

WORKING PAPER

Improving Family Planning Service Delivery in Ghana

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ABBREVIATIONS

ADDRO	Anglican Diocesan Development and Relief Organization
CBA	community-based agent
CHAG	Christian Health Association of Ghana
CHN	community health nurse
CHO	community health officer
CHPS	Community-Based Health Planning and Services
CPR	contraceptive prevalence rate
CRS	Catholic Relief Services
DHIMS2	District Health Information Management System, Version 2
FGD	focus group discussion
FP	family planning
GDHS	Ghana Demographic Health Survey
GHS	Ghana Health Service
GRCS	Ghana Red Cross Society
HIS	health information system(s)
IUD	intrauterine device
LCS	licensed chemical seller
LMIC	low- and middle-income country
MDG	Millennium Development Goal
MEHAP	Maternal Health Social Accountability Project
MSI	Marie Stopes International
NGO	nongovernmental organization
OCP	oral contraceptive pill
PARDA	Participatory Action for Rural Development Alternatives
PHC	primary healthcare
PMA2020	Performance Monitoring and Accountability 2020 survey
RH	reproductive health
RMS	regional medical store
SDG	Sustainable Development Goal
SDM	Standard Days Method
SDP	service delivery point
TFR	total fertility rate
UER	Upper East Region
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Background: Family planning (FP) is one of the most cost-effective interventions for improving the health of children and women, and the achievement of Millennium Development Goal (MDG) 4 (reducing under-five child mortality by two-thirds) and MDG 5 (reducing maternal mortality by three-fourths) from the 1990 figures by 2015. Despite several national and global initiatives to improve health outcomes, challenges remain in low- and middle-income countries (LMICs) to achieve national and global targets.

Ghana has a long history of population policies and FP programs that have contributed to increased use of contraceptive services and improved maternal and child health. However, the country has not achieved MDGs 4 and 5, particularly in the three northern regions, which are the poorest and most deprived. This study focuses on one of those areas—the Upper East Region (UER). Although the UER has made great strides in improving access to FP services, there is still a huge unmet need.

The objectives of this study were to map out the distribution of all FP service providers in the region and document how the community-based FP information system is linked to the national system as a means to recommend strategies for supporting program planning and implementation and improving FP services.

Method: This study used cross-sectional mixed methods and covered the region's 13 districts. Data collection was conducted using records reviews and facility mapping through use of interview questionnaires. This was complemented with focus group discussions (FGDs) with FP service delivery personnel in selected districts and subdistricts. The data were analysed using MS Excel and SPSS version 21, and the mapping using QGIS version 2.18.

Findings: We recorded 435 FP service delivery points (SDPs), with wide variation across the 13 districts. The majority were functional Community-Based Health Planning and Services (CHPS) zones (244; 56%), followed by licensed chemical sellers (LCSs) (78; 18%). The remainder consisted of hospitals (15), health centres (60), clinics (25), pharmacies (11), and maternity homes (2). Nearly three-fourths (72%) were government facilities, 25 percent were private, and 13 percent were run by the Christian Health Association of Ghana (CHAG), an umbrella organization of religious nongovernmental organizations (NGOs).

The facilities' wide range of personnel delivering FP services included medical practitioners, midwives, nurses, technicians, and volunteers, with nurses constituting the majority. About two-thirds of SDPs had electricity, 59 percent had potable water, and only 25 percent provided privacy for clients. Other challenges included lack of geographical access to FP services, providers' limited training on FP methods, and frequent stockouts of FP commodities.

The range of contraceptive methods offered varied by facility. Eighty-six percent offered condoms, followed by oral contraceptive pills (OCPs) (84%), injectables (78%), and implants (67%). Fewer than half of the facilities provided other FP options; only two facilities offered vasectomy, and seven offered female sterilization.

The FP information system is paper and electronic based. It is integrated into the general health information system (HIS) and then fed into the national District Health Information Management System (DHIMS2) data platform. FP data from pharmacies and LCSs are not reported to the system. The system also does not capture information on community mobilization and FP education.

Recommendations: Access to quality FP services should be improved, and inequities in the region, which skew resources to urban areas, should be addressed. The FP logistics management system should be reviewed urgently to address factors leading to frequent stockouts at SDPs. All demarcated CHPS

zones should be provided with the necessary health personnel and equipment to operate optimally. Demand creation strategies should be prioritized and monitored. Last, all FP service statistics should be fully integrated, thus bringing all stakeholders on board. This step will improve the availability of logistics for record keeping and data management, quality assurance, and monitoring and supervision.

INTRODUCTION

Family planning is one of the most cost-effective interventions for reducing maternal and child deaths, and improving the health of children and women, as reflected in MDGs 4 and 5, respectively. Several global initiatives and national efforts have helped reduce maternal and child mortality in the last three decades; however, many LMICs have not achieved MDGs 4 and 5 (Countdown to 2015, 2015; FP2020, 2012; Global Strategy for Women's, Children's and Adolescents' Health, 2010; WHO [AFRO]/USAID, 2008; United Nations Development Programme [UNDP], 2000). FP service use increases when services are of high quality and accessible to communities. Access to FP services is hindered by poverty, poor access to commodities, civil conflicts, poor program coordination, and dwindling donor funding (WHO [AFRO]/USAID, 2008).

Reliable and timely information is important for decision making, program planning, and implementation at all levels. HIS tend to focus mostly on the public sector, despite significant contributions to health service delivery, especially FP services, at the community level and from the private sector. For example, a study in Kenya revealed that about 40 percent of women received contraceptives from the private sector—similar to private sector use for contraceptives in Ghana (36.3%). Information is a high priority in the agenda for the Sustainable Development Goals (SDGs), in which countries are called on to develop effective and efficient HIS at all levels.

Current multilateral and bilateral initiatives (e.g., SDGs; Global Strategy for Women's, Children's and Adolescents' Health; and the FP2020 movement) are building momentum for the realization of universal access to reproductive and sexual health, including FP, by 2030. Thus, it is opportune for LMICs to improve their HIS and FP program performance.

The Ghana Context

Ghana has a pluralistic health service delivery system, encompassing public, private self-financing, and private non-self-financing (e.g., religious missions, NGOs) sectors. The country's health service organization conforms to the 10 political and administrative regions, and a decentralized district assemblies system comprises 216 metropolitan, municipal, and district assemblies. District health services constitute the country's primary healthcare (PHC) and form the bedrock of the national health system, with the regional- (secondary) and tertiary-level health facilities providing support. District health services are further organized into a three-tier system, composed of community, subdistrict, and district levels. At the community level, the SDPs are the CHPS zones, pharmacies, and LCSs. The CHPS strategy demarcates subdistricts into CHPS zones, where trained nurses called community health officers (CHOs) are placed to work in partnership with community health committees and volunteers to deliver integrated basic PHC. The subdistrict level is composed of health centres, clinics, and maternity homes staffed with physician assistants, midwives, nurses, and other technical auxiliary and mid-level staff who provide integrated PHC services. The primary referral hospitals and district health administration at the district level are responsible for overall planning and coordination of services in the districts.

By an Act of Parliament in 2003, Ghana established the National Health Insurance Scheme to remove financial barriers to accessing services and, together with the CHPS strategy, achieve universal health coverage. The revised National Health Insurance Scheme Act 852 of 2012 provides free FP services in its benefits packages; however, the modalities for implementation still have not been resolved because the scheme faces financial sustainability challenges.

Over the years, Ghana, like many LMICs, has developed a robust routine HIS, complemented by periodic surveys to provide information for decision making at all levels. However, most of these systems remain fragmented and mainly focus on the public sector. Since the introduction of an Internet-based national

HIS (DHIMS2) in 2012, the system captures routine summary health service data, including FP data. Although the country's health information policy requires the capture of private sector, public sector, and community-based data, regions and districts appear not to adhere uniformly to this practice, resulting in incomplete data capture, difficulties in logistics forecasting and procurement, and marked differences in performance recorded by routine data and surveys.

National FP Program

Ghana created its first population policy in 1969 and established a national FP program in 1970. FP was a key component of the national PHC strategy adopted in 1978 and continues to be a national priority in subsequent national health policies. The country has been signatory to most of the global health and FP initiatives, and has incorporated them into its national programs (United Nations General Assembly Declaration, 2015; FP2020, 2012; Global Strategy for Women's, Children's and Adolescent's Health, 2010; WHO [AFRO]/USAID, 2008; UNDP, 2000; ICPD, 1994; Alma-Ata PHC Declaration, 1978). Its 1993 revised population policy noted a declining total fertility rate (TFR), but continued high population growth rate, poor program coordination, and low utilization of FP services, which the policy sought to address. Through social mobilization, education, and access to a wide range of contraceptive methods, the government's objectives were to promote small family size and a minimum interval of two years between births (Revised National Population Policy, 1994; Ghana Demographic Health Survey [GDHS], 1993; GDHS, 1988). The National Population Council was established in 1994 to provide direction, coordination, and monitoring and evaluation. The Ministry of Health, through the Ghana Health Service (GHS), was to lead implementation of the multisectoral FP program. Several subsidiary policies, guidelines, and protocols are in place for effective implementation, such as a reproductive health (RH) policy and protocols, an adolescent RH policy, national FP protocols, and an RH commodity security strategy.

Family planning is an integral part of reproductive, maternal, newborn, child, and adolescent health services, which constitute an important component of the PHC package and are integrated into general health services at all levels, especially in the public sector.

The national FP policy provides for a range of FP methods. The short-term methods include female and male condoms, OCPs, monthly hormonal injectables, foam/jelly, and emergency contraceptives. The long-term reversible methods are the three-month injectables, implants, intrauterine devices (IUDs) and diaphragms. Female sterilization and vasectomy services constitute the permanent methods. Natural FP methods include withdrawal, lactational amenorrhea (LAM), and the rhythm method.

The country has made significant progress in population health; it has reduced the TFR from 6.4 in 1988 to 4.2 in 2014, though it could not achieve MDGs 4 and 5, which included targets of 40 under-five deaths per 1,000 and 85 maternal deaths per 100,000 live births, respectively. Knowledge of contraception is almost universal but the modern contraceptive prevalence rate (CPR) among currently married women is 22 percent, and 30 percent have an unmet need for FP. Round five of the Ghana Performance Monitoring and Accountability 2020 (PMA2020) survey, conducted in the last quarter of 2016, reported an improved CPR of 25.8 percent, but also a higher unmet need of 31.7 percent. Regarding the popularity of FP methods, injectables, implants, and OCPs are the most preferred, in that order. Bilateral tubal ligations are rare (1% among all women and 2% among currently married women), along with female condoms and vasectomy (Ghana PMA2020, 2016; GDHS, 2014, GDHS, 1988).

In 2008, 38 percent of contraceptives came from the public sector and 51 percent from the private sector. By 2014, the trend had reversed, with 64 percent coming from the public sector and one-third (33%) from the private sector. The major reason for this decrease in private sector supply was the reduced contribution of LCSs, from 38 percent in 2008 to 22 percent in 2014. Long-acting reversible contraceptives and permanent methods are accessed mostly from the public sector, whereas short-term

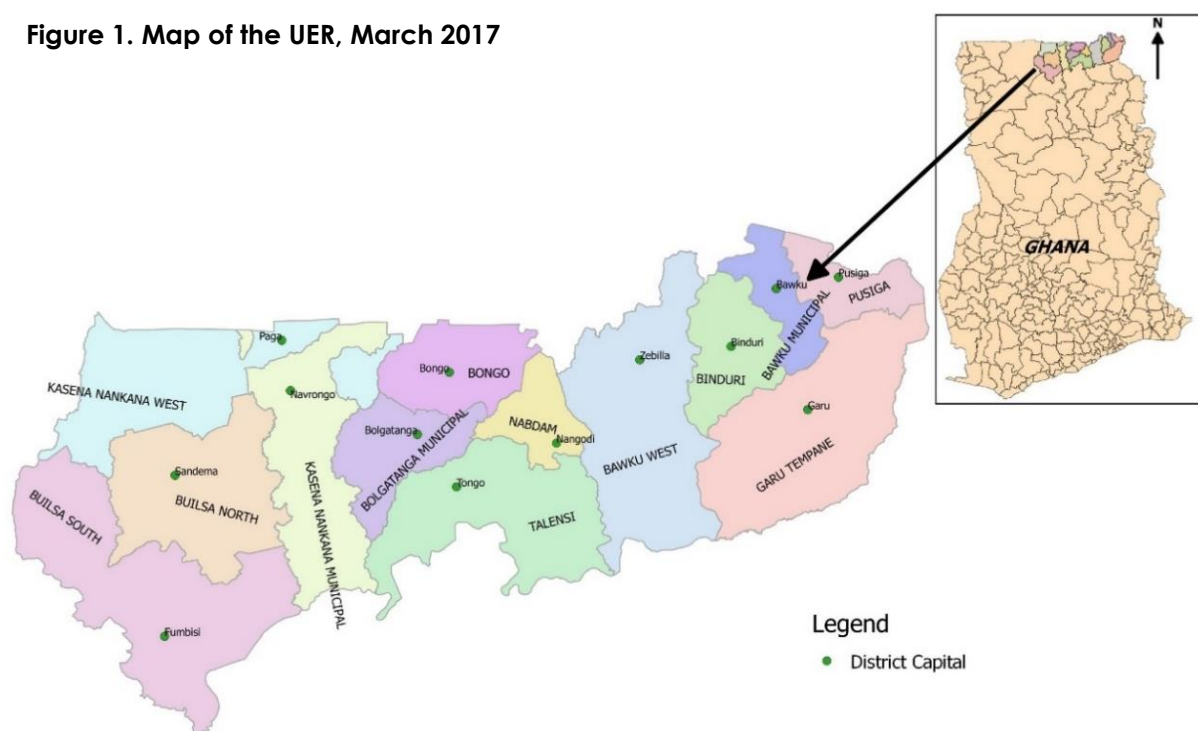
methods, especially male condoms and OCPs, come mostly from the private sector (GDHS, 2014). There are large missed opportunities in the areas of FP information, education, and communication. More than three-quarters (77%) of women do have contact with health fieldworkers or facility-level providers. Nearly one in four (24%) men think that contraception is women’s business; nearly half (46%) believe that if women practice FP, they will become promiscuous (GDHS, 2014). A quarter of women who previously had used modern contraceptives have discontinued using them (GDHS, 2014).

Health outcomes are not uniform, with the three poorest regions in the northern part of the country having the worst indicators. To gather national and regional data, demographic and health surveys have been conducted in Ghana since 1988. In addition to occasional special studies, Ghana is 1 of 10 countries implementing the PMA2020 project, which provides information mainly for national and top-level decision making. Disaggregated data are lacking for lower-level planning. DHIMS2 offers a useful platform for routine data collection from all service providers to address this problem.

Context of the Study Area

UER is one of the most deprived regions in Ghana; it is predominantly rural and situated in the northernmost part of the country. It has a population of about 1.1 million, with 80 percent living below the poverty line. The region has 13 administrative and political districts subdivided into 91 subdistricts, and 399 demarcated CHPS zones, 290 of which are considered functional, though only 246 are established as separate service delivery entities in the DHIMS2 database (UER Annual Report, 2016).

Figure 1. Map of the UER, March 2017



Integrated RH services, including FP, are provided at all levels of healthcare (community, subdistrict, district, and regional) but they vary according to the types and qualifications of available personnel. During the study period, the region was implementing completely free FP services in six districts and subsidized services, as in rest of the country, in the remaining seven districts.

The region’s health indicators have been improving, following the national trend, though most of them are worse than the national average. The under-five mortality rate fell from 180 per 1,000 live births in

1993 to 72 per 1,000 in 2014. The TFR declined from 6.4 in 1993 to 4.9 in 2014. From 1993 to 2014, antenatal care from a skilled provider rose from 85.9 percent to 98.4 percent, delivery by a skilled provider increased from 19.0 percent to 84.6 percent, the modern CPR increased from 7.2 percent to 23.3 percent, and unmet need for FP dropped from 28.8 percent to 26.5 percent (GDHS, 1993, 2014).

Access to FP services, especially long-term methods, has improved in the last five years through interventions supported by partners such as Ipas, Marie Stopes International (MSI), and the United Nations Population Fund (UNFPA). The region has a good reputation for health system research; one study conducted there in the 1990s informed the adoption of the national CHPS policy for strengthening PHC, and it has become a showcase, attracting study tours from several African countries (Awoonor-Williams, et al., 2013a; Awoonor-Williams, Sory, Nyonator, Phillips, Wang, & Schmitt, 2013b; Nyonator, et al., 2003).

Study Purpose and Objectives

Despite improvements in the regional FP acceptor rate, there is huge variation between districts, ranging from 9 percent in Bawku Municipal to 67 percent in Nabdam (UER Annual Report, 2015). Geographical inaccessibility to services could be a major factor in this significant variation. Although there are many players in FP service delivery, comprehensive information on providers and services is lacking. This lack creates a barrier to effective and efficient planning and implementation aimed at minimizing variations in health outcomes and ensuring equitable access to FP services.

This study's purpose was to build local research capacity and address gaps in routine FP information for decision making at all levels. The study had three objectives:

- Map out FP service providers in the UER, their geographical coverage, and the FP methods they offer
- Document the community-based FP information system and assess its links to the national system (DHIMS2)
- Recommend strategies for integrating and strengthening the two systems for improved decision making and performance

Gathering information on the three sectors (government, NGO, and private) that deliver contraceptive commodities and services will facilitate effective FP programming from the community level to the regional levels to address areas of inequities, inefficiencies, and high unmet need (MEASURE Evaluation, 2016). Mapping service providers by location, types of services provided, and geographical coverage will constitute an important step in identifying gaps in FP service delivery and duplication of services. Integrating community-based information into the DHIMS2 database will provide complete and readily available data for decision making at all levels.

METHODS

This study used cross-sectional mixed methods to cover the 13 districts in the UER. It consisted of records reviews and data extraction from the DHIMS2 database. The data collectors conducted the survey of all types of FP service providers in the 13 districts by interviewing those providers present at the time of the survey, using a structured interview questionnaire. Two districts were purposely selected and two FGDs were conducted. For the field survey, the study area was zoned into three areas—eastern, central, and western—covering five, four, and four districts, respectively, to facilitate field supervision by three field supervisors.

Sensitization and Training

A one-day sensitization workshop was organized for the regional health management team to obtain their buy-in and facilitate project execution. Seventeen data collectors were selected, at least one per district based on the projected number of service providers, and three supervisors, based on their good knowledge of the geography of the districts. They participated in a one-day training covering an overview of the study, how to administer a structured interview questionnaire, the format for extracting secondary data, use of the geographical positioning system devices, and guidelines for conducting the field exercise. The supervisors received additional support on field supervision guidelines.

Data Collection

Depending on the size of the district one or more trained data collectors carried the survey in each district for four weeks. During the fieldwork, each data collector first reported to the district health management team and reviewed district records on subdistricts, CHPS zones, health facilities, FP service providers, FP services, and health NGOs working in that district. Some of this information guided the detailed planning of the fieldwork, which they shared with their respective supervisors. Next, the data collectors visited every subdistrict, met the subdistrict team to brief them on the study, checked the information on FP providers in the subdistrict, and then visited every FP provider. The data collectors interviewed those who consented to the survey using a structured questionnaire and took the coordinates of the SDP. Only two LCSs in Builsa North District refused the interview. The supervisors visited every data collector during the first week of data collection and at least twice during the remaining data collection period. Where data gaps were detected in the filled questionnaire, that data collector was asked to go back to collect the missing data.

Builsa South (which provided free FP services) and Bawku West (whose clients pay for FP services) were purposely selected. FGDs were held with the district health management team, staff from different subdistrict health teams, and CHOs. The plan was to conduct separate FGDs with each of these groups; on the day of the activity, however, the districts scheduled the groups, and they all reported to the same venue at the same time. This situation made conducting separate discussions difficult. The discussion topics included FP service quality and coverage performance, logistics and information systems, and challenges with FP service delivery.

Research team members monitored the data collection by visiting each district during the data collection period to ensure the guidelines were followed.

Data Analysis and Mapping

The research team analysed the secondary data and produced the background information on the region and the thirteen districts. The structured interview data were coded, and members of the team entered them into Microsoft Excel. Data were compared and cleaned before being exported to SPSS 21 version

software for analysis. FGD data were transcribed and analysed by thematic areas, and service provider data were analysed by service provider type, sector (i.e., public, private, or NGO), distribution by district and subdistrict, FP service personnel, and their training. The data were presented in tables and maps depicting the distribution of providers in the region by district. The different FP services and methods were also analysed by service provider type, ownership, distribution by district and subdistrict, and commodity stockouts. Mapping was conducted using QGIS version 2.18.

Ethics

Ethical clearance for the study was obtained from the Navrongo Health Research Centre Ethical Review Board. Administrative clearance was obtained by writing to the regional director of health services, who in turn wrote to all the district directors of health services to inform them of the study and request their full cooperation and support.

RESULTS

This report presents the results in two parts. The first part presents the regional-level analysis; the second presents that of the district level.

Regional-Level Analysis

This part consists of three sections. The first section presents the health facilities profile. The second section describes the mapping of FP methods and services provided by health facilities; the third section describes the FP information system. Further details can be found in the following appendices:

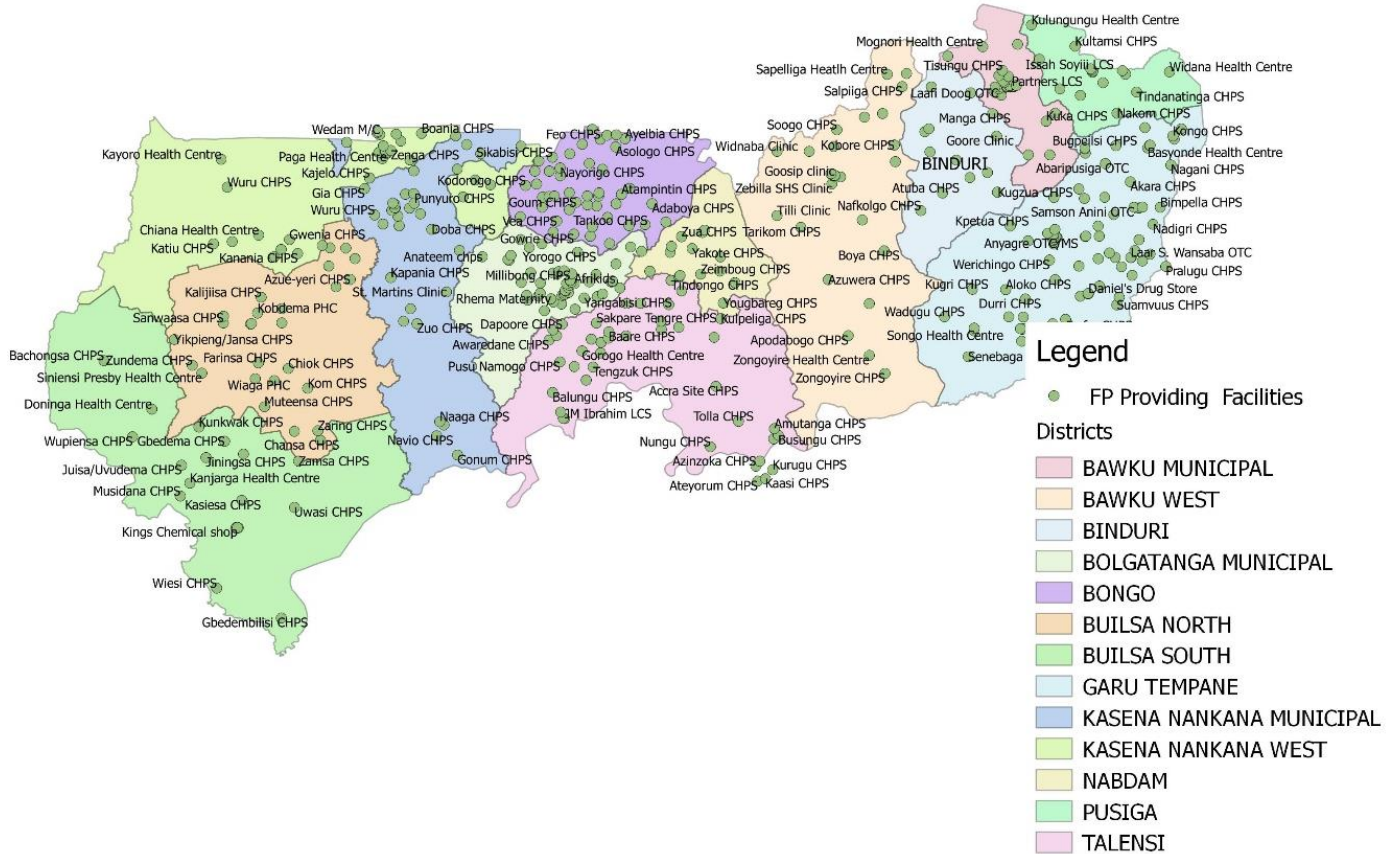
1. Appendix A. Upper East Regional Maps of Service Provider Types
2. Appendix B. Upper East Regional Maps of SDPs for Different Types of FP Services
3. Appendix D. Tables of FP Providers
 - Table 1. Types of personnel delivering FP services, by service provider type
4. Appendix E. Tables of Distribution of FP Services
 - Table 2. Numbers and proportions of SDPs offering different FP services on a static and outreach basis, by service provider type
 - Table 3. Delivery of different FP methods at static and outreach SDPs, by sector

Service Providers' Profiles

Access to quality FP services requires the availability of health facilities with a working environment conducive to productivity for both staff and clients, an effective and functional logistics supply chain at the SDPs, and competent and available personnel to deliver FP services.

The survey recorded 435 SDPs, comprising hospitals, health centres, clinics, CHPS zones, pharmacies, and LCSs. Figure 2 illustrates the geographical distribution of FP SDPs in the UER.

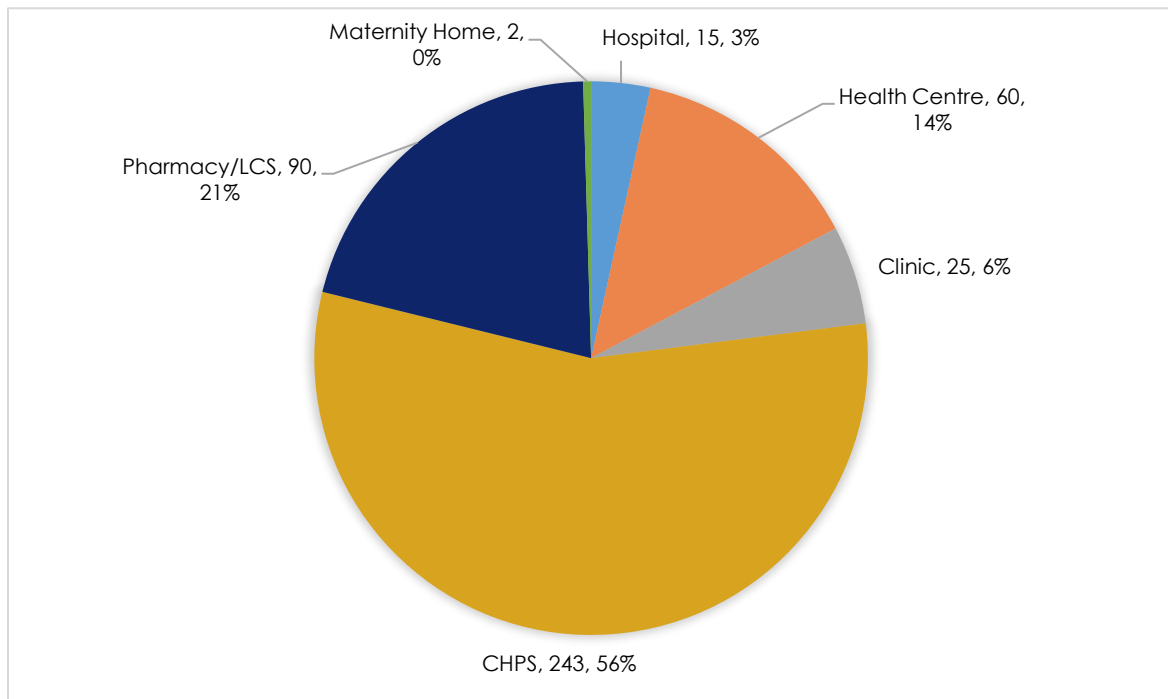
Figure 2. Map of the UER showing distribution of FP SDPs, by district



Service Providers by Type, Distribution, and District

CHPS constituted most SDPs in all districts, representing more than half (56%) of all FP service providers, followed by Pharmacy LCSs (21%).

Figure 3. Types of FP SDPs



Sixty-two percent (243) of the 399 demarcated CHPS zones were functional (i.e., delivering services at the time of data collection), as shown in Figure 3. They ranged from 24 percent functional CHPS in Bawku Municipal to 92 percent in Talensi (details in Appendix A). Most of the pharmacies and LCSs (62 out of 90, or 69%) were concentrated in three districts: 28 in Garu Tempene and 19 and 15 in Bolgatanga and Bawku Municipalities, respectively.

There was wide variation in distribution of the total number and types of SDPs by district and subdistrict. Pusiga District (15) had the fewest, and Garu Tempene District the most (84); both were in the eastern part of the region. The regional average population per SDP was 2,400, with Garu Tempene having the best ratio (1,662 people per SDP) and Binduri District having the worst (more than 5,000 people per SDP).

Table 1. Number and average population per SDP, by district

District	2016 population	Number of SDPs	Average pop. / SDP
Bawku Municipal	105,849	31	3,414
Bawku West	101,011	28	3,608
Binduri	66,145	13	5,088
Bolgatanga Municipal	141,310	51	2,771
Bongo	90,818	44	2,064
Builsa North	60,667	25	2,427
Builsa South	39,223	21	1,868
Garu Tempene	139,649	84	1,662
Kassena Nankana Municipal	118,101	28	4,218
Kassena Nankana West	75,910	42	1,807
Nabdam	36,336	20	1,817
Pusiga	61,956	15	4,130
Talensi	86,758	33	2,629
Total	1,044,193	435	2,400

The 15 hospitals were in 10 district capitals; Bolgatanga and Bawku Municipals each had three hospitals, and Pusiga District had two (see Table 2). Three districts (Binduri, Builsa South, and Nabdam) had none.

Table 2. Types of SDPs offering FP services, by district

District	Type of SDP						Total
	Hospital	Health centre	Clinic	CHPS	Pharmacy /LCS	Maternity home	
Bawku Municipal	3	6	0	6	15	1	31
Bawku West	1	4	6	14	3	0	28
Binduri	0	2	3	8	0	0	13
Bolgatanga Municipal	3	7	5	16	19	1	51
Bongo	1	5	1	35	2	0	44
Builsa North	1	4	1	19	0	0	25
Builsa South	0	3	0	14	4	0	21
Garu Tempene	1	8	4	42	29	0	84
Kassena Nankana Municipal	1	2	1	20	4	0	28
Kassena Nankana West	1	7	1	29	4	0	42

Nabdram	0	2	2	13	3	0	20
Pusiga	2	3	0	7	3	0	15
Talensi	1	7	1	20	4	0	33
Total	15	60	25	243	90	2	435

Only Bolgatanga Municipal and Bongo District had at least one facility at a higher level than a functional CHPS zone for all their subdistricts. Of the 91 subdistricts, 27, or nearly one-third, had functional CHPS zones only. The subdistricts are listed in Table 3.

Table 3. Subdistricts without an SDP at a higher level than a functional CHPS zone, by district

District	Number of subdistricts	Number of subdistricts with no facility higher than CHPS		
		Number	Percentage	Subdistricts
Bawku Municipal	7	2	28.6	Baribari, Kuka East
Bawku West	8	3	37.5	Boya-Gantongo, Tanga-Timonde, Zebilla North
Binduri	6	3	50.0	Aniisi-Kulkparigu, Atuba-Kafkolga, Zawse-Bansi
Bolgatanga Municipal	9	0	0.0	0
Bongo	6	0	0.0	0
Builsa North	6	2	33.3	Kadema, Sandema East
Builsa South	6	3	50.0	Gbedema, Uwasi, Wiesi
Garu Tempene	9	1	11.1	Worikambo
Kassena Nankana Municipal	7	5	71.4	Mayoro, Navrongo East, Pungu, Vunania-Kapania, Wuru
Kassena Nankana West	9	3	33.3	Kafiu-Nakong, Mirigu-Nabanga, Navio
Nabdram	5	2	40.0	Sakote, Zanlerigu
Pusiga	5	2	40.0	Nakom-Zuabulga, Sarabogo
Talensi	8	1	12.5	Tolla-Nungu
Total	91	27	29.7	27

Service Providers by Sector

Nearly three-quarters (311; 71%) of the SDPs were government owned (see Table 4). They comprised a regional hospital, district hospitals (5), health centres (51), clinics (11), and CHPS zones (242). Apart from the police clinic in Bolgatanga, the regional capital, the rest were run by GHS.

The private sector represented a quarter of the service providers (110), comprising hospitals (7), health centres (2), clinics (10), maternity homes (2), pharmacies (11), and LCSs (79). The LCSs constitute 73 percent of the private sector and 18 percent of the total.

The NGO sector had only 14 facilities, or 3 percent of the total. Thirteen of them were operated by CHAG; only one was a nonreligious NGO facility—Afrikids Medical Centre, located in Bolgatanga. Fourteen other NGOs operating in the health sector had no SPDs of their own. Among them, MSI was the only one directly involved in FP service delivery by providing logistics, training personnel on FP, and organizing outreach for the provision of long-term contraception in selected health facilities in three districts. Outreach services were defined as using health personnel from higher levels to periodically provide FP services at lower levels, where they are not typically available. Outreach may occur at designated points in communities as well as through house-to-house visits.

The rest of the 13 NGO-operated facilities were involved in community mobilization and education on maternal and child health, including FP.

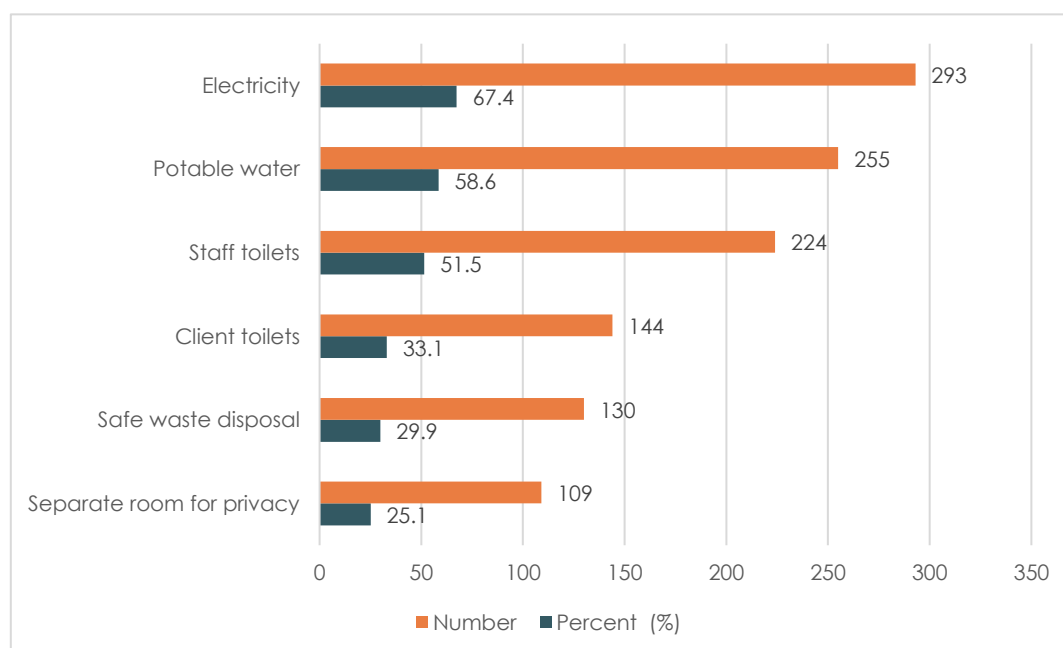
Table 4. Different types of SDPs offering FP services, by sector and district

District	Service providers, by sector			Total
	Government	NGO	Private	
Bawku Municipal	10	1	20	31
Bawku West	23	0	5	28
Binduri	12	0	1	13
Bolgatanga Municipal	26	3	22	51
Bongo	41	1	2	44
Builsa North	22	3	0	25
Builsa South	17	0	4	21
Garu Tempene	49	1	34	84
Kassena Nankana Municipal	23	1	4	28
Kassena Nankana West	36	0	6	42
Nabdam	15	1	4	20
Pusiga	9	1	5	15
Talensi	28	2	3	33
Total	310	14	111	435

Availability of Basic Amenities

Basic amenities are essential for quality FP service delivery. Among the 435 FP SDPs surveyed, about one-third (32.6%) did not have electricity. As shown in Figure 4, only one-third had a toilet for clients, and the majority did not have safe waste disposal or separate rooms to provide privacy for FP service delivery.

Figure 4. Number and percentage of SDPs with basic amenities for quality FP service delivery

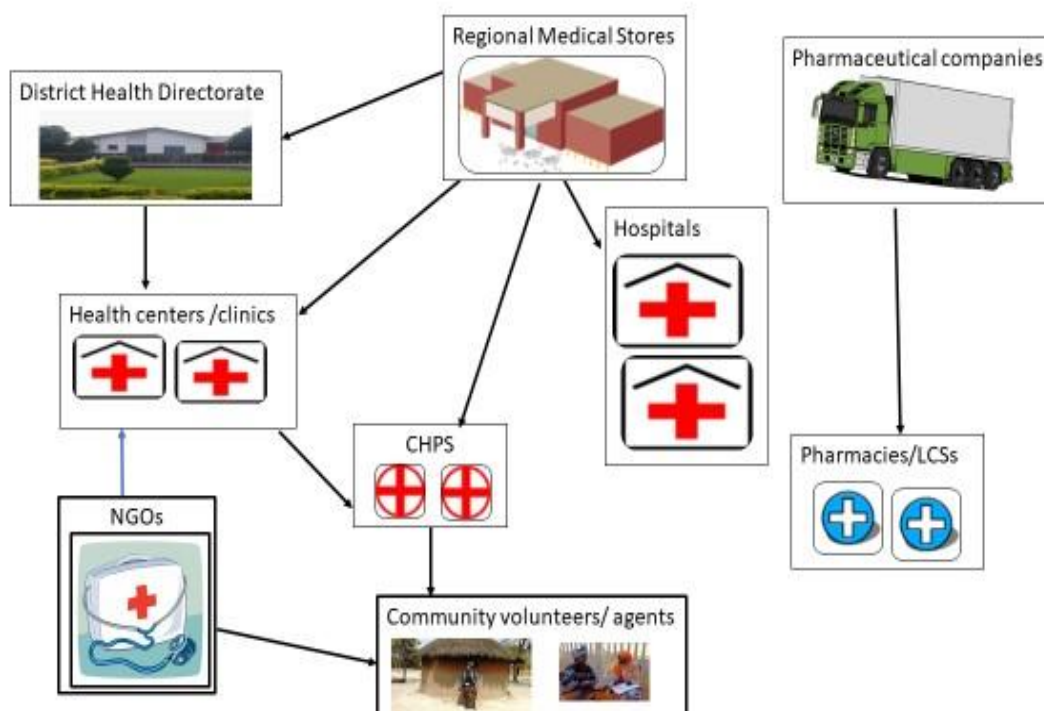


Family Planning Logistics Supply System

Most service providers obtain their FP commodities from the regional medical stores (RMSs) of the GHS, except for pharmacies and LCSs, which source OCPs and male condoms from pharmaceutical companies or their agents. NGOs are an important source for female condoms and IUDs. Some of the district health administrations receive and collate requests from the SDPs and submit them as a composite request; others let their SDPs submit their requests directly to the RMS. Supplies are delivered directly to the SDPs only after the regional RH coordinator has vetted and approved the quantities to be supplied.

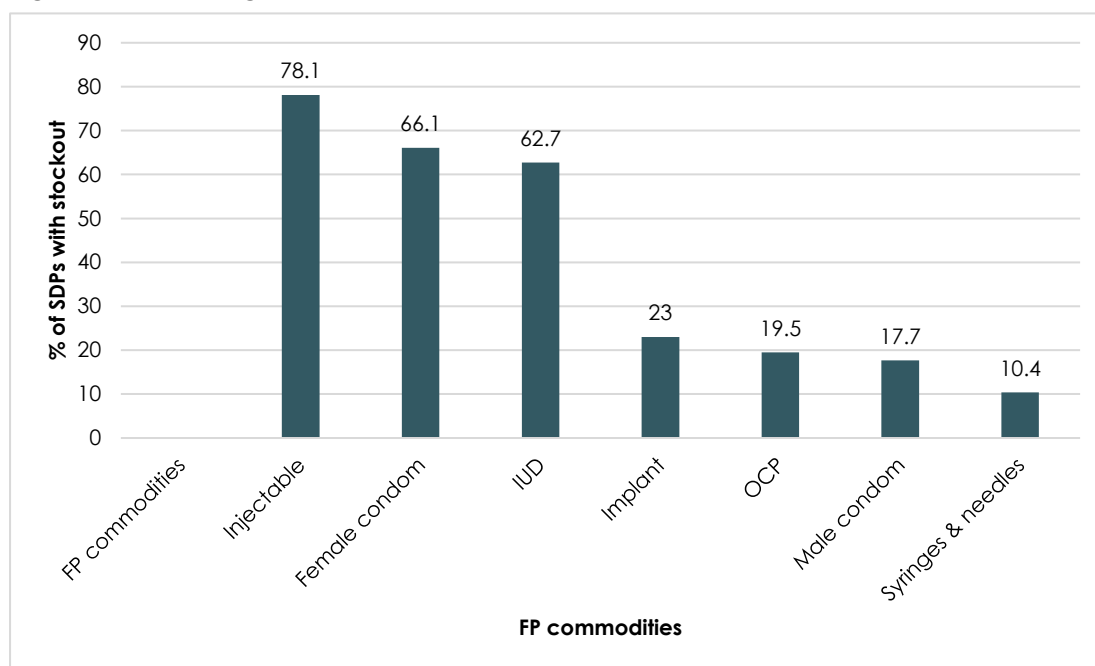
At the facility level, supplies records management follows the same system used for medicines, as shown in Figure 5 below.

Figure 5. FP logistics supply system for the UER



The survey reported a high percentage of SDPs with stockouts of various FP commodities, ranging from about 10 percent for syringes and needles to 78 percent for OCPs, despite their availability in the RMSs. A major challenge was that the schedule delivery model the SDPs use meant that late submission of requests by some service providers caused delays in the packaging and delivery process. Figure 6 below presents the stockout rates for various commodities.

Figure 6. Percentage of SDPs with a stockout in the past seven days



Personnel for FP Service Delivery

The availability of adequate numbers of health personnel who are well trained and competent in the various FP methods is essential for quality FP service delivery. Health personnel providing FP services include medical practitioners, midwives, community health nurses/community health officers (CHNs/CHOs), pharmacists, pharmacy technicians/attendants, and volunteers. Only medical practitioners are trained to provide permanent contraceptive methods. Midwives are trained to deliver all long-acting and short-term methods; with the introduction of a task-shifting policy, some CHOs/CHNs are also trained on implant insertion and removal in addition to the short-term methods. The rest are mainly trained to dispense short-term methods.

Most of the facilities, especially the large ones, had mixed teams of personnel providing FP services. Most SDPs (70%) had CHNs/CHOs and midwives providing these services. Most SDPs had provided FP training for CHNs/CHOs (83%) and midwives (74%) within the last three years. Three hospitals and one health centre had medical practitioners on their teams; these three hospitals had provided FP training for them within the last three years.

Mapping Availability of Different FP Methods and Services in the Region

The region offered the following FP methods and services: condoms (male and female), OCPs, hormonal contraceptive injectables, hormonal implants, IUDs, vasectomy services, female sterilization, cycle beads for the Standard Days Method (SDM), and counselling on natural methods. These FP services were offered at static clinics and through periodic outreach services, including home visits. Male condoms, OCPs, injectables, and implants were the most common methods at static clinics, in decreasing order. Diaphragms, contraceptive jelly, contraceptive foam, female condoms, and permanent methods rarely were reported. The most common FP methods offered by mobile clinics were injectables, male condoms, and OCPs (Table 5).

Table 5. Number and percentage of SDPs offering FP services on a static and outreach basis

FP Services	Mode of service delivery			
	Static providers		Outreach providers	
	Number	Percentage (%)	Number	Percentage (%)
Male condom	373	85.7%	171	39.3%
OCP	366	84.1%	160	36.8%
Injectable	338	77.7%	208	47.8%
Implant	290	66.7%	29	6.7%
IUD	32	7.4%	29	6.7%
Female sterilization	7	1.6%	6	1.4%
Vasectomy services	2	0.5%	5	1.1%
Counselling	347	79.8%	251	57.7%
Natural methods	190	43.7%	126	29.0%
SDM (cycle beads)	105	24.1%	38	8.7%
Other methods	39	9.0%	16	3.7%

Family Planning Counselling

Family planning counselling was the third most common FP service provided at static clinics (80%); it was most common during outreach (58%). The government sector is the major player in FP counselling, constituting 84 percent of static and 92 percent of outreach providers. The private and NGO sector providers were at 12 percent and 4 percent for static counselling, respectively and for both 4 percent for outreach counselling services.

Table 6. Number and percentage of SDPs offering FP counselling on static and outreach basis, by sector

Sector	No. SDPs	Static counselling services			Outreach counselling services		
		Number	Percentage (%)	As % of all SDPs	Number	Percentage (%)	As % of all SDPs
Government	310	292	93.9	84.1	232	74.6	92.4
NGO	14	12	85.7	3.5	10	71.4	4.0
Private	111	43	38.7	12.4	9	8.1	3.6
Total	435	347	79.8	100	251	57.7	100

By service provider type, all hospitals (100%), CHPS zones (96%), health centres (90%), and clinics (84%) offered counselling on a static basis. Measured by outreach, counselling was offered at most CHPS sites (78%), clinics (67%), health centres (63%), and hospitals (40%). CHPS constituted 67 percent and 76 percent of all static and outreach counselling providers, respectively. Only about a quarter of the pharmacies and LCSs offered FP counselling.

Ten of the 13 districts had at least 80 percent of their providers offering FP counselling at static SDPs, whereas 5 of the 13 districts had at least 90 percent of the providers offering FP counselling. Bawku (48%) and Bolgatanga (73%) Municipals and Garu Tempane (63%) were the only districts with less than 80 percent coverage for FP counselling. Builsa South was the only district with all 21 of its providers

offering FP counselling at static clinics and 81 percent during outreach. For a map of the distribution of SDPs offering FP counselling, see Appendix B, Figure 11.

Oral Contraceptive Pill

For the static sites, 366 (84%) offered OCPs; for the outreach SDPs, 160 (37%) offered this method. Among the static SDPs, 92 percent of health centres, 89 percent of pharmacies/LCSs, 87 percent of hospitals, 82 percent of CHPS zones, and 72 percent of clinics offered OCPs. On an outreach basis, 57 percent of health centres, fewer than half of the clinics (40%) and CHPS zones (44%), and a third of the hospitals (33%) offered this method.

Public providers of OCPs constituted 72 percent and 92 percent of static and outreach providers, respectively. The major providers were CHOs from the CHPS zones, representing 54 percent of the static and 67 percent of the outreach providers, respectively. About a quarter of the providers at static SDPs were from the private sector; the main players were the pharmacies and LCSs, which were 23 percent of all providers of this method.

By geographical distribution, Talensi district had 97 percent and 72 percent of its SDPs offering OCPs on a static and outreach basis, respectively. Both the static and outreach services for this method reached 92 percent in Builsa North. Five districts had more than 90 percent of their providers offering OCPs. Only three districts had less than 80 percent of their facilities offering this method: Bawku Municipal (77%), Garu Tempane (71%), and Binduri (69%). For a map of the distribution of SDPs offering OCPs, see Appendix B, Figure 12.

Male Condoms

About 86 percent and 39 percent of SDPs offered male condoms through static and outreach service, respectively. The proportion of static providers by sector was as follows: government (87%), private sector (83%), and NGOs (76.6%). For outreach, the breakdown was 50 percent of government and NGOs, and only 8 percent of the private sector.

The government sector was the majority provider of static (72%) and outreach services (91%). The private sector constituted 22 percent of providers at static SDPs.

By service provider type at static clinics, 92 percent of pharmacies/LCSs, 87 percent of health centres, 67 percent of hospitals, and 60 percent of clinics offered male condoms. CHPS zones were the major providers at static (58%) and outreach (73%) SDPs. Pharmacies and LCSs were the main private providers of this method (22% of all providers).

There was wide district variation in condom availability, ranging from as low as 47 percent in Pusiga District to 100 percent in Kassena Nankana Municipal and Talensi District for static services. Six districts scored more than 90 percent in availability, whereas four districts scored below 80 percent—Kassena Nankana (79%), Builsa South (7%), Binduri (69%), and Pusiga (47%). For outreach services, Pusiga scored zero. For the rest of the districts, availability ranged widely, from Bolgatanga Municipal (16%) to Builsa North District (80%). For a map of the distribution of SDPs offering male condoms, see Appendix B, Figure 13.

Hormonal Injectable Contraceptives

A total of 338 (78%) SDPs offered hormonal injectable contraceptives on a static basis, and 208 (48%) through outreach services. The percentages of those providing outreach hormonal injectable

contraceptives were government (61%), NGOs (50%), and only 10 percent from the private sector. Government providers offered this method on a static (97%) and outreach basis (62%). The government providers constituted 89 percent of static services and 92 percent of SDPs.

Hospitals and maternity homes (100%), CHPS zones (97%), health centres (95%), and clinics (84%) offered this method on a static basis. CHPS zones constituted 70 percent of providers at both static and outreach sites. Only 6 of the 87 pharmacies/LCSs (7%) offered this method.

The district variation in injectable contraceptives ranged from Bawku Municipal (55%) to Builsa North (96%) for static services, and Binduri District (15%) and Builsa North District (92%) for outreach services. Four districts scored more than 90 percent: Builsa North (90%), Bongo (90%), Binduri (92%), and Builsa South (91%). Four districts scored below 80 percent: Nabdam (75%), Garu Tempene (64%), Bolgatanga Municipal (59%), and Bawku Municipal (55%). For a map of the distribution of SDPs offering injectables, see Appendix B, Figure 14.

Implants

Two-thirds of SDPs (290) offered hormonal implant insertion and removal in static clinics, but only 29 (7%) of them during outreach. For static services, 90 percent were in the government sector, 15 percent in the private sector, and a mere 4 percent from NGOs.

Hospitals (100%), health centres (93%), CHPS zones (81%), and clinics (68%) offered implants on a static basis. CHPS zones made up 69 percent and 72 percent of the static and outreach providers, respectively.

The proportion of SDPs offering implant insertion ranged from 43 percent in Bawku West to 82 percent in Bongo District. Pusiga had 80 percent coverage. The four districts that had less than 60 percent coverage were Bolgatanga Municipal (59%), Garu Tempene (55%), Bawku Municipal (45%), and Bawku West (43%). For a map of the distribution of SDPs offering implants, see Appendix B, Figure 15.

IUDs

Only 32 (7%) SDPs offered IUDs. Twenty-eight (88%) were from the government sector, with an equal number from NGOs and the private sector (two each, or 6%).

The IUD service providers constituted one-third of hospitals (5) and 18 percent of health centres (11). Though only 12 CHPS zones (5%) offered IUDs, they were a majority, representing 38 percent of the providers of this method.

IUD insertion and removal were available in only 24 (26%) of the 91 subdistricts in the region. IUDs were unavailable in two districts—Builsa South and Nabdam. Nine (28%) of the IUD providers were in Bolgatanga Municipal. For a map of the distribution of SDPs offering IUDs, see Appendix B, Figure 16.

Cycle Beads for the SDM

Less than one-quarter of providers (105) offered cycle beads on a static basis. They comprised government (95), NGOs (7), and private (3) staff. Only 38 offered cycle beads during outreach: 92 percent (35) from the government and 8 percent (3) from NGOs.

Although hospitals (33%), health centres (40%), and CHPS zones (28%) offered the method, CHPS zones constituted two-thirds of those facilities offering it.

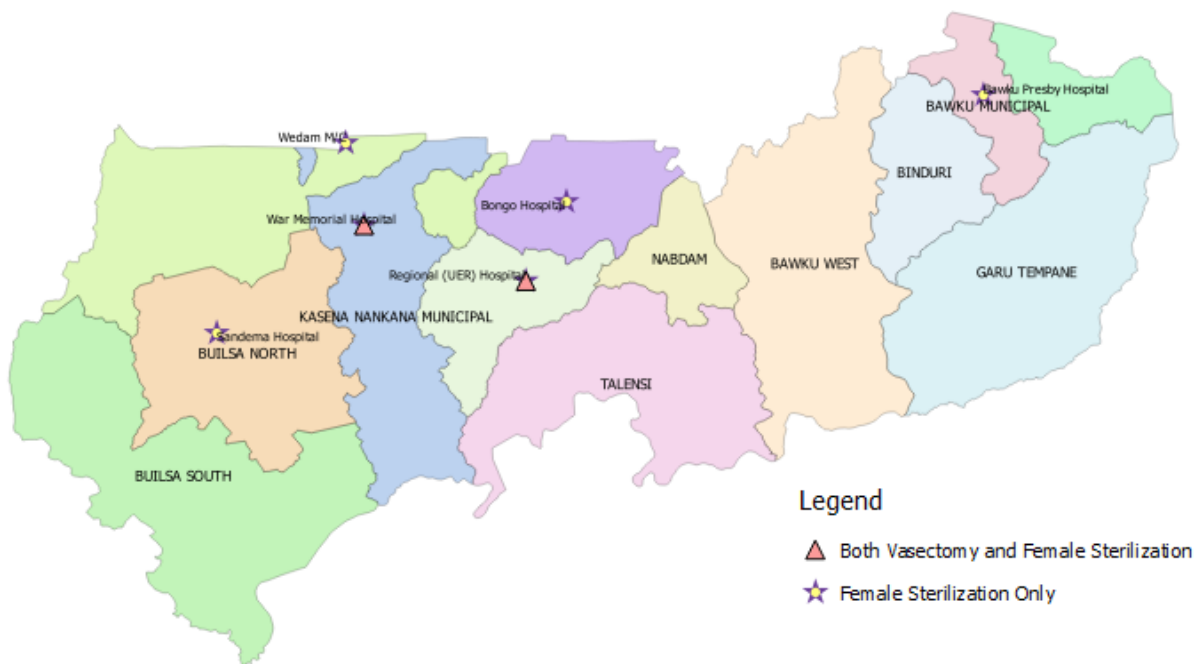
Four districts recorded more than 35 percent coverage: Builsa North (68%), Nabdam (45%), Bongo (39%), and Kassena Nankana West (39%). No provider distributed cycle beads in Binduri; coverage was

low in Garu Tempane (8%), Bawku Municipal (7%), and Pusiga (7%). For a map of the distribution of SDPs offering cycle beads, see Appendix B, Figure 17.

Permanent Contraceptive Methods

Female sterilization and vasectomy services were offered only in the regional and War Memorial hospitals. Female sterilization was offered in six districts, as indicated in the regional map below.

Figure 7. Distribution of service providers offering female sterilization and vasectomy in UER



Natural Family Planning Methods

Less than half of the service providers (44%) offered counselling on natural FP methods during static service provision. The proportion was even lower (29%) during outreach services. Though 79 percent of NGOs and 55 percent of government facilities offered counselling on natural FP methods, the government sector still constituted 90 percent of providers at both static and outreach SDPs. It is worth noting that 11 and 7 of the 13 CHAG providers offered counselling on natural FP methods on a static and outreach basis, respectively.

The proportion of CHPS zones offering counselling on natural FP methods was about half (51%) at static sites and slightly more than one-third (36%) at outreach sites. These sites constituted 67 percent and 71 percent of the natural FP providers, respectively. By district, providers of natural FP counselling ranged from 11 percent in Garu Tempane to 76 percent in Builsa North for static services, and 2 percent in Garu Tempane and 73 percent in Pusiga for outreach. The Pusiga results were unique in that they showed more outreach services (73%) than static points (40%). For a map of the distribution of SDPs offering counselling for natural FP methods, see Appendix B, Figure 18.

Other Family Planning Methods

Only 39 (9%) static SDP providers and 16 (4%) outreach providers offered other methods, such as spermicide (foam tablets or jelly), diaphragms, and female condoms. Eighty percent were from the

government sector and 5 percent were CHPS zones. Binduri and Kassena Nankana West did not offer any of these other FP methods. For a map of the distribution of SDPs offering other FP methods, see Appendix B, Figure 19.

Family Planning Information System

The FP information system is both paper and electronic based, providing partially integrated logistics and service delivery information. This information is presented here under three main headings: primary data generation and management, reporting and use, and gaps and suggestions for remedying them.

Primary Data Generation and Management

The FP information system comprises FP commodity supplies and service delivery data, and reporting through the various levels. The record keeping and reporting tools used are in paper form, electronic form, or both. They comprise service registers commodities' logbooks, tally sheets, and monthly summary reporting forms.

FP registers for each year capture clients' serial and card numbers, date of visit(s), name, address, phone number, age, educational level attained, and marital status. They also capture the FP method chosen, whether the client is a first-time user or continuing the last method used, client's current chosen method, the 12-month calendar, client's source of FP information, and service provider comments. Daily logbooks capture the date, client's serial number, whether the client is a first-time or continuing FP user, type of method chosen, quantity of commodities dispensed, and service provider's remarks and signature. Tally sheets capture the number of clients seen each day, their profile by method provided, and quantity of commodities distributed; they also record the daily summaries. These daily records are then summarized in monthly summary reporting forms and entered into the DHIMS2 database at the SDPs or submitted to the next level up for data entry. At those SDPs where different staff run the FP clinic and the maternity unit, the two data sources are aggregated to obtain the totals. Note: some SDPs forget to add the maternity unit data, thus resulting in underreporting.

All 435 facilities surveyed used record books to capture primary data, but only 63 percent had approved registers, 6 percent had daily tally sheets and 5 percent summary reporting forms (see Table 7). The availability of these record keeping tools varied by district, service provider type, and ownership. The use of registers ranged from as low as around 11 percent in Kassena Nankana Municipal to about 96 percent in Bongo. We found registers in nearly 80 percent of SDPs in the government sector, almost half (50%) of the NGO SDPs, and almost one-fifth of private sector SDPs. The explanation was that there was a shortage of record books nationwide. This shortage was confirmed by the regional-level officers.

Table 7. Number and percentage of SDPs with paper-based FP record books, by type and sector

FP record book	Hospital	H/C	Clinic	CHPS	Pharmacy /LCS	Maternity home	Total	Gov.	NGO	Private	Total
# of SDPs	15	60	25	243	90	2	435	310	14	111	435
FP registers	13 (87%)	46 (8%)	15 (60%)	192 (79%)	4 (4%)	2 (100%)	272 (62%)	245 (78%)	7 (50%)	20 (19%)	272 (63%)
Tally sheets	2 (13%)	4 (7%)	4 (16%)	12 (4%)	3 (3%)	0 (0%)	25 (6%)	19 (6%)	1 (7%)	5 (46%)	25 (6%)

Summary sheets	2 (13%)	4 (7%)	1 (4%)	11 (3%)	2 (2%)	0 (0%)	20 (5%)	18 (6%)	0 (0%)	2 (2%)	20 (5%)
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The availability of electronic registers was seen as an opportunity to migrate from a paper-based to an electronic system. Although this possibility held out bright prospects for some SDPs, there were challenges regarding good Internet connectivity in some geographical locations and the availability of computers or tablets for data capture and transmission, as shown in Tables 8 and 9 below.

Table 8. Availability of Internet connectivity and computers/tablets at SDPs, by service provider type and sector

Indicator	SDP type						Sector			Total
	Hospital	H/C	Clinic	CHPs	Pharmacy /LCS	Maternity home	Govt.	NGO	Private	
# of SDPs	15	60	25	243	90	2	310	14	111	435
Internet connectivity	12 (80%)	47 (78%)	15 (0%)	105 (43%)	46 (51%)	2 (100%)	155 (50%)	9 (64%)	63 (57%)	227 (52%)
Computer or tablet	10 (67%)	47 (78%)	12 (48%)	87 (36%)	17 (19%)	2 (100%)	136 (44%)	9 (64%)	30 (27%)	175 (40%)

Table 9. Number and proportion of FP service providers using the approved records documents, by district

District	No. of SDPs	Registers	As a % of those using registers	Tally sheet	Summary sheet
		No. (%)		No. (%)	No. (%)
Bawku Municipal	31	16 (52%)	6%	0 (0%)	0 (0%)
Bawku West	28	24 (86%)	9%	9 (32%)	11 (39%)
Binduri	13	9 (69%)	3%	0 (0%)	0 (0%)
Bolgatanga Municipal	51	29 (57%)	11%	2 (4%)	1 (2%)
Bongo	44	42 (96%)	15%	0 (0%)	0 (0%)
Builsa North	25	4 (16.0%)	2%	3 (12%)	2 (8%)
Builsa South	21	18 (86%)	7%	1 (5%)	0 (0%)
Garu Tempene	84	55 (66%)	20%	1 (1%)	1 (1%)
Kassena Nankana Municipal	28	3 (11%)	1%	1 (4%)	2 (7%)
Kassena Nankana West	42	37 (88%)	14%	1 (2%)	1 (2%)
Nabdam	20	12 (60%)	4%	4 (20%)	0 (0%)
Pusiga	15	12 (80%)	4%	2 (13%)	1 (67%)
Talensi	33	11 (33%)	4%	1 (30%)	1 (30%)
Total	435	272 (63%)	100%	25 (6%)	20 (5%)

Reporting

More than half (226; 52%) of the providers had reliable Internet connectivity, and 176 (41%) used computers or tablets to manage their data. The SDPs with computers or tablets upload data directly to the DHIMS2. SDPs without these submit their data either to the subdistrict or district for data entry. There

was no established system for FP record keeping and reporting from pharmacies/LCSs and community volunteers.

Several major challenges confronting the FP information system were identified during the SDP interviews and FGDs. Important data useful for decision making were not captured by the reporting system, some service providers were not reporting, and there were not enough FP record books. Other challenges included lack of computers/tablets, poor Internet connectivity in some areas, insufficient and sporadic release of funds to buy credit for Internet connectivity to upload data, lack of monthly written feedback, and lack of regular in-service training for providers. Some of the data gaps centered around social mobilization, education, and male involvement in FP. Inadequate record books pose the danger of incomplete record keeping and reporting. Some of the officers at those SDPs without computers reported using their own computers for data management, but also raised concerns about data confidentiality and safety issues, especially when staff are reposted. District and regional health management teams acknowledged the lack of computers, tablets, and funds to support information management.

On the issue of feedback from the districts, the CHPS zones in particular expressed dissatisfaction with a lack of regular written feedback on their service statistics, yet their superiors were quick to admonish them for data entry errors. One FDG participant expressed his frustration as follows:

They are only interested in the data. They do not care about how you get the data and submit. Sometimes we are not provided with funds to buy Internet credits for uploading the data.

District and regional health management teams explained that they gave feedback through the quarterly review meetings they held with service providers.

District-Level Analysis

This part of the report presents a synopsis, by district and subdistrict, of the analysis of FP service providers, FP services, the human resources for FP planning and the FP information system, and the sectors involved in FP service delivery. The detailed analyses can be found in the following appendices:

1. Appendix C. District Maps of SDPs
2. Appendix D. Tables of FP Providers
 - Table 4. Service providers in the UER's subdistricts, by type
 - Table 5. Distribution of nonreligious health NGOs and development partners, by district
 - Table 6. Health NGOs and the geographic and health service areas in which they operate
 - Table 7. Number of SDPs with different types of personnel in their FP delivery teams, and those who provided FP training for them within the three years before the survey, by district
3. Appendix E. Tables of Distribution of FP Services
 - Table 8. Number and proportion of SDPs offering different FP services on a static basis, by subdistrict
 - Table 9. Number and proportion of SDPs offering different FP methods at static and outreach points, by district
 - Table 10. Proportion of demarcated CHPS zones offering FP services, by district

Bawku Municipal

Bawku Municipal has 7 subdistricts with 25 demarcated CHPS zones, of which 15 (60%) were reported as functional but only six (24%) were effectively functional—that is, delivering services at the period of the survey.

This district has 31 SDPs, consisting of hospitals (3), health centres (6), CHPS (6), pharmacies (4), LCSs (11), and 1 maternity home. They comprise government (10), private (20), and faith-based (1) facilities (the CHAG hospital, which is the district hospital). This district recorded the highest proportion of private sector providers (65%) in the region. These providers consist of hospitals (2), health centres (2), pharmacies/LCSs (15), and 1 maternity home. Data could be collected from only six of the nine CHPS zones reporting through the DHIMS2, which could partially explain the relatively higher proportion of private sector facilities. All the hospitals, two health centres, four pharmacies, 11 LCSs, and the maternity home were located in the three urban subdistricts of Bawku Township, representing 77 percent of all SDPs in the district. MSI operates the only NGO in Bawku Municipal, supporting outreach programs for long-acting FP services. It works in 11 SDPs in six subdistricts. For a map showing the distribution of service providers, by type, in Bawku Municipal, see Appendix C, Figure 20.

Regarding human resources, 14 (or 45%) of the FP teams included midwives, with 12 having received training within the three years preceding the survey; 12 (39%) had CHOs/CHNs with all having received training; 9 (or 29%) had LCSs/attendants, with 5 having received training; and 6 (19%) had pharmacists/technicians, with four having received training. Although one team had a medical practitioner who had received training, that person did not offer FP services.

The SDPs offering OCPs, male condoms, and hormonal injectables were 77 percent, 68 percent, and 55 percent, respectively. This district had the lowest proportion of SDPs offering FP counselling (48%). Forty-five percent of SDPs provided implants, 10 percent provided IUD insertions, 1 SDP offered female sterilization, and none performed vasectomies. This relatively low performance could have been because of the higher proportion of private sector actors, which tend to focus less on FP services.

The main source of hormonal injectables and implants was GHS. However, GHS provided only 32 percent of OCPs and male condoms, whereas pharmaceutical companies provided 39 percent of OCPs and 52 percent of male condoms.

Fifty-two percent of SDPs had FP registers; none had tally and summary sheets. Twenty-one (68%) of the service providers reported through the DHIMS2. Electronic record keeping was not widespread in the district; 55 percent and 52 percent of the SDPs had Internet connectivity and computers/tablets, respectively.

Bawku West District

This district has eight subdistricts and 32 demarcated CHPS zones, of which 21 (66%) were functional but only 14 (44%) provided delivery services at the time of the survey.

There were 28 SDPs—23 government and five private—comprising clinics (2), pharmacies (2) and 1 LCS. The government providers were the district hospital, health centres (4), clinics (4), and CHPS zones (14). The district hospital, pharmacies, and LCS were in Zebilla South subdistrict. Thirteen, or nearly half of the SDPs, were in the two subdistricts in the Zebilla Township. There were two subdistricts (Boya/Gbantongo and Tango/Timonen), with one CHPS zone each. World Vision Ghana, Anglican Diocesan Development and Relief Organization (ADDRO), and Oxfam/Participatory Action for Rural Development Alternatives (PARDA) were the three NGOs supporting various aspects of maternal and

child health in selected communities in the district. For a map showing the distribution of service providers, by type, in Bawku West, see Appendix C, Figure 21.

Almost all SDPs offered FP counselling (93%), followed by OCPs (89%), male condoms (86%), injectables (82%), and implants (43%). Only one SDP offered IUD insertion; none offered female sterilization or vasectomy services, though one SDP provided outreach services (i.e., education) on female sterilization. The SDPs in this district had relatively high outreach services for injectables (61%), OCPs (60.7%), and male condoms (46%).

For human resources, three teams included midwives, all of whom had received FP training in the three years before the survey. Twenty-four teams (86%) had CHOs/CHNs, but only five received training within that period. Three teams included chemical sellers/attendants; one team each included a pharmacy technician and volunteers/community-based agents (CBAs).

The main source of FP commodities for most service providers was GHS, except male condoms for the pharmacies/LCSs, for which pharmaceutical companies were the main source. Most of the commodities were purchased and sold to clients. There were high stockouts for injectables (72%) and implants (14%).

Regarding FP record keeping and reporting, most SDPs (86%) had FP registers, but less than one-third had tally sheets (32%) and summary sheets (39%) much higher than in most districts. The proportion of SDPs with Internet connectivity was 68 percent, compared to only 11 percent having computers/tablets.

Binduri District

This district has six subdistricts and 23 demarcated CHPS zones, of which 17 (74%) were functional; however, only 8 (35%) were delivering services at the time of the survey.

Binduri had the lowest number of SDPs (13), comprising CHPS zones (8), health centres (2), and clinics (3), one of which was the only private facility in the district. There was no hospital in the district. Three subdistricts (Aniisi/Kukpariga, Atuba/Nafkolga, and Zawse/Bansi) had neither a clinic nor a health centre. For a map showing the distribution of service providers, by type, in Binduri, see Appendix C, Figure 22.

All 12 government sector service providers offered FP counselling and injectables. Most offered implants (77%), OCPs (69%), and male condoms (69%). The Zawse CHPS zone was the only facility providing IUD insertions. Female sterilization and vasectomy services were not available in Binduri. Outreach was rarely conducted in the district, with only six, four, two, and one SDPs offering male condoms, OCPs, injectables, and counselling outreach services, respectively.

Regarding human resources, only the Binduri health centre had two medical practitioners on the FP team, but they had not received any training on FP in the three years before the survey. Seven (or 54%) of the teams included midwives, although four had received training; 11 (or 85%) included CHOs/CHNs, with 10 trained; and five (or 35%) had volunteers/CBAs with none trained. The district had three NGOs (Maternal Health Social Accountability Project [MEHAP], Ghana Red Cross Society [GRCS], and Afrikids) supporting maternal and child health activities in selected communities.

GHS was the main supplier of FP commodities. SDPs purchased the supplies from GHS and charged the clients. In the seven days before the survey, 31 percent of the SDPs had stockouts for OCPs, 23 percent for male condoms, 15 percent for injectables, and 8 percent for implants.

Regarding FP record keeping, nine of the facilities had registers but none had tally or summary sheets. All the government sector providers reported through the DHIMS2, but the one private clinic in the district did not do so. Thirty-eight percent of the SDPs had both Internet connectivity and computers/tablets.

Bolgatanga Municipal

The municipality has nine subdistricts and 37 demarcated CHPS zones, with 22 being functional and reporting through the DHIMS2. Thirty-nine facilities reported through the DHIMS2.

The district had 51 SDPs run by government (26), private providers (22), and NGOs (3). The provider types were hospitals (3), health centres (7), clinics (7), functional CHPS zones (16), LCSs (14), pharmacies (5), and 1 maternity home. The three hospitals were the regional hospital, Afrikids Medical Centre, an NGO-supported hospital, and a private hospital. All were in the Plaza subdistrict. The two subdistricts (Bolgatanga Central and Plaza) that constitute Bolgatanga Township had 23 (45%) of all SDPs in the district. The rest of the subdistricts had at least a clinic or health centre in addition to CHPS zones. MSI supports selected SDPs in the provision of long-term FP methods in the municipal. For a map showing the distribution of service providers, by type, in Bolgatanga Municipal, see Appendix C, Figure 23.

Regarding human resources, two teams had medical practitioners, with one trained in FP; 23 (or 45%) midwives, with 21 trained; 26 (51%) CHOs/CHNs, with 23 trained; nine (18%) pharmacists/technicians, with five trained; and 15 (29%) chemical sellers/attendants, with 10 trained. Two teams had volunteers/CBAs; both teams had received training.

The percentages of SDPs offering various FP services were as follows: OCPs (90%), male condoms (84%), FP counselling (73%), injectables (59%), implants (59%), and IUDs (18%). The regional hospital was the only facility offering both female sterilization and vasectomy services. The SDPs offered the following outreach services: FP counselling (45%), injectables (29%), natural FP methods (26%), OCPs (22%), male condoms (16%), and other FP methods (16%). The five subdistricts that had no SDP providing IUD services were Bolgatanga Central, Bolgatanga South, Sherigu, Sumbrungu, and Zuarungu Moshie.

GHS mainly provided FP commodities, but pharmaceutical companies contributed significantly regarding male condoms and OCPs. The NGO sector also contributed to the provision of IUDs and implants. There were high stockouts for OCPs (67%) and implants (20%).

Regarding FP record keeping, 57 percent of SDPs had FP registers, but only four had summary sheets and one had tally sheets. Internet connectivity and availability of technology was relatively high, with 71 percent of SDPs connected to the Internet and 69 percent using computers or tablets.

Bongo District

This district has six subdistricts and 40 demarcated CHPS zones, of which 36 (90%) were functional; 35 reported through the DHIMS2. The total number of facilities reporting to the DHIMS2 was 43 (98%).

The 44 recorded service providers comprised government facilities (41), LCSs, (2), and 1 CHAG health centre. The government sector providers were a district hospital, four health centres, a clinic, and 35 CHPS zones. The SDPs were fairly evenly distributed among the subdistricts, ranging from six in Valley zone to 10 in Bongo Central, where the two LCSs were also located. The district also had the largest numbers of NGOs (6) supporting maternal and child health. They were MSI, Mission Hope, Water Aid, Youth Harvest, GRCS, and Afrikids. For a map showing the distribution of service providers, by type, in Bongo, see Appendix C, Figure 24.

The percentages of SDPs offering various FP services were as follows: injectables (96%), male condoms (93%), OCPs (84%), FP counselling (84%), implants (82%), natural methods (64%), cycle beads (39%), and IUDs (7%). The district hospital offered female sterilization on an outreach basis to three other

SDPs. The district had high coverage of outreach services, as follows: FP counselling (86%), injectables (73%), male condoms (71%), OCPs (59%), and implants (27%).

Regarding human resources, only one SDP had a medical practitioner on its team who had received FP training in the three-year period before the survey. Nineteen SDPs (43%) had midwives on their FP delivery teams, and all had received training. Among the 44 SDPs, 41 (93%) had CHOs/CHNs on their FP delivery teams; 38 (93%) had received training. Three out of the five SDPs that had volunteers/CBAs had received such training.

Most of the FP commodities were offered free to clients. The sources were GHS and some NGOs. Stockout rates were high: IUDs (68%), male condoms (50%), injectables (38%), OCPs (36%), and implants (27%).

Regarding FP record keeping, all the government sector providers had FP registers, but none had sheets for tallying and summaries. The proportion of SDPs with Internet connectivity was 39 percent, compared to 70 percent with computers or tablets.

Builsa North District

This district has six subdistricts and 31 demarcated CHPS zones, of which 20 were functional. Although all 19 facilities were reporting, only 15 reported separately through DHIMS2.

The district had 25 SDPs—22 in the government sector and three from CHAG. The government service providers comprised one district hospital, one health centre, one clinic, and 19 CHS zones. No private sector SDPs were recorded; the two LCSs in Sandema town, the district capital, refused to participate in the survey. The SDPs in the subdistricts ranged from three to six. The three NGOs supporting community-based maternal and child health activities were ADDRO, MEHAP, and Tuma-Kavi. For a map showing the distribution of service providers, by type, in Builsa North, see Appendix C, Figure 25.

The percentages of SDPs offering various FP methods were as follows: 96 percent for FP counselling and injectables, 92 percent for OCPs and male condoms, and 76 percent for implants. There were only two SDPs providing IUD insertion on a static and outreach basis. The district hospital in Sandema offered female sterilization and provided female sterilization outreach services to one facility. No SDPs offered vasectomy services; one facility offered vasectomy outreach services. A high proportion of SDPs offered various outreach services: FP counselling (92%) injectables (92%), OCPs (84%), male condoms (80%), counselling on natural FP methods (72%), cycle beads (44%), and implants (16%).

Human resources for FP services were lacking, with only the district hospital having a medical practitioner on its FP team; however, he had not received training in the three years before the survey. Thirteen (or 52%) of the teams included midwives, with eight having received training; 24 (9%) had CHOs/CHNs, with 20 receiving training; and two volunteers/CBA teams receiving no training.

GHS was the primary source of FP commodities. They were dispensed free to clients because the SDPs had not paid for them. There were high stockout rates, however—88 percent for the injectables and OCPs.

FP record books were scarce. Only four SDPs had registers, three had tally sheets, and two had summary sheets. The percentages of SDPs with Internet connectivity and the availability of computers or tablets were 40 percent and 32 percent, respectively.

Builsa South District

This district has six subdistricts and 25 demarcated CHPS zones, of which 14 (56%) were functional.

The survey recorded 21 SDPs comprising three health centres and 14 CHPS zones from the government sector, and four LCSs from the private sector. The CHPS zones constituted two-thirds of providers. Three subdistricts (Gbedema, Uwasi, and Wiesi) had CHPS zones only, and all the LCSs were located in Fumbisi, the district capital. Afrikids supports the district in community mobilization for maternal and child health. For a map showing the distribution of service providers, by type, in Builsa South, see Appendix C, Figure 26.

Regarding FP service provision, the SDPs offered the following: FP counselling (100%), injectables (91%), OCPs (86%), male condoms (76%), implants (76%), and counselling on natural FP methods (48%). Most (81%) of the SDPs conducted outreach services for FP counselling, whereas fewer than half did outreach for the injectable and natural FP methods (48% for each method), and OCPs (33%). No IUD insertion, female sterilization, or vasectomy services were available in the district.

Seventeen (81%) of the SDPs had midwives and eight (38%) had CHOs/CHNs on their FP delivery teams. None had a medical practitioner. Four (19%) teams had LCSs/attendants, and three (14%) had volunteers/CBAs. All the teams with CHOs/CHNs had received training in FP in the three years before the survey, but only five of the teams with midwives had received such training within that period.

The SDPs sourced FP commodities mainly from GHS, though NGOs and pharmaceutical companies supplied a significant number of SDPs with some commodities. About two-thirds of the supplies were free to the SDPs and subsequently dispensed free to clients. Clients were charged for those FP supplies that the SDPs did not receive for free. Four FP methods were out of stock at the various SDPs in the seven days before the survey: implants (12%), IUDs (13%), OCPs (18%), and injectables (100%).

Regarding record keeping, 86 percent of the SDPs had FP registers, only one had tally sheets, and none had summary sheets. All the government sector providers reported through the DHIMS2, but none of the LCSs did so. Fewer than half (48%) of the SDPs had Internet connectivity, and even fewer (29%) had computers or tablets.

Garu Tempene District

This district has nine subdistricts and 53 demarcated CHPS zones, of which 43 (85%) were functional.

The 84 recorded SDPs in the district comprised seven health centres and 42 CHPS zones from the government sector; one CHAG health centre from the NGO sector; and one hospital, four health centres, and 29 LCSs from the private sector. Half of the SDPs were CHPS zones, and more than one-third (35%) consisted of LCSs, located in each subdistrict. Twenty percent of the SDPs in the district were in Garu, the district capital, including 17 SDPs and the private hospital. For a map showing the distribution of service providers, by type, in Garu Tempene, see Appendix C, Figure 27.

Regarding human resources for FP, one SDP team had a medical practitioner, and he had received FP training in the three years before the survey. Nineteen (23%) of the teams had midwives, with seven having received training; 54 (or 4%) had CHOs/CHNs, with 25 receiving training; 23 (27%) had LCSs/attendants, with six receiving training; and three had pharmacy technicians, with all having received training. None of the teams had volunteers/CBAs.

The percentages of SDPs offering various FP services were as follows: male condoms (90%), OCPs (71%), injectables (64%), FP counselling (63%), and implants (55%). Nine SDPs offered counselling on natural FP methods, and seven SDPs distributed cycle beads for the SDM. Only one SDP provided IUD

services; one SDP offered outreach services for female sterilization. No vasectomy services were available in the district.

The FP service delivery teams at the SPDs included a medical practitioner, midwives, CHOs/CHNs, pharmacy technicians, and chemical store attendants. None of the teams had a volunteer/CBA. The one team with a medical practitioner and all three teams with pharmacy technicians received FP training in the three years before the survey. Seven of the 19 midwives, 25 of the CHOs/CHNs, and six of the chemical store attendants had received FP training in that period.

GHS was the main supplier of FP commodities; pharmaceutical companies and NGOs were significant suppliers for OCPs and male condoms, however. Stockouts occurring in the seven days before the survey included injectables (65%), male condoms (15%), OCPs (11%), and implants (8%). Only one SDP had FP registers and tally sheets; none had summary sheets. Fifty-seven (57%) of SDPs reported through the DHIMS2. More than half (57%) of the SDPs had Internet connectivity, compared with only 8 percent having computers or tablets.

Kassena Nankana Municipal

This district has seven subdistricts and 33 demarcated CHPS zones, of which 24 (72.7%) were functional. Among the 28 service providers, 23 were government affiliated: 20 CHPS zones, one hospital, and two health centres. The district had a CHAG clinic and four LCSs. The LCSs were all located in Navrongo Central subdistrict. Five of the subdistricts had no higher-level health facility than a CHPS zone. The GRCS supported the district in mobilizing communities for maternal and child health activities. For a map showing the distribution of service providers, by type, in Kassena Nankana Municipal, see Appendix C, Figure 28.

For the human resource teams for FP, only one SDP had a medical practitioner; he had not received FP training in the three years before the survey. Nineteen (68%) had midwives, with eight receiving training; and 24 (86%) had CHOs/CHNs, with 17 receiving training. Three pharmacy technicians, three chemical sellers/attendants, and six volunteer/CBAs teams received no FP training during that period.

The facilities offered male condoms (100%), OCPs (96%), FP counselling (89%), injectables (86%), and implant insertion (79%). Two SDPs offered IUDs, one offered female sterilization, and none offered vasectomy services.

The district hospital had two medical practitioners on its FP service delivery team, but they had not received any FP training in the three years before the survey. Nineteen SDPs had midwives and 24 SDPs had CHOs/CHNs on their teams, but only eight of the midwives and 17 of the CHOs/CHNs had received FP training. Six (21%) of the teams had volunteers/CBAs and none was trained.

The SDPS purchased their FP commodities from the RMS, and their clients then paid for them. Commodity stockouts were high in the week before the survey, as follows: hormonal injectables (68%), OCPs (29%), implants (28%), and male condoms (18%).

Three SDPs had FP registers, two had the summary sheets, and one had tally sheets. Twenty of the CHPS zones reported separately in the DHIMS2. The LCSs did not report. Sixty-eight percent of SDPs had Internet connectivity; only 25 percent had computers or tablets.

Kassena Nankana West District

This district has nine subdistricts and 35 demarcated CHPS zones, of which 31 (88%) were functional. The 44 service providers comprised CHPS zones (29), health centres (7), one clinic, one private hospital,

and four LCSs. Twelve of the providers, including all the LCSs, were in Paga Central subdistrict. Catholic Relief Services (CRS) supported the district in some maternal and child health activities. For a map showing the distribution of service providers, by type, in Kassena Nankana West, see Appendix C, Figure 29.

Of the FP teams, 24 (8%) had CHOs/CHNs, 19 (68%) had midwives, and three each had pharmacy technicians and chemical sellers/attendants. All these teams received FP training in the three years before the survey. The two volunteer/CBAs teams did not receive such training in that period.

FP counselling and hormonal injectables were offered at 88 percent of the SDPs, along with OCPs (81%), male condoms (79%), and implant insertions (79%). Three SDPs provided IUD insertion, one provided female sterilization services, and none provided vasectomy services. Three subdistricts (Katiu-Nakong Mirigu-Nabango, and Navio) had CHPS zones only.

Thirty-six (86%) of SDPs had CHOs/CHNs as part of their FP teams; eight had midwives. There were only two teams with volunteers/CBAs; none had a medical practitioner.

Most SDPs obtained their FP commodities from the RMS. LCSs, however, purchased male condoms and OCPs from pharmaceutical companies, and subsequently charged clients.

Stockout rates were generally higher than in most districts in the week before the survey: injectables (95%), OCPs (29%), and male condoms (24%).

Eighty-eight percent of the SDPs had FP registers, but only one location had tally and summary sheets. All other providers, apart from the pharmacies/LCSs, reported through the DHIMS2. About half (51%) of the SDPs had Internet connectivity, and 71 percent had computers or tablets.

Nabdram District

This district is the smallest in population, with five subdistricts and 20 demarcated CHPS zones, of which 13 (5%) were functional. The 20 SDPs comprised CHPS (13), clinics (2), health centres (2), and LCSs (3). There was no hospital in the district; two subdistricts (Sakote and Zanlerigu) had no SDP higher than a CHPS zone. The district had one private health centre and one private clinic. CRS supported the area in organizing community emergency transport systems. For a map showing the distribution of service providers, by type, in Nabdram, see Appendix C, Figure 30.

Among FP teams, 16 had CHOs/CHNs and nine had midwives. All the teams were given FP training in the three years before the survey. Three others had chemical sellers/attendants and had not received such training.

The SDPs offered male condoms (95%), OCPs (90%), FP counselling (85%), injectables (75%), implant insertion (70%), and counselling on natural FP methods (70%). There were no female sterilization or IUD services available, but the district did have outreach for vasectomy services. The SDPs offered the following outreach services: FP counselling (65%), injectables (45%), male condoms (45%), and OCPs (35%).

Twelve of the SDPs had FP registers, six had tally sheets, and none had summary sheets. All providers except LCSs reported their service data in the DHIMS2, either through the subdistrict (14), district (2), or region (1). Only five percent of the SDPs had Internet connectivity, compared to 35 percent having computers or tablets.

Pusiga District

This district has five subdistricts and 20 demarcated CHPS zones, of which 11 (55%) were functional; only seven reported separately through the DHIMS2.

The 15 SDPs comprised two private hospitals, three LCSs (all located at Pusiga Central subdistrict), two government health centres, seven CHPS zones, and one CHAG health centre. Two subdistricts had no higher-level SDP than a functional CHPS zone. Three NGOs (MSI, MEHAP, and the Rural Water and Children Development Agency) supported maternal and child health activities in some communities. For a map showing the distribution of service providers, by type, in Pusiga, see Appendix C, Figure 31.

Ten (40%) of SDPs had midwives and 11 had CHOs/CHNs on the teams providing FP services. All had received training on FP within the last three years. There was no medical practitioner or volunteer/CBA on any of the teams.

The SDPs offered OCPs (87%), FP counselling (80%), hormonal injectables (80%), implants (80%), male condoms (47%), IUDs (40%), counselling on natural FP methods (40%), and other methods (33%). Only one SDP offered cycle beads for SDM. The district had no female sterilization or vasectomy services available.

The SDPs obtained most of their FP commodities from the GHS and then charged their clients, except for IUDs, which they provided for free. Stockouts were relatively low, as follows: OCPs (13%), male condoms (13%), and hormonal injectables (13%); the exceptions were implants (40%) and IUDs (60%).

Twelve of the 15 SDPs had FP registers; only two had tally sheets and one had summary sheets. Apart from the LCSs, the other service providers reported to the district through the DHIMS2.

All the SDPs had Internet connectivity, but only about half (53%) had computers or tablets.

Talensi District

The district has eight health subdistricts and 25 demarcated CHPS zones, of which 20 (80%) were functional. There were 33 FP SDPs, administered as follows: government (28), CHAG (2), and private LCSs (4). There was one district hospital, one clinic, seven health centres, and 20 CHPS zones. The CHPS zones constituted 61 percent of SDPs. Five subdistricts had at least one health centre, one had a clinic, and the other two had only functional CHPS zones as their highest-level SDP. Five NGOs supported maternal and child health activities in the district. They were CRS, Flash, PARDA, the Institute of Social Research and Development Ghana (ISRAD), and World Vision Ghana. For a map showing the distribution of service providers, by type, in Talensi, see Appendix C, Figure 32.

Twenty-four (73%) of the SDPs had CHOs/CHNs on their teams, 10 had midwives, 10 had volunteers/CBAs, and none had a medical practitioner. All the CHOs/CHNs had received training on FP within the last three years, six out of the 10 teams with midwives received such training, and only one team provided FP training to volunteers.

The SDPs offered male condoms (100%), OCPs (97%), FP counselling (94%), implants (89%), hormonal injectables (88%), and counselling on natural FP methods (64%). The only IUD provider was in Kwalugu subdistrict, but that facility did not have IUDs in stock. Female sterilization and vasectomy services were not available in the district.

The main source of commodities for the government and NGOs was the GHS. The four LCSs obtained contraceptives from pharmaceutical companies. Stockouts of FP commodities were not a major problem.

Eleven facilities had FP registers, but only one had tally and summary sheets. Twenty-eight of the SDPs reported to the district through the DHIMS2. Only the LCSs did not report. Eighteen percent of SDPs had Internet connectivity, and 36 percent had computers or tablets.

DISCUSSION

Mapping FP Services and Service Delivery Points

The mapping showed the SDPs to be multisectoral, including several provider types: hospitals, health centres, clinics, CHPS zones (CHOs/CHNs), maternity homes, pharmacies, and LCSs. They were widely distributed by provider type and across the government, NGO, and private sectors, with higher concentrations in urban areas, especially the district capitals. For instance, three districts—Binduri, Builsa South, and Nabdam—had no hospitals; two others—Kassena Nankana West and Pusiga—had only private hospitals more focused on curative care than public health services such as FP. Although national health policy dictates that each subdistrict should have at least one health centre or clinic, the findings reveal that more than a third (34%) of the 91 subdistricts had neither.

The large numbers of CHPS zones make the government the major provider of FP services. The CHPS policy adopted in 2000 was aimed at bringing primary healthcare services, including FP, closer to the population. At the time of the survey, only 62 percent of the 399 demarcated CHPS zones were functional, with wide variation by district, from 56 percent in Builsa South to 90 percent in Bongo. Apart from permanent methods and IUD insertion, which were offered by medical practitioners and midwives, the CHPS zones were consistently the leading SDPs in offering FP methods, constituting more than half of all SDPs. There is still potential for the CHPS zones to increase their contribution if more of the demarcated zones become functional.

The private sector comprised about a quarter of the SDPs regionally but was more prominent in some districts, like Bawku Municipal (65%), Bolgatanga Municipal (45%), Garu Tempane (39%), and Pusiga (33%). Consequently, it is not possible to provide effective access to FP services in these four areas without engaging the private sector in program planning and implementation. This sector, however, seeks to provide health services that offer attractive profit margins, which FP services do not show. It is a disincentive for the private sector to actively pursue the FP market when some government sector providers offer FP services free to clients. In such a situation, without active engagement and adequate support from the regional and district health administrations, the private sector will not be motivated to expand its package of services to contribute to FP program performance.

In the NGO sector, CHAG was the main service provider because of the SDP locations, though it had comparatively few sites. For example, Bawku Presbyterian Hospital, a CHAG facility, was the only site offering female sterilization in the eastern part of the region, covering five districts and more than one-third of the regional population. Most NGOs were involved in social mobilization and education on maternal and child health issues, with only a few working specifically in FP. NGOs focus on those aspects of health in which their sponsors are interested; they might become more interested if properly engaged and supported. They could play a critical role in demand creation and addressing misconceptions and fears about some FP methods.

The national FP policy standards and guidelines define the categories of health personnel authorized to provide each FP method at different levels of care. At the community level, these personnel included trained community volunteers or CBAs, LCSs, pharmacists/technicians, and CHOs/CHNs. At the subdistrict level, midwives, nurses, and physician assistants provided FP services in health centres, clinics, and maternity homes, and medical practitioners did so in some urban centres. These medical specialists also provided FP services at the district and higher levels.

Most SDPs included CHOs/CHNs, followed by midwives. Although all 15 hospitals had medical practitioners on staff, only six had medical practitioners on their FP teams, raising questions of prioritization of FP, lack of FP training, and lack of equipment. Similar questions are raised by the lack of midwives on some of the FP teams at health centres and clinics. The 2016 annual report of the region

reported 1,440 active volunteers in the health sector in the region; based on our survey, however, only 36 were involved in FP activities.

Availability of FP commodities at SDPs is an important factor in access to FP services. This access depends very much on the supply chain management system. Though SDPs in the UER were using the scheduled delivery approach, it appeared to present some difficulties as there were high levels of reported stockouts for many commodities, resulting in some providers seeking alternative solutions, such as borrowing from nearby SDPs or asking clients to purchase contraceptives from pharmacies. However, not all commodities, such as implants, IUDs, and some of the hormonal injectable contraceptives, are routinely sold in pharmacies. FP commodities must be available at the point of service delivery to be accessible.

There was a big gap between the potential for FP provision and actual availability of different types of FP services in the region's SDPs. For example, all SDPs should have been offering condoms, OCPs, and FP counselling, at a minimum; however, coverage for these services were 86 percent, 84 percent, and 80 percent, respectively. The package of FP services offered varied widely, depending on the type and ownership of SDP, after taking into consideration the level of care permitted by policy. Government facilities tended to provide a wider menu of FP options than NGO facilities and the private sector. Still, 13 percent, 16 percent, and 6 percent of government sector providers were not offering male condoms, OCPs, and FP counselling, respectively, at their static SDPs. Similarly, 15 percent of the government sector providers did not offer hormonal injectable or implants.

The organization of outreach programs was a strategy to increase access to FP services, particularly in areas without static SDPs, with a focus on services such as FP counselling and dispensing short-term methods. Overall, 58 percent of SDPs had organized outreach services, with the majority in the government (75%) and NGO (71%) sectors, and only 8 percent in the private sector. This distribution is understandable because the private sector usually does not cover a defined area, and is not motivated to do outreach work, which represents additional cost. There is, however, a need to understand the huge variations between districts—between Binduri (8%), Bawku Municipal (19%), Bongo (86%), and Builsa North (92%), for example. According to the CHPS policy, CHPS zones should focus more on outreach programs, including home visits; strangely, however, only 1 out of 8 CHPS zones in Binduri performed outreach services, even though health resources there are scarce; the district had the fewest number of SDPs (13) in the UER. Therefore, outreach health services are especially important in reaching many communities.

Access to IUDs was even more restricted, with only 32 SDPs in just 24 of the 91 subdistricts providing them. Neither Builsa South nor Nabdam had an IUD provider. Only one of the seven private hospitals in the UER—Wedam Medical Center in Kassena Nankana West—offered IUDs. Two government hospitals—in Tongo and Zebilla—did not offer them. The 60 health centres and most of the 25 clinics had midwives trained on IUDs and provided them with the necessary logistics to expand access to this method.

Though reportedly client preferences were low for some FP methods, such as IUDs, female condoms, and female sterilization and vasectomy services, this low demand could also be the result of inadequate counselling on these methods, especially if SDP staff knew they could not provide these methods.

FP Information System

Community-based FP information was partially integrated into the national DHIMS2 database, which captures government and some private-sector FP service data. However, there is no system for capturing data from private pharmacies and LCSs. Community mobilization and FP education data also not were

captured by the system. Complete information from all sectors is required for effective programming, service delivery, and performance assessment. These issues have been identified, and modalities are being worked out to address gaps in data integration in the existing system.

Basic data on clients, FP commodities dispensed, and inventories of stock are required from pharmacies and LCSs and could be collected using a simple format. Information obtained from community mobilization and education activities on activities, target audiences, and topics covered was also identified as important.

At the SDPs, the information system was mostly paper based but some of them were using computers and tablets to capture information and upload the summary data into the DHIMS2 platform or submit data to the next higher level for entry. The shortage of paper-based data collection tools was of great concern to providers and an important factor in the incomplete capture of FP information. This issue should be addressed urgently. Lack of availability of computers and tablets, and poor Internet connectivity are challenges that need attention at the national level. Some of these challenges could be ameliorated by integrating health programs for resource sharing and efficiency.

Although the country is moving in this direction, the process should be sped up. The e-tracker electronic system currently being piloted in some parts of the country offers a great opportunity for integrating and improving the entire system. It has the potential to provide complete information to guide the implementation of free FP services, which are part of the National Health Insurance benefits package and other national programs. To do so requires incentives for the private sector to buy in, as it involves costs in both equipment and expertise.

Although logistics information is included in the summaries entered into the DHIMS2 platform, data from the RMS, the main provider of FP commodities, is not linked to it. Hence, although the region is implementing a scheduled distribution system that receives requisitions from facilities, collating and submitting the requisitions is so time consuming that the system actually contributes to frequent stockouts. A “last mile” distribution system is being implemented at the national level, which involves suppliers sending commodities directly to health facilities. The two systems must be studied to see which one is more appropriate for adoption. Meanwhile, an immediate investigation is required to address bottlenecks in the current system, understand the high stockouts for some commodities, and redress the problem.

RECOMMENDATIONS

This study revealed the need to increase access to short- and long-term FP methods across the region and strengthen the information system. The following recommendations can improve FP services across the region. The study participants made many of these suggestions through the interviews and FGDs.

No measurable indicators exist for community mobilization, FP education, and male involvement, which are priorities in the country's FP strategy (Family Planning 2020 Ghana's Commitment, Ghana-Family-Planning-CIP [2015]). We recommend including key indicators for community mobilization, community education, and male engagement in FP to the DHISM2, so these activities can be better monitored and evaluated.

There is an immediate need to address frequent stockouts of FP commodities at SDPs by improving the logistics management system. A reliable supply of various commodities will improve access to FP services and promote client and health personnel satisfaction. This improvement will require reviewing the current system in the UER and comparing it with the "last mile" delivery approach being implemented in other regions.

Some SDPs do not offer the full complement of FP services they are expected to provide, as spelled out in the national FP policy. The factors underlying this issue should be addressed, including a lack of trained personnel on FP teams; trained personnel being assigned to other services; a poor logistics management system; and a lack of basic infrastructure, such as running water, waste disposal, and private examination rooms. Each hospital should have at least one medical practitioner trained on female sterilization and vasectomy. SDPs with midwives that currently do not offer IUDs or implants should be upgraded (e.g., private examination rooms built, a safe waste disposal system instituted) and include stocks of long-acting reversible contraceptives so they can expand their services to offer these methods. In the long term, the FP program needs to explore the possibility of task shifting IUD insertions to the CHPS zones, as has happened for implant insertion.

Efforts should be made to make the CHPS in all demarcated CHPS zones functional by providing the necessary infrastructure, equipment, commodities, and trained personnel to expand access to short- and long-term FP methods at the community level. These efforts will require national-level prioritization of CHPS development, which has proven to be a cost-effective strategy for increasing access to primary healthcare services, including FP. By improving in-service training, monitoring, and supervision, CHPS has great potential to expand FP access tremendously.

Although the government sector has the potential to expand FP service delivery, the private and NGO sectors play a significant part in certain localities and in the delivery of certain methods. Hence, district and regional management teams must actively engage these sectors on a continual basis in program planning and implementation.

Improving demand for FP services must be prioritized using information, education, and communication strategies. The CHOs should prioritize FP during the regular community meetings they hold to discuss health matters of concern. Targeted meetings and FGDs should also be organized for specific groups, such as traditional and religious leaders, adolescents, males, and elderly women. These approaches should be complemented with mass media approaches, especially discussions on local FM radio stations. All these efforts will require a multisector approach, especially through engaging the NGOs, relevant government sectors, and the media.

Though significant integration of the FP information system has been accomplished, gaps identified by this study need to be addressed. Stockouts of data registers and other data tools hamper data collection and reporting. Service providers not currently reporting to the DHIMS2—primarily pharmacies and some

private sector service providers—should be supported in coming on board, particularly given the significant role they play in dispensing short-term FP methods in some districts. Appropriate data collection forms should be developed for the pharmacies/LCSs. Likewise, personnel should be trained on data collection and reporting, and given incentives to report regularly. Gaps in data should be addressed, and new guidelines developed and rolled out to all levels. Efforts should be made to equip SDPs with computers/tablets to save staff time and improve data quality and management. Feedback mechanisms, such as monitoring and supervision, should also be improved to ensure data quality and completeness, thus improving its usefulness for decision making.

When sharing the preliminary report with stakeholders at the regional level, the deputy director responsible for information, monitoring, and evaluation at the national level announced the development of forms for entering information, education, and communication data. Cascading training from the national to the community level will be needed to roll these forms out. Before this study was finalized, the regional director of health services in the UER issued a memo to all district health management teams to ensure that FP data are captured from all pharmacies/LCSs.

CONCLUSION

There is an inequitable distribution of service provider types and SDPs in the UER by subdistrict and district, skewed toward urban areas. The government is the major provider of FP services in the region, but the private sector makes a significant contribution, especially in certain subdistricts and districts. Several NGOs conduct community mobilization and education in reproductive, maternal, and child health, but few work specifically in FP. The involvement of community volunteers/agents in FP commodity dispensing is also minimal, though the region has a large pool of volunteers/CBAs working in various aspect of healthcare.

There is wide variation by service provider type and district regarding which FP methods SDPs offer. Most SDPs offer male condoms, OCPs, FP counselling, hormonal injectables, and implants, in decreasing order. IUD insertion and female sterilization and vasectomy services are available in only a few SDPs, with most districts not having any SDPs that offer them.

CHPS zones are the major SDPs for all FP methods, partly because of their numbers relative to other types of providers. They have great potential to improve the inequitable distribution of providers and increase access to both short- and long-term FP contraceptive methods in most communities. Their FP information is well integrated into the national DHIMS2 system, but the national health information system is missing data from other types of FP providers.

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APPENDIX A. UER Maps of FP Services

Figure 8. UER map of distribution of private sector FP SDPs

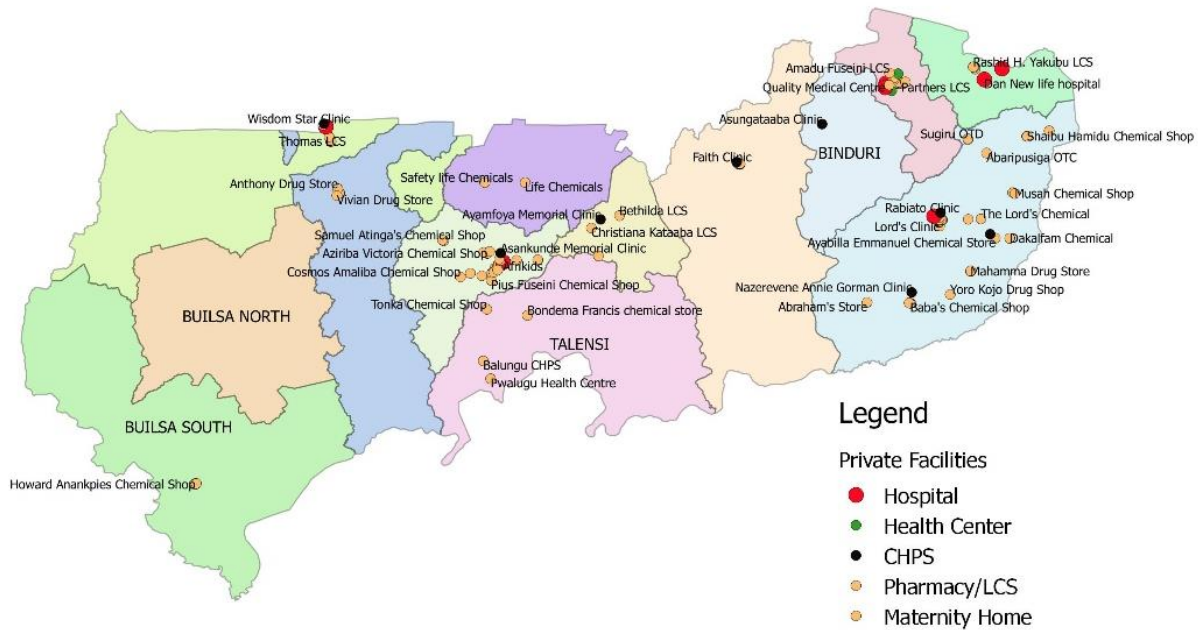


Figure 9. UER map of distribution of CHAG FP service providers

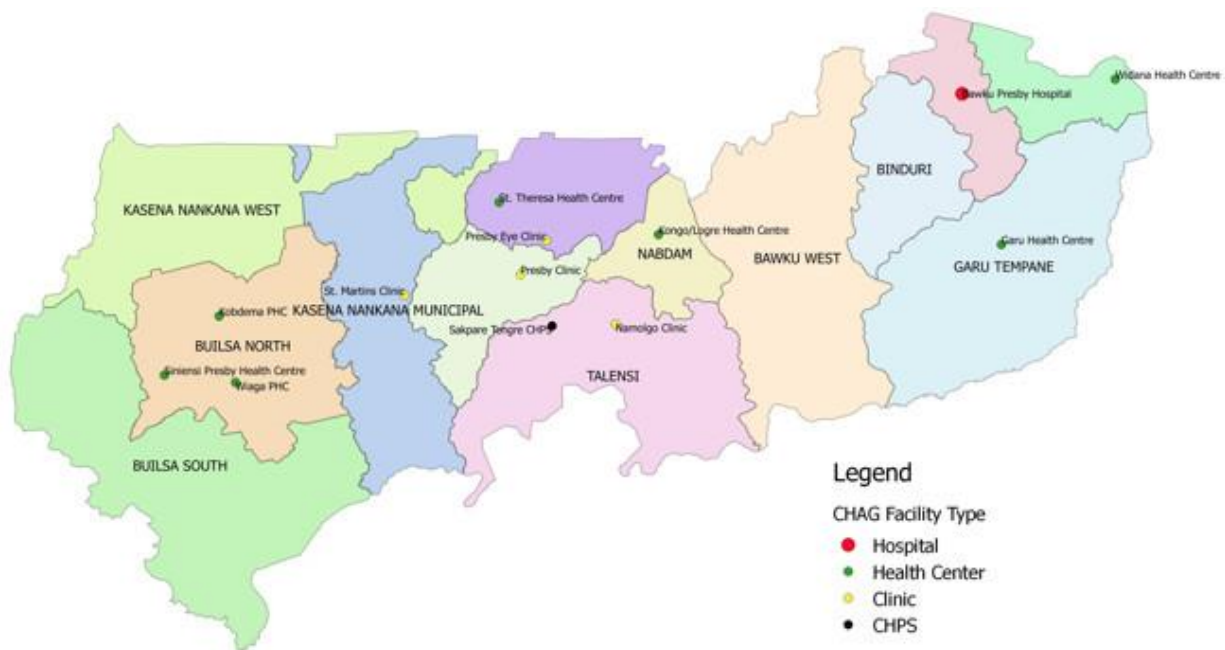
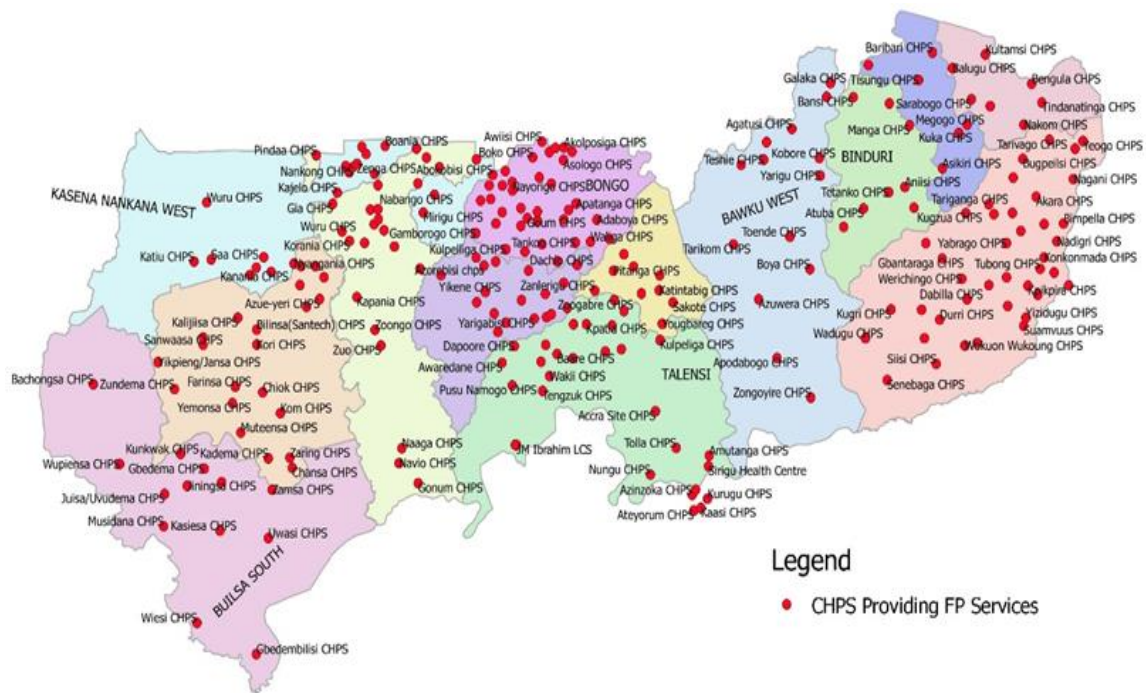


Figure 10. UER map of CHPS zones providing FP services (i.e., functional CHPS)



APPENDIX B. UER Maps of SDPs for Different Types of FP Services

Figure 11. Distribution of SDPs offering FP counselling

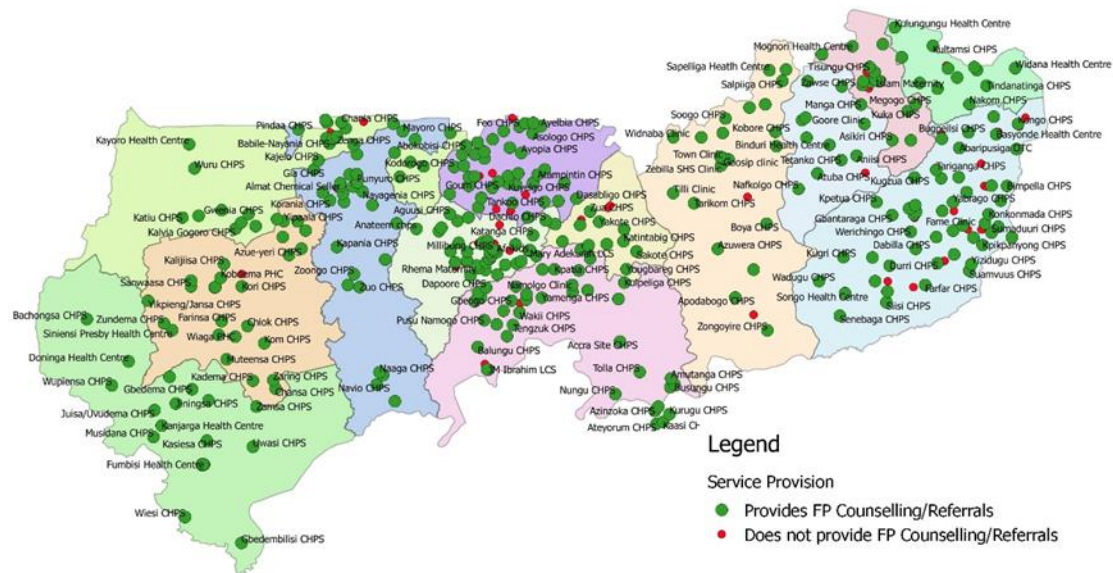


Figure 12. Distribution of SDPs offering OCPs

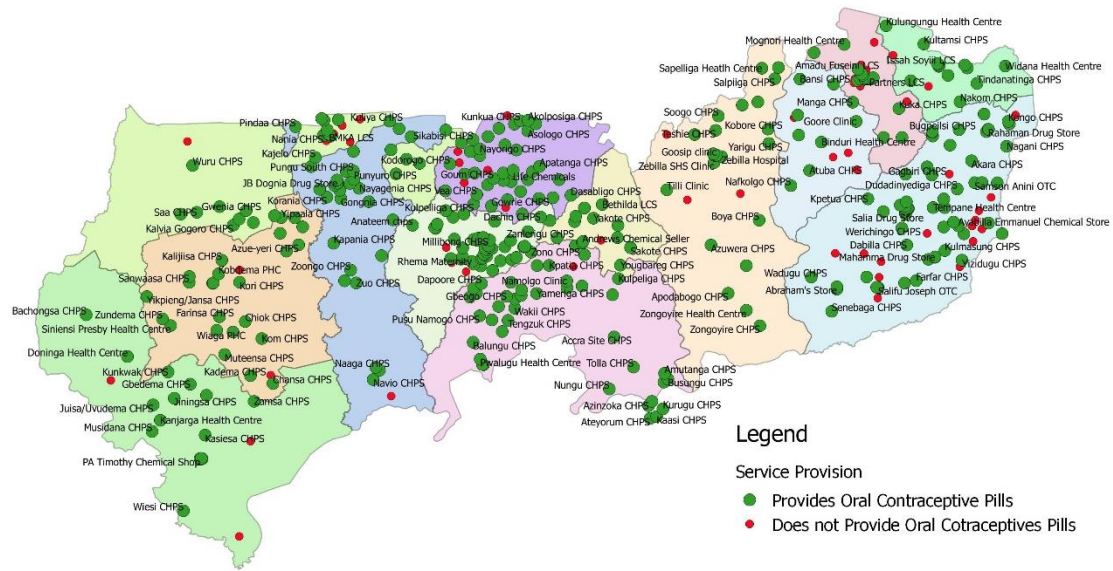


Figure 13. Distribution of SDPs dispensing male condoms

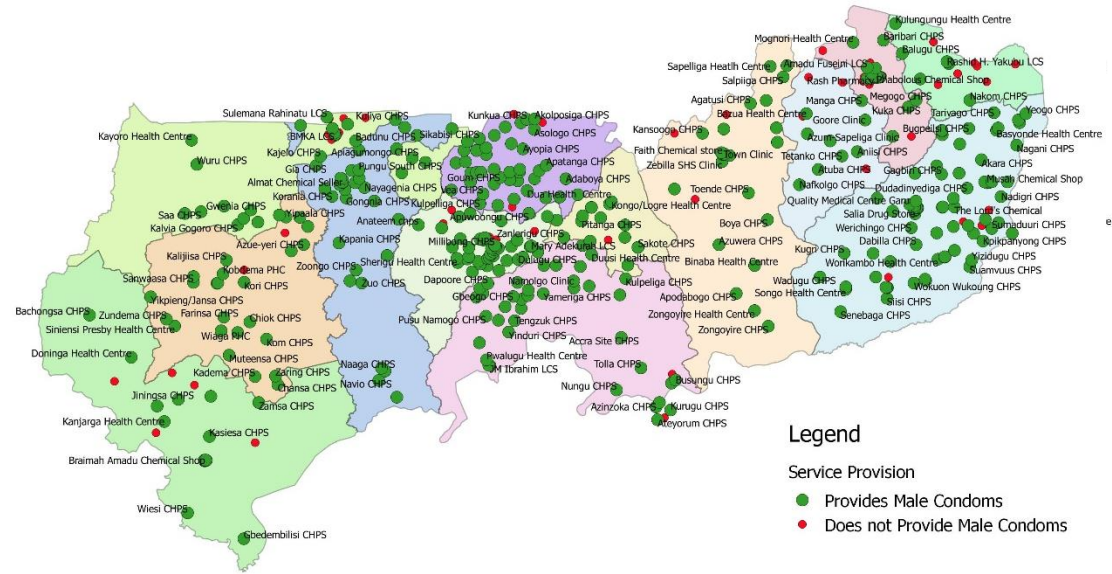


Figure 14. Distribution of SDPs offering hormonal injectable contraceptives

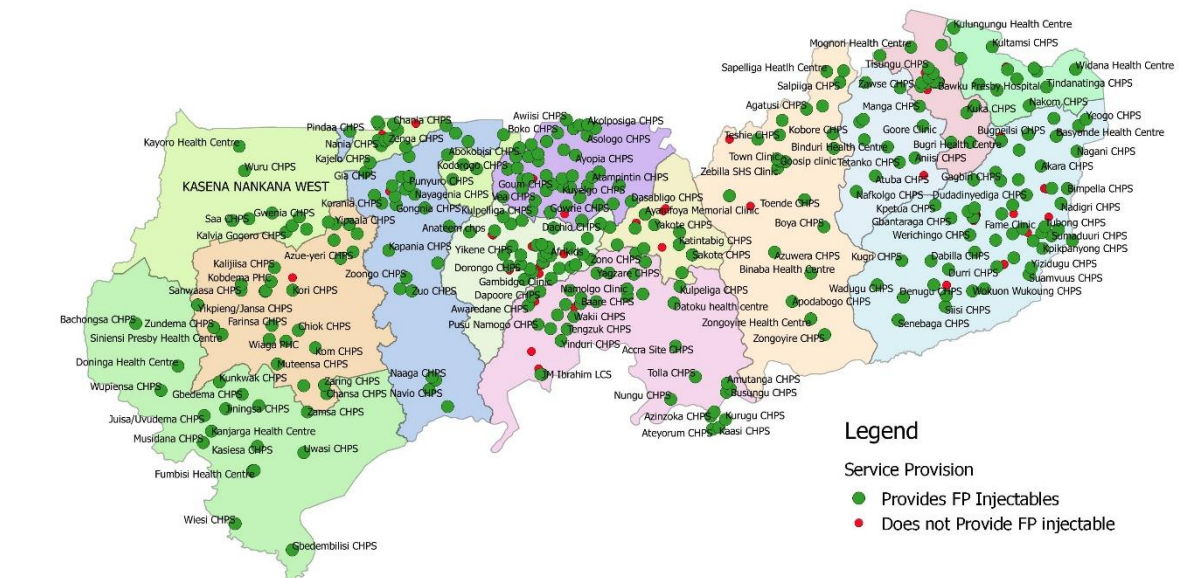


Figure 15. Distribution of SDPs offering hormonal contraceptive implants

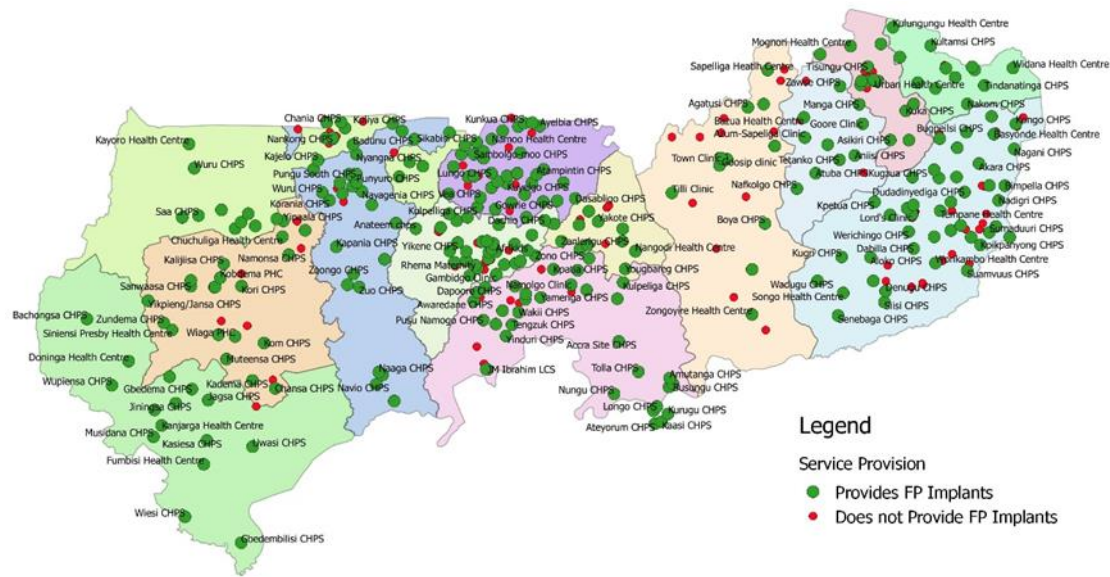


Figure 16. Distribution of SDPs offering IUDs

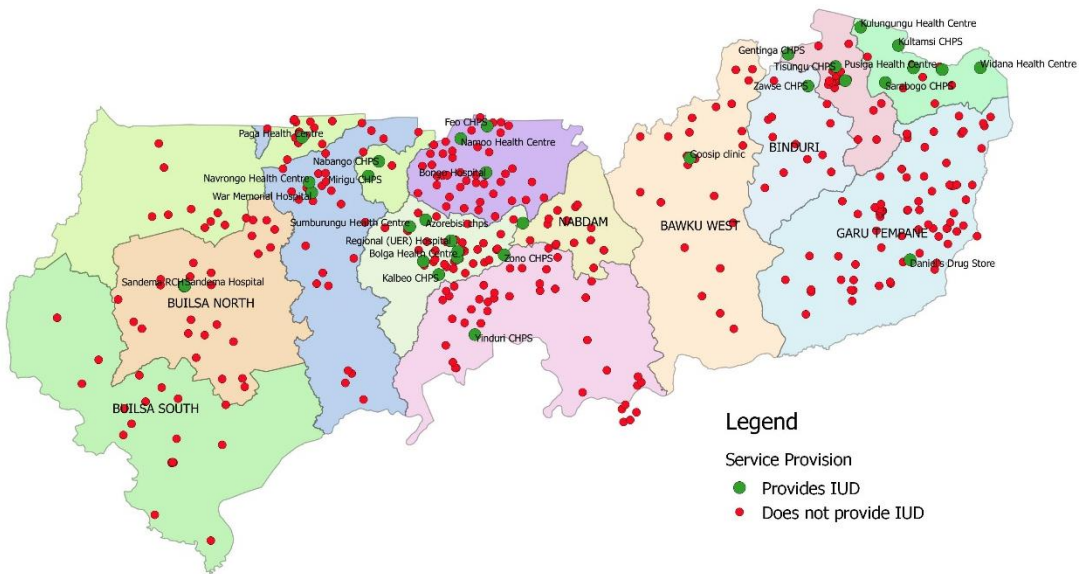


Figure 17. Distribution of SDPs offering cycle beads for the SDM

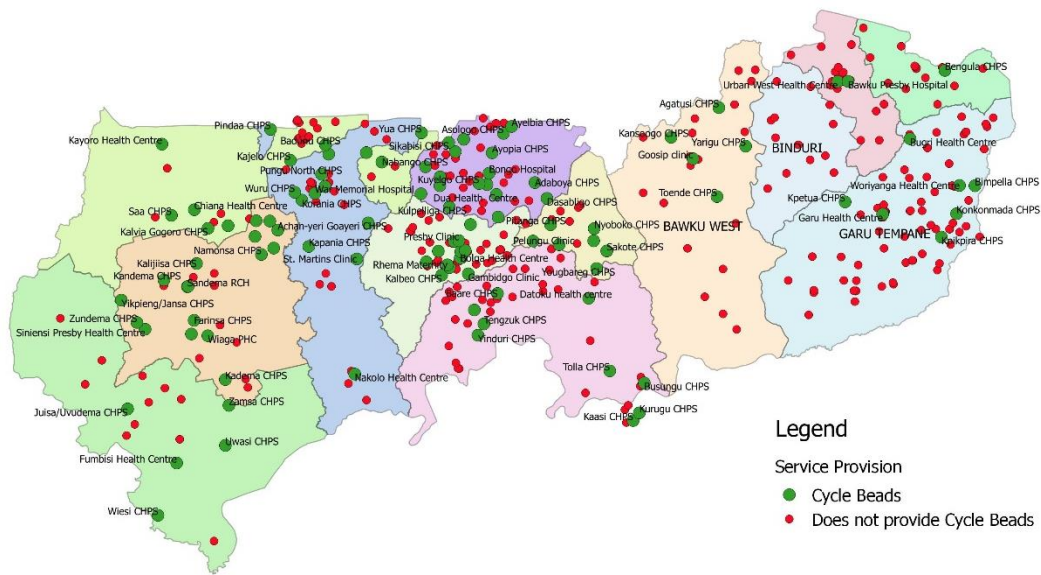


Figure 18. Distribution of SDPs offering counselling for natural FP methods

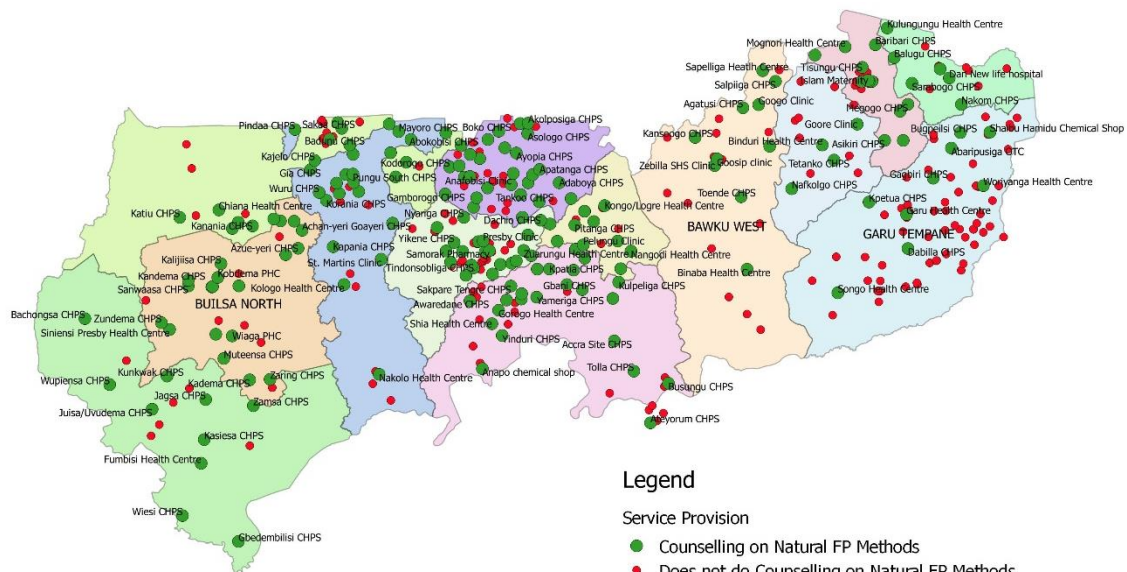
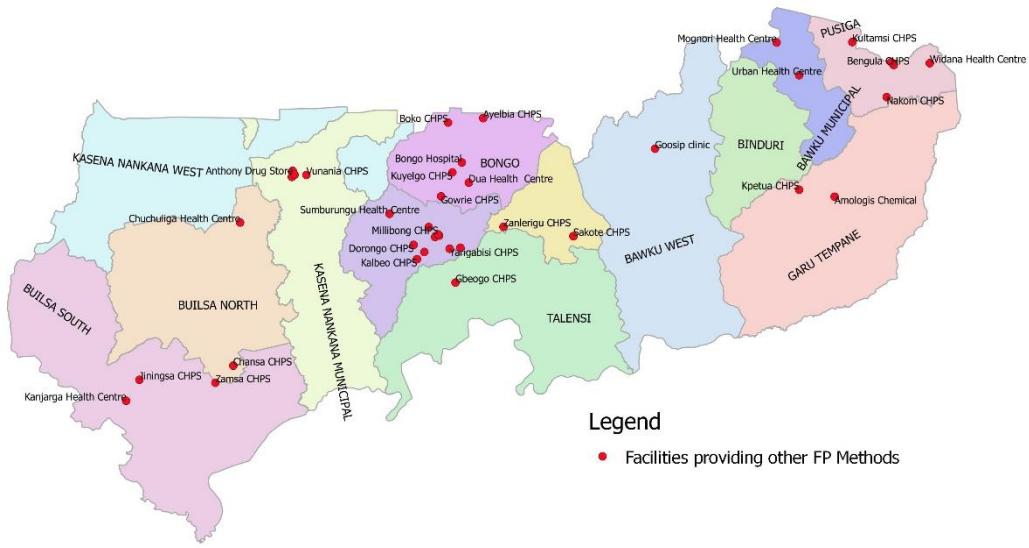


Figure 19. Distribution of SDPs that provide other types of FP methods



APPENDIX C. District Maps of SDPs

Figure 20. Bawku Municipal map showing the distribution of service providers, by type

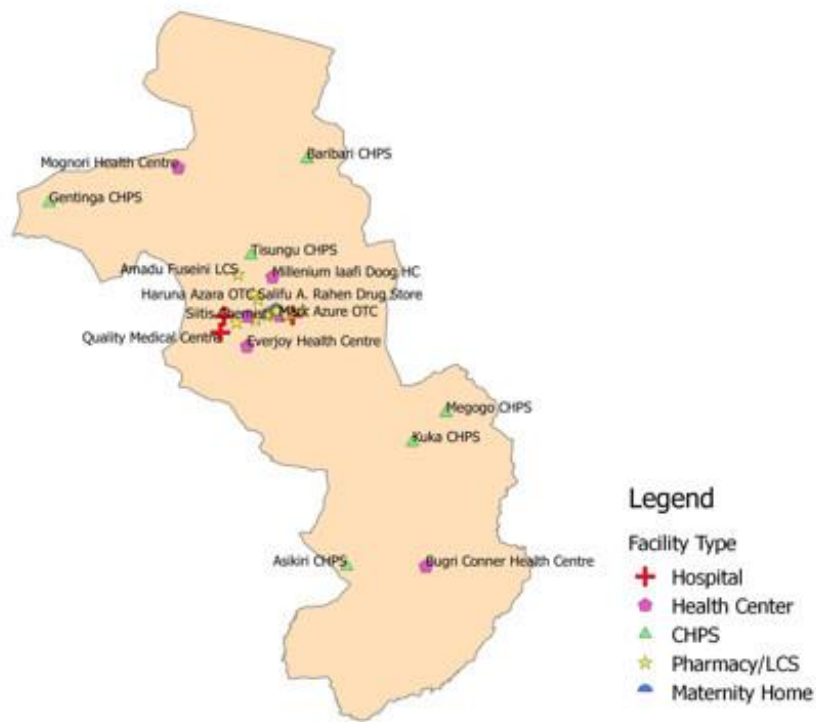


Figure 21. Bawku West District map showing the distribution of service providers, by type

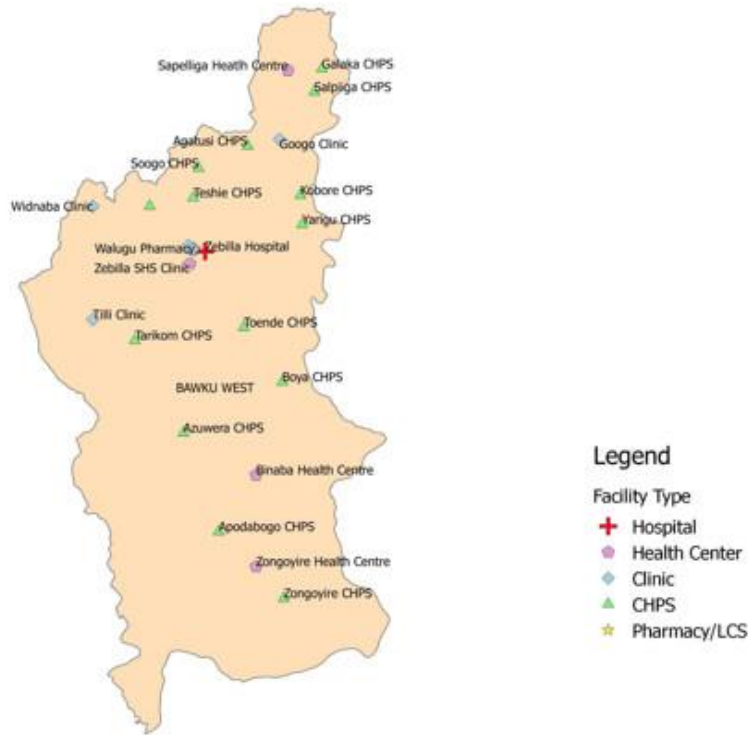


Figure 22. Binduri District map showing the distribution of service providers, by type



Figure 23. Bolgatanga Municipal map showing the distribution of service providers, by type

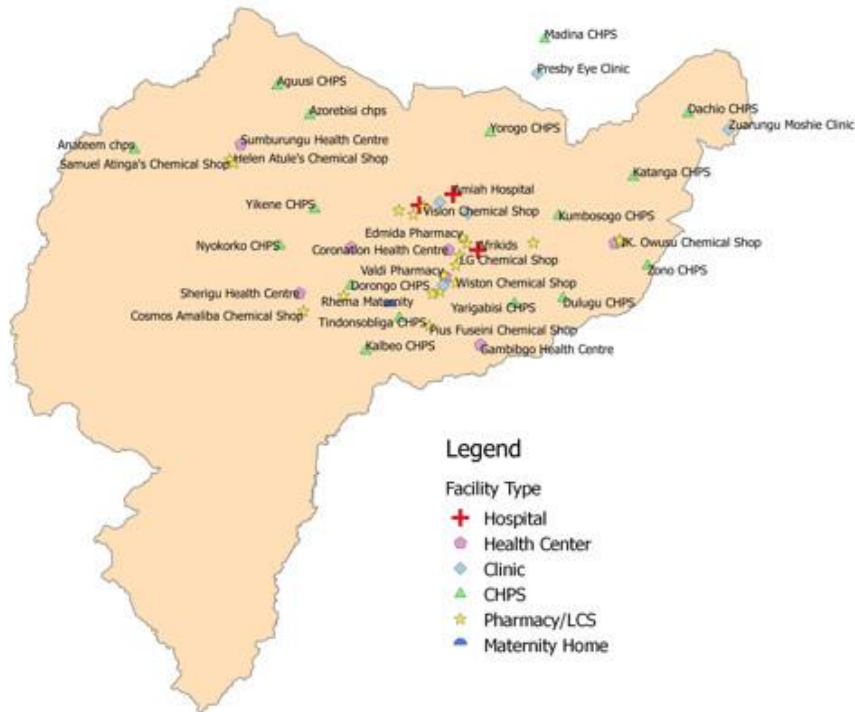


Figure 24. Bongo District map showing the distribution of service providers, by type

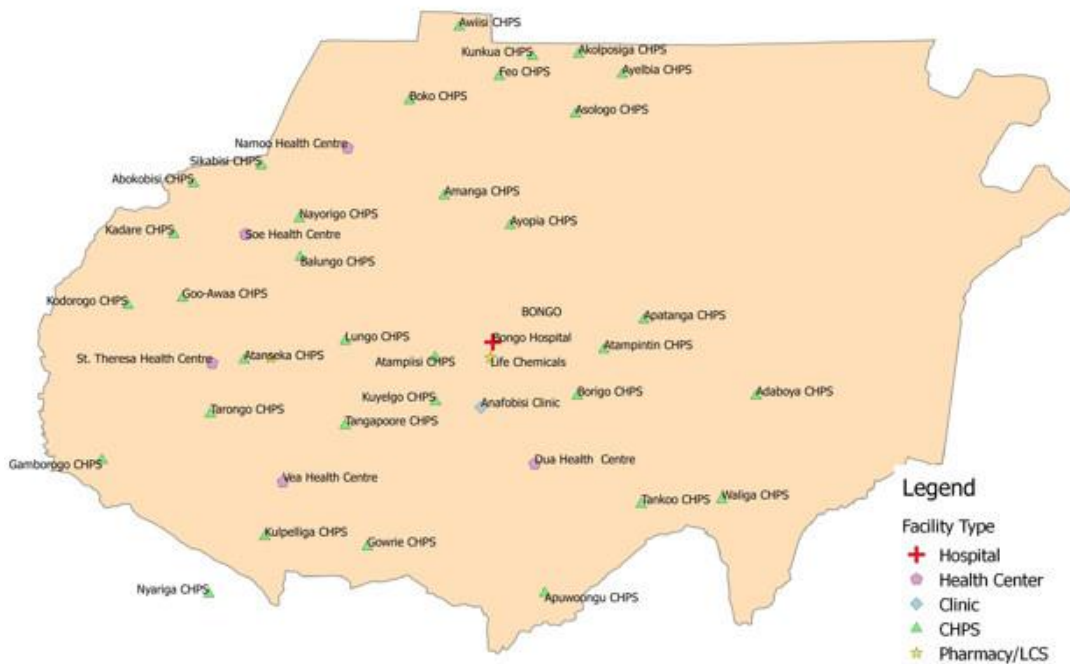


Figure 25. Builsa North District map showing the distribution of service providers, by type

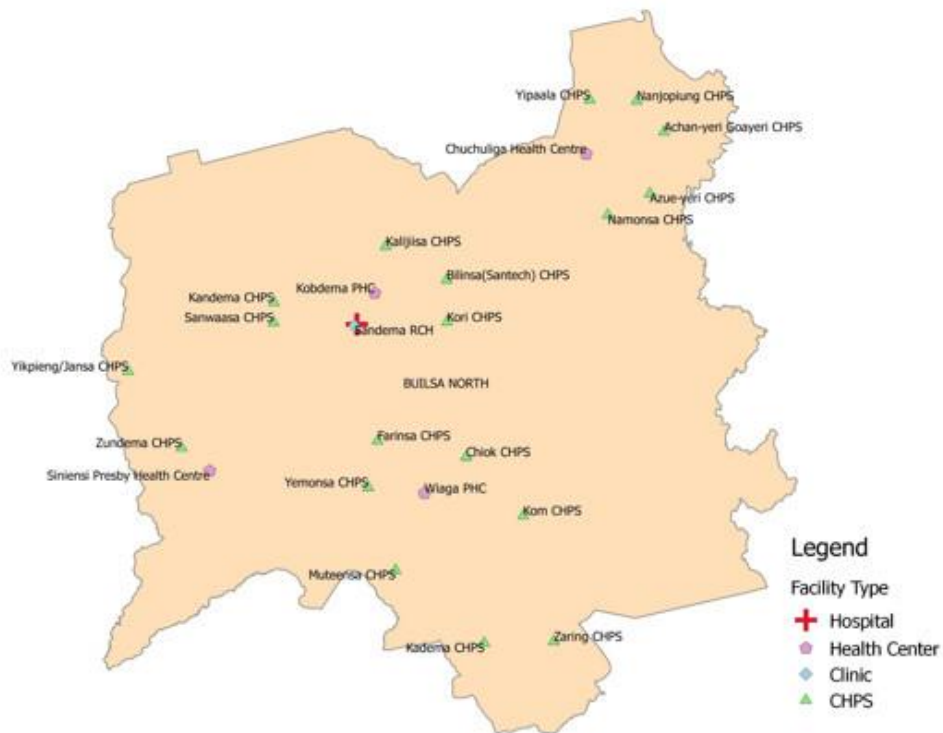


Figure 26. Builsa South District map showing the distribution of service providers, by type



Figure 27. Garu Tempene District map showing the distribution of service providers, by type

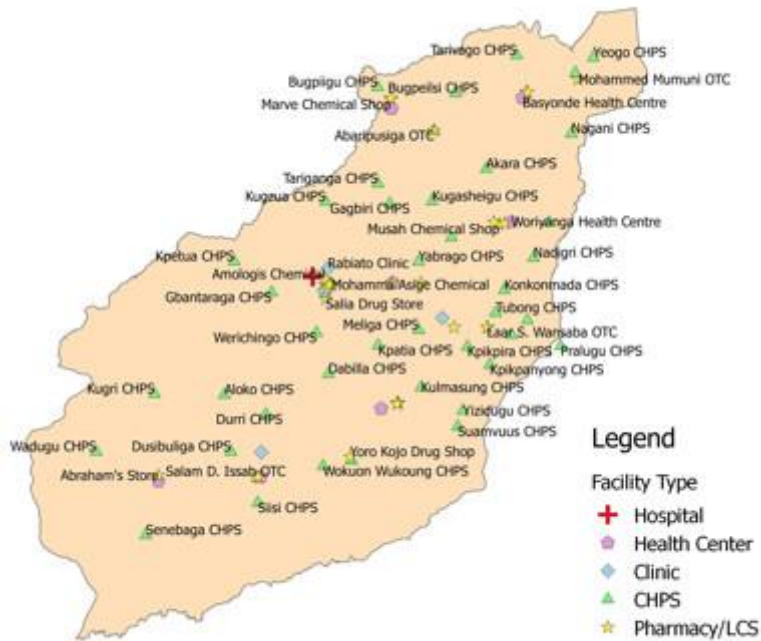


Figure 28. Kassena Nankana Municipal map showing the distribution of service providers, by type



Figure 29. Kassena Nankana West District map showing the distribution of service providers, by type



Figure 30. Nabdram District map showing the distribution of service providers, by type

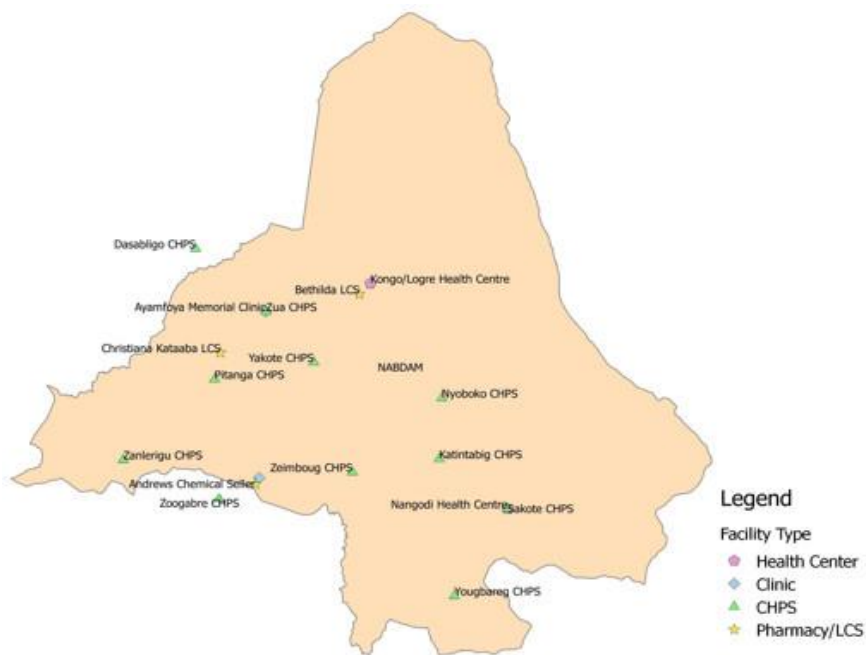


Figure 31. Pusiga District map showing the distribution of service providers, by type

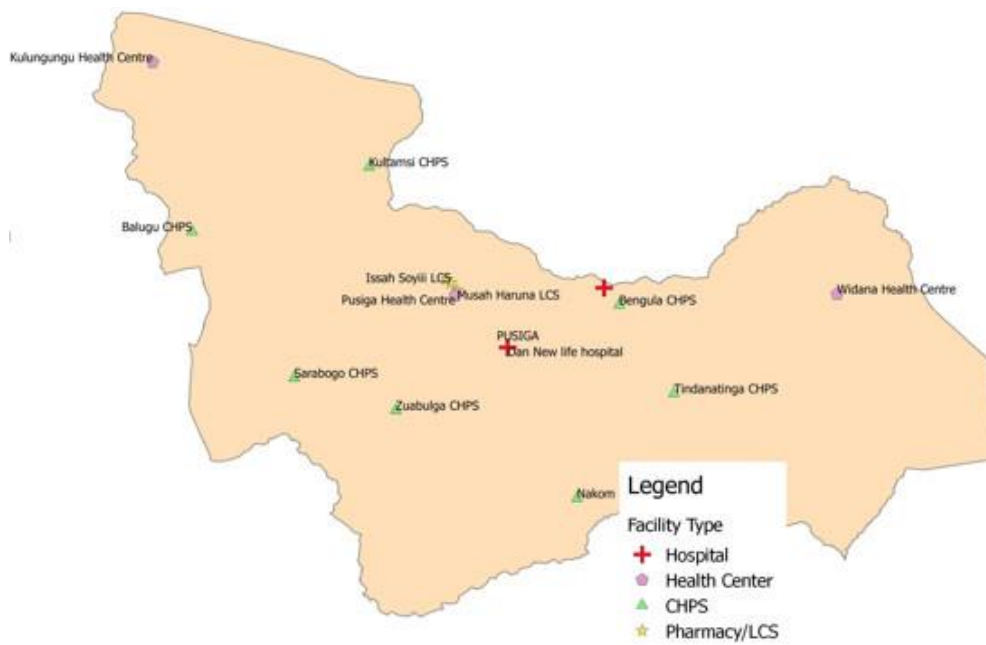
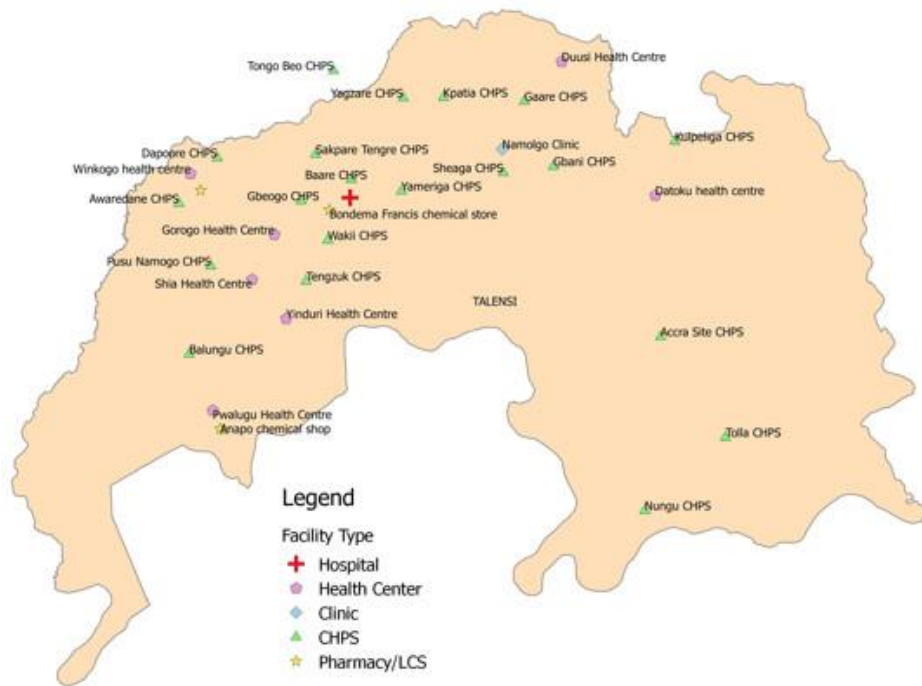


Figure 32. Talensi District map showing the distribution of service providers, by type



APPENDIX D. Tables of FP Providers

Table 10. Service providers in the UER's subdistricts, by type

Bawku Municipal							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Baribari	0	0	0	1	0	0	1
Kuka East	0	0	0	2	0	0	2
Kuka West	0	1	0	1	0	0	2
Mognori	0	1	0	1	0	0	2
North Natinga	0	1	0	0	4	1	6
South Natinga	1	0	0	0	4	0	5
Urban West	2	3	0	1	7	0	13
Total	3	6	0	6	15	1	31
Bawku West District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Binaba	0	1	0	1	0	0	2
Boya/Gbantongo	0	0	0	1	0	0	1
Sapelliga/Googo	0	1	1	3	0	0	5
Tanga/Timonde	0	0	0	1	0	0	1
Tilli/Widnaba	0	0	2	1	0	0	3
Zebila South	1	1	3	2	3	0	10
Zebilla North	0	0	0	3	0	0	3
Zongoyire	0	1	0	2	0	0	3
Total	1	4	6	14	3	0	28
Binduri District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Anisi/Kukparigu	0	0	0	3	0	0	3

Atuba/Nafkolga	0	0	0	2	0	0	2
Bazua	0	1	1	0	0	0	2
Binduri Central	0	1	1	0	0	0	2
Manga/Goore	0	0	1	1	0	0	2
Zawse/Bansi	0	0	0	2	0	0	2
Total	0	2	3	8	0	0	13
Bolgatanga Municipal							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Bolga Central	0	1	1	2	8	1	13
Bolga North	0	0	1	2	0	0	3
Bolga South	0	1	0	1	0	0	2
Gambibgo	0	1	0	1	0	0	2
Plaza	3	1	2	0	4	0	10
Sherigu	0	1	0	2	2	0	5
Sumburungu	0	1	0	3	2	0	6
Zuarunga Moshie	0	1	0	2	0	0	3
Zuarungu	0	0	1	3	3	0	7
Total	3	7	5	16	19	1	51
Bongo District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Beo	0	1	0	6	0	0	7
Bongo Central	1	0	1	6	2	0	10
Namoo	0	1	0	6	0	0	7
Soe	0	1	0	6	0	0	7
Valley Zone	0	1	0	5	0	0	6
Zorko	0	1	0	6	0	0	7
Total	1	5	1	35	2	0	44

Builsa North District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Chuchuliga	0	1	0	5	0	0	6
Kadema	0	0	0	3	0	0	3
Sandema East	0	0	0	3	0	0	3
Sandema West	1	1	1	2	0	0	5
Siniensi	0	1	0	2	0	0	3
Wiaga	0	1	0	4	0	0	5
Total	1	4	1	19	0	0	25
Builsa South District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Doninga	0	1	0	2	0	0	3
Fumbisi	0	1	0	1	4	0	6
Gbedema	0	0	0	2	0	0	2
Kanjarga	0	1	0	4	0	0	5
Uwasi	0	0	0	3	0	0	3
Wiesi	0	0	0	2	0	0	2
Total	0	3	0	14	4	0	21
Garu Tempene District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Basyonde	0	1	0	7	3	0	11
Bugri	0	1	0	5	3	0	9
Denugu	0	1	1	5	3	0	10
Garu	1	2	0	6	8	0	17
Kpikpira	0	0	0	6	3	0	9
Songo	0	1	0	3	1	0	5
Tempene	0	1	3	2	1	0	7
Worikambo	0	0	0	4	4	0	8

Woriyanga	0	1	0	4	3	0	8
Total	1	8	4	42	29	0	84
Kassena Nankana Municipal							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Kologo	0	1	1	3	0	0	5
Mayoro	0	0	0	3	0	0	3
Navrongo central	0	0	0	0	1	0	1
Navrongo Central	1	1	0	1	3	0	6
Navrongo East	0	0	0	3	0	0	3
Pungu	0	0	0	4	0	0	4
Vunania/Kapania	0	0	0	2	0	0	2
Wuru	0	0	0	4	0	0	4
Total	1	2	1	20	4	0	28
Kassena Nanakana West District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Chiana	0	1	0	6	0	0	7
Kandiga	0	1	0	4	0	0	5
Katin-Nakong	0	0	0	2	0	0	2
Kayaro	0	1	0	2	0	0	3
Mirigu-Nabanga	0	0	0	5	0	0	5
Nakolo	0	1	0	1	0	0	2
Navio	0	0	0	3	0	0	3
Paga Central	1	1	1	5	4	0	12
Sirigu	0	2	0	1	0	0	3
Total	1	7	1	29	4	0	42
Nabdram District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total

Kongo/Pitanga	0	1	1	3	1	0	6
Nangodi	0	1	0	2	1	0	4
Pelungu	0	0	1	3	1	0	5
Sakote	0	0	0	3	0	0	3
Zanlerigu	0	0	0	2	0	0	2
Total	0	2	2	13	3	0	20
Pusiga District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Kulungungu/Kultamsi	0	1	0	2	0	0	3
Nakom/Zuabulga	0	0	0	2	0	0	2
Pusiga Central	2	1	0	1	3	0	7
Sarabogo	0	0	0	1	0	0	1
Widana	0	1	0	1	0	0	2
Total	2	3	0	7	3	0	15
Talensi District							
Subdistrict	Hospital	H/C	Clinic	CHPS	Pharmacy/LCS	Maternity home	Total
Datoko	0	1	0	1	0	0	2
Duusi/Gbani	0	1	0	2	0	0	3
Gorogo/Banga	0	1	0	3	0	0	4
Namdgo/Kpatia	0	0	1	3	0	0	4
Pwalugu	0	2	0	1	2	0	5
Tolla/Nungu	0	0	0	3	0	0	3
Tongo	1	0	0	4	1	0	6
Winkogo/Shia	0	2	0	3	1	0	6
Total	1	7	1	20	4	0	33

Table 11. Distribution of nonreligious health NGOs and development partners, by district

	District	NGOs or Projects	Development Partners
1	Bawku Municipal	MSI	
2	Bawku West	World Vision, ADDRO, Oxfam/PARDA	USAID-SPRING
3	Binduri	MEHAP, GRCS, Afrikids	
4	Bolgatanga Municipal	MSI, Afrikids	
5	Bongo	MSI, Mission for Hope, Water Aid, Youth Harvest, GRCS, Afrikids	United Nations Children's Fund (UNICEF), Korean International Cooperation Agency, Japan International Cooperation Agency, USAID-SPRING
6	Builsa North	Tuma-Kavi, MEHAP, ADDRO	UNICEF
7	Builsa South	AFRIKIDS	UNICEF, Korean International Cooperation Agency, Savannah Accelerated Development Authority/Millennium Villages Project
8	Garu Tempene		USAID-SPRING
9	Kassena Nankana Municipal	GRCS	
10	Kassena Nankana West	CRS	UNICEF
11	Nabdam	CRS	
12	Pusiga	MSI, Rural Women & Children Development Agency, MEHAP	
13	Talensi	CRS, Friendship, Love and Sexual Health program, PARDA, ISRAD, World Vision	USAID-SPRING, USAID-IPAS

Table 12. Health NGOs and the geographic and health service areas in which they operate

NGO	District	Operational area
1. MSI	Bawku Municipal – 6 subdistricts in 11 facilities	Long-term FP
	Bolgatanga Municipal – all subdistricts	
	Bongo – Bongo Beo subdistrict	
	Pusiga – Nakom/Zuabuliga	
2. Afrikids	Bolgatanga Municipal – Afrikids Medical Center	Hospital
	Binduri – Zawse-Bansi subdistrict	Maternal & child health
	Bongo – Al subdistricts	Maternal & child health
	Builsa South – Kanjarga subdistrict	Maternal & child health
3. CRS	Kassena Nankana West – All subdistricts	Community emergency transport systems and nutrition
	Nabdam – All subdistricts	
	Talensi - All subdistricts	
4. GRCS	Binduri – All subdistricts	Maternal, newborn & child health
	Bongo – All subdistricts	
	Kassena Nankana Municipal – 5 subdistricts	
5. Adventist Development and Relief Agency	Bawku West – Boya/Gbantongo subdistrict	Malaria prevention and treatment, Integrated community case management
	Builsa North – Sandema East	CHPS concept
6. MEHAP	Binduri – All subdistricts	Maternal & child health
	Builsa North – Sandema West subdistrict	
	Pusiga – Kulungugu/Kultamse	
7. World Vision	Bawku West – Binaba subdistrict	Financial support
	Talensi – All subdistricts	Maternal & child health
8. Water Aid	Bongo – Namoo subdistrict	Family planning

9. OXFAM-PARDA	Bawku West – Sapeliga-Googo subdistrict	Maternal health
	Talensi – Duusi/Gbani, Gorogo & Namolgo/Kpaita subdistricts	
10. Mission for Hope	Bongo – Bongo Soe subdistrict	Child nutrition
11. Rural Women and Children Development Agency	Pusiga – Pusiga Central subdistrict	Malaria care & female genital mutilation prevention
12. Youth Harvest	Bongo – Zorko subdistrict	Adolescent reproductive health
13. Tuma-Kavi	Builsa North – Chuchuliga subdistrict	Malaria care
14. Friendship, Love and Sexual Health program	Talensi – All subdistricts	Maternal & child health
15. ISRAD	Talensi – Gorogo, Namolgo/Kpatia & Winkogo subdistricts	Maternal & child health

Table 13. Types of personnel delivering FP services, by service provider type

Type of facility	Medical practitioners	Midwives	CHNs/CHOs	Pharmacist/technicians	Attendants	Volunteers	Others
Hospital	3	12	10	2	0	0	0
Health centre	1	45	52	3	2	7	2
Clinic		16	17	0	0	2	1
CHPS		83	224	3	1	24	3
Pharmacy/LCS		2	1	16	62	3	4
Maternity home		2					
Total	4	160	304	24	65	36	9
%	0.9%	36.8%	69.9%	5.5%	14.9%	8.3%	2.1%

Table 14. Number of SDPs with different types of personnel in their FP delivery teams and those that provided FP training for them in the three years before the survey, by district*

District	No. of SDPs	Medical practitioners	Midwives	CHOs/CHNs	Pharmacists/Technicians	Attendants	Volunteers	Others
		No. of SDPs	No. of SDPs	No. of SDPs	No. of SDPs	No. of SDPs	No. of SDPs	No. of SDPs
Bawku Municipal	31	0 (0)	14 (12)	12 (12)	6 (4)	9 (5)	0 (0)	0 (0)
Bawku West	28	0 (0)	10 (3)	24 (5)	1 (0)	3 (2)	1 (0)	1 (0)
Binduri	13	1 (0)	7(4)	11 (10)	0 (0)	1 (0)	5 (0)	0 (1)
Bolga Municipal	51	2 (1)	23 (21)	26 (23)	9 (5)	15 (10)	2 (2)	3 (4)
Bongo	44	1 (1)	19 (16)	41 (38)	0 (1)	2 (2)	5 (3)	6 (7)
Builsa North	25	1 (0)	13 (8)	24 (20)	0 (0)	0 (0)	2 (0)	8 (1)
Builsa South	21	0 (0)	8 (5)	17 (17)	1 (1)	4 (5)	3 (3)	9 (9)
Garu Tempene	84	1 (1)	19 (7)	54 (25)	3 (3)	23 (6)	0 (1)	0 (0)
Kassena Nankana Municipal	28	1 (0)	19 (8)	24 (17)	1 (0)	3 (0)	6 (0)	10 (0)
Kassena Nankana West	42	0 (0)	12 (12)	36 (36)	0 (1)	4 (4)	2 (0)	2 (2)
Nabdram	20	0 (0)	0 (9)	1 (14)	0 (0)	0 (0)	0 (0)	0 (1)
Pusiga	15	0 (0)	6 (7)	10 (11)	3 (0)	0 (0)	0 (0)	0 (0)
Talensi	33	0 (0)	10 (6)	24 (24)	0 (0)	1 (3)	10 (1)	9 (2)
Total	435	7 (3)	160 (118)	304 (252)	24 (15)	65 (37)	36 (10)	48 (29)

*Numbers in parentheses are the number of SDPs that provided training in the three years before the survey.

APPENDIX E. Tables of Distribution of FP Services

Table 15. Number and proportion of SDPs offering different FP services on a static and outreach basis, by service provider type

SDPs	Hospitals	Health centres	Clinics	CHPS	Pharmacies /LCSs	Maternity homes	Total
FP counselling							
Number	15	60	25	243	90	2	435
Static services	15 (100%)	51 (89.5%)	21 (84%)	234 (94.7%)	24 (27.0%)	2 (100%)	347 (79.8%)
Percentage of all static SDPs providing FP counselling	4.3%	14.7%	6.1%	67.4%	6.9%	0.6%	100.0%
Outreach services	6 (40.0%)	38 (66.7%)	16 (64.0%)	190 (76.9%)	1 (1.1%)	0 (0.0%)	251 (57.7%)
Percentage of all outreach SDPs providing FP counselling	2.4%	15.1%	6.4%	75.7%	0.4%	0.0%	100.0%
Oral contraceptive pills							
Number	15	60	25	243	90	2	435
Static services	13 (86.7%)	55 (91.7%)	18 (72.0%)	198 (81.5%)	80 (88.9%)	2 (100%)	366 (84.1%)
Percentage of all static SDPs providing OCPs	3.60%	15.00%	4.90%	54.10%	21.90%	0.50%	100.00%
Outreach services	5 (33.3%)	34 (56.7%)	10 (40.0%)	108 (44.4%)	3 (3.3%)	0 (0.0%)	160 (36.8%)
Percentage of all outreach SDPs providing OCPs	3.10%	21.30%	6.30%	67.50%	1.90%	0.00%	100.00%
Male condoms							
Number	15	60	25	244	90	2	435
Static services	10 (66.7%)	52 (86.7%)	15 (60.0%)	212 (86.9%)	83 (92.2%)	1 (50.0%)	373 (85.7%)
Percentage of all static SDPs providing male condoms	2.70%	13.90%	4.00%	56.80%	22.30%	0.30%	100.00%
Outreach services	5 (33.3%)	31 (51.7%)	10 (40.0%)	121 (49.6%)	4 (4.4%)	0 (0.0%)	171 (39.3%)
Percentage of all outreach SDPs providing male condoms	2.90%	18.10%	5.80%	70.80%	2.30%	0.00%	100.00%
Injectable hormonal contraceptives							
Number	15	60	25	243	90	2	435
Static services	15 (100%)	57 (95.0%)	21 (84.0%)	236 (96.7%)	7 (7.9%)	2 (100%)	338 (77.7%)
Percentage of all static SDPs providing Injectables	4.40%	16.90%	6.20%	69.80%	2.10%	0.60%	100.00%

SDPs	Hospitals	Health centres	Clinics	CHPS	Pharmacies /LCSs	Maternity homes	Total
Outreach services	8 (53.3%)	40 (66.7%)	10 (40.0%)	147 (60.2%)	3 (3.4%)	0 (0.0%)	208 (47.8%)
Percentage of all outreach SDPs providing injectables	3.80%	19.20%	4.80%	70.70%	1.40%	0.00%	100.00%
Hormonal implants							
Number	15	60	25	243	90	2	435
Static services	15 (100%)	56 (93.3%)	17 (68.0%)	197 (81.1%)	3 (3.3%)	2 (100%)	290 (66.7%)
Percentage of all static SDPs providing hormonal implants	5.2%	19.3%	5.9%	67.9%	1.0%	0.7%	100.0%
Outreach services	1 (6.7%)	6 (10.0%)	1 (4.0%)	21 (8.6%)	0 (0.0%)	0 (0.0%)	29 (6.7%)
Percentage of all outreach SDPs providing hormonal implants	3.4%	20.7%	3.4%	72.4%	0.0%	0.0%	100.0%
Cycle beads for standard days method							
Number	15	60	25	243	90	2	435
Static services	5 (33.3%)	24 (40.0%)	6 (24.0%)	68 (27.9%)	1 (1.1%)	1 (50.0%)	105 (24.1%)
Percentage of all static SDPs providing cycle beads	4.8%	22.9%	5.7%	64.8%	1.0%	1.0%	100.0%
Outreach services	1 (20.0%)	7 (29.2%)	2 (33.3%)	28 (41.2%)	0 (0.0%)	0 (0.0%)	38 (8.3%)
Percentage of all outreach SDPs providing cycle beads	2.6%	18.4%	5.30%	73.7%	0.0%	0.0%	100.0%
Natural FP methods							
Number	15	60	25	243	90	2	435
Static services	8 (53.3%)	40 (66.7%)	11 (44.0%)	126 (51.6%)	3 (3.4%)	2 (100%)	190 (43.7%)
Percentage of all static SDPs providing natural FP method counselling	4.2%	21.1%	5.8%	66.3%	1.6%	1.1%	100.0%
Outreach services	6 (40.0%)	23 (38.3%)	6 (24.0%)	89 (36.5%)	2 (2.2%)	0 (0.0%)	126 (29.0%)
Percentage of all outreach SDPs providing natural FP method counselling	4.8%	18.3%	4.8%	70.6%	1.6%	0.0%	100.0%
Other FP methods							
Number	15	57	25	247	89	2	435
Static services	3 (20.0%)	8 (14.0%)	1 (4.0%)	22 (8.9%)	5 (5.6%)	0 (0.0%)	39 (9.0%)
Percentage of all static SDPs providing other FP methods	7.7%	20.5%	2.6%	56.4%	12.80%	0.0%	100.0%

SDPs	Hospitals	Health centres	Clinics	CHPS	Pharmacies /LCSs	Maternity homes	Total
Outreach services	2 (13.3%)	3 (5.3%)	0 (0.0%)	5 (2.0%)	6 (6.7%)	0 (0.0%)	16 (3.7%)
Percentage of all outreach SDPs providing other FP methods	12.5%	18.8%	0.0%	31.3%	37.5%	0.0%	100.0%

Table 16. Delivery of the different FP methods at static and outreach basis, by sector

FP services	Sector of service provider			
	Government	NGO	Private	Total
FP counselling				
Number of service providers	310	14	111	435
Static services	292 (94.2%)	13 (92.9%)	43 (38.7%)	347 (79.8%)
Percentage of all static SDPs providing FP counselling	84.1%	3.7%	12.4%	100.0%
Outreach services	232 (74.8%)	10 (76.9%)	9 (8.1%)	252 (57.7%)
Percentage of all outreach SDPs providing FP counselling	92.1%	4.0%	3.6%	100%
Oral contraceptive pills				
Number of service providers	310	14	111	435
Static services	260 (83.9%)	12 (85.7%)	94 (84.7%)	366 (84.1%)
Percentage of all static SDPs providing OCPs	71.0%	2.8%	25.7%	100.0%
Outreach OCP services	146 (47.1%)	6 (42.9%)	8 (7.2%)	160 (36.8%)
Percentage of all outreach SDPs providing OCPs	91.3%	3.8%	5.0%	100.0%
Male condoms				
Number of service providers	310	14	111	435
Static services	270 (87.1%)	11 (78.6%)	92 (82.9%)	373 (85.7%)
Percentage of all static SDPs providing male condom	72.4%	2.9%	24.7%	100.0%
Outreach services	155 (50.0%)	7 (50.0%)	9 (8.1%)	171 (39.3%)
Percentage of all outreach SDPs providing male condoms	90.6%	4.1%	5.3%	100.0%
Hormonal injectables				

FP services	Sector of service provider			
	Government	NGO	Private	Total
Number of service providers	310	14	111	435
Static services	299 (96.5%)	12 (85.7%)	27 (24.3%)	338 (77.7%)
Percentage of all static SDPs providing hormonal injectables	88.5%	3.6%	8.0%	100.0%
Outreach services	190 (61.3%)	7 (50.0%)	11 (9.9%)	208 (47.8%)
Percent of all outreach SDPs providing hormonal injectables	91.3%	3.4%	5.3%	100.0%
Hormonal implants				
Number of service providers	310	14	111	435
Static services	260 (83.9%)	12 (85.7%)	18 (16.2%)	290 (66.7%)
Percentage of all static SDPs providing hormonal implants	89.7%	4.1%	6.2%	100.0%
Outreach services	27 (8.7%)	2 (14.3%)	0 (0.0%)0	29 (6.7%)
Percentage of all outreach SDPs providing hormonal implants	93.1%	6.9%	0.0%	100.0%
IUDs				
Number of service providers	310	14	111	435
Static services	28 (9.0%)	2 (14.3%)	2 (1.8%)	32 (7.4%)
Percentage of all static SDPs providing IUDs	87.5%	6.3%	6.3%	100.0%
Outreach services	2 (100%)	0	0	2
Percentage of all outreach SDPs providing IUDs	100%	0.0%	0.0%	100%
Cycle beads for SDM				
Number of service providers	310	14	111	435
Static services	95 (30.6%)	7 (50.0%)	3 (2.7%)	105 (24.1%)
Percentage of all static SDPs providing cycle beads method	90.5%	6.7%	2.9%	100.0%
Outreach services	35 (11.3%)	3 (21.4%)	0 (0.0%)	38 (8.7%)
Percentage of all outreach SDPs providing cycle beads method	92.1%	7.9%	0.0%	100.0%
Natural FP methods				

FP services	Sector of service provider			
	Government	NGO	Private	Total
Number of service providers	310	14	111	435
Static services	169 (54.5%)	11 (78.6%)	10 (9.0%)	190 (43.7%)
Percentage of all static SDPs providing natural FP method	88.9%	5.8%	5.3%	100.0%
Outreach services	114 (90.5%)	7 (5.6%)	5 (4.0%)	126 (29.0%)
Percentage of all outreach SDPs providing natural FP method	90.5%	5.6%	4.0%	100.0%
Other FP methods				
Number of service providers	310	14	111	435
Static services	31 (10.0%)	1 (7.1%)	7 (6.3%)	39 (9.0%)
Percentage of all static SDPs providing natural FP method	79.5%	2.6%	17.9%	100.0%
Outreach services	10 (3.2%)	0 (0.0%)	6 (5.4%)	16 (3.7%)
Percentage of all outreach SDPs providing natural FP method	62.5%	0.0%	37.5%	100.0%

Table 17. Number and proportion of SDPs offering different FP services on a static basis, by subdistrict

Bawku Municipal												
Subdistrict	Number of providers	FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Baribari	1	1	1	0	1	0	0	1	0	0	1	0
Kuka East	2	2	2	1	2	0	0	2	0	0	2	0
Kuka West	2	2	2	2	2	0	0	1	0	0	2	0
Mognori	2	2	2	2	2	1	0	1	0	0	2	1
North Natinga	6	1	2	6	2	0	0	5	0	0	2	1
South Natinga	5	1	2	5	1	1	0	4	1	1	1	0
Urban West	13	6	6	8	4	1	0	7	0	1	2	0
Total	31	15	17	24	14	3	0	21	1	2	12	2

Percent (%)		48.4	54.8	77.4	45.2	9.7	0	67.7	3.2	6.5	38.7	6.5
Bawku West District												
Subdistrict	Number of providers	FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Binaba	2	2	2	2	1	0	0	2	0	0	1	0
Boya/Gbantongo	1	1	1	1	1	0	0	1	0	0	0	0
Sapelliga/Googo	5	5	5	5	3	0	0	5	0	1	4	0
Tango/Timonen	1	0	1	0	0	0	0	1	0	1	1	0
Tilli/Widnaba	3	3	1	1	1	0	0	1	0	0	0	0
Zebila South	10	10	7	10	5	1	0	9	0	2	3	1
Zebilla North	3	3	3	3	0	0	0	2	0	1	1	0
Zongoyire	3	2	3	3	1	0	0	3	0	0	0	0
Total	28	26	23	25	12	1	0	24	0	5	10	1
Percent (%)		92.9	82.1	89.3	42.9	3.6	0	85.7	0.00%	17.9	35.7	3.6
Binduri District												
Subdistrict	Number of providers	Counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural method	Other methods
Aniisi/Kukparigu	3	2	2	0	2	0	0	2	0	0	1	0
Atuba/Nafkolga	2	2	2	2	2	0	0	2	0	0	1	0
Bazua	2	2	2	1	1	0	0	1	0	0	0	0
Binduri Central	2	2	2	2	2	0	0	2	0	0	1	0
Manga/Goore	2	2	2	2	2	0	0	2	0	0	1	0
Zawse/Bansi	2	2	2	2	1	1	0	0	0	0	0	0
Total	13	12	12	9	10	1	0	9	0	0	4	0
Percent (%)		92.3	92.3	69.2	76.9	7.7	0	69.2	0.00%	0	30.8	0
Bolgatanga Municipal												

Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Bolgatanga Central	13	8	4	11	4	2	0	12	0			
Bolgatanga North	3	1	2	2	2	0	0	2	0	1	0	0
Bolgatanga South	2	2	2	2	2	0	0	2	0	1	2	0
Gambibgo	2	2	2	2	2	0	0	2	0	1	2	1
Plaza	10	7	6	10	6	2	1	8	1	3	4	2
Sherigu	5	3	3	3	3	1	0	5	0	1	2	1
Sumburungu	6	5	4	6	4	2	0	3	0	0	1	1
Zuarungu	7	6	4	7	4	2	0	7	0	0	3	1
Zuarungu Moshie	3	3	3	3	3	0	0	2	0	0	3	0
Total	51	37	30	46	30	9	1	43	1	12	21	9
Percent (%)		72.5	58.8	90.2	58.8	17.6	2	84.3	2	23.5	41.2	17.6
Bongo District												
Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Beo	7	5	7	6	7	0	0	6	0	3	5	1
Bongo Central	10	7	8	9	7	1	0	10	1	3	5	2
Namoo	7	7	7	7	6	1	0	7	0	3	4	1
Soe	7	6	7	6	5	1	0	5	0	3	4	1
Valley Zone	6	5	6	6	6	0	0	6	0	1	5	1
Zorko	7	7	7	3	5	0	0	7	0	4	5	0
Total	44	37	42	37	36	3	0	41	1	17	28	6
Percent (%)		84.1	95.5	84.1	81.8	6.8	0	93.2	2.3	38.6	63.6	13.6
Builsa North District												
Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods

Chuchuliga	6	6	6	6	4	0	0	5	0	6	5	1
Kadema	3	3	3	2	2	0	0	3	0	1	3	0
Sandema East	3	2	2	2	2	0	0	2	0	1	2	0
Sandema West	5	5	5	5	5	2	0	5	1	3	5	0
Siniensi	3	3	3	3	3	0	0	3	0	3	2	0
Wiaga	5	5	5	5	3	0	0	5	0	3	2	0
Total	25	24	24	23	19	2	0	23	1	17	19	1
Percent (%)		96	96	92	76	8	0	92	4	68	76	4.00%
Builsa South District												
Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Doninga	3	3	3	2	3	0	0	2	0	0	2	0
Fumbisi	6	6	4	6	2	0	0	6	0	1	2	0
Gbedema	2	2	2	2	2	0	0	0	0	0	1	0
Kanjarga	5	5	5	5	5	0	0	4	0	1	2	2
Uwasi	3	3	3	2	2	0	0	2	0	2	1	2
Wiesi	2	2	2	1	2	0	0	2	0	1	2	0
Total	21	21	19	18	16	0	0	16	0	5	10	4
Percent (%)		100	90.5	85.7	76.2	0	0	76.2	0	23.8	47.6	19
Garu Tempene District												
Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Basyonde	11	6	7	8	6	0	0	9	0	0	1	0
Bugri	9	7	7	8	7	0	0	9	0	1	3	0
Denugu	10	5	6	6	4	0	0	8	0	0	1	0
Garu	17	10	9	15	9	0	0	17	0	2	2	2
Kpikpira	9	6	6	3	4	0	0	6	0	2	0	0
Songo	5	4	4	5	4	0	0	5	0	0	1	0

Tempane	7	6	6	5	6	0	0	6	0	0	0	0
Worikambo	8	4	4	5	1	1	0	8	0	0	0	0
Woriyanga	8	5	5	5	5	0	0	8	0	2	1	0
Total	84	53	54	60	46	1	0	76	0	7	9	2
Percent (%)		63.1	64.3	71.4	54.8	1.2	0	90.5	0	8.3	10.7	2.4
Kassena Nankana Municipal												
Subdistrict		FP counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural methods	Other methods
Mayoro	3	3	3	3	3	0	0	3	0	1	3	0
Navrongo Central	7	4	3	6	2	2	1	7	1	1	2	3
Navrongo East	3	3	3	3	3	0	0	3	0	1	2	0
Pungu	4	4	4	4	4	0	0	4	0	2	4	0
Vunania/Kapania	2	2	2	2	2	0	0	2	0	2	1	1
Wuru	4	4	4	4	3	0	0	4	0	3	4	0
Total	28	25	24	27	22	2	1	28	1	11	18	4
Percent (%)		89.3	85.7	96.4	78.6	7.1	3.6	100	3.6	39.3	64.3	14.3
Kassena Nankana West District												
Subdistrict	Number of providers	Counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural method	Other methods
Chiana	7	7	7	7	7	0	0	6	0	3	6	0
Kandiga	5	5	5	5	5	0	0	4	0	2	1	0
Katin-Nakong	2	2	2	2	2	0	0	2	0	0	2	0
Kayaro	3	3	3	2	3	0	0	3	0	2	0	0
Mirigu-Nabanga	5	5	5	4	4	2	0	5	0	2	3	0
Nakolo	2	2	2	2	2	0	0	2	0	1	2	0
Navio	3	3	3	1	3	0	0	3	0	1	2	0
Paga Central	12	7	7	8	4	1	0	6	1	1	1	0
Sirigu	3	3	3	3	3	0	0	2	0	1	1	0

Total	42	37	37	34	33	3	0	33	1	13	18	0
Percent (%)		88.1	88.1	81	78.6	7.1	0	78.6	2.4	31	42.9	0
Nabdram District												
Subdistrict	Number of providers	Counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural method	Other methods
Kongo/Pitanga	6	4	4	5	3	0	0	6	0	2	5	0
Nangodi	4	3	3	4	3	0	0	4	0	2	2	1
Pelungu	5	5	3	4	3	0	0	4	0	1	3	0
Sakote	3	3	3	3	3	0	0	3	0	3	3	1
Zanlerigu	2	2	2	2	2	0	0	2	1	1	1	2
Total	20	17	15	18	14	0	0	19	1	9	14	4
Percent (%)		85	75	90	70	0	0	95	5	45	70	20
Pusiga District												
Subdistrict	Number of providers	Counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural method	Other methods
Kulungungu/Kultamsi	3	3	3	2	3	2	0	2	0	0	2	1
Nakom/Zuabulga	2	2	2	1	2	0	0	1	0	0	1	1
Pusiga Central	7	4	4	7	4	2	0	3	0	1	2	2
Sarabogo	1	1	1	1	1	1	0	1	0	0	1	0
Widana	2	2	2	2	2	1	0	0	0	0	0	1
Total	15	12	12	13	12	6	0	7	0	1	6	5
Percent (%)		80	80	86.7	80	40	0	46.7	0	0	40	33.3
Talensi District												
Subdistrict	Number of providers	Counselling	Injectable	OCP	Implant	IUD	Vasectomy	Male condom	Female sterilization	Cycle beads	Natural method	Other methods
Datoko	2	2	2	2	2	0	0	2	0	1	2	0
Duusi/Gbani	3	3	3	2	3	0	0	3	0	0	3	0
Gorogo/Banga	4	4	4	4	3	0	0	4	0	2	2	1

Namolgo/Kpatia	4	4	4	4	2	0	0	4	0	0	3	0
Pwalugu	5	4	3	5	3	1	0	5	0	1	2	0
Tolla/Nungu	3	3	3	3	3	0	0	3	0	1	2	0
Tongo	6	5	5	6	5	0	0	6	0	1	5	0
Winkogo/Shia	6	6	5	6	5	0	0	6	0	0	2	0
Total	33	31	29	32	26	1	0	33	0	6	21	1
Percent (%)		93.9	87.9	97	78.8	3	0	100	0	18.2	63.6	3

Table 18. Number and proportion of SDPs offering different FP methods at static and outreach points, by district

District	Bawku Municipal	Bawku West	Binduri	Bolgatanga	Bongo	Bulisa North	Bulisa South	Garu Tempane	Kassena Nankana M	Kassena Nankana West	Nabdram	Pusiga	Talensi	Total
FP Counselling														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	15 (48.4%)	26 (92.9%)	12 (92.3%)	37 (72.5%)	37 (84.1%)	24 (96%)	21 (100%)	53 (63.1%)	25 (89.3%)	37 (88.1%)	17 (85%)	12 (80%)	31 (93.9%)	347 (79.8%)
Outreach services	6 (19.4%)	22 (78.6%)	1 (7.7%)	23 (45.1%)	38 (86.4%)	23 (92%)	17 (81%)	34 (40.5%)	21 (75%)	22 (52.4%)	13 (65%)	7 (46.7%)	24 (72.7%)	251 (57.7)
OCPs														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	24 (77.4%)	25 (89.3%)	9 (69.2%)	46 (90.2%)	37 (84.1%)	23 (92%)	18 (85.7%)	60 (71.4%)	27 (96.4%)	34 (81%)	18 (90%)	13 (86.7%)	32 (97%)	366 (84.1%)
Outreach services	10 (32.3%)	17 (60.7%)	2 (15.4%)	15 (29.4%)	32 (72.7%)	23 (92%)	10 (47.6%)	35 (41.7%)	11 (39.3%)	17 (40.5%)	9 (45%)	3 (20%)	24 (72.7%)	208 (47.8%)
Male condoms														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435

District	Bawku Municipal	Bawku West	Binduri	Bolgatanga	Bongo	Buisa North	Buisa South	Garu Tempone	Kassena Nankana M	Kassena Nankana West	Nabdram	Pusiga	Talensi	Total
Static services	21 (67.7%)	24 (85.7%)	9 (69.2%)	43 (84.3%)	41 (93.2%)	23 (92%)	16 (76.2%)	76 (90.5%)	28 (100%)	33 (78.6%)	19 (95%)	7 (46.7%)	33 (100%)	373 (85.7%)
Outreach services	8 (25.8%)	13 (46.4%)	6 (46.2%)	8 (15.7%)	31 (70.5%)	20 (80%)	9 (42.9%)	18 (21.4%)	13 (46.4%)	13 (31%)	9 (45%)	0.0%	23 (69.7%)	171 (39.3%)
Injectable hormonal contraceptives														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	17 (54.8%)	23 (82.1%)	12 (92.3%)	30 (58.8%)	42 (95.5%)	24 (96.0%)	19 (90.5%)	54 (64.3%)	24 (85.7%)	37 (88.1%)	15 (75.0%)	12 (80.0%)	29 (87.9%)	338 (77.7%)
Outreach services	10 (32.3%)	17 (60.7%)	2 (15.4%)	15 (29.44%)	32 (72.7%)	23 (92.0%)	10 (47.6%)	35 (41.5%)	11 (39.3 %)	17 (40.5%)	9 (45%)	3 (20%)	24	208 (47.8%)
Hormonal implants														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	14 (45.2%)	12 (42.9%)	10 (76.9%)	30 (58.8%)	36 (81.8%)	19 (76.0%)	16 (76.2%)	46 (54.8%)	22 (78.6%)	33 (78.6%)	14 (70.0%)	12 (80.0%)	26 (78.8%)	290 (66.7%)
Outreach services	3 (9.7%)	2 (7.1%)	0 (0.0%)	0 (0.0%)	12 (27.3%)	4 (16.0%)	1 (4.8%)	1 (1.2%)	0 (0.0%)	2 9(4.8%)	1 (5.0%)	0 (0.0%)	3 (9.1%)	29 (6.7%)
Cycle beads for SDM														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	2 (6.5%)	5 (17.9%)	0 (0.0%)	12 (23.5%)	17 (38.6%)	17 (68.0%)	5 (23.8%)	7 (8.3%)	11 (39.3%)	13 (31.0%)	9 (45.0%)	1 (6.7%)	6 (18.2%)	105 (24.1%)
Outreach services	0 (0.0%)	1 (3.6%)	0 (0.0%)	1 (2.0%)	7 (15.9%)	11 (44.0%)	2 (9.5%)	0 (0.0%)	5 (17.9%)	6 (14.3%)	3 (15.0%)	0 (0.0%)	2 (6.1%)	38 (8.7%)
Natural FP methods														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435

District	Bawku Municipal	Bawku West	Binduri	Bolgatanga	Bongo	Buisa North	Buisa South	Garu Tempone	Kassena Nankana M	Kassena Nankana West	Nabdram	Pusiga	Talensi	Total
Static services	12 (38.7%)	10 (35.7%)	4 (30.8%)	21 (41.2%)	28 (63.6%)	19 (76.0%)	10 (47.6%)	9 (10.7%)	18 (64.3%)	18 (42.9%)	14 (70.0%)	6 (40.0%)	21 (63.6%)	190 (43.7%)
Outreach services	7 (22.6%)	5 (17.9%)	1 (7.7%)	12 (23.5%)	27 (61.4%)	18 (72.0%)	10 (47.6%)	2 (2.4%)	12 (42.9%)	4 (9.5%)	2 (10.0%)	11 (73.3%)	15 (45.5%)	126 (29.0%)
Other FP methods														
Number of providers	31	28	13	51	44	25	21	84	28	42	20	15	33	435
Static services	2 (6.5%)	1 (3.6%)	0 (0.0%)	9 (17.6%)	6 (13.6)	1 (4.0%)	4 (19.0%)	2 (2.4%)	4 (14.3%)	0 (0.0%)	4 (20.0%)	5 (33.3%)	1 (3.0%)	39 (9.0%)
Outreach services	1 (3.2%)	0 (0.0%)	1 (7.7%)	8 (15.7%)	1 (2.33%)	1 (4.0%)	3 (14.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (5.0%)	0 (0.0%)	0 (0.0%)	16 (3.7%)

Table 19. Proportion of demarcated CHPS zones offering FP services, by district

District	Number of demarcated CHPS	CHPS zones offering FP services	
		Number	%
Bawku Municipal	25	6	24.0%
Bawku West	32	14	43.8%
Binduri	23	8	34.8%
Bolgatanga Municipal	37	16	43.2%
Bongo	40	35	87.5%
Builsa North	31	20	64.5%
Builsa South	25	14	56.0%
Garu Tempane	53	42	79.2%
Kassena Nankana Municipal	33	20	60.6%
Kassena Nankana West	35	30	85.7%
Nabdam	20	13	65.0%
Pusiga	20	7	35.0%
Talensi	25	23	92.0%
Total	399	248	62.2%

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