Integrating Family Planning into Primary Health Care in Ghana

GHANA

Ghana is among the low- and middle-income countries that are taking steps to achieve universal health coverage (UHC). The performance of primary health care (PHC) systems in these countries and their ability to deliver quality essential health services contribute to this process. This fact sheet provides an overview of Ghana's progress in integrating one such service: family planning.

Ghana has long been committed to maintaining a strong family planning program as an essential component of the country's broader development agenda. It has also made admirable progress in PHC service delivery and financing and has taken significant steps to include family planning as part of routine, facility-based care within the PHC system.

The government has committed to incorporating clinical family planning methods as a covered benefit under the national health insurance scheme and increasing the share of domestic funding for contraceptive commodities from one-quarter to one-third.

Family planning was an original area of focus for Ghana's Community-based Health Planning and Services (CHPS) program, which was created to expand access to basic health care in rural and underserved communities. The current family planning strategy proposes further integration with PHC and broader health system functions in order to increase family planning coverage and realize cost savings within the overall health system.

However, family planning coverage lags behind the government's stated goals, including the FP2020 commitments Ghana made at the 2012 London Summit on Family Planning. The country's modern contraceptive prevalence rate is 22%, short of its FP2020 goal of 29%.

As part of its FP2020 commitments, the government approved the *Ghana Family Planning Costed Implementation Plan 2016–2020* (GFPCIP), which outlines strategies for improving sexual and reproductive health. The plan also notes the importance of more fully integrating family planning into other aspects of PHC—such as maternal and child health services, antiretroviral therapy clinics, and client-initiated HIV testing—to improve efficiency and yield financial savings on the way to meeting the FP2020 commitments.

AT A GLANCE

- In Ghana, 24% of the population lives in poverty; unmet need for family planning is highest among the lowest wealth quintile.
- The private sector provides about one-third of family planning services in Ghana. Integration with government-led procurement, planning, and oversight is mixed.
- External donors still fund most contraceptive commodities in Ghana.
- Family planning was initially excluded from the national health insurance package; reforms are underway to fully include it, but the optimal reimbursement mechanisms have yet to be determined.
- Expanded access to a diverse mix of modern contraceptive methods is essential to the successful integration of family planning into primary health care and achieving universal health coverage.

How Family Planning Fits into the Health Care System

Ghana Health Service (GHS), an agency within the Ministry of Health, oversees the family planning program. GHS is also responsible for supervising accreditation of health facilities, paying staff salaries at public health centers, and leading supportive supervision for health workers. While the government administers the family planning program, donors such as the United Nations Population Fund and the United States Agency for International Development have significant influence over the direction of the program because of the funds they contribute for service delivery and commodities.

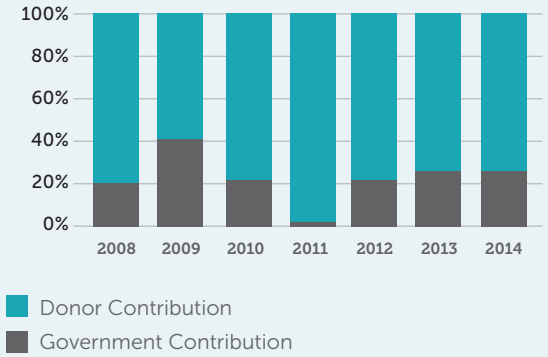
Family planning services are included in the main PHC structure in Ghana, both through health facilities and through the CHPS strategy, which grew out of a pilot program launched in 1998 to provide family planning and other basic PHC services to rural and underserved areas. The program places community health nurses in remote areas; those nurses recruit and manage a network of community health volunteers, who help with community engagement and health promotion and can provide condoms and information on other available family planning methods. However, the program has been plagued by high turnover among staff and volunteers.

One gap in realizing the GHS mandate on guiding and supervising health services is the lack of private-sector involvement. The private sector provides approximately one-third of family planning services in Ghana but is not well incorporated into the health system or well regulated by the government. This leaves the private sector largely excluded from access to subsidized family planning commodities, accreditation, and GHS supervision. One exception is the Christian Health Association of Ghana, a network of 302 faith-based health facilities that works closely with the Ministry of Health to provide health care in underserved areas.

Health Financing and Contraceptive Choice

Ghana still relies on donor funding for a significant portion of its health budget, especially for family planning service delivery and commodities, which are distributed to public-sector facilities. (See the figure on this page.) The World Bank currently funds some family planning services at the PHC level, but this funding goes only to public providers; these providers tend to use the funds to offer short-acting contraceptive methods because these methods are generally cheaper. As the government considers further integrating family planning into PHC, it must consider the costs, who pays those costs, and the tradeoffs that accompany different reimbursement structures.

Funding Sources for Family Planning Commodities in Ghana



Source: GFPCIP

In 2003, Ghana launched the National Health Insurance Scheme (NHIS), which covers a package of preventive and curative services for approximately 40% of Ghanaians. Funding for the NHIS comes mostly from a 2.5% earmark from Ghana's value-added tax and smaller funding sources such as donor contributions and investment income. The NHIS also charges very low premiums (currently about US$6 to US$8 per year) to informal-sector members; the premiums are waived for large categories of high-need individuals.

Family planning services were excluded as a covered benefit in the initial NHIS law, passed in 2003, because donors were heavily funding such services and commodities. During the revision of the NHIS law in 2012, family planning services were included in the benefits package. However, this has not been implemented due to continued dependence on donor contributions for family planning commodities. Nonetheless, as part of its FP2020 commitments, the government said it would recalibrate the health system to function without the same levels of donor funding and would ensure that family planning is covered under the NHIS.

To facilitate this process, the government is piloting implementation of family planning services under the NHIS in selected districts. This will help determine the costs of covering family planning in the benefits package. The critical issue is provider reimbursement—whether to pay providers using capitation (paying an agreed-upon amount per person for a specific time period and package of PHC

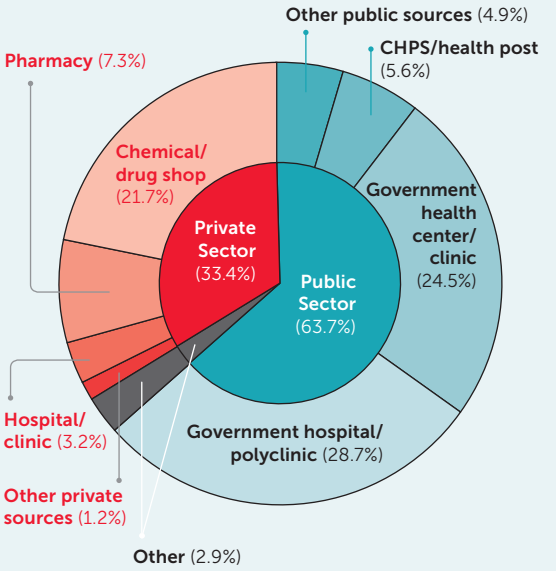
services, including family planning), bundled payment (covering an episode of family planning counseling, method provision, and follow-up), or fee-for-service (reimbursement for each service provided). Costing of family planning services is especially challenging because those services should be accompanied by rights-based informed consent and counseling, which is time-consuming. Accounting for this time is important in considering reimbursements, including whether the basis of payment for counseling will be the same as for commodities.

External funding for contraceptive commodities helps ensure choice in the public sector. The system for ordering and delivering contraceptives is different for the private sector; this limits choice in private-sector facilities and makes it difficult to forecast overall contraceptive commodity needs for the country. The private sector has also historically been excluded from procurement planning for national family planning efforts.

Private-sector facilities purchase commodities from commercial suppliers. The method mix provided at private facilities is much more limited than those at public facilities, particularly for long-acting reversible methods. Less than a quarter of private facilities offer intrauterine devices (IUDs) or implants, and less than a third provide injectables.

The figure in the next column shows where Ghanaian women obtain modern contraceptive methods.

Source of Most Recent Modern Contraceptive Method Among Women Ages 15 to 49

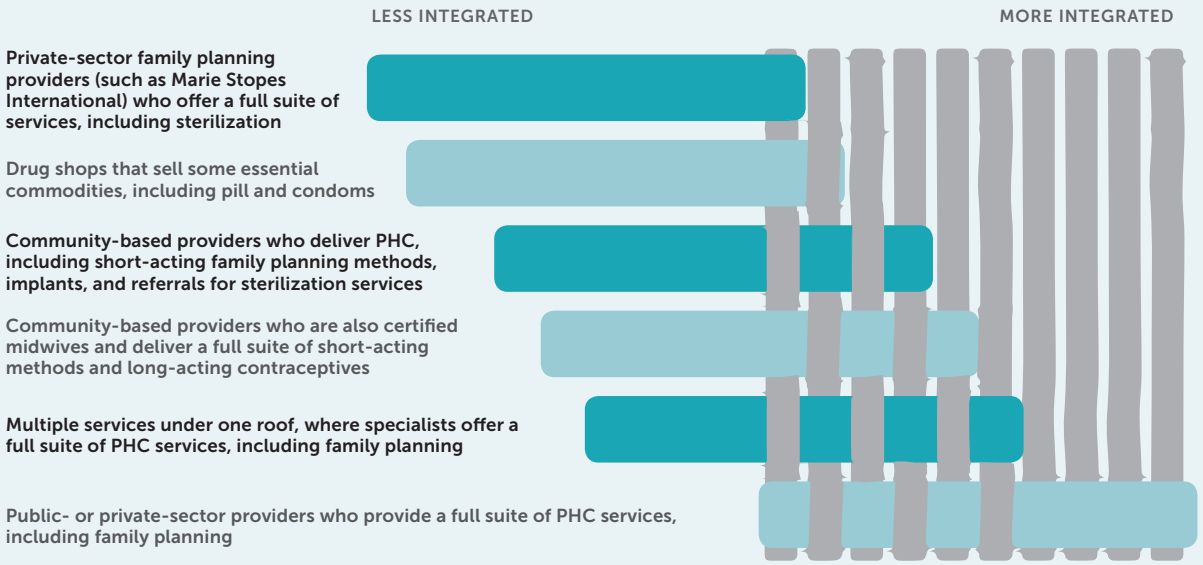


Source: Ghana Demographic and Health Survey 2014

Current Level of Integration

The following figure illustrates the degree to which family planning is already integrated into PHC in various service delivery settings in Ghana. In some settings, the PHC provider offers a comprehensive

Continuum of Integration Across Ghanaian Health Services



suite of family planning services—counseling, the full range of family planning methods, appropriate health education, and sexual health services, including testing for HIV and sexually transmitted infections. The least integrated setting is a standalone private-sector facility that offers only family planning and no other PHC services.

Obstacles to Integration

A number of obstacles stand in the way of fully integrating high-quality family planning services into PHC in Ghana. Some of those obstacles are structural:

- Family planning programs have typically been housed in discrete areas within facilities and staffed by dedicated providers, so other facility staff have not participated in providing family planning within the broader aspects of care.
- Linkages among health facilities, services based at CHPS compounds, and community-based outreach services are weak.
- NHIS reimbursements to providers for family planning services are frequently delayed, which can lead providers to charge clients out of pocket for services.
- High turnover among community health nurses and volunteers limits the availability of family planning counseling and method provision at the most basic level of care.
- An insufficient number of clinicians and midwives are available to provide long-acting contraceptive methods, specifically implants and IUDs.
- Information systems for tracking family planning service delivery in Ghana are largely vertical, and the data are of variable quality.

Other obstacles are related to service delivery. One issue is provider motivation. Providers often recommend short-acting methods, which are easier to administer and require less time for counseling, rather than those that might best suit a client's needs. Another issue is provider competence. Many providers lack training in insertion and removal of long-acting methods, which limits the range of methods offered. A further obstacle is lack of informed choice. Many clients are unaware of the range of methods available to them and the benefits and potential side effects of each method. They are thus heavily reliant on information from providers, who are not always able or willing to provide counseling on all methods.

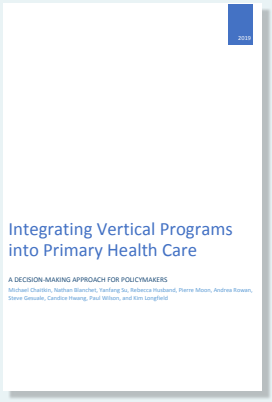
Next Steps

Ghana's national government, including the Ministry of Health and GHS, have shown a clear commitment to scaling up family planning coverage and meeting the country's ambitious FP2020 commitments. At the same time, the country's health goals and strategies are shifting away from single-issue health programs toward more holistic, people-centered care that advances progress toward UHC. The country has also dedicated time and resources to developing sound family planning policies and a national strategy that includes several key points of integration with PHC.

Feasible next steps for Ghana would include:

- Addressing policy gaps to promote a more integrated, people-centered approach to health
- Building a resilient, self-funded health system as the country decreases its reliance on donor funding
- Better aligning government agencies, donors, and partners on integration of family planning services and PHC
- Ensuring timely reimbursement of family planning services through NHIS and better reporting
- Addressing the challenge of NHIS payment mechanisms

FOR A MORE DETAILED DISCUSSION, see *Integrating Vertical Programs into Primary Health Care: A Decision-Making Approach for Policymakers* and the Ghana and Malawi case studies at **www.r4d.org/integrating-vertical-programs.**



RESULTS FOR DEVELOPMENT

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