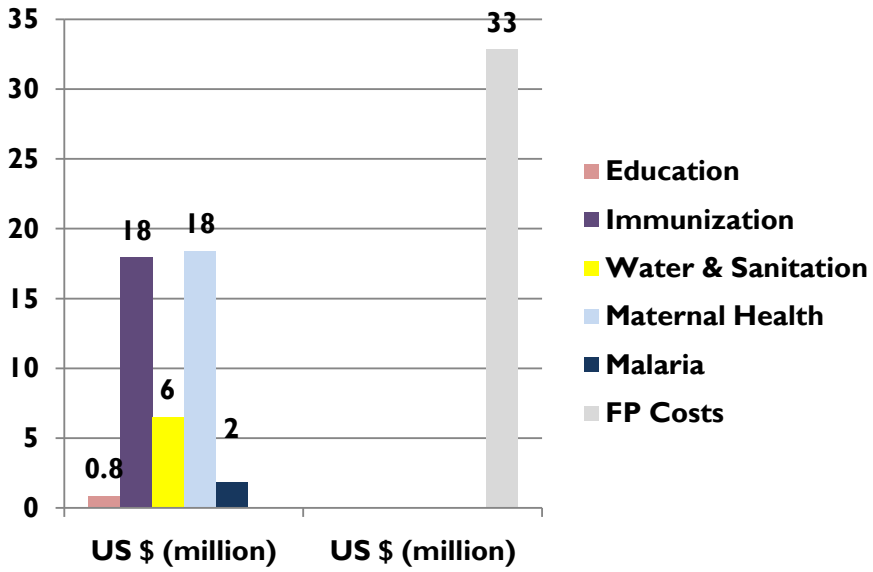
I. BACKGROUND

Ghana is an aspiring middle-income country in West Africa bordered by Togo, Burkina Faso, and Côte d'Ivoire. It has experienced peaceful democratic transitions in the past eight years and gained resource wealth with the recent discovery of oil. The *Ghana Poverty Reduction Strategy II (GPRS II) 2006–2009* (NPDC, 2005) presents the Government of Ghana's (GOG) strategy for improving the "real standard of living" of its citizens through investments in health, education, better nutrition, water, and transport. The strategy focuses on attaining the Millennium Development Goals (MDGs) and reaching middle-income status by 2015. The GPRS II identifies "private-sector-led growth" and resulting productivity gains of Ghana's labor force as the principal driver of development.

The GPRS II also recognizes the importance of "population management" and identifies the following program priorities: promoting access to and use of family planning (FP) services; educating youth on sexual and reproductive health (RH) issues; promoting sexual health and delaying marriage and childbearing; promoting compulsory education for girls through secondary school; and improving the coverage of births and death registrations. Although the country has achieved success in reducing poverty rates from 52 percent in 1991 to 29 percent in 2000 (MOF, 2007), similar success in MDGs related to maternal mortality, gender, and child health has not been achieved. Increased emphasis on population management and investment in the national FP program will advance progress in each of these areas, as well as ensure that population growth does not overtake gains in social and economic development.

Ghana's population is growing rapidly and, if it continues to grow at the current rate of 2.7 percent, will double in 26 years (NPC, 2006). The total fertility rate (TFR) has declined from 6.4 children per woman in 1993 to 4.0 children per woman in 2007; reaching the lowest level in West Africa (ICF Macro, 2010). Increased investment in the national FP program will reduce government spending on other social service programs. A recent update of the MDG analysis of the costs and benefits of the family planning program showed that each dollar invested in family planning in Ghana in 2010 could have a net return of 40 percent as a result of reduced spending on other social services (Health Policy Initiative, 2009) (see Figure 1).

Figure 1: Social Sector Cost Savings from Investments in Family Planning, Ghana



Source: Health Policy Initiative, 2009.

Fertility has declined despite low and declining use of modern family planning methods. Researchers attribute this to either widespread abortion or abstinence (Aboagye et al., 2007). In 2008, 36 percent of Ghanaian married women of reproductive age (MWRA) had an unmet need for family planning; 23 percent wanted to wait at least two years before their next birth; and 13 percent did not want any more children. Stakeholders are concerned about the role that unmet need for FP plays in maternal deaths, and conservative estimates attribute as many as 20 percent of all maternal deaths to abortion (HSAO, 2008). Although Ghana has made progress in reducing maternal mortality from an estimated 540 maternal deaths per 100,000 live births in 2000 to 451 per 100,000 live births in 2007 (PRB, 2010), much more needs to be done to achieve the target of 145 maternal deaths per 100,000 live births established in MDG 5. Increases in FP use, especially use of more cost-effective long-acting and permanent methods (LAPMs), will enable Ghanaian women to reach their desired level of fertility; substantially reduce abortion, and significantly improve maternal health.

II. METHODOLOGY

The United States Agency for International Development (USAID)/Ghana and the Family Health Department (FHD) of the Ghana Health Service (GHS) requested that the USAID | Health Policy Initiative, Task Order 1, identify the policy and operational barriers to increasing LAPM use in Ghana. The Health Policy Initiative first conducted a desk review to pinpoint constraints that limit the accessibility and use of LAPM. The project then consulted USAID/Ghana and the FHD to identify key policymakers, implementing partners, and service providers who could provide important perspectives on including family planning in the maternal health benefit package provided by the National Health Insurance Scheme (NHIS) (see Annex 1).

The Health Policy Initiative also surveyed 37 regional and district-level GHS officials, representing all regions, who were participating in the Ministry of Health (MOH) Annual Performance Review Meeting in Koforidua, Ghana. The project worked with the FHD and DELIVER Project to develop a brief questionnaire to collect interviewees' perspectives on

- Increasing access to LAPM services at the community level by training community health nurses (CHNs) to provide implants and intrauterine devices (IUDs);
- Eliminating user fees and the "return-to-project fund" accounts; and
- Including FP commodities in the logistic system for other essential commodities (see Annex 2).

III. FERTILITY TRENDS

The TFR in Ghana is the lowest in West Africa and has declined from 6.4 in 1993 to 4.0 in 2008 (GSS, GHS, and ICF Macro 2009). Fertility is closely linked to a woman's education and wealth. Married women of reproductive age in the poorest households have an average of 6.4 births; whereas those in the wealthiest have only 2.3 births. Similarly, women with no education have an average of 6.0 births; whereas those who have attained secondary education or higher have an average of 2.1 births. A significant regional disparity exists in fertility. For example, women living in Greater Accra have an average of 2.5 births; whereas those living in the Northern Region have 6.8 births. When asked to give the ideal number of children women would like to have, their responses averaged 4.3 children and men's responses averaged 4.5 children (ICF Macro, 2010).

Ghana's population is quite young; more than 43 percent are below 15 years of age (PRB, 2010). The median age at first marriage for Ghanaian women ages 25–49 is 19.8; however, sexual activity begins about 1.5 years before marriage (ICF Macro, 2010). More than half of Ghanaian MWRA are pregnant or

have given birth by the time they are 20.7 years old, and 13 percent of married Ghanaian women ages 15–19 are pregnant or have already given birth.

Table 1: Trends in Fertility-Related Indicators 1993–2008

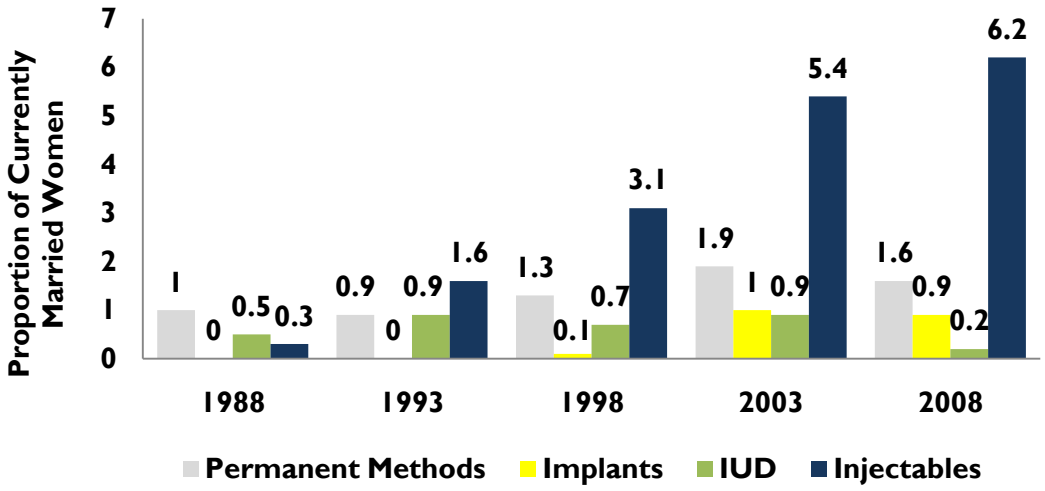
Fertility Indicators	1993	1998	2000	2003	2008
Total fertility rate	6.4	5.2	4.4	4.4	4
Contraceptive prevalence rate	12.9	20.3	22	25.3	23.5
Modern method contraceptive prevalence rate	5.2	10.1	13.3	18.7	16.6
Unmet need for family planning	NA	23	35.6	34	35.3

(GSS, GHS, and ICF Macro, 2009)

Almost one of every four Ghanaian women is using some kind of FP. Contraceptive use doubled from 12.9 percent of MWRA in 1993 to 25.3 percent in 2003 (GSS, GHS, and ICF Macro, 2009). Between 2003 and 2008, however, contraceptive use declined to 23.5 percent of MWRA. Ghana has reached the highest level of modern method use in West Africa: 16.6 percent of MWRA use a modern method. Use of modern methods tripled from 5.2 percent of MWRA in 1993 to 18.7 percent of MWRA in 2003 and then declined, reaching 16.6 percent in 2008.

Traditional methods and injectables are the preferred FP methods in Ghana. The 2008 Ghana Demographic and Health Survey (DHS) found that 6.9 percent of MWRA use traditional methods, 6.2 percent use injectables, 4.7 percent use the pill, 2.4 percent use male condoms, and 0.3 percent use diaphragms or jelly (GSS, GHS, and ICF Macro, 2009). The long-acting methods available in Ghana include the intrauterine device (IUD) and implants; 0.2 percent of MWRA use the IUD, and 0.9 percent use implants. The permanent methods available include both male and female sterilization; 1.6 percent of MWRA use female sterilization. Use of LAPMs rose slowly from 1988 to 2003 and then declined from 3.8 percent of MWRA in 2003 to 2.7 percent of MWRA in 2008.

Figure 2: Trends in Long-Acting and Permanent Methods versus Injectables: 1988–2008



Source: GSS, GHS, and ICF Macro, 2009.

Most FP users pay for their methods. Even though counseling is provided for free, users must pay for their contraceptives in public health facilities. The median fee paid for supply methods, including pills,

injectables, and condoms, is about 50 *pesewas* (ICF Macro, 2010). More than half of current modern method users obtain their method from the private sector; 84 percent of pill users and 71 percent of condom users purchase their methods from private drug stores; while 87 percent of injectable users obtain their methods from public hospitals, health centers, or health posts. The majority of LAPM users also obtain their methods from the public sector.

Unmet need is defined as the percentage of women who want to delay their next birth by at least two years or to have no more children. In Ghana, 36 percent of MWRA have an unmet need for FP; 23 percent wish to space their births, and 13 percent wish to limit their births (ICF Macro 2010). Unmet need for FP has increased from 34 percent of MWRA in 2003 to 36 percent in 2008. Currently married women ages 15–19 years have the highest rate of unmet need at 61.7 percent. Unmet need is closely linked to wealth: 36.2 percent of MWRA in the poorest households have an unmet need for FP, compared with only 24.2 percent of MWRA in the wealthiest households. More rural MWRA have an unmet need for FP at 37.6 percent, compared with 32.3 percent of urban MWRA. In addition, unmet need varies greatly by region and is highest in the central (49%), eastern (39.6%), and western (39.4%) regions. Only in Greater Accra and upper west regions do less than 30 percent of MWRA have an unmet need for FP.

Knowledge of FP is nearly universal in Ghana. More than 90 percent of women have heard of at least one contraceptive method, regardless of where they live (GSS, GHS, and ICF Macro, 2009). Knowledge is high across all wealth and education levels. However, lack of access to information and services has been a formidable obstacle to women wanting to space or limit their births. The majority of nonusers of FP did not have any contact with an FP provider the year before being surveyed, and among women who visited a health facility, only 13 percent discussed family planning (ICF Macro, 2010).

IV. THE POLICY ENVIRONMENT

In 1969 Ghana issued the *Ghana Population Policy*, which affirmed the GOG's commitment to manage population resources in a manner consistent with achieving economic growth and improving the quality of life of its citizens. Since then, the GOG has consistently voiced its support for programs and policies to manage population growth. In 1994 the GOG reinvigorated this commitment by revising the 1969 policy into the *National Population Policy* (NPC, 1994). The new policy established the National Population Council (NPC), housed in the Ministry of Presidential Affairs, and mandated the council to implement population management efforts, such as those delineated in the GPRS II. The policy environment has undergone significant transition in the past several years, following a very close presidential election. A new minister of health was appointed in February 2010. The NPC must coordinate the resources, strategies, and activities of several public and private sector organizations to implement the population program. The Ministry of Health (MOH) oversees health service delivery by developing policies and protocols, coordinating financing, and supporting monitoring and quality assurance. The Ghana Health Service (GHS) is responsible for personnel, policy implementation and training. The FHD and the Reproductive and Child Health Department of the GHS are responsible for delivery of maternal and child health, FP, and safe motherhood and RH services. The Interagency Coordinating Committee on Contraceptive Security, formed in 2008, advocates for increases in support and resources for FP and RH services and for repositioning family planning higher on the national agenda.

The 1994 *National Population Policy* calls for a reduction in the annual population growth rate from 3 to 1.7 percent by 2020. This is to be achieved by reducing fertility from a TFR of 5 in 2000 to a TFR of 3 in 2020 and an increase in modern method use to 50 percent of MWRA by 2020 (NPC 1994). To reinvigorate implementation of the *National Population Policy*, the NPC and the FHD developed a *Road Map to Reposition Family Planning (2006–2010)* (Akitobi et al., 2009). This document explicitly calls for a reduction in FP unmet need from 36 percent in 2008 to 20 percent by 2020, as well as for achieving the

fertility and population growth targets cited above. Principal changes outlined in the road map include (1) expanding outreach to clients, (2) training new cadres of health workers in family planning, (3) integrating family planning logistics into the supply chain for essential commodities, (4) and revising population projections to better inform GOG policy and planning. The road map currently guides population and FP programming in Ghana. Other strategies and policy documents that guide population activities include the *National Reproductive Health Strategic Plan (2007–2011)* (GHS 2003); the *Health Sector Five-Year Programme of Work (2007–2011)* (MOH 2007); the *Adolescent Reproductive Health Strategy* (NPC 2000); the *Meeting the Commodity Challenge: The Ghana National Contraceptive Security Strategy, 2004–2010* (MOH 2004), which is currently being updated; and the *National HIV/AIDS and Sexually Transmitted Infection Policy* (GAC 2004).

The NHIS was introduced in 2003. For a fee, members can receive care for specified services at facilities that have been accredited by the National Health Insurance Council (the governing board of the National Health Insurance Authority) (Akitobi et al., 2009). Enrollment is based on a sliding fee scale; selected groups, including pregnant women and children under 18 who can demonstrate need, are eligible for free enrollment. Fifty-five percent of all Ghanaians are currently enrolled in the NHIS (PPME, 2008). Coverage for FP was explicitly excluded from the NHIS because the national FP program has traditionally been heavily subsidized by donors. Instead, policymakers classified family planning as an "essential public good" that, like immunization, would be provided free at all GHS facilities (Akitobi et al., 2009). In 2007, reports of very high levels of maternal mortality and concern about lack of progress in achieving MDG 5 motivated the minister of health to declare maternal mortality a national emergency. He also specified that selected maternal health services, including prenatal, postnatal, and antenatal care up to six weeks post-delivery and services for children under the age of 18 would be included in the NHIS benefits.

Although the GOG has been very effective in developing policies and strategies for meeting the FP needs of its population, it has not consistently prioritized FP service delivery or provided the national program with the necessary funding. Total annual funding for the national FP program between 2003 and 2009 ranged from a high of $8,750,000 in 2007 to a low of $4,470,000 in 2005 (PPAG, 2009). The average annual funding during that period was $6,047,100. The portion contributed by the GOG ranged annually from a high of 41.4 percent in 2005, when the GOG contributed $1,850,000, to a low of 0 percent in 2009. Although variations in annual funding levels are to be expected as a result of varying program needs, a distinct downward trend has existed in GOG contributions since 2003. This, together with the changing priorities of the donor community, has severely reduced both access and quality of FP services in Ghana. In 2011, the Interagency Coordinating Committee on Contraceptive Security identified a $7 million gap between requirements and commitments for forecasted contraceptive commodity needs alone (PPAG, 2009). If the GOG is to achieve all of the goals established in its policies and strategies, it must commit the necessary funding to support population and FP programs.

V. POLICIES AFFECTING LAPM USE

In the past 10 years, the use of all contraceptive methods has dropped, as has the use of LAPMs. Ghana's FP program has seen a steady decline in couple-years of protection provided from 1,163,944 in 2004 to 892,853 in 2006 and a further decline to 598,572 in 2007 (QHP and GHS, 2009a). The GHS attributes this more than 50 percent drop to the attrition of trained personnel; low demand for methods, particularly for LAPM; and lack of support for FP from leaders and managers. To reverse this downward trend, barriers to LAPM use must be identified and policies that impede access to services reformed.

Eligibility Criteria

The *National Reproductive Health Service Policy and Standards* (GHS, 2003) states that all women, including those lactating, are eligible for hormonal implants (Norplant) and all women are eligible for intrauterine devices (Copper T). The document goes on to qualify eligibility for IUDs by stating that "for nulliparous women, particularly adolescents, IUD is not the first choice" and that noneligibility should be considered for women at "increased risk of STIs (sexually transmitted infections) including multiple sexual partners" and who are "HIV positive clients." In addition, the document states that all women, or all men in the case of vasectomy, who do not want to have any more children are eligible for tubal ligation.

These eligibility criteria do not present barriers to the use of LAPM; however, research conducted in 2005 on trends in IUD use recommended that the MOH clarify its eligibility criteria for the IUD, considering that the World Health Organization in 2004 stated that HIV-positive women and those women most at risk can generally use IUDs but may require careful follow-up (Osei et al., 2005).

Demand Generation

Nearly all Ghanaian women know about family planning, and 62.6 percent of women know about female sterilization, whereas only 36.6 percent know about male sterilization (GSS, GHS, and ICF Macro, 2009). 42.5 percent of women know about the IUD, and 63.8 percent know about implants. These high levels of awareness and the fact that 35 percent of Ghanaian women do not want any more births indicate that a great deal of potential demand for LAPMs may exist. In fact, an assessment of the impact of an FP promotional campaign on uptake of LAPM in 37 districts demonstrated that an FP campaign consisting of health talks at community gatherings, durbars, skits, and radio talk shows triggered a spike in uptake of FP methods from 369 couple-years of protection for new LAPM clients in one month to 665 couple-years of protection for new LAPM clients the next (QHP and GHS, 2009a). This 80 percent increase occurred despite sporadic interruptions in service availability resulting from commodity stockouts and lack of trained personnel and supplies.

Increased funding and support is needed for behavior change communication (BCC) campaigns to encourage more women to use LAPM. These campaigns should be linked with training and other efforts to improve FP counseling. Service providers should be proactive and take advantage of both new visits and revisits in order to counsel clients on the benefits of LAPM. They should also explain to FP clients that, although LAPMs are more expensive than re-supply methods initially, they are actually more cost-effective in the long run, because they require fewer visits to the health facility and are effective for a longer period.

Service Availability

The standards presented in the *National Reproductive Health Service Policy and Standards* (GHS 2003) state that implants and IUDs are to be made available at the subdistrict level. Voluntary surgical contraception, both bilateral tubal ligation and vasectomy, and implants and IUDs are to be made available at the district level as well as in regional and teaching hospitals. The standards also state, "Clients shall be referred to a higher level of service delivery where services required are not provided at that level or where management of complications and side effects are beyond the competence of the service provider." Despite these standards stating that LAPM should be made available at facilities at the subdistrict, district, and regional levels, LAPM services are not widely available throughout the country. A facility assessment conducted in 13 districts in 2009 found that almost half (46%) of districts surveyed did not have instruments to insert implants or IUDs, or commodities, or trained service providers (QHP and GHS, 2009a). A separate facility survey conducted in 2005 in 27 districts in seven regions found that

72.3 percent of all hospitals offer tubal ligation and only 17 percent offer vasectomy (QHP and GHS, 2005). The assessment also found that only 49.7 percent of all levels of facilities surveyed provided IUDs and 33 percent provided implants. If LAPMs are not available in a facility, providers refer clients to another facility or counsel them to use a less effective supply method. Difficulty accessing services discourages clients and causes them to abandon their interest in using LAPMs.

Research has demonstrated that uptake of all FP methods can double if a broad array of contraceptive methods are provided for free by community health nurses at the community level. The Ghana Essential Medicines Initiative (GEMI) doubled use of all FP methods by providing FP information and services in such places as the market, church, or riverside, where women in rural communities work and congregate (Population Council, 2010). GEMI also increased IUD use fivefold by providing community health officers in selected Community Health and Family Planning Project districts with updates on IUD insertion and removal, as well as supplies and equipment to provide IUD services at the community level. Although these pilot projects are resource intensive and difficult to replicate, they do demonstrate the potential impact of targeted government subsidies and the fact that rural Ghanaian women will use modern FP methods and LAPMs if they have easy access to information and services.

User Fees

According to key stakeholders, user fees for FP contraceptives are a significant barrier for clients, particularly for women in rural areas and poorer households. Although FP counseling is provided free of charge, users are required to pay an average of 10 percent of the international cost for the contraceptive (PPME, 2008). Estimates of out-of-pocket spending for FP reach as high as $2 million per year (PPAG, 2009). Contraceptives have been classified as an "essential public good" that, like immunizations, should be provided for free; however, in practice, users are asked to pay for contraceptives in all public sector facilities. In 2008 the median fee paid for pills, injectables, and male condoms was 50 *pesewas* (ICF Macro 2010). Stakeholders agree that, regardless of facility level or location, consumers pay more than the established public sector price for FP commodities. Research should be conducted to verify this anecdotal evidence.

User fees are collected and accounted for in the return-to-project accounts at the facility level. An FHD policy allows facilities to retain 50 percent of the fees collected for use in purchasing occasional supplies or managing intermittent stockouts. The facility must send the remaining 50 percent to the district. The district, in turn, is authorized to retain 25 percent of the funds and to send the balance to the regions. The region then forwards a portion to the FHD in Accra. This system for collecting, reporting, and transferring funds from one level to another is complex, difficult to monitor and frequently plagued by delays and errors. More important, many incentives exist in the system for underreporting of both commodities distributed and fees collected. The contraceptive logistics system uses this reporting system, as well as information about prior contraceptive distributions, to determine levels of commodity resupply for each facility. Because the return-to-project fund accounting system suffers from delays, errors, and underreporting, basing levels of commodity resupply on the information the system generates results in frequent stockouts. Most stakeholders expressed concern about linking resupply of FP commodities to the return-to-project funds accounting system and observed that this practice creates distortions and, at times, interruptions in the availability of commodities at the facility level.

Stakeholders identified including benefits for FP services in the NHIS as a priority issue and as an important strategy to reduce out-of-pocket expenses for FP clients and increase FP use. In June 2008 the Planning, Performance, Monitoring, and Evaluation (PPME) division of GHS examined the costs and benefits for LAPMs and injectables in the national health insurance program (PPME, 2008). The study found that adding these services to the NHIS benefit package both reduces clients' healthcare costs and satisfies their unmet need for FP. The analysis demonstrated that including provision of LAPMs and

injectables in the NHIS package would result in substantial numbers of averted births. Averting these births would then reduce NHIS costs related to pregnancy, delivery, and newborn care. The cost per pregnant woman for pregnancy-related services is estimated at 80 cedis and the cost per pregnant woman of other medical services is 20 cedis per year; the cost of providing services to newborn children is estimated to be 15 cedis (PPME, 2008). If family planning were covered in 2009, by 2011 the NHIS would realize almost 11 million cedis in net savings in 2011 alone. This amount increases to more than 18 million cedis by 2017. Although National Health Insurance Authority policymakers recognize these results, they have also expressed interest in seeing evidence that free FP services will result in increased use of LAPMs and injectables in Ghana. The GEMI Project demonstrated that, when both user fees and opportunity costs of accessing services, such as costs for transportation, are removed and rural women are provided a wide range of contraceptive options free of charge in their community, they will use LAPMs (Population Council, 2010).

Reliable Commodity Supply

As the *National Reproductive Health Strategic Plan (2007–2011)* (GHS 2007) states, "While national family planning programs routinely operate within adverse conditions such as scarcity of personnel, inadequate facilities, disruptions in logistics and transport, etc., the absence of the commodities around which the program is built can constitute an absolute barrier." Stockouts of long-acting methods have been a barrier for increasing use. In a 2008 assessment of 13 facilities, 46 percent of facilities providing IUDs and Jadelle implants suffered stockouts (QHP and GHS, 2009a). Research conducted in 2002 found that, although 17 percent of facilities claimed they provided implants, almost one-third did not have commodities on the day of the survey (JHSPH, 2007).

The GOG has recently made contraceptive security a priority and developed the Ghana national contraceptive security strategy for 2004–2010 (MOH, 2004). This strategy identifies and promotes needed changes in the procurement processes and logistics system that distributes contraceptives to health facilities. The Interagency Coordinating Committee on Contraceptive Security is actively advocating for increased resources to cover the $7 million contraceptive-commodity funding gap over a three-year period and to integrate contraceptives into the logistics system for other essential commodities. Despite efforts to redesign the FP logistics system so that contraceptives are integrated into the logistics system of other health commodities, the contraceptive supply chain continues to operate separately. Stakeholders from the DELIVER Project pointed out that involving district officials in reporting and resupply decisions contributes to delays in commodity distribution. In addition, linking reporting and management of contraceptive distribution with the return-to-project funds account makes it difficult to track stock and resupplies accurately. If FP is included in the benefits of the NHIS, additional reporting will be required. It is important that the GHS and MOH work together closely to improve the efficiency and effectiveness of this logistics system. In addition, policies regarding contraceptive procurement should be improved to streamline contraceptive purchasing.

Trained Personnel

Lack of trained personnel is a serious constraint that pervades Ghana's health system and limits provision of LAPM. Many trained providers leave the country or stop practicing, taking their skills with them. Attrition is a serious problem affecting all types of service providers from doctors down to community health assistants. Between 1996 and 2002, the number of doctors in Ghana declined by 17 percent and the number of nurses dropped by 24 percent (JHSPH, 2007). Staff shortages are more acute in rural than urban facilities. One way to address these staff shortages is to review the functions of each service provider to determine if opportunities exist for shifting tasks and increasing the types of service providers authorized and trained to provide each method. For example, the *National Reproductive Health Service Policy and Standards* (GHS, 2003) currently authorizes only FP nurses and midwives or doctors to insert

and remove IUDs and implants. Authorizing and training nurses and medical assistants to insert and remove IUDs and implants will increase access to those methods, as well as free up FP nurses, midwives, and doctors for tasks requiring greater skill and training. The GEMI pilot project successfully trained CHNs to insert and remove IUDs. In addition, anecdotal evidence from some implementing partners and district management teams indicate that CHNs with appropriate training are already providing some long-acting methods. The MOH director of human resources is interested in revising current standards and protocols and shifting more tasks to CHNs, so that more clients can be reached with services. The Nurses and Midwife Council Ghana does not want to see the role of midwives and FP nurses modified and opposes revisions of the standards. However, midwives have been losing revenue as a result of the tariff structure in the NHIS. This may motivate the council to engage in negotiations and be more willing to compromise on changes to both services that midwives provide and levels at which they are reimbursed for those services.

Systems for facilitative supervision, on-the-job training, and continuous training need to be strengthened to maintain competency of personnel despite the high levels of attrition and the difficulty of maintaining skills that are rarely used. The 2005 assessment of facilities in 37 districts found that, of the 29 FP providers working in the districts, less than one-third had received FP training in the past three years. Also, the competence of personnel providing IUDs and implants in all 37 districts was inadequate (QHP and GHS, 2005). In 2008, USAID/Ghana's Quality Health Partners project conducted a facility assessment of 13 districts and found that 4 did not have trained personnel to provide either male or female sterilizations and, of the staff available to provide FP services, only 28 percent were trained to provide implants, 14 percent to provide IUDs, 2 percent tubal ligations, and 1 percent vasectomy services.

Quality Assurance

Poor quality of care may be as effective a barrier to increased LAPM use as user fees. Stakeholders agreed that quality of information provided and counseling given to address side effects of LAPMs needs improvement. The most frequently cited reasons for future nonuse given by nonusers of FP are concerns about health and side effects (GSS, GHS and ICF Macro, 2009). Stakeholders also suggested that health workers, especially doctors, working in facilities with heavy patient loads are biased against LAPMs because LAPMs take more time to provide. They also suggested that health workers do not take adequate time to provide effective counseling for LAPM clients. In addition, stakeholders expressed concern about the effectiveness of current supervision for improving poor FP service provision. Health workers in the central and eastern regions suggested that current supervisory visits are for administrative purposes only and do not include performance monitoring. In addition, visits do not occur on a regular quarterly basis as scheduled. District teams cited the challenges presented by lack of vehicles, high number of facilities to monitor, and staff shortages. The Nurses and Midwife Council acknowledged that it is not currently fulfilling its mandate and that, due to staff shortages, it is forced to monitor performance in only a sample of facilities. The Marie Stopes International franchising system includes a supervisory system that appears to be working well. It has developed a set of minimum performance standards that must be maintained to remain in the franchise system and conducts monthly supervision to monitor performance. Stakeholders stressed that monitoring systems to ensure quality of care must cover not only public sector services, but also those provided by private sector providers. Stakeholders recommended that these monitoring systems be strengthened and expanded to ensure quality of care and that, as a first step, private sector providers be included in upcoming contraceptive updates and technical training for LAPMs.

VI. RECOMMENDATIONS TO REFORM POLICIES AND INCREASE LAPM USE

Reduce cost barriers to the use of LAPMs by including coverage of services in the NHIS scheme. Stakeholders identified the priority of including coverage of LAPM services in the NHIS in

order to increase use. Stakeholders also observed that careful consideration must be taken in implementing this new benefit to maximize its impact on both reducing unmet need for FP and providing cost savings to the NHIS.

Covering family planning under the National Health Insurance Scheme would result in savings of more than 18 million cedis in 2017.

Conduct research to determine the potential impact of reducing both costs for services and opportunity costs associated with obtaining services on demand for LAPMs. The GHS and key stakeholders have identified reducing costs to use LAPMs as an immediate priority. Costs include both user fees for obtaining services, as well as opportunity costs, such as transportation and time required to obtain services. Strong evidence exists that eliminating costs to users for services and reducing opportunity costs by expanding the provider pool and broadening the mix of methods available at the community level will improve use. The FHD and other stakeholders will also benefit from conducting a costing exercise to understand program costs for providing family planning services in the public sector, including the costs of removing barriers through training and IEC campaigns, versus costs of scalable outreach programs in family planning. Additional research should be done to understand better the price elasticity of demand for LAPM in Ghana. Research also needs to be done to understand fully the impact of reducing fees collected for the sale of contraceptives on operations at each level of the health system. The FHD is especially interested in understanding the potential impact at the regional and district levels of eliminating return-to-project funds and the system of accounting for them. This research should also identify needed changes in reporting and tracking of contraceptive inventories that will improve efficiency of the contraceptive distribution system and reduce stockouts.

Support integration of contraceptive commodities into the procurement and logistics system for essential health medicines. The GHS is working closely with the DELIVER project to improve the current contraceptive procurement and logistics systems as an important component of the repositioning FP effort. This effort needs support for improving all components of the system, including projecting contraceptive needs, advocating for and coordinating GOG and donor funding and support, and strengthening systems for reporting, managing inventories, and monitoring performance. The training conducted by the Health Policy Initiative for GHS in developing projections for meeting unmet need for family planning was the first step by the FHD to update its planning for commodity and service requirements for the next five years. If LAPMs are going to be made available at the community levels, greater attention to the supply chain and the resupply decisions will need to be made to ensure that supply does not become a barrier to access.

Increase funding and support for BCC and efforts to improve counseling on LAPM. Increased funding and support for BCC campaigns that promote smaller family size, present benefits of LAPM, address misconceptions concerning the health consequences of long-acting methods, and present testimonials of satisfied users of LAPM can significantly increase use. The messages in these campaigns should coordinate and complement information provided by health providers during group counseling and one-on-one counseling sessions provided at health facilities. Training to improve providers' counseling skills and update their knowledge of LAPMs is also needed.

Increase availability of trained personnel by revising service delivery standards so that community health nurses can be authorized and trained to insert and remove IUDs and implants. Stakeholders at the central, regional, and district levels supported revising the role of community health nurses. For this change truly to have an impact, pre-service and in-service training curricula need to be revised, as do systems for supervision. There is a strong need to have a policy dialogue on expanding access with full participation of professional nursing and midwifery groups, physicians and the Ministry of Health, Human Resources Directorate.

Increase support for continuous training, facilitative supervision, and performance monitoring. These support systems are essential to ensuring high-quality service delivery that will increase use of LAPM. Other approaches to consider for achieving these results include improvement collaborations or peer review.

ANNEX A. LIST OF STAKEHOLDERS CONSULTED

Last Name	First Name	Organization
Aboagye	Patrick	Deputy Head, FHD/GHS
Acheampong	O. B.	National Health Insurance Authority
Apewokin	Esther	National Population Council
Asare	Gloria Q.	Head, FHD/GHS
Banful	Alex	Ghana Social Marketing Foundation International
Bruce	Egbert	USAID | DELIVER
Burns	Richard	Exp. Ghana
Darko	Veronica	Nurses and Midwives Council
Mensah-Atteyeh	Eric	Nurses and Midwives Council
Fiagbey	Emmanuel	Voices Malaria/BCC Project
Jehu-Appiah	Koma S.	Ipas
Jones	Barbara	Community Health and Family Planning Project-TA
Kanlisi	Nicholas	EngenderHealth
Nyame	Faustina	Marie Stopes International
Sai	Fred	Presidential Advisor on Population
Senoo	Cecilia	Hope for Future Generations
Sory	Elias	Director, Ghana Health Service
Tapsoba	Placide	Population Council
Yankey	Frances	Planned Parenthood Association of Ghana

ANNEX B: SURVEY TOOL

Reproductive and Child Health Department Annual Workshop, March 23rd-March 26th, Koforidua

The Family Health Department is interested in understanding Regional team views on how to operationalize strategies given in the *Road Map to Reposition Family Planning 2006–2010*. The road map seeks to integrate family planning into health sector and socioeconomic planning. Some of the key strategies included in the road map are

I. Increasing the pool of trained providers
II. Reducing barriers: costs to clients, geographic distance, cultural distance
III. Integrating logistics of FP commodities with other essential commodities

We are requesting your participation in this anonymous survey. Please fill this survey out, and we will share the results with you on Day Three of this meeting and use the results in Contraceptive Security Planning

	I. Increasing Pool of Trained Providers	
1.	To increase access to implants in rural communities, CHNs should be trained to provide implants.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree
2.	To increase access to implants in rural communities, it is sufficient to train only midwives to provide implants.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree
3.	Currently, how many midwives are trained AND providing long-acting methods?	
	# trained and providing IUDs Do not include, if not providing.	☐ 100 percent 75 percent ☐ 50 percent ☐ 25 percent ☐ < 25 percent
	# trained and providing implants Do not include, if not providing.	☐ 100 percent 75 percent ☐ 50 percent ☐ 25 percent ☐ < 25 percent
	Comments on increasing pool of providers:	
	II. Reducing barriers: costs to clients	
4.	Eliminating client payments for family planning methods will increase use of long-acting methods, including implants.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree
5.	Eliminating funds collected from clients will have what impact on FP services?	☐ Positive ☐ Negative ☐ Minor Impact ☐ No Impact
6.	In what way are these funds most used by your region?	☐ Training ☐ Incentives to providers ☐ IEC ☐ Not available in time ☐ Insufficient for activities ☐ Supervision
7.	Would you support including FP coverage in national health insurance?	☐ Yes ☐ No
	Comments on costs to clients:	

III. Integrate FP commodities in health logistics		
8.	Regions should provide FP along with other commodities directly to service delivery points.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree
9.	We frequently or for long periods experience stockouts of FP methods.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree
10.	The current system of FP logistics in your region is working well to keep stocks available at service delivery points.	☐ Strongly Agree ☐ Agree ☐ No opinion ☐ Disagree

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