GHANA TREND REPORT

Ghana Trend Analysis for Family Planning Services 1993, 1996, 2002

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Ghana Trend Analysis for Family Planning Services, 1993, 1996, and 2002

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Key Findings

This analysis assesses trends in aspects of family planning services in Ghana, using information from studies conducted in 1993, 1996, and 2002.

Infrastructure and service availability

- Infrastructure and service availability have improved.

  As per national reproductive health programme policies, almost all facilities (96 percent) now offer family planning services five or more days per week.

  Infrastructure has also improved, with availability of private rooms for family planning client examinations increasing from 59 percent in 1993 to 91 percent in 2002.

  Availability of all infrastructure support items assessed (piped water, a functioning client toilet, and electricity) has also improved, from 28 percent in 1993 to 34 percent in 2002.

  Infrastructure at health centres, which have the largest number of family planning service sites, has shown the least improvement.

- Client satisfaction with the level of privacy when receiving services and with waiting times showed substantial improvement and supported the value of the infrastructure improvements.

Essential equipment for family planning services

- Availability of equipment and materials for client examinations has not changed.

  Less than half (47 percent) of facilities are fully equipped for examinations of family planning clients (having a functioning blood pressure apparatus, stethoscope, weighing scale, vaginal speculum, and examination table). Planned Parenthood Association of Ghana (PPAG) and maternity clinics are somewhat better equipped than hospitals and health centres.

- Availability of consumable commodities has improved, with 95 percent of facilities having both clean gloves and sterile syringes and needles.

  However, gloves are present in the family planning service area (where they need to be for routine utilisation in only two in three facilities).

Availability of contraceptive methods

- The number of different contraceptive methods offered has increased for hospitals and private clinics and remained the same for health centres. Health centres continue to offer at least five methods, and hospitals have increased the number of methods offered, from six to eight.

- The percentage of facilities offering the intrauterine device (IUD) has decreased.

- There has been little improvement, and some deterioration, in the reliability of stock supply of contraceptive methods. No method was available in all facilities where the method was offered.

Each different method of contraception was missing on the day of the survey (2002) in 10 to 30 percent of facilities offering the method.

- Only one in five hospitals and less than half of all health centres and maternity centres had commodities available for all contraceptive methods offered, on the day of the survey. This is a deterioration from findings in 1996, when 77 percent of hospitals and 66 percent of health centres had commodities available for all methods offered.

Availability of services with family planning

- Sexually transmitted infection (STI) service availability at any site in facilities offering family planning has increased substantially (from 42 percent in 1993 to 71 percent in 2002). In addition, 39 percent of facilities in 2002 indicated that STI services are also offered by family planning providers.

- There is a marked improvement in the availability of guidelines for STI services (from 19 percent in 1996 to 70 percent in 2002).

- More providers are asking relevant questions to screen family planning clients for STIs; one in three observed family planning clients were assessed for STIs in 2002 (up from one in four in 1993 and one in five in 1996).

- Fewer facilities are offering condoms as a contraceptive method (decreasing from 96 percent in 1993 to 91 percent in 2002). Around 87 percent of facilities offering condoms for contraception had them available on the day of the survey in 2002. Prescriptions of condoms either for contraception or for dual-method use has remained at a meager 1 to 2 percent of observed clients. Both of these findings are of concern because of the public health implications for STIs, particularly HIV/AIDS.

- Client educational materials for STIs and HIV/AIDS are more available, increasing from 25 percent in 1996 to 37 percent in 2002. PPAG facilities have the greatest improvement, with 93 percent having any information-education-communication (IEC) materials for STIs or HIV/AIDS (2002).

Provider qualifications, experience, and training

- The qualifications of providers of family planning services have remained essentially the same, with a small increase (from 2 percent in 1993 to 5 percent in 2002) in doctors providing the service.

- The proportion of family planning providers (primarily nurses) who have received in-service training on counselling for family planning during the past five years has increased significantly, from 38 percent in 1993 to 60 percent in 2002.

Adherence to standards in practice

- There is little change in the consistency with which key elements of an initial history and examination for new clients are assessed. More than one in four new clients are not asked about the age of their youngest child and do not have their weight or blood pressure measured. Two in three of them are not asked about their breastfeeding status.

- A larger proportion of new clients are encouraged to ask questions or share concerns about methods (from 31 to 71 percent of observed new clients in 1993 and 2002, respectively).

- In 2002, an average of one in five observed and interviewed clients reported that during the current visit they did not receive information on at least one of the major points queried (how to use their method, what the side effects are, or what to do for problems). Despite this, client's knowledge about how to use their specific method remains high, indicating that they either receive their information elsewhere or have received the information during previous visits.

- Availability of client educational materials about family planning has remained fairly constant for the last decade. While three in four facilities have posters, less than half have other types of IEC materials. The notable exception is PPAG clinics, where more than 90 percent of facilities have both posters and other types of IEC materials.

- Use of visual aids during client counselling has remained low, with utilisation observed for only one in four clients.

Recommendations

- The weaknesses identified should be discussed with district-level supervisors to determine the feasibility for improvement. Supervisory practices that support adherence to quality standards and the continuous availability of essential equipment and commodities should be implemented.

- Although there were no stockouts at the national level, the reasons for the gaps in supply of contraceptive methods need to be assessed, and interventions must be made to ensure consistent distribution.

- The new distribution system adopted by the Ministry of Health, which allows regions to directly supply service delivery points, bypassing districts, should be put into effect.

- Offering condoms either as a primary or a dual method of contraception is essential as an intervention for preventing STI/HIV infection. Barriers to promoting this method should be identified, and active interventions should be developed to ensure that providers promote condom use when appropriate.

- Within guidelines for family planning services, instructions should be included for the use of IEC material. The availability and use should then be supported through proper supply, training, and supervision.

- A source of water for all facilities is critical for infection control. Where piped water is not feasible, water must be made available in the service area, preferably in containers with a tap to allow running water.

- Facilities must ensure that there is a functioning latrine, which is critical to client comfort and infection prevention.

- For improved availability of essential equipment, the existing systems for maintenance and/or replacement of minor equipment should be reviewed, barriers to effective implementation should be addressed, and then changes should be made to rectify the problems.

Acronyms

ANC	Antenatal care
BP	Blood pressure
CBD	Community-based distribution
CHAG	Christian Health Association of Ghana
CSM	Contraceptive Social Marketing
FP	Family planning
FPHP	Family Planning and Health Programme
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GHANAPA	Ghana Population and AIDS Project
GRMA	Ghana Registered Midwives Association
GSPA	Ghana Service Provision Assessment
GSS	Ghana Statistical Service
IEC	Information-education-communication
IUD	Intrauterine device
MOH	Ministry of Health
NGO	Nongovernmental organisation
ORC	Opinion Research Corporation
PPAG	Planned Parenthood Association of Ghana
RCHU	Reproductive and Child Health Unit
SAS	Situation Analysis Study
STI	Sexually transmitted infection
TFR	Total fertility rate
USAID	United States Agency for International Development

1 INTRODUCTION

The Ghana National Population Policy of 1994 includes the following objectives (Ghana National Population Council, 1994):

- To reduce the total fertility rate to 4.0 by 2010 and to 3.0 by 2020
- To increase the modern contraceptive prevalence rate to 28 percent by 2010 and to 50 percent by 2020
- To achieve a minimum birth spacing of at least two years for all births by 2020.

To achieve these objections, the Reproductive and Child Health Unit (RCHU) of the Ghana Health Service (GHS), which is responsible for family planning services, has made increasing availability and appropriate utilisation of family planning services a priority.

Knowledge and use of family planning have increased markedly in Ghana, and the country is well on its way to achieving its population policy goals. According to the Ghana Demographic and Health Surveys, overall contraceptive use among married women has steadily increased over the last 15 years, from 13 percent in 1988 to 25 percent in 2003, with use of modern methods increasing from 5 to 19 percent. The total fertility rate (TFR) declined from 6.4 births per woman in 1988 to 4.4 in 2003 (Ghana Statistical Service et al., 2004). This has so far exceeded the TFR target set.

In addition to a need for monitoring progress using individual and household information, there is a need to monitor the supply side of family planning services. This analysis reviews the data from three facility-based surveys designed to provide information on the availability and quality of the facility-based family planning services in Ghana.

In 1993 and 1996, the Ghana Situation Analysis Studies, focusing on family planning services, were carried out with technical support from the Population Council (Ghana Statistical Service et al., 1994; Ghana Statistical Service et al., 1997). In 2002, the Ghana Service Provision Assessment (GSPA) survey was carried out with technical support from ORC Macro (Ghana Statistical Service et al., 2003). Although the three studies covered different health services and used different data collection tools, there were sufficient similarities in the data collection and the methodologies for family planning services to allow an analysis of changes over time in some essential family planning service components.

1.1 Background on family planning programme strategies for Ghana

It is important to place changes in family planning services in the context of a country's family planning programme strategy. In Ghana, government support of family planning programmes began in 1969, with some of the major programme initiatives being the Contraceptive Social Marketing (CSM) project (1987-1990), the Ghana Family Planning and Health Programme (FPHP) (1990-1996), and, more recently, the Ghana Population and AIDS Project (GHANAPA) (1996-2000). The initial focus of these projects was to increase demand and utilisation of modern methods for family planning through social marketing. The FPHP continued social marketing strategies and worked to expand the capacity of the public and private sectors to provide family planning services, supplies, and information, including addressing sexually transmitted infections (STIs) and HIV infections (Miller et al., 1998; Adamchak et al., 1995). As a result of the 1993 Situation Analysis Study for family planning services, much effort was put forth to developing protocols, standards and guidelines and to training nurses to provide family planning services. Traditionally, in-service training programmes have always focused more on nurses, as they are the major providers of the nonsurgical family planning methods, with underlying assumptions that doctors have

adequate exposure during their medical training for the nonsurgical methods and that doctors provide only a small proportion of family planning services.

There has been an increase in the variety of methods available. Between 1993 and 1996, there was a particular focus on expanding access to permanent (mini-laparotomies and vasectomies) or long-term methods (intrauterine devices [IUDs] and implants). In addition, the Catholic Church made a specific effort to promote natural family planning. Since 1996, the monthly (combined) injectable and the female condom have been introduced in both the public and private sectors. In-service training has been provided by the RCHU to nurses to provide the monthly injectables and emergency contraception and by EngenderHealth, a nongovernmental organisation (NGO), to medical officers and doctor-nurse teams in the vasectomy procedure. This has increased the variety of methods that can be safely offered at facilities.

Between 1996 and 2002, the programme focus was on extending the range of family planning services offered to the public, providing more choice in methods and developing strategies to reach special groups, such as adolescents and men. The FPHP increased availability by modifying its policy to indicate that the consent of a partner is desirable but not necessary for a particular method to be offered to a client. In addition, provision was made for individuals with mental disability or serious psychiatric illness, where the client is not competent to make an informed choice, and for adolescents, for contraceptives to be provided in consultation with all relevant parties, including persons in loco parentis and trained service providers.

The RCHU sees the family planning session as an important opportunity for identifying and managing other reproductive health problems, including STI/HIV/AIDS. There has been a deliberate effort to train providers of family planning services in the management of STIs (counselling, diagnosis, and treatment/provision of drugs) using syndromic management. The syndromic management approach was initiated in the public health system to address some of the shortcomings in the management of STIs in resource-poor settings, where staff and equipment are rarely available. Additionally, the concept of dual protection from STI/HIV/AIDS and pregnancies through the use of condoms has been championed by the RCHU. Along with the described expansion of the package of interventions for family planning services, the policy has been to promote availability of family planning services daily, rather than only on certain days. For many facilities, however, surgical methods are only offered on specific days, when a visiting medical officer consults at the clinic.

Finally, the Ghana reproductive health programmes have placed an emphasis on improving infection control measures, specifically advocating that Veronica buckets (buckets with a tap) be available in service areas where there is no piped water.

1.2 Objectives and design of the comparative study

The objective of this comparative study is to provide an analysis of trends for selected family planning service indicators measured in 1993, 1996, and 2002. This information is important for health programme planners and policy decisionmakers when reviewing their strategies for improving family planning services.

This study is designed to—

- Describe trends in family planning service delivery indicators measured in 1993, 1996, and 2002
- Describe changes over time in the readiness of government and nongovernment facilities to provide quality family planning services

- Identify the strengths and the areas where improvement is needed in services, resources, or processes used in providing family planning services
- Describe changes in indicators for client knowledge about and satisfaction with family planning services.

2 METHODOLOGY

2.1 Description of the survey methods

The Ghana Situation Analysis Studies (SASs) of 1993 and 1996 were developed by the Population Council's Africa Operations Research and Technical Assistance Project. The 2002 GSPA was developed by ORC Macro as part of the MEASURE *DHS*+ project.

The three surveys collected information on the supply side of different maternal, child, and reproductive health services. This study, however, focuses mainly on family planning services.

Methodologies for data collection used for the three surveys include the following:

- A questionnaire was used to collect information on facility infrastructure, management systems, supplies, and equipment important for providing quality family planning services. Information was gathered through interviewing key informants and by observing the presence and conditions of equipment, supplies, and documents, where applicable.
- Client-provider interactions were observed. A checklist was used to collect information on procedures followed during examinations and provision of contraceptive methods, as well as information shared between the provider and client.
- Exit interviews were conducted with observed clients for information on their understanding of the consultation or examination, recollection of instructions received, and perception of services provided
- Family planning service providers were interviewed for information on their qualifications, work experience, training, and supervision.

2.2 Description of survey samples

All three surveys collected data from a sample of government and NGO-managed health facilities.

The sampling frame (the total listing of facilities from which the sample was selected) for the 1993 SAS was significantly smaller than that of the 1996 SAS and the 2002 SAS. The sample for the 1993 SAS included all government hospitals, all clinics operated by the Planned Parenthood Association of Ghana (PPAG), a sample of maternity centres registered with the Ghana Registered Midwives Association (GRMA) (nongovernmental facilities), and health centres that were known to be providing family planning services.

After 1993, there was an expansion of family planning services, with the number of facilities eligible to provide family planning services increasing. This resulted in the sampling frame for the 1996 and 2002 surveys increasing substantially over that used for the 1993 survey. The 1996 SAS and the 2002 GSPA included a sample of Ministry of Health (MOH), Christian Health Association of Ghana (CHAG), and GRMA hospitals, health centres, and maternity centres, as well as all PPAG clinics. PPAG had expanded its working locations between 1993 and 1996, but these service locations had significantly decreased by 2002, as a result of PPAG changing its focus from family planning to adolescent health and subsequently closing many of its family planning clinics. Numbers may have decreased further as a result of attrition of nurses and inadequate resources to maintain all of PPAG's service points.

The samples for each of the three surveys were selected to be nationally representative of facilities providing family planning services, by type of facility, with proportional regional representation.

Although the sample sizes for the three surveys varied, because of financial considerations, the methodology for selecting the samples was similar.

The three surveys did not originally classify facilities in the same manner for analysis. To ensure comparisons of like facilities, this study regrouped facilities into four main categories: all types of hospitals (teaching, regional, district, and, in 2002, polyclinics), health centres (health centres, health clinics, and health posts), PPAG clinics, and private maternity centres. Table 2.1 provides information on the sampling frame for each survey, and Table 2.2 provides information on the sample by type of facility, as classified in the indicated survey.

Table 2.1 Sampling frame for surveys

Number of facilities from which the sample for each survey was drawn, by type of facility and year of survey, Ghana 1993-2002

	Number of facilities from which sample was drawn		
Type of facility	1993	1996	2002
Hospital	66	114	144
Health centre	551	707	962
PPAG clinic	35	44	15
Private maternity centre	223	313	323
Total	875	1,178	1,444

Table 2.2 Sample for surveys of family planning services

Number of facilities and percentage of the sample frame represented for each survey, by type of facility and year of survey, Ghana 1993-2002

	Number of facilities and percentage of sample frame represented					
	1993		1996		2002	
Type of facility	Number	Percent	Number	Percent	Number	Percent
Hospital	59	14.5	60	19.2	63	14.7
Teaching hospital	2	0.5	na	na	2	0.5
Regional hospital	8	2.0	na	na	na	na
District hospital	49	12.3	na	na	na	na
Regional/district hospital	na	na	na	na	57	13.3
Polyclinic	na	na	na	na	4	0.9
Health centre/clinic	243	60.9	158	50.5	259	60.5
Health centre	167	41.9	158	50.5	140	32.7
Health post	na	na	na	na	16	3.7
Health clinic	44	11.0	na	na	na	na
Clinic	na	na	na	na	87	20.3
Other	32	8.0	na	na	16	3.7
PPAG clinic[1]	22	5.5	33	10.5	13	3.0
Private maternity centre	75	18.8	62	19.8	93	21.7
Total	399	100.0	313	100.0	428	100.0

[1] All three surveys collected data from all PPAG clinics functioning at the time.
na = Not applicable (classification not used during this survey)

2.3 Method of analysis

The data collection tools for the three surveys were reviewed to ensure that only comparable data were used in this trend analysis. Percentages in this report may vary from those in original survey reports because of the regrouping of response categories when necessary for comparability across the three surveys.

Data for each survey are presented by type of facility and for all facilities combined, weighted to ensure appropriate national representation for each type of facility.

The standard for family planning services does not vary by type of facility or managing authority. If a facility cannot meet the standard (e.g., for providing implant or sterilisation), it is not expected to offer the service.

3 RESULTS

There are several aspects to ensuring quality health services. An initial investment in infrastructure, equipment, and training of staff is required. In addition, there is a need for policies to guide providers in what services should be offered, as well as at what frequency, and what elements of services are necessary to meet the expected standard. Finally, there is a need for systems to ensure that standards are maintained, equipment is kept in functioning condition, resupply of consumable items and pharmaceuticals is reliable, providers are kept up to date on standards and elements relevant to their services, and adherence to standards is supported (Jain et al., 1992).

This study assesses changes in the basic infrastructure for facilities and for service provision, the frequency with which services are offered, the number of clients served, and availability of essential equipment, resources, and trained staff. In addition, observation of client-provider interactions provides information on actual practices when assessing the client history, providing counselling, and when examining the client. Finally, client interviews provide information on clients' perceptions of what they are told and their opinion of service conditions.

When interpreting trend results it must be remembered that the proportion of all facilities in the country that were eligible for the survey increased substantially between 1993 and 1996, and again between 1996 and 2002 due to an expansion of FP services. Thus, while data for each survey do provide representative information on the status of FP services for that time period, trend changes may reflect not only changes in measured indicators, but also a difference in the characteristics of facilities providing FP services.

3.1 Basic infrastructure and service availability

Information on facility infrastructure and availability of equipment and contraceptive supplies was collected using an inventory questionnaire. In addition, interviews were conducted with key informants to ascertain the frequency with which family planning services were offered, and the methods of contraception offered in the facility.

3.1.1 Essential infrastructure to support services

Certain infrastructure and health system components support the appropriate utilisation and delivery of services with a standard quality. Clients are more likely to visit facilities with a basic infrastructure that both provides for client comfort and supports quality services (Tuoane et al., 2004).

Elements of the facility infrastructure that were assessed include the availability of piped water, electricity, and a functioning client toilet. The percentage of facilities with a piped water supply is essentially unchanged, decreasing from 44 to 37 percent from 1993 to 1996, but increasing to 42 percent in 2002 (Table 3.1). The decrease in 1996 was primarily noted in health centres and maternity centres. The surveys also assessed whether water (either piped or provided in a container) was available in the family planning service area. The 1993 and 1996 survey question was for "adequate water in the family planning examination room," and the 2002 survey asked for any water in the examination room. Availability of water in the family planning examination room (either piped or in a bucket) has increased significantly, from 69 to 74, to 85 percent in 1993, 1996, and 2002, respectively.

Availability of electricity has steadily increased, from 50 to 57, to 70 percent in 1993, 1996, and 2002, respectively. All types of facilities had substantial increases in availability of electricity.

There is little change in availability of toilets, with around three in four facilities having a functioning client toilet.

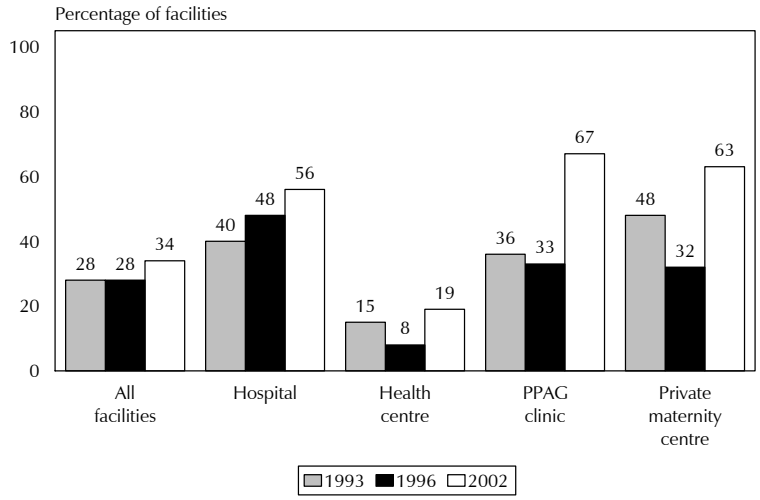
Availability of all three infrastructure components (piped water, electricity, and a functioning toilet) has increased from 28 percent in 1993 and 1996 to 34 percent in 2002 (Figure 3.1). While the trend is positive, especially at hospitals and PPAG clinics, the overall change is not statistically significant (Appendix Table A.1). The least improvement in infrastructure is noted at health centres, which comprise the largest proportion of facilities offering family planning services.

Table 3.1 Health facility infrastructure

Percentage of health facilities with piped water, electricity, and a functioning client latrine/toilet, by type of facility and year of survey, Ghana 1993-2002

	Percentage of facilities with specific infrastructure											
	Water in family planning service area			Piped water			Electricity			Functioning client toilet/latrine		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	81	85	93	52	62	64	74	83	97	74	67	90
Health centre	60	67	83	36	21	29	32	35	59	61	56	65
PPAG clinic	73	70	100	41	45	80	68	64	87	59	48	87
Private maternity centre	79	76	86	59	34	68	72	60	89	96	87	91
Total	69	74	85	44	37	42	50	57	70	72	69	74

Figure 3.1
Percentage of facilities with piped water, electricity, and functioning client toilet/latrine, by survey year, Ghana 1993-2002



3.1.2 Service availability

Effective family planning services should offer a variety of methods and commodities, so that the method most suitable for a client can be provided. Choice in family planning methods increases the level of acceptance and user continuation of services (Hatcher et al., 2001). Services also need to be available with a frequency convenient for clients.

The median number of days per week that facilities offer family planning services has increased from five (1993 and 1996) to seven (2002). This increase in service frequency is noted for all types of facilities (Figure 3.2). The percentage of facilities offering family planning services at least five days per week increased from 91 percent in 1993 to 96 percent in 2002, after a decrease to 80 percent in 1996 (Table 3.2).

Figure 3.2
Median number of days per week family planning services are offered at facilities, by survey year, Ghana 1993-2002

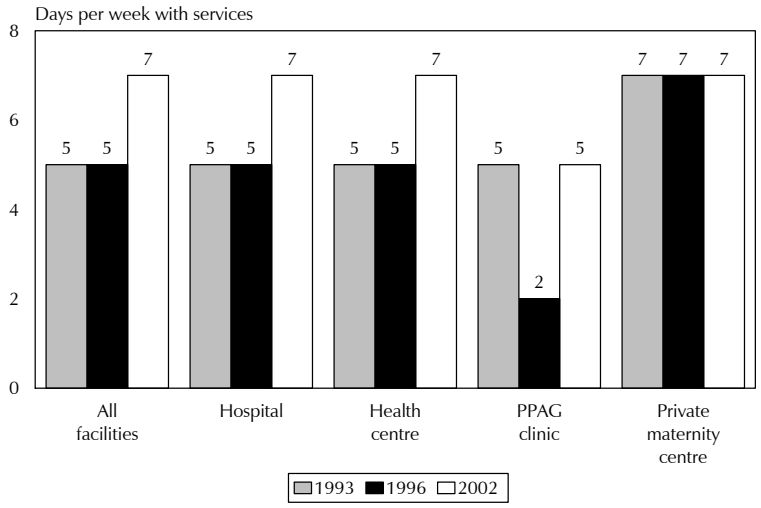


Table 3.2 Frequency of availability of family planning services

Percentage of health facilities that offer family planning services five or more days per week, by type of facility and year of survey, Ghana 1993-2002

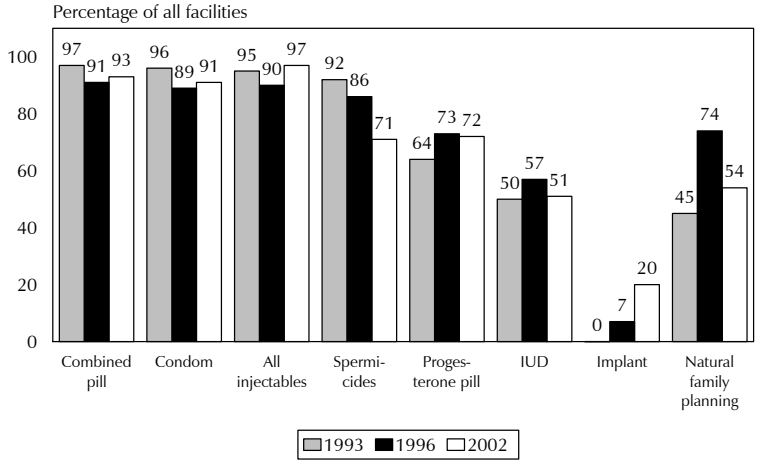
	Percentage of facilities offering family planning services 5+ days per week		
Type of facility	1993	1996	2002
Hospital	86	76	100
Health centre	92	87	93
PPAG clinic	73	42	93
Private maternity centre	96	95	100
Total	91	80	96

Services for specific family planning methods

A total of six modern methods of family planning (combined pill, condoms, injectables, spermicides, progesterone-only pill, and natural methods) can be offered by essentially all types of facilities in these three surveys, with the staffing and infrastructure routinely available. IUDs, implant methods, and sterilisation can also be offered if providers are trained and have the appropriate qualifications, and if the infrastructure for maintaining infection control is present. Appropriately trained staff and the infrastructure required to offer these methods are most commonly found at hospitals and at a percentage of PPAG clinics and private maternity centres.

Among all facilities in Ghana, the most commonly offered methods are the combined estrogen/ progesterone pill, condoms, and injections (Figure 3.3.1). There have been slight, although statistically significant decreases (see Appendix Table A.1) in the percentage of facilities offering the combined pill (97 percent in 1993 to 93 percent in 2002) and the condom (96 percent in 1993 to 91 percent in 2002). Among the 91 percent of facilities offering the condom in 2002, 81 percent offered the male condom and 68 percent offered the newly introduced female condom.

Figure 3.3.1
Percentage of all facilities offering specific family planning methods, by survey year, Ghana 1993-2002



The number of facilities offering spermicides has steadily declined. Although spermicides were one of the most commonly offered methods in 1993 (92 percent of facilities), only 86 percent of facilities offered spermicides as a method of family planning in 1996 and 71 percent in 2002 (Figure 3.3.1). The implant, introduced after 1993, was offered by 20 percent of facilities in 2002. Facilities offering natural family planning increased from 45 percent in 1993 to 54 percent in 2002, although this is a decline from the brief jump to 74 percent in 1996. The percentage of facilities offering injectables, IUDs, and the progesterone-only pill has remained essentially the same, after some fluctuation in 1996.

Although the percentage of health centres and hospitals offering IUDs has decreased (Figures 3.3.2 and 3.3.3, respectively), the percentage of PPAG and private maternity centres offering this method has steadily increased (Appendix Table A.2). The proportion of PPAG clinics offering IUDs increased from 77 percent in 1993 to 87 percent in 2002, and the proportion of private maternity centres offering IUDs increased from 25 percent in 1993 to 70 percent in 2002.

Figure 3.3.2
Percentage of hospitals offering specific family planning methods, by survey year, Ghana 1993-2002

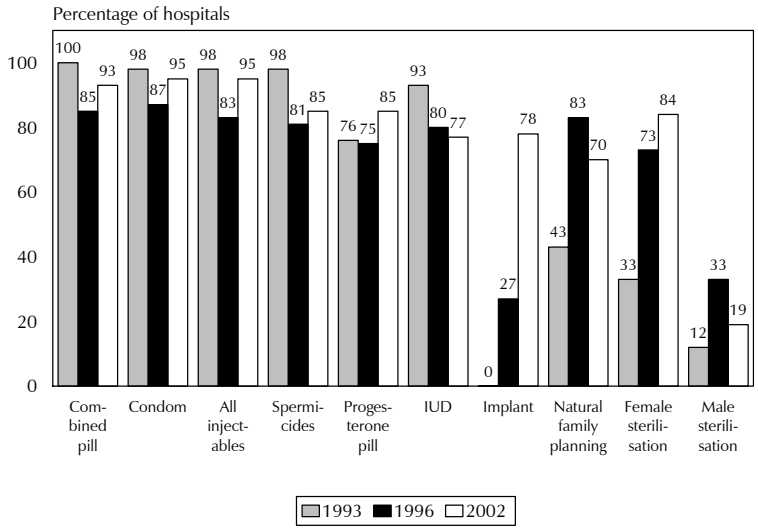
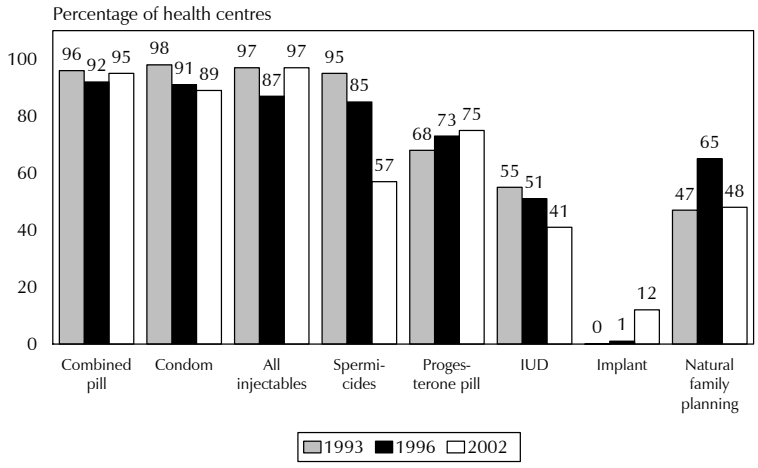


Figure 3.3.3
Percentage of health centres offering specific family planning methods, by survey year, Ghana 1993-2002



Sterilisation services are offered primarily in hospitals, where there is a more developed infrastructure and medical doctors to perform the procedure. The percentage of hospitals offering female sterilisation has steadily increased, from 33 percent (1993) to 84 percent (2002). Availability of male sterilisation has not increased as much, with 12 percent of hospitals offering the service in 1993 and 17 percent in 2002, a decrease after a climb to 33 percent in 1996 (Figure 3.3.2).

Overall, the number of different methods offered by facilities has increased. There has been a steady increase in the number of methods offered by hospitals, with the average number of methods increasing from 6.5 (1993) to 7.3 (1996), to 8.2 (2002) (Table 3.3). PPAG clinics have also increased the number of methods offered, from an average of 5.5 in 1993 to 7.7 in 2002 (after an increase to an average of 8.4 methods in 1996). The pattern is similar for private maternity centres. Although the average number of methods offered by health centres increased from 5.5 (1993) to 6.2 (1996), it then dropped to 5.2 methods in 2002.

Table 3.3 Number of different family planning methods offered

Average number of family planning methods offered, by type of facility and year of survey, Ghana 1993-2002

	Mean (median) number of family planning methods offered		
Type of facility	1993	1996	2002
Hospital	6.5 (6)	7.3 (8)	8.2 (8)
Health centre	5.5 (6)	6.2 (7)	5.2 (5)
PPAG clinic	5.5 (6)	8.4 (8)	7.7 (8)
Private maternity centre	5.0 (5)	5.9 (6)	5.7 (6)
All facilities	5.4 (6)	6.6 (7)	5.6 (6)

Note: The total number of methods asked about in 1993 was 9, and the total number of methods asked about in 1996 and 2002 was 12.

3.2 Essential commodities, equipment, and management practices

Effective systems to ensure a continuous supply of commodities and functioning equipment require constant management support and supervision to reinforce the importance of maintaining a supply of offered commodities and functioning equipment (Setty-Venugopal et al., 2002).

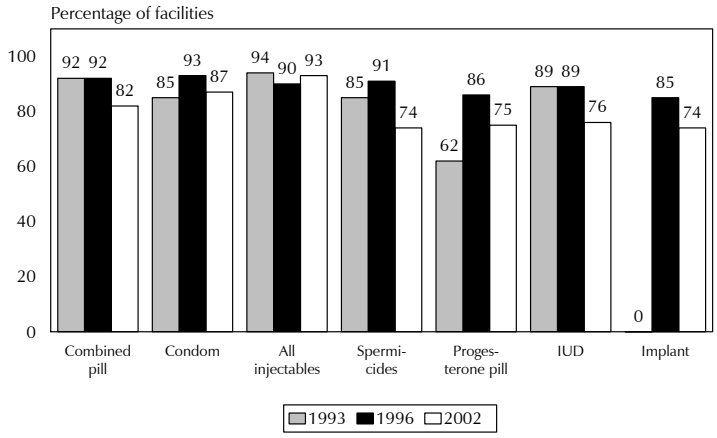
The availability of commodities and equipment for family planning services was confirmed through observation of the items.

3.2.1 Availability of family planning commodities

The presence of family planning commodities with a valid date of expiration ensures that the methods offered can be provided to clients, thus minimising the need for clients to either change their current method or purchase the method outside the facility to avoid interruption in contraceptive use. The three surveys assessed whether each facility had the commodity in stock on the day of the survey for each method of contraception offered. In addition to availability of the commodity, the 1993 and 1996 surveys asked about a lack of supplies (stockout) during the preceding six months. Stockout rates were assessed in 2002 using only information on commodity availability the day of the survey.

Overall, the supply for contraceptive methods has not improved (Figure 3.4.1). One in four facilities offering the implant method, IUDs, the progesterone-only pill, or spermicides did not have the method available on the day of the survey (2002).

Figure 3.4.1
Percentage of facilities offering specific family planning methods that have the family planning commodities available, by survey year, Ghana 1993-2002



With the exception of the implant method, hospitals and health centres have shown similar supply problems over time for each method of contraception (Figures 3.4.2 and 3.4.3). Although only 12 percent of health centres offer the implant method, 80 percent of these had the implant available on the day of the survey. This was true for only 66 percent of the hospitals (78 percent) that offered the implant. The trend in stock availability is similar for private maternity centres, but availability is much better in PPAG clinics (Appendix Table A.3).

Figure 3.4.2
Percentage of health centres offering specific family planning methods that have the family planning commodities available, by survey year, Ghana 1993-2002

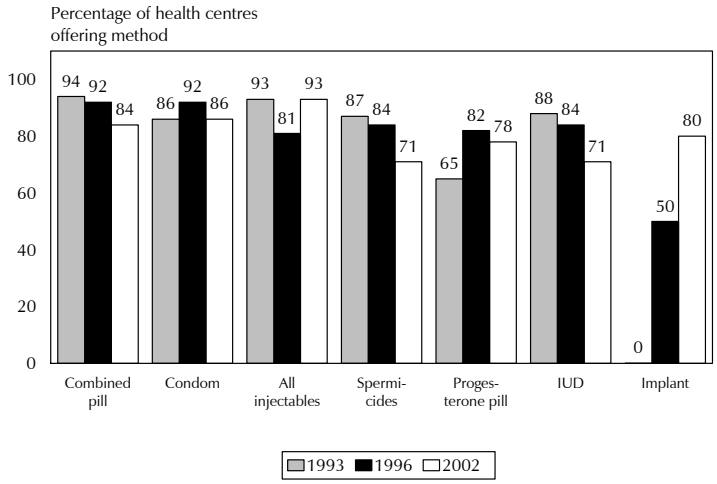
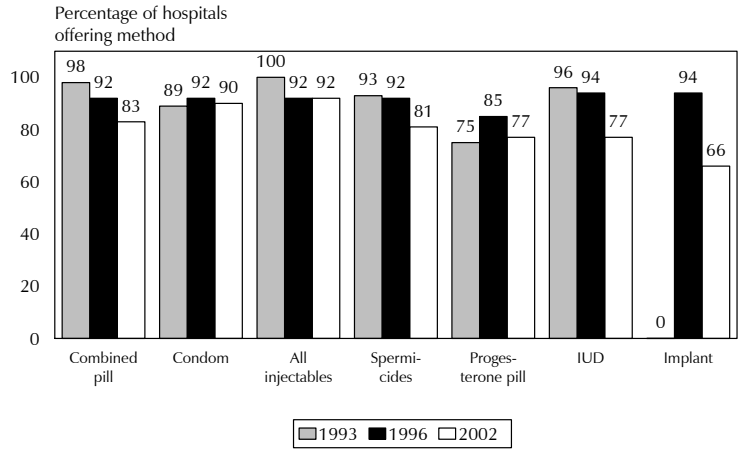
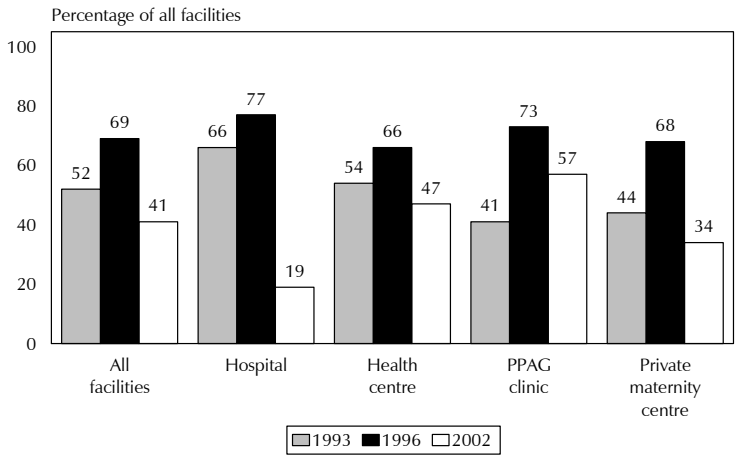


Figure 3.4.3
Percentage of hospitals offering specific family planning methods that have the family planning commodities available, by survey year, Ghana 1993-2002



Among all types of facilities, hospitals are the least likely to have a supply of all contraceptive methods they offer, with only 19 percent of hospitals having commodities for all methods offered available on the day of the survey in 2002 (Figure 3.5). As noted previously, a lack of the implant method is a major contributing factor. Health centres are somewhat better supplied, with 47 percent having a supply of all offered methods available on the day of the survey. For both hospitals and health centres, however, this is a decline in commodity availability from both 1993 and 1996. The trend is similar for private maternity centres. Supply for PPAG clinics improved greatly between 1993 and 1996, although it must be noted that the number of eligible PPAG clinics decreased substantially.

Figure 3.5
Percentage of facilities that have supplies of all contraceptive methods offered by the facility, by survey year, Ghana 1993-2002



3.2.2 Infrastructure and equipment for examination

The surveys assessed a number of items relating to the capacity to conduct examinations. One basic component is the presence of an examination room offering both auditory and visual privacy. While in 1993 only 59 percent of all facilities had a private or separate examination room, this number increased to 83 percent by 2002 (Table 3.4). The increase was most evident in private facilities (maternity centres and PPAG clinics) (Figure 3.6). Facilities with the capacity to provide visual privacy for an examination, either in a private room or by using a screen or curtain, remained essentially the same, at 86 percent.

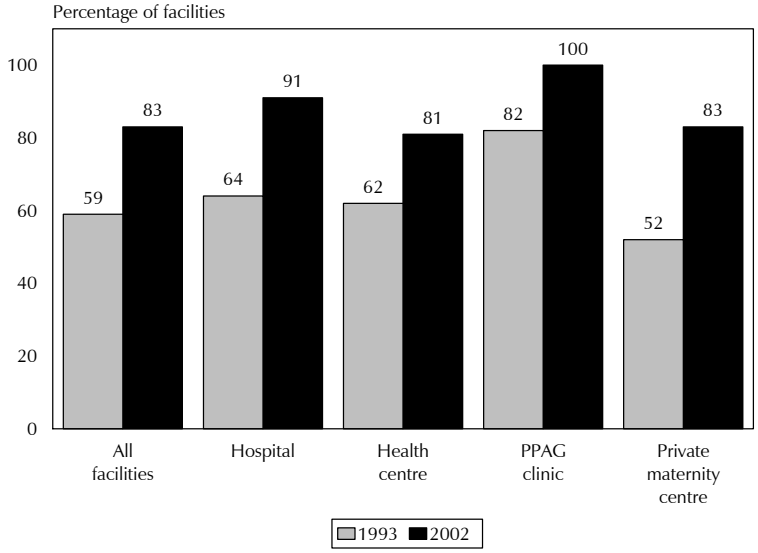
Table 3.4 Health facilities with private or separate examination room

Percentage of health facilities that have private or separate examination room (but not separate examination area), by year of survey, Ghana 1993-2002

	Percentage of facilities with private or separate examination room		
Examination room	1993	1996	2002
Examination room with auditory privacy	81	83	u
Examination room with visual privacy	86	87	86
Private/separate examination room	59	u	83

u = Unknown (information not available)

Figure 3.6
Percentage of facilities with private or separate examination rooms, by survey year, Ghana 1993 and 2002



Different equipment is required to safely administer different types of family planning methods.

Women receiving methods that have estrogen need to have their blood pressure (and, possibly, weight) monitored; for a pelvic examination, an examination table, speculum, and clean gloves are required; for injectable contraceptives, sterile syringes and needles are required.

Availability of functioning equipment for measuring blood pressure (sphygmomanometer apparatus and stethoscope) has decreased slightly, from 91 percent of facilities in 1993 and 1996 to 86 percent in 2002 (Table 3.5). This decrease is statistically significant (Appendix Table A.1). Availability of functioning weighing scales increased slightly, from 84 percent in 1993 to 88 percent in 2002.

Table 3.5 Essential equipment available in working order

Percentage of health facilities with specific essential equipment in working order, by type of facility and year of survey, Ghana 1993-2002

	Percentage of facilities with essential equipment in working order																	
	Functioning blood pressure gauge/apparatus			Functioning stethoscope			Weighing scale			Vaginal speculum			Examination table[1]			All five specified items		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	93	90	86	93	83	94	88	93	85	98	81	79	86	92	99	78	60	58
Health centre	87	80	82	85	74	87	83	87	87	64	58	44	74	76	89	42	36	38
PPAG clinic	82	100	93	82	94	100	77	85	100	86	79	100	91	85	100	64	67	93
Private maternity centre	97	95	97	96	89	96	84	90	90	64	73	77	97	97	93	56	63	66
Total	91	91	86	89	85	90	84	89	100	67	71	56	81	88	91	50	56	47

[1] Includes all examination tables observed in the facility (e.g., either in the family planning unit, antenatal care unit, delivery unit, or unit where STIs are treated).

Examination tables are more available, steadily increasing from 81 percent of all facilities in 1993 to 91 percent in 2002 (Table 3.6), and vaginal speculums are less available, except in private maternity centres and PPAG clinics.

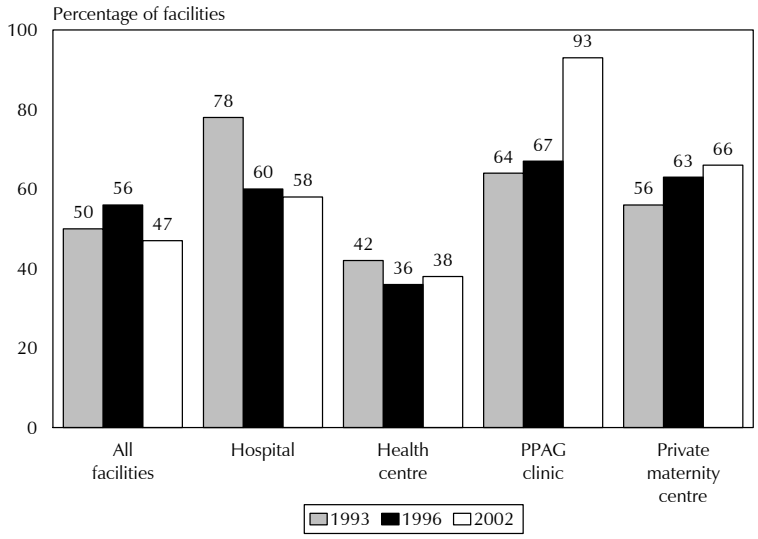
Table 3.6 Availability of materials for client education about family planning services

Percentage of health facilities that have specific IEC materials available for family planning education, by type of facility and year of survey, Ghana 1993-2002

	Percentage of facilities with materials for client education in family planning								
	Family planning poster			Booklets, pamphlets, or brochures on family planning			Both posters and booklets, pamphlets, or brochures on family planning		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	67	85	84	41	52	67	34	52	61
Health centre	67	82	69	36	41	41	28	37	34
PPAG clinic	91	79	100	59	45	94	59	42	93
Private maternity centre	83	89	89	59	42	46	40	40	43
Total	74	85	75	45	44	45	35	42	40

The availability of all of the five items assessed for offering a variety of contraceptive methods (blood pressure apparatus, stethoscope, weighing scale, speculum, and examination table) has changed little, from 1993 (50 percent) to 2002 (47 percent), after a slight increase to 56 percent of facilities in 1996 (Figure 3.7). Hospitals and health centres were less fully equipped in 2002 than in 1993. In contrast, PPAG clinics and private maternity centres were better equipped (Table 3.6).

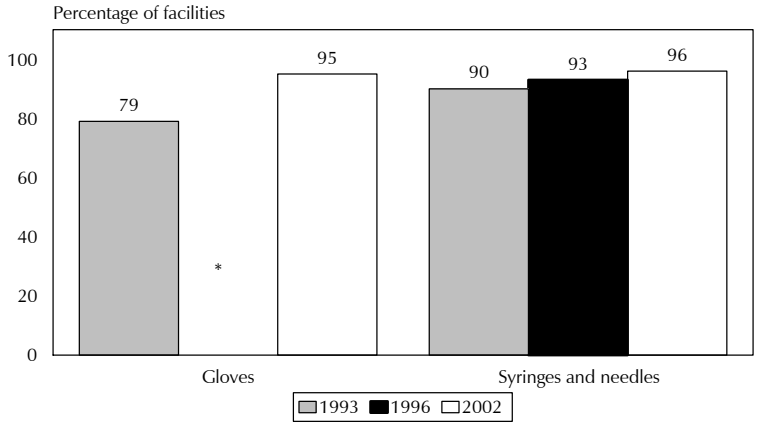
Figure 3.7
Percentage of facilities with blood pressure apparatus, stethoscope, weighing scale, speculum, and examination table, by survey year, Ghana 1993-2002



Maintenance of equipment is a critical concern. The 2002 survey asked whether facilities had systems for maintenance and/or repair of small equipment. Almost nine of ten facilities (88 percent) indicated that they did have a system, with 72 percent saying that they send the equipment offsite for repair.

There has been improvement in the supply of consumable commodities relevant to family planning services. The 1993 and 1996 surveys assessed the availability of clean gloves "for family planning," and the 2002 survey assessed the availability of clean gloves anywhere in the facility as well as specifically in the family planning area. Overall availability of gloves anywhere in the facility improved from 79 percent in 1993 to 95 percent in 2002. The availability of gloves in the family planning service area (where they must be located for easy access when needed) is less common, with only 69 percent of facilities having clean gloves present in the family planning service area in 2002. The overall percentage of facilities with sterile syringes and needles (for the injectable method and for local anaesthetic for implants) is high, and the trend is positive over time, from 90 to 98 percent from 1993 to 2002 (Figure 3.8).

Figure 3.8
Percentage of facilities with essential supplies and commodities (gloves, syringes, and needles), by survey year
Ghana 1993-2002



Note: The 1993 survey had two items: disposable gloves and gloves, without specifying whether or not they were clean. The 2002 survey asked for clean gloves (either disposable or reusable). In this study, only disposable gloves and clean gloves are being compared.
The 1993 and 1996 surveys did not specify whether or not syringes and needles were sterilised, so it is assumed that interviewers looked for sterile ones. In 2002, the survey specified sterile needles and syringes.
* No data

3.2.3 Information-education-communication materials for family planning services

Information-education-communication (IEC) materials, such as posters, booklets, pamphlets, or visual aids, contribute to the effectiveness of counselling and client education. Overall, the availability of IEC materials improved between 1993 and 1996, but by 2002 had reverted to levels similar to those seen in 1993, with three in four facilities having family planning posters and less than half (45 percent) having any materials to give the client. The decline from 1996 to 2002 is primarily attributed to a decrease in IEC materials in health centres (Table 3.7).

Table 3.7 Availability of materials for client education about sexually transmitted infections

Percentage of health facilities that have specific IEC materials available for STI education, by type of facility and year of survey, Ghana 1993-2002

	Percentage of facilities with materials for client education about STIs							
	Flip chart for STIs/HIV		Brochures or pamphlets for HIV/AIDS		Brochures or pamphlets for STIs		Any IEC materials on STIs or HIV/AIDS	
Type of facility	1996	2002	1996	2002	1996	2002	1996	2002
Hospital	19	25	32	27	24	36	39	51
Health centre	8	8	18	23	13	20	25	33
PPAG clinic	6	80	21	87	12	63	24	93
Private maternity centre	3	13	16	29	11	24	19	41
Total	7	12	20	25	14	22	25	37

IEC materials related to STIs were only assessed in the 1996 and 2002 surveys. The availability of any IEC materials for STIs or HIV/AIDS increased from 25 percent in 1996 to 37 percent in 2002, with increased availability noted in all types of facilities (Table 3.8).

Table 3.8 Facilities offering services for sexually transmitted infections and for family planning

Percentage of facilities where services for both STIs and family planning are offered, and percentage where STI services are also provided by family planning service providers, by type of facility and year of survey, Ghana 1993-2002

	Percentage of facilities offering both STI and family planning services				
			2002[b]		
Type of facility	1993[a]	1996	In the facility	In the family planning unit	Referred elsewhere in facility
Hospital	60	60	100	25	75
Health centre	39	51	63	26	61
PPAG clinic	73	76	93	93	7
Private maternity centre	39	60	78	79	15
Total	42	61	71	39	51

[a] Only consultation services for STIs were specified.
[b] Family planning unit may both offer STI services and refer, depending on the symptoms.

3.2.4 Services relevant to family planning clients

Providing a package of services relevant to a client's day-to-day needs is thought to improve appropriate utilisation through client familiarity with a facility and providers, and to increase convenience when multiple services are needed at the same time (Kaboré et al., 2003). Family planning users are frequently mothers with children. As such, in addition to family planning, they often need to access basic services for children and other reproductive health issues.

Provision of STI services for family planning clients

One means of improving case detection and treatment for STIs is to provide case detection and treatment in all sites where clients may seek services. Thus, in addition to expanding general curative care for STIs, there has been a reproductive health programme emphasis on integrating STI services with family planning.

Table 3.9 Availability of guidelines for services for sexually transmitted infections

Percentage of facilities with guidelines for services for STIs, by type of facility and year of survey, Ghana 1996 and 2002

	Percentage of facilities with guidelines for services for STIs	
Type of facility	1996	2002
Hospital	48	83
Health centre	21	63
PPAG clinic	9	93
Private maternity centre	13	85
Total	19	70

The percentage of facilities offering both family planning and STI services steadily increased, from 42 percent in 1993 to 61 percent in 1996, to 71 percent in 2002. This increase in STI services is noted for all types of facilities (Table 3.9). The 2002 survey asked specifically whether STI services are offered in the family planning clinic (regardless of whether STI services are offered at other service sites). Thirty-nine percent of facilities reported that their family planning service providers also provide STI services if needed by the client (Table 3.9). The availability of guidelines for STI services also increased, from 19 percent in 1996 to 70 percent in 2002 (Table 3.10). This was noted for all types of facilities.

Table 3.10 Availability of ANC, delivery, postnatal, and immunization services at facilities that offer family planning services

Among facilities offering family planning services, percentage that also offer antenatal care (ANC), delivery services, postnatal care, and immunization services, by type of facility and year of survey, Ghana 1993-2002

Type of service/ type of facility	Percentage of facilities offering family planning that also offer specific services		
	1993	1996	2002
At least one of the ANC/delivery/ postnatal services			
Hospital	98	97	98
Health centre	89	92	92
PPAG clinic	36	45	43
Private maternity centre	96	100	99
Total	87	87	94
All three services (ANC, delivery, postnatal)			
Hospital	71	87	74
Health centre	67	78	64
PPAG clinic	5	18	20
Private maternity centre	84	92	83
Total	67	74	69
ANC services			
Hospital	95	93	88
Health centre	84	92	88
PPAG clinic	32	42	37
Private maternity centre	96	100	97
Total	83	86	90
Delivery services			
Hospital	78	89	95
Health centre	74	81	81
PPAG clinic	9	18	27
Private maternity centre	95	98	97
Total	74	77	86
Postnatal services			
Hospital	86	93	75
Health centre	84	86	68
PPAG clinic	18	27	27
Private maternity centre	83	92	84
Total	79	78	72
Any immunisation services[1]			
Hospital	97	95	100
Health centre	97	91	97
PPAG clinic	23	21	50
Private maternity centre	47	42	75
Total	83	59	92

[1] The 1993 data had only one item for immunisation service in general, without specifying whether it was for children or women, so it was understood that this was for any service available. The data in 1996 and 2002 had specified whether the immunisation service was for either children or women.

Provision of family planning and maternity services

The broader Maternal and Child Health/Family Planning Programme of the health system in Ghana supports provision of family planning services in conjunction with maternity services. This facilitates provision of services for birth spacing and for avoiding unwanted or high-risk pregnancies for postpartum women.

Table 3.11 Service statistics for new clients for family planning services

Number of new family planning clients per month who received services in facilities, by type of facility and year of survey, Ghana 1993-2002

	Median (mean) number of new clients per month		
Result	1993	1996	2002
Hospital	15 (28)	21 (51)	20 69)
Health centre	8 (11)	9 (13)	5 (13)
PPAG clinic	59 (72)	10 (28)	73 (112)
Private maternity centre	4 (7)	3 (5)	3 (6)
Total	8 (15)	6 (18)	5 (19)

About two-thirds of facilities offer family planning services as well as the three maternity services assessed (antenatal care, postnatal care, and delivery services). Availability of this package of services in a facility has changed only minimally, increasing from 67 percent in 1993 to 74 percent in 1996, but falling back to 69 percent in 2002 (Table 3.11). Over 90 percent of facilities offer family planning and at least one of the assessed maternity services (increasing from 87 percent in 1993 and 1996 to 94 percent in 2002). PPAG clinics, with a programme focus primarily on adolescent health and family planning, are the least likely to offer any maternity services.

Provision of family planning and immunisation services

Family planning clients frequently have small children who are eligible for immunisation services. The availability of immunisation services in the same facility where family planning services are offered may facilitate a family's ability to access both services. Facilities offering both services increased overall (83 to 92 percent from 1993 to 2002), with a large improvement noted in the private maternity centres and PPAG clinics (Table 3.11), following small declines from 1993 to 1996 in all types of facilities.

3.2.5 Family planning service statistics

The median number of new family planning clients receiving services in a facility each month has decreased from eight in 1993 to six in 1996, to five in 2002. The mean, while increasing in 1996 (from 15 to 18 new clients per month) remains essentially the same (19 new clients per month in 2002) (Table 3.12). Thus, while overall slightly more new clients are being seen, the increase is in a small proportion of facilities, with most facilities seeing less than ten new family planning clients each month. However, there has been a large increase in the numbers of each type of facility that offers family planning, except for PPAG clinics, as noted in discussion of the sample frame.

Table 3.12 Qualifications of interviewed family planning service providers

Percent distribution of interviewed family planning providers by level of qualifications, according to type of facility and year of survey, Ghana 1993-2002

	Percentage of interviewed family planning service providers with qualifications											
	Hospital			Health centre			PPAG clinic			Private maternity centre		
Qualifications	1993	1996[a]	2002[a]	1993	1996[a]	2002[a]	1993	1996[a]	2002[a]	1993	1996[a]	2002[a]
Medical doctor	3	5	22	1	5	2	0	5	4	3	1	0
Nurse midwife/midwife[1]	64	57	54	50	44	47	38	53	56	81	74	55
Auxiliary nurse[2]	32	33	23	46	48	41	14	3	35	12	10	42
Extension health worker[3]	1	0	0	2	1	0	49	22	0	4	3	0
Other	0	5	1	0	2	10	0	17	4	0	11	3
Total	100	100	100	100	100	100	100	100	100	100	100	100

[1] In 2002, the category included public health nurses and medical assistants as well as nurses and midwives
[2] In 2002, the category included midwife assistant as well as auxiliary nurse.
[3] In 2002, the extension worker category was being phased out.
[a] In addition to the described categories of provider, 8 percent were categorised as "other" in 1996, and 7 percent in 2002. These "other" staff identified themselves primarily as ward orderly/assistant/maid who helped the nurses providing family planning services.

3.2.6 Qualification, experience, and in-service training for family planning service providers

Each survey interviewed family planning service providers who were present the day of the survey, to ascertain their qualifications, how long they had worked in the facility, and whether they had received in-service training in family planning. All providers who were available were interviewed in 1993 and 1996. In 2002, all providers were interviewed in all facilities with eight or fewer providers, and a random sample was selected in other facilities (primarily hospitals) if there were several providers of family planning services.

Qualifications of family planning service providers

The composition of family planning service providers has changed little in the last decade, except for an increase in doctors, from 2 percent in 1993 to 5 percent in 2002. This change occurred mainly in hospitals and the PPAG clinics (Figure 3.9 and Table 3.13).

Figure 3.9
Percentage of interviewed family planning service providers with specific qualifications, by survey year, Ghana 1993-2002

Table 3.13 Number of years family planning service providers worked at the facility

Percentage of family planning providers who worked at facility for specific numbers of years, by type of facility and year of survey, Ghana 1993-2002

	Percentage of providers who worked at the facility for:											
	0-2 years			3-5 years			6-10 years			>10 years		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	36	34	32	27	29	19	22	23	23	15	14	26
Health centre	41	46	45	34	29	27	21	18	16	4	7	12
PPAG clinic	38	23	41	19	18	31	11	35	13	32	24	13
Private maternity centre	12	32	22	23	35	21	42	17	20	23	17	38
Total	34	34	38	30	27	24	25	24	18	11	15	20

Work experience of family planning service providers

Providers' experience was measured both by their total work experience and by how long they have provided family planning services in particular.

Between 1993 and 2002, the proportion of new staff (those who have worked for two or fewer years in the facility) has changed slightly (34 percent in 1993 and 1996, and 38 percent in 2002); however, the number of staff who have worked in the facility for more than ten years has increased significantly, from 11 percent in 1993 to 20 percent in 2002 (Table 3.14). More experience in providing family planning services is also noted, with the percentage of providers who have been providing family planning services for more than 10 years increasing from 13 percent in 1993 to 33 percent in 2002 (data not shown).

Table 3.14 Average number of years providers offered family planning service

Average number of years (median and mean) that current family planning service providers have offered family planning services, by type of facility and year of survey, Ghana 1993 and 2002

	Number of years providers offered family planning services			
	Median		Mean	
Type of facility	1993	2002	1993	2002
Hospital	4	6	5	9
Health centre	4	7	5	9
PPAG clinic	10	12	12	13
Private maternity centre	4	5	5	7
Total	4	6	6	9

In-service training in family planning

Although there is substantial benefit to having more experienced service providers, this increases the need for in-service training to refresh knowledge and keep practices current. Moreover, family planning is an evolving subject, with new methods and new information about methods periodically becoming available. Thus, updates are necessary for service providers. The surveys queried whether providers had received in-service training on family planning during the five years preceding each survey.

The proportion of staff who have received in-service training related to counselling for family planning during the preceding five years has increased from 38 and 39 percent, in 1993 and 1996, respectively, to 60 percent in 2002 (Table 3.15). This major increase in the percentage of staff trained in the preceding five years is noted for all qualifications of providers except physicians, where around 50 percent had received the in-service training during the preceding five years, for all three survey years.

In-service training on specific methods is appropriate for providers in facilities where the method is offered. The percentage of health workers who have received in-service training about the IUD during the past five years decreased slightly from 26 to 22 percent (1993 and 1996) but then increased to 31 percent in 2002. As expected, training on insertion of IUDs was received primarily by doctors and nurses/midwives. While overall levels of exposure to training on IUD insertion increased only slightly, there is variation by provider qualification, with an increase in nurses receiving the training (increasing from 40 percent in 1993 to 54 percent in 2002, after a decrease to 34 percent in 1996) and a decrease in doctors receiving the training (from 54 percent in 1993 to 35 and 40 percent in 1996 and 2002, respectively). Staff exposure to in-service training on the implant method has increased from 1 percent in 1993 to 8 percent in 1996 and 14 percent in 2002, with doctors being the main recipients. The percentage of physicians with in-service training on the implant during the preceding five years has increased from 12 percent in 1993 to 66 percent in 2002. In-service training on the mini-laparotomy (for female sterilisation) has also increased among physicians with 40 percent having received in-service training during the preceding five years in 1993, and 68 percent in 2002 (after a major decrease to 13 percent in 1996).

Table 3.15 In-service training in family planning in the five years preceding the survey

Percentage of providers of family planning (FP) services who ever received in-service or practical training in specific topics, by qualifications of provider and year of survey, Ghana 1993-2002

	Percentage of providers receiving in-service training in specific topics											
	IUD			Implant			Mini-laparotomy			FP counselling		
Qualifications	1993	1996	2002	1993	1996	2002	1993	1996	2002	1993	1996	2002
Medical doctor	54	35	40	12	4	66	40	13	68	49	51	52
Nurse midwife/midwife	40	34	54	1	13	18	1	15	10	41	51	71
Auxiliary nurse	6	2	4	0	1	4	0	3	2	33	20	56
Total	26	22	31	1	8	14	1	11	9	38	39	60

4 COMPLIANCE WITH STANDARDS OF PRACTICE

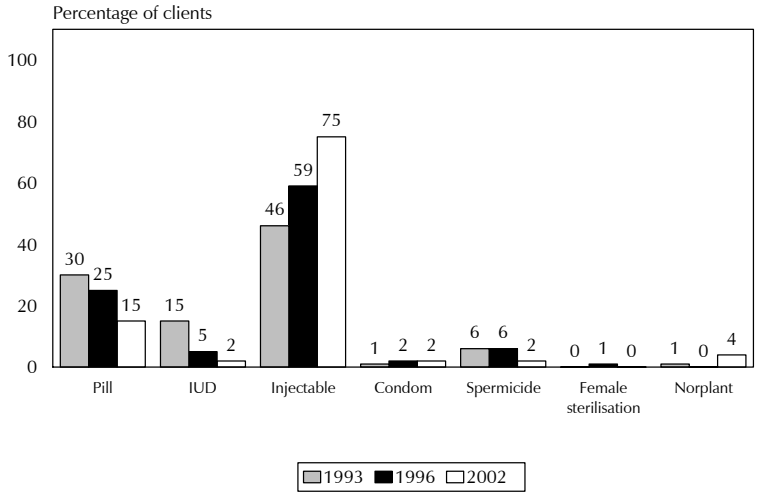
Availability of guidelines for family planning services was not assessed in 1993 and 1996. The 2002 survey, however, found guidelines for family planning in the family planning service area in 72 percent of all facilities.

4.1 Methods prescribed to observed clients

From 1993 to 2003, results from the GDHS Household Questionnaire have shown a modest increase in women reporting they currently use pills (3 to 6 percent), any injectables[1] (2 to 5 percent), and male condoms (2 to 3 percent) as methods for family planning, with no change in the use of IUDs (1 percent). The use of the female condom, while rare, is becoming measurable with 0.1 percent of women reporting that they use the method. The trends in methods received by observed clients reflect the increase in utilisation of injectables, but not of pills.

Among all observed clients, the most common method prescribed (either newly or for continuing clients) is the injectable. Almost all injectables provided are progesterone only, with only 4 percent of the observed clients in 2002 receiving the newly introduced combined injectable method (data not shown). The proportion of observed clients receiving injectables has increased steadily, from 46 percent in 1993 to 59 percent in 1996, to 75 percent in 2002. The number of observed clients receiving the combined oral pill have decreased from 30 percent in 1993 to 15 percent in 2002. The proportion of observed clients receiving the IUD has declined from 15 percent in 1993 to 5 percent in 1996, to only 2 percent in 2002 (Figure 4.1). Provision of the implant method, however, increased from 1 percent in 1993 to 4 percent in 2002.

Figure 4.1
Percentage of clients who received specific family planning methods or were prescribed methods during their visit, by survey year, Ghana 1993-2002



[1] The surveys do not differentiate between the monthly combined and progesterone-only methods.

Provision of the implant method to new family planning clients had reached 8 percent by 2002. Figures 4.2 and 4.3 show that, in general, the proportions of new women receiving a method and of returning clients receiving a method are proportions that might be expected when women continue with a method, when considering the time when the method is valid (e.g., before resupply or reinsertion is required).[2] The exception is spermicides. The proportion of returning clients who receive spermicides is much lower for all three surveys than the proportion of women who are prescribed spermicides.

Figure 4.2
Percentage of new clients who received specific family planning methods during their visit, by survey year, Ghana 1993-2002

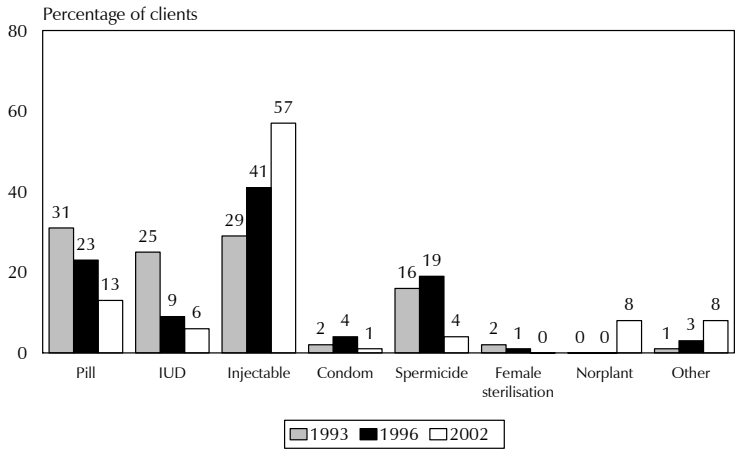
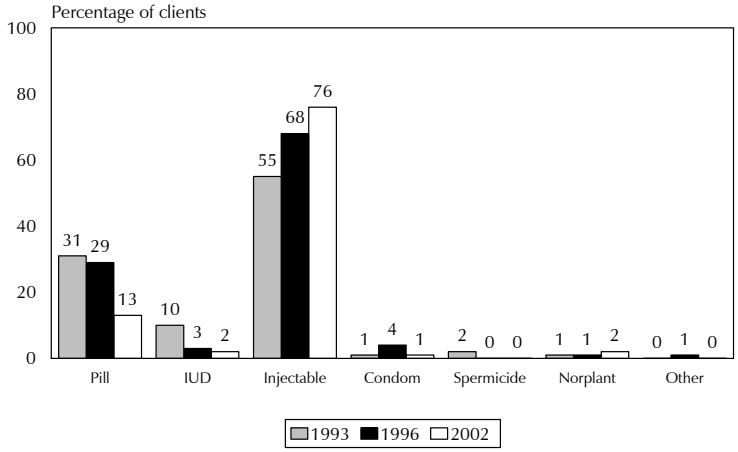


Figure 4.3
Percentage of returning clients who received the family planning methods they had been using, by survey year, Ghana 1993-2002



[2] In Figures 4.2 and 4.3 "other" includes rhythm, lactational amenorrhoea, and sterilisation methods.

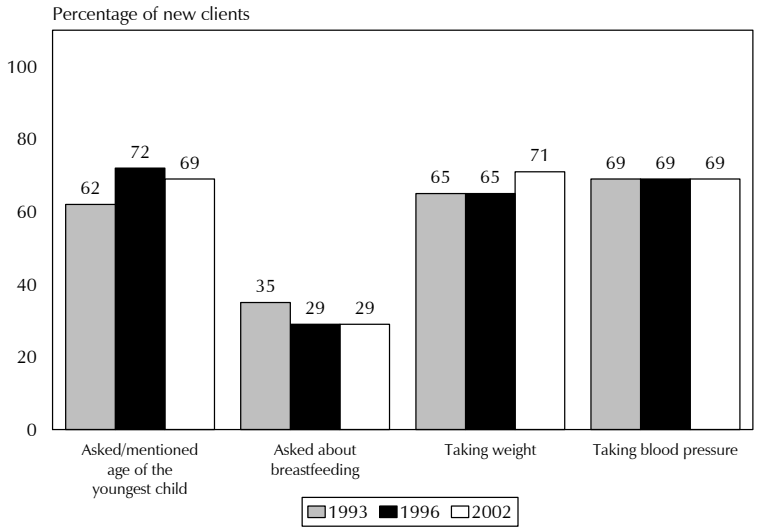
4.2 Assessment of relevant history and examination

Observers of family planning services noted whether commonly accepted standards for quality in examining, treating, and counselling family planning clients were followed. A checklist was used to document specific examinations that occurred or information that was shared between the provider and the client. In total, 664 clients were observed in 1993, 819 in 1996, and 611 in 2002.

A reproductive history provides important information for guiding the provider when counselling a client on the most appropriate family planning method. This is particularly important for new family planning clients.

Overall, changes in the percentage of new family planning clients assessed for the age of their youngest child and breastfeeding status (both relevant to method appropriateness) have not been consistent. In 1993, 62 percent of new clients were asked about the age of their youngest child. This increased to 72 percent in 1996 and was similar (69 percent) in 2002. The percentage of eligible observed clients for whom breastfeeding status was assessed decreased from 35 percent in 1993 to 29 percent in 1996 and 2002 (Figure 4.4).

Figure 4.4
Percentage of new family planning clients who were assessed for specific items regarding their reproductive history, by survey year, Ghana 1993-2002



In addition to a reproductive history, baseline weight and blood pressure measurements provide information on a client's general health as well as her eligibility for family planning methods with estrogen.

Weighing new clients was a little more consistent in 2002 (71 percent), increasing from 65 percent in 1993 and 1996. The increase was observed in all types of facilities (Table 4.1). The percentage of new clients for whom blood pressure was observed being measured has not changed over time, remaining at 69 percent.

Health services are frequently organised so that routine information and measurements are taken upon arrival, prior to being seen by the family planning service provider. The 2002 survey takes this system for service provision into account. If a facility was observed to systematically measure blood pressure and/or weight outside the consultation room prior to clients being seen by the family planning service provider, all observed clients from that facility were assumed to have had the measurement taken, even if the observer did not see a specific observed client being measured (as might occur when there is a waiting time between when the measurements are taken and when the family planning service provider sees that client). When this definition for an observed measurement is applied (2002), compliance with standards is actually higher than previously observed, with 86 percent of all new clients having their blood pressure measured and 83 percent of new clients having their weight measured (Table 4.1).

Table 4.1 Examination of new family planning clients

Percentage of observed new family planning clients who had their weight and blood pressure measured, by type of facility and year of survey, Ghana 1993-2002

	Percentage of observed new family planning clients measured			
			2002	
Type of measurement and type of facility	1993	1996	Observed client	Observed or system[1]
Weight				
Hospital	71	59	77	97
Health centre	60	66	72	79
PPAG clinic	54	68	66	66
Private maternity centre	72	67	44	73
Total	65	65	71	83
Blood pressure				
Hospital	70	59	86	100
Health centre	65	58	63	82
PPAG clinic	69	68	66	66
Private maternity centre	80	78	62	81
Total	69	69	69	86

[1] If a client received services in a facility where it was observed that all family planning clients were routinely weighed or had their blood pressure measured prior to consultation, the client was credited with having the measurement taken even if the observer did not see the measurement taken on the particular client.

A significant improvement was noted in the assessment of abnormal vaginal discharge, a symptom that may be related to STIs. Abnormal vaginal discharge was assessed for 26 percent of the observed family planning consultations in 1993, decreasing to 20 percent in 1996, but increasing significantly to 35 percent in 2002 (Table 4.2). This improvement, while still not attained at an appropriate level for screening of patients, was noted for clients seen at hospitals and health centres, but not for those seen in PPAG clinics or private maternity centres.

Table 4.2 Assessment of symptoms of sexually transmitted infections

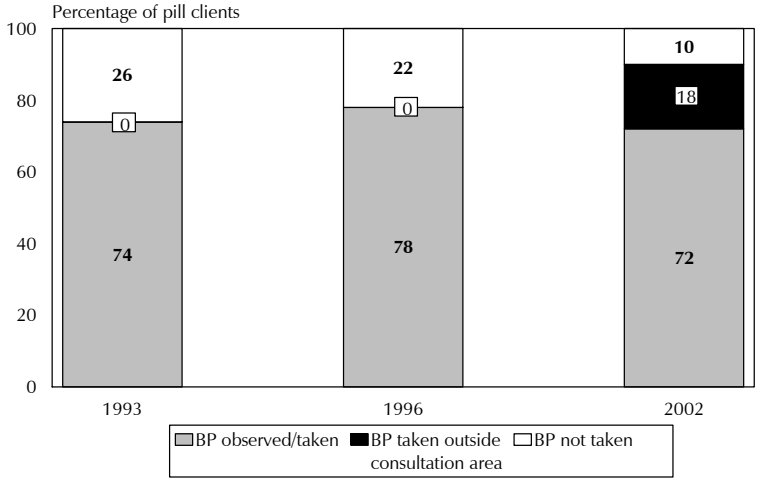
Percentage of family planning clients for whom observers noted the sharing of information between the provider and the client about abnormal vaginal discharge, by type of facility and year of survey, Ghana 1993-2002

Type of facility	Percentage of family planning clients who received information about abnormal vaginal discharge		
	1993	1996	2002
Hospital	26	31	38
Health centre	29	27	37
PPAG clinic	20	17	21
Private maternity centre	24	14	25
Total	26	20	35

Note: Observers in 1993 and 1996 assessed whether the provider asked about any unusual vaginal discharge. The observers in 2002 were to assess if information was shared about possible symptoms of STIs, such as abnormal discharge.

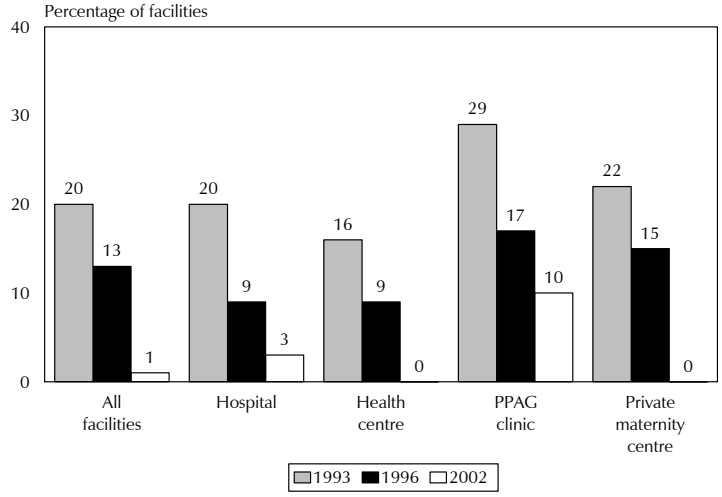
Examination for clients receiving methods with estrogen should include monitoring blood pressure. Among those clients who received combined oral pills (estrogen based), the percentage of clients observed having their blood pressure measured remained essentially the same (around three-quarters). During the 2002 survey, however, it was noted that 18 percent of clients, for whom the observer did not see blood pressure being measured, were at facilities where the blood pressure was routinely measured outside of the consultation room (Figure 4.5). Thus, the true proportion of eligible women who had their blood pressure measured is probably 90 percent.

Figure 4.5
Percentage of new and returning combined pill clients who had their blood pressure taken, by survey year, Ghana 1993-2002



Pelvic examinations are not routinely required for family planning clients. Rather, their need is determined by the history of a client (for screening or diagnosing infection or illness) and by the method of contraception desired. The percentage of observed clients receiving pelvic examinations has declined from 20 to 13, to 1 percent in 1993, 1996, and 2002, respectively (Figure 4.6). This trend follows the decrease in the percentage of observed clients receiving IUDs (where a pelvic examination is required).

Figure 4.6
Percentage of facilities that conduct pelvic examinations, by survey year, Ghana 1993-2002



When a client receives a pelvic examination, she should be informed about the procedure prior to starting, the health service provider should wash hands prior to the examination, and clean gloves should be used for the examination. The percentage of clients who were informed about the procedure was about the same for 1993 and 1996 (76 and 78 percent, respectively). All 15 observed clients in 2002 who had pelvic examinations were informed about the procedure, providing some indication of improvement in client counselling for the procedure. There was no significant change in providers washing their hands prior to starting the examination (around 70 percent) or in use of clean gloves (around 88 percent) between 1993 and 1996. Although the number of observed pelvic examinations was small in 2002 (15), the data suggest that both hand-washing and use of clean gloves have improved (Table 4.3).

Table 4.3 Observed practices for pelvic examinations

Among observed family planning clients who received pelvic examinations, the percentage for whom the indicated item was observed, by type of facility and year of survey, Ghana 1993-2002

	Percentage of observed pelvic examination clients for whom the provider:								
	Informed the client about the procedure			Washed hands prior to the examination			Used clean gloves for examination		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	67	81	*	64	100	*	87	94	*
Health centre	79	71	*	81	74	*	89	91	*
PPAG clinic	67	73	*	67	64	*	67	91	*
Private maternity centre	88	82	*	68	64	*	100	85	*
Total	76	78	100	72	69	80	89	88	93

Note: An asterisk indicates that a figure is based on too few cases to show and has been suppressed.

4.3 Counselling about methods of contraception

To identify complications related to a contraceptive method and to improve client acceptance and continued utilisation, it is important to know of any questions or concerns that clients may have about different methods. The percentage of new clients who either asked about or who expressed concern about any contraceptive methods increased significantly, from 31 percent in 1993 (and 39 percent in 1996) to 71 percent in 2002 (Table 4.4). The improvement in assessment of new clients' concerns about methods of family planning was noted across all types of facilities.

The assessment of concerns by returning clients about methods of family planning significantly decrease between 1993 and 1996 (71 to 52 percent, respectively) but then increased to 79 percent (significantly higher than both 1993 and 1996) in 2002 (Table 4.5).

Table 4.4 Assessment of new clients' concerns about contraceptive methods

Percentage of new family planning clients who either expressed concern about a method of family planning or were asked by the provider about concerns, by type of facility and year of survey, Ghana 1993-2002

	Percentage of new family planning clients who discussed concerns about a family planning method		
Type of facility	1993[a]	1996[b]	2002[c]
Hospital	23	36	81
Health centre	33	40	64
PPAG clinic	32	41	79
Private maternity centre	38	38	82
Total	31	39	71

[a] Observer assessed if information was shared about problems with method.
[b] Observer assessed if information was shared about problems or concerns with method.
[c] Observer assessed if information was shared about concerns with method.

Table 4.5 Assessment of returning clients' concerns about contraceptive method being used

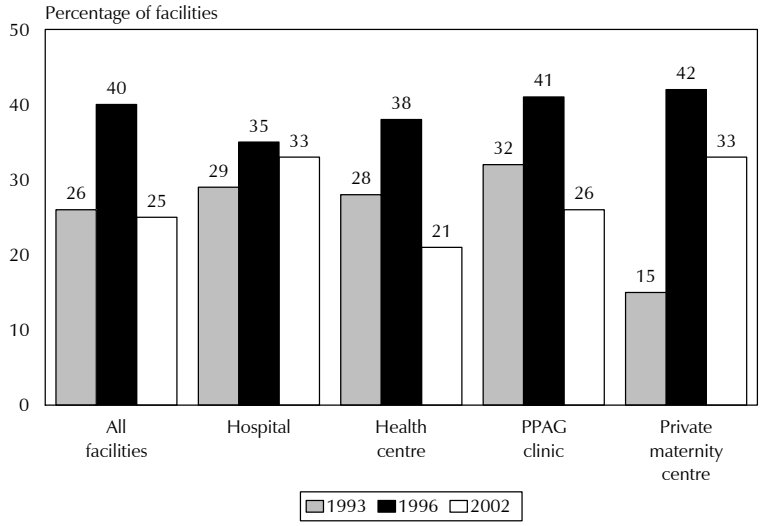
Percentage of returning family planning clients who either expressed concern or were asked if they had any concerns about the method they were using, by type of facility and year of survey, Ghana 1993-2002

	Percentage of retuning family planning clients who discussed concerns about the method they were using		
Type of facility	1993[a]	1996[b]	2002[c]
Hospital	66	58	80
Health centre	70	59	80
PPAG clinic	71	52	88
Private maternity centre	82	46	68
Total	71	52	79

[a] Observer assessed if information was shared about problem with method.
[b] Observer assessed if information was shared about problems or concerns with method.
[c] Observer assessed if information was shared about concerns with method.

Visual aids are considered an important element in client education and counselling. As noted in Tables 3.7 and 3.8, less than half of facilities have visual materials to support client education related to family planning or STIs. Overall, the use of visual aids during observed consultations has remained essentially the same (around 25 percent) from 1993 to 2002, after a significant increase (to 40 percent) in 1996 (Figure 4.7), although there have been changes by type of facility. The use of visual aids increased markedly at private maternity centres (from 15 to 33 percent in 1993 and 2002, respectively), with a jump to 42 percent in 1996. Conversely, the use of visual aids has declined over this same time period in health centres and PPAG clinics (again, after a marked increase in 1996).

Figure 4.7
Percentage of facilities that use visual aids during consultations, by survey year, Ghana 1993-2002



5 CLIENT KNOWLEDGE AND OPINION

In the exit interview, clients were asked about their experience and their satisfaction with the family planning services they received.

5.1 Client reports on family planning information received

On average, the percentage of clients reporting that they received an explanation about how their method works decreased slightly, from 89 to 82 percent from 1993 to 2002, respectively (Figure 5.1). The decrease was reported by clients in all types of facilities (Table 5.1), although most dramatically in private maternity centres (dropping from 90 percent in 1993 to 45 percent in 2002). The percentage of clients who reported that they were told about possible side effects significantly improved, from 67 percent in 1993 to 79 percent in 2002. The percentage of clients who were told what to do for side effects decreased slightly overall, from 76 percent (1993) to 70 percent (2002). Again, the most dramatic decrease in explanations to clients was noted in private maternity centres.

Figure 5.1
Percentage of clients who reported receiving specific education on family planning methods, by survey year, Ghana 1993 and 2002

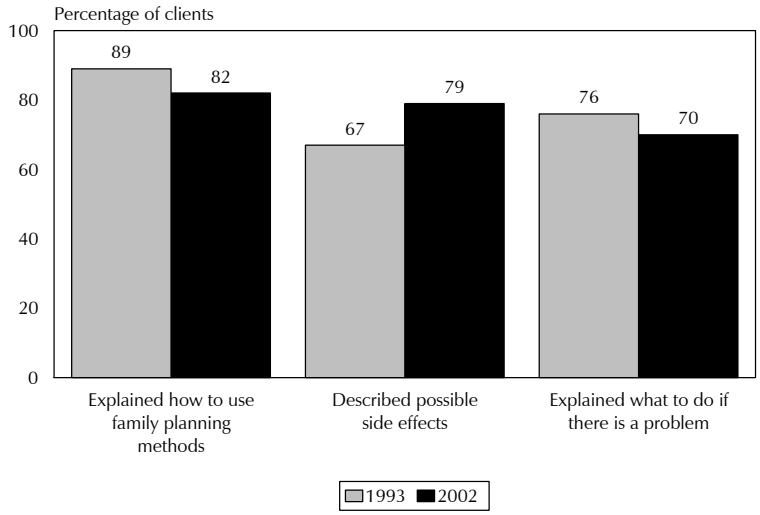


Table 5.1 Client reports on family planning education received

Percentage of observed family planning clients who reported receiving specific information about their family planning method, by type of facility and year of survey, Ghana 1993 and 2002

	Percentage of observed family planning clients who reported that a provider:					
	Explained how to use family planning method		Described possible side effects of method		Explained what to do if there is any problem with method	
Type of facility	1993	2002	1993	2002	1993	2002
Hospital	95	93	66	81	82	72
Health centre	84	82	71	81	73	70
PPAG clinic	95	89	53	84	80	82
Private maternity centre	90	45	75	54	73	54
Total	89	82	67	79	76	70

Note: No information was available for 1996.

5.2 Clients' knowledge of critical information about their family planning method

Almost all clients knew how to appropriately use their method. At exit interviews, almost all pill users (99 percent) could correctly state how often to take the pill. This was consistent for all three surveys. Overall, the percentage of clients correctly stating how to check their IUD changed slightly, decreasing from 87 percent in 1993 to 83 percent in 1996, but then increasing to 92 percent in 2002 (Figure 5.2 and Table 5.2). Similarly, almost all clients knew how long their injectable method worked, with knowledge in 2002 being slightly lower than that in 1996 (97 and 99 percent, respectively).

Figure 5.2
Percentage of clients with specific knowledge about the family planning method they were using (or had been prescribed), by survey year, Ghana 1993-2002

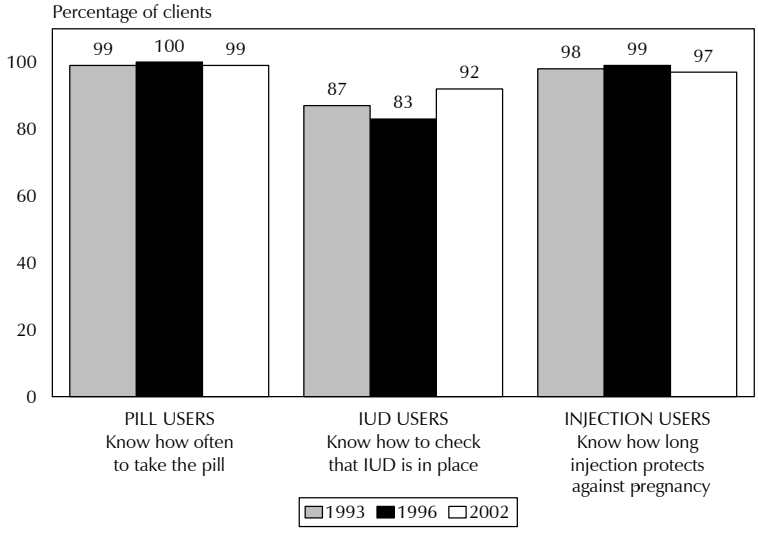


Table 5.2 Client knowledge of critical information about their family planning method

Among interviewed family planning clients who were using, or had been prescribed a family planning method (pill, IUD, or injection), the percentage who could correctly state specific information about their method, by type of facility and year of survey, Ghana 1993-2002

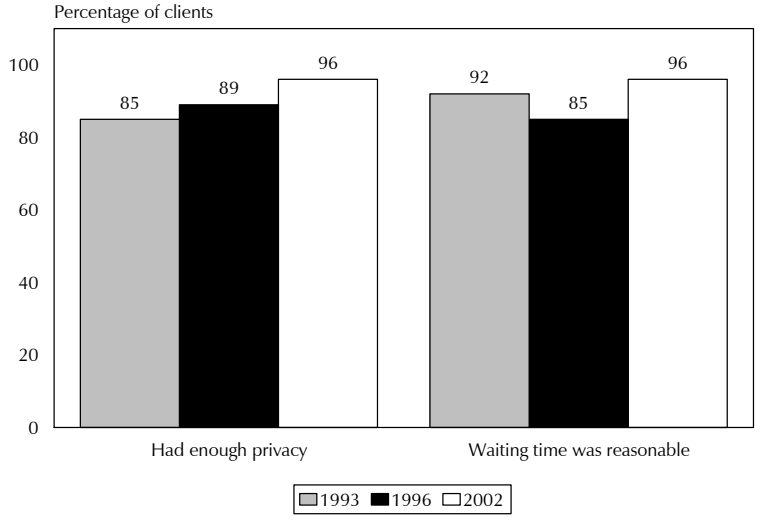
	Clients' knowledge of family planning methods								
	PILL USERS: Know how often to take the pill			IUD USERS: Know how to check the IUD is in place			INJECTION USERS: Know how long injection protects against pregnancy		
Type of facility	1993	1996	2002	1993	1996	2002	1993	1996	2002
Hospital	100	100	100	98	90	*	97	99	99
Health centre	99	99	98	82	81	*	97	100	96
PPAG clinic	100	100	100	86	67	*	94	100	97
Private maternity centre	100	100	100	67	83	*	100	99	100
Total	99	100	99	87	83	92	98	99	97

Note: An asterisk indicates that a figure is based on too few cases to show and has been suppressed.

5.3 Client satisfaction

When asked about issues commonly identified as those that clients perceive as important for quality of service and satisfaction, the overall percentage of clients reporting that they thought there was sufficient privacy during the consultation and examination increased from 85 to 89, to 96 percent in 1993, 1996, and 2002, respectively (Figure 5.3). This increase in client satisfaction with the level of privacy provided was noted in all types of facilities (Table 5.3).

Figure 5.3
Percentage of clients reporting they were satisfied with the level of privacy during consultation and the length of the waiting time, by survey year, Ghana 1993-2002



The overall percentage of clients reporting that they thought the waiting time was reasonable also improved, from 92 percent in 1993 to 96 percent in 2002 (after a slight decrease to 85 percent in 1996).

Improvement in client satisfaction for all assessed issues was noted, in particular, among hospital clients.

Table 5.3 Client satisfaction

Percentage of interviewed clients who reported that they were satisfied with the privacy during the consultation and the waiting time, by type of facility and year of survey, Ghana 1993-2002

	Percentage of interviewed clients who reported that:					
	Privacy was not a problem			Waiting time was not a problem		
Type of facility	1993	1996	2002	1993	1996	2002
Hospital	85	94	98	90	90	97
Health centre	84	90	96	93	92	96
PPAG clinic	85	94	97	93	88	92
Private maternity centre	82	85	92	95	79	96
Total	85	89	96	92	85	96

6 DISCUSSION AND CONCLUSION

Among the three surveys, interpretation of the trends in family planning service elements assessed must be conducted in the context of a large expansion of family planning services; 26 percent more facilities were eligible for the survey in 1996 than in 1993, and 18 percent more were eligible in 2002 than in 1996. From 1993 to 2002, the number of hospitals from which the sample was drawn more than doubled, the number of health centres almost doubled, and the number of private maternity centres increased by one-third. This resulted in more rural facilities, where infrastructure is less developed than in urban areas, being included in the sample. Thus, although the samples for the three surveys were drawn with the same methodology, and all are representative of family planning services at the national level, with proportional regional representation, findings may reflect the consequences of new, expanding services and may not necessarily be changes in the situation for previously existing services.

6.1 Infrastructure availability

The service delivery environment has improved over time, with availability of private examination rooms increasing significantly between 1993 and 2002. Client exit interviews supported the value of this improvement, with increased satisfaction noted with the level of privacy when receiving services.

Although the largest proportion of facilities offering family planning services are health centres, despite some improvement, they have consistently had the poorest infrastructure for service delivery. A large proportion of health centres are in rural areas, and infrastructure elements such as piped water and electricity may be beyond the capacity of an individual facility. There are, however, measures that can be taken to improve the service delivery environment. It is possible to bring water to the service area, even if a piped system does not exist. This practice has been implemented, as noted by the steady and significant improvement in water availability in the service area, despite lower percentages of facilities having piped water. There are relatively inexpensive and low-technology means for providing adequate sanitation for clients (e.g., construction of latrines), even when funding and piped water are not available.

6.2 Service availability

The evident trends in improved access to family planning services, increased availability of long-term methods and increased STI service availability indicate some successful results in these Ghana reproductive health priorities. Almost all facilities offer family planning services at least five days per week, with most reporting by 2002 that they offered services seven days per week. Although facilities reported that services were available seven days per week, observers did not ascertain whether any nonemergency client coming to a facility on Sunday would actually be served or would be advised to return during normal working hours.

As per the national policy, there was an increase in the number of different methods of family planning available within the health system. The significant increase in the number of methods offered by health centres between 1993 and 1996 may be a result of the policy to train nurses to provide more methods. This policy is evident when reviewing in-service training. The proportion of staff who had received in-service education on newly introduced methods (nurses and doctors for implant, and doctors for mini-laparotomy) increased steadily, and service availability for these two methods also increased steadily.

Whether the drop in the number of methods offered between 1996 and 2002 is driven by supply (provider and facility) or demand (client) is uncertain. It is possible that this is client driven, with increased counselling enabling the clients to make their choices, including opting for the long-term implant method over the IUD. The response of the provider when asked about methods of contraception offered by the

facility may reflect the methods that providers actually discuss with clients, as opposed to those officially offered by the facility. Without a specific focus, methods for which there is little demand may be discussed less frequently by providers. This may be the case with the rhythm method, which was reported to be offered significantly more often in 1996—after the Catholic church supported its emphasis—than in 1993, but by 2002, was reported less often. Spermicides are not a popular means of contraception, and the number of providers reporting that their facility offered this method was greatly reduced from 1993 to 2002 (from 95 to 57 percent of health centres). One other reason for the decrease in facilities offering spermicides is the policy decision whereby nonoxynol-9 vaginal foaming tablets were withdrawn from the system, currently leaving only one spermicidal method, Neosampoon, available. The diaphragm is also not popular and is essentially never provided through health facilities. Diaphragms, previously available at PPAG clinics, have been discontinued.

Despite an increase in training on the IUD for nurses and consistent provision of training for doctors, the percentage of hospitals and health centres offering IUDs decreased. With the expanded number of facilities offering family planning, a drop in the proportion offering IUDs may mean that training has not kept up with service sites, since training must not only be sufficient to add new sites, but also to maintain old sites when there is staff turnover. Each service site must have a provider trained in IUD insertion or it cannot offer the service.

Contrary to findings in hospitals and health centres, IUD availability increased in private maternity centres and PPAG clinics. Maternity and PPAG clinics are private and may have some advantages. Maternity centres have lower staff turnover, which supports the continuity of the presence of trained staff to provide services for the family planning methods requiring special skills, such as the IUD. Both clinics focus on reproductive health services, with the PPAG clinics increasingly focusing on adolescent reproductive health, and as such may have made more of an effort to ensure the availability of IUDs. It can be expected that service availability for the implant method will also be affected by the continued presence of staff trained to provide the method.

The three surveys in this study showed a consistent decrease in the percentage of observed clients receiving IUDs (from 15 to 5, to 2 percent in 1993, 1996, and 2002, respectively). It is not believed that there was a specific effort made during any of the three surveys to observe IUD insertions. Thus, the steady decrease in the percentage of observed women receiving IUDs is most likely a result of both the long-term effectiveness of IUDs (depending on the type of IUD, women only need to return every five to ten years after they have had their one-month postinsertion review) and no increase in demand.

The number of new family planning clients recorded at health centres and maternity centres has decreased, although contraceptive prevalence has not. This most likely is a result of expanding the number of facilities where services are available, which increased the availability of the most commonly used methods of contraception (pills, injections) at pharmacies and locations other than health facilities, as well as the availability of community-based distribution (CBD) workers. The increase in new clients noted for hospitals and PPAG clinics may be a result of client perception of better quality (better infrastructure, highly qualified staff, and increased choice in methods of contraception), or it may be due to geographic location, with these types of facilities located more commonly in urban areas.

6.3 Availability of equipment and supplies

The availability of equipment and supplies needed to provide quality services for specific contraceptive methods actually declined in both hospitals and health centres, with less than half of the facilities having all items assessed. Although 88 percent of facilities reported that they had a system for repair or replacement of small equipment, such as that assessed for family planning, the results indicate that the systems do not achieve a consistent availability of functioning equipment. The availability of method

commodities actually decreased significantly for most methods between 1996 and 2002, despite the government reporting no country-level shortage of stock during that time period. This indicates that the problem is a management, rather than a supply, problem.

The Ghana national programme's focus on infection control has shown some success, with the almost universal availability of sterile syringes and needles and the already noted improvement in water availability in the family planning service area. Although clean gloves are available in most facilities, availability in the family planning service area has actually decreased. There is limited improvement observed in infection control practices (hand-washing and use of clean gloves) during pelvic examinations.

6.4 Other relevant services

The private facilities (maternity centres and PPAG clinics) have increased their package of services, with PPAG clinics increasing both their maternity and immunisation services, and maternity centres expanding their immunisation services. The expansion of immunisation services in maternity centres may be due to a government strategy for government nurses to bring immunisation services to the maternity centres on an agreed upon schedule (usually once every two to four weeks).

The impact of the reproductive health policies to increase STI services has been notable. Some success in reported integration of services (assessed in 2002) is evident, particularly in the private PPAG clinics and maternity centres. Although STI services were reported to be offered by providers of family planning services in more than three in four maternity clinics and nine in ten PPAG clinics, assessment of clients for symptoms of STIs was observed less often in these facilities than in health centres or hospitals. It is possible that supervision to support the increased attention to STIs is stronger in government than in private facilities.

6.5 Adherence to standards of practice

The dual-method use of condoms is not widely promoted in health facilities, with less than 5 percent of observed clients receiving condoms. The small proportion of facilities offering condoms as a method of contraception (with a significant decrease in condom availability as a contraceptive method in health centres) is of concern, given the public health risks related to STIs and, specifically, HIV/AIDS. Clients utilising the public and NGO health facilities in these surveys are primarily married women, and increasing their exposure to the dual-method concept is needed. However, the reproductive health unit has recognised that high-risk groups, men, and adolescents are reluctant to use public health facilities for STI or family planning services. In response to this, the RCHU is implementing programmes to ensure that "youth-friendly" services conditions are implemented in facilities. In addition, the RCHU has partnered with the Ghana Social Marketing Foundation to implement innovative ways of ensuring condom availability at pharmacies, bars, and other locations that men or adolescents frequent.

In general, there was no change in the assessment of clients for appropriate methods (completeness of the reproductive history, physical assessment of new family planning clients, or monitoring blood pressure for women receiving estrogen-based methods). Methodological issues may have provided misleadingly low levels of weight and blood pressure measurements in 1993 and 1996. When the 2002 survey took into account service delivery patterns, where measurements were routinely taken outside the consultation room, the percentage of new clients assumed to have been weighed increased from 71 percent (observed) to 83 percent (observed or receiving services in facility where clients are routinely weighed outside the consultation room), and the percentage of new clients assumed to have had their blood pressure measured, increased from 69 to 81 percent (2002 data). It is not unreasonable to assume that the observer would not

see a specific client being weighed and having blood pressure measured if this occurred upon arrival and then the client waited for consultation services.

Counselling has been identified as an important factor for improving client acceptance and continuation with family planning methods as well as improving effectiveness of chosen methods of contraception.

There was a dramatic improvement in providers encouraging new clients to ask questions about methods that had been discussed, increasing from 31 percent in 1993 to 71 percent in 2002, and there was some improvement in assessments of whether continuing clients had any problems or concerns with their method (the improvement over 1996 levels was significant). Clients' knowledge about critical information on the use of their contraceptive method was better than would be expected, given the observed counselling. This is most likely an indication that general knowledge about methods is better (and continuing clients have probably received information on their method during previous visits) or that clients discuss methods among friends outside the clinic. however, critical information on method use should be reinforced during every visit, both to ensure the accuracy of perceived knowledge and to provide information to dispel rumors, myths, and misconceptions, which can be major deterrents for clients not attending clinics for family planning services. The GDHS reports have documented that most women wanting to prevent pregnancy but not using modern contraceptive methods report fear of side effects as the main reason.

Although there was little change in the availability of educational materials related to family planning in facilities, use of visual aids when counselling clients did improve between 1993 and 1996, possibly in response to programme measures to expand and improve family planning services. Why the improvement was not sustained into 2002 is uncertain, given the significant increase in the percentage of nurses and auxiliary nurses who had received recent (within the preceding five years) in-service education on topics related to counselling for family planning.

6.6 Conclusions

The programme initiatives between 1993 and 1996 resulted in programme expansion and improvement in infrastructure to support family planning services, with the achievements being maintained over the time period reviewed. Improvement in elements required to maintain quality services, however, while noted immediately after the major programme initiatives, were not maintained after expansion of services was achieved.

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Appendix A

Table A.1 Statistical significance for changes in measurement of family planning service variables

Statistical significance for changes in measurement of family planning service variables, Ghana 1993-2002

Continuous variables (mean ± SD)	1993 reference	1996 reference	2002 compared with 1993	2002 compared with 1996
Days per week with FP services available	5.4 (±1.4)	5.2 (±1.8)	6.5 (±1.0)**	6.5 (±1.0)**
Average number of clients per month	15.0 (±26.0)	18.0 (±43.0)	19.0 (±51.0)	19.0 (±51.0)
Duration that provider worked (years)	5.4 (±5.6)	5.6 (±5.5)	6.2 (±6.7)**	6.2 (±6.7)*
Duration that FP services offered (years)	5.8 (±4.9)	u	8.6 (±7.9)**	u
Infrastructure (percent)				
Piped water	44	37	42	42**
Electricity	50	57	70**	70**
Piped water and electricity	31	33	39*	39
Functioning toilet/latrine	72	69	74	74
Piped water, electricity, and latrine	28	28	34	34
Private examination room	59	u	83**	u
Essential equipment (percent)				
Blood pressure gauge	91	91	86*	86*
Stethoscope	89	85	90	90*
Weighing scale	84	89	88	88
Vaginal speculum	67	71	56*	56*
Examination table	81	88	91**	91
All five items	50	56	47	47
IEC material (percent)				
FP poster	74	85	75	75**
FP booklet	45	44	45	45
FP poster/booklet	35	42	40	40
Flip chart for STIs/HIV	u	7	u	12*
Brochure for HIV	u	20	u	25
Brochure for STIs	u	14	u	22**
IEC for STIs or HIV	u	25	u	37**
FP methods offered (percent)				
Combined pill	97	91	93*	93
Progesterone pill	64	73	72	72
Condom	96	89	91**	91
All injectables	95	90	97	97**
Spermicides	92	86	71**	71**
IUD	50	57	51	51
Implant	u	7	u	20**
Natural method	45	74	54*	54**
All methods (except implant and natural FP)	36	46	38	38*
FP commodities available if offered				
Combined pill	92	92	82**	82**
Progesterone pill	62	86	75**	75**
Condom	85	93	87	87**
All injectables	94	90	93	93
Spermicides	85	91	74**	74**
IUD	89	89	76**	76**
All methods available	49	76	48	48*

Continued…

Table A.1—*Continued*

Continuous variables (mean ± SD)	1993 reference	1996 reference	2002 compared with 1993	2002 compared with 1996
Provision of other services (percent)				
STI services	42	61	71**	71**
STI guidelines	u	19	u	70**
ANC	83	86	90	90
Delivery	74	77	86	86
Postnatal	79	78	72	72
Immunisation	77	59	92	92
At least one (ANC, delivery, postnatal)	87	87	94**	94**
All three (ANC, delivery, postnatal)	68	74	69	69
Observed FP methods prescribed				
Pills	30	26	14**	14**
Condom	1	2	6**	6**
Injectables	44	57	63**	63*
Spermicides	6	3	2**	2
IUD	19	10	3**	3**
FP methods received by new clients				
Pills	31	23	13**	13*
IUD	25	9	6**	6
Injectables	25	41	57**	57**
Spermicides	16	19	4**	4**
FP methods used by returning clients				
Pills	31	29	13**	13**
IUD	10	3	2**	2
Injectables	55	68	76**	76**
Reproductive history/examination (new clients)				
Asked the youngest child's age	62	72	69	69
Asked about breastfeeding	35	29	29	29
Taking weight	65	65	71*	71
Taking blood pressure	69	69	86	86
BP taken for combined pills recipients	74	78	90**	90*
Pelvic examination				
Informed client about the procedure	76	78	100*	100*
Washed hand prior to examination	72	69	80	80
Used clean gloves	89	88	93	93
FP consultation				
Used visual aid	26	40	25	25**
Explained the use of methods	89	u	82	u
Described side effects	67	u	79*	u
Explained what to do if problems	76	u	70	u
Clients				
Had enough privacy	85	89	96**	96**
Reasonable waiting time	92	85	96**	96**
Know how often to take the pill	99	100	99	99
Know how to check the IUD in place	87	83	92	92

* Significant at 0.05 level
** Significant at 0.01 level
FP = Family planning
SD = Standard deviation

Table A.2 Family planning methods offered

Percentage of facilities that offer each of the indicated family planning methods (combined pill, progesterone-only pill, condom, all injectables, spermicides, IUD, female sterilisation, male sterilisation, natural methods), by type of facility and year of survey, Ghana 1993-2002

Family planning method offered and type of facility	Percentage of facilities		
	1993	1996	2002
Combined pill	**97**	**91**	**93**
Hospital	100	85	93
Health centre	96	92	95
PPAG clinic	100	100	100
Private maternity centre	95	89	87
Condom	**96**	**89**	**91**
Hospital	98	87	95
Health centre	98	91	89
PPAG clinic	95	97	100
Private maternity centre	92	85	88
All injectables[1]	**95**	**90**	**97**
Hospital	98	83	95
Health centre	97	87	97
PPAG clinic	86	97	100
Private maternity centre	93	90	99
Spermicides	**92**	**86**	**71**
Hospital	98	81	85
Health centre	95	85	57
PPAG clinic	100	100	100
Private maternity centre	83	81	65
Progesterone-only pill	**64**	**73**	**72**
Hospital	76	75	85
Health centre	68	73	75
PPAG clinic	45	97	50
Private maternity centre	67	61	57
IUD	**50**	**57**	**51**
Hospital	93	80	77
Health centre	55	51	41
PPAG clinic	77	85	87
Private maternity centre	25	39	70
Implant[2]	**u**	**7**	**20**
Hospital	u	27	78
Health centre	u	1	12
PPAG clinic	u	12	100
Private maternity centre	u	0	9
Rhythm (natural) family planning	**45**	**74**	**54**
Hospital	43	83	70
Health centre	47	65	48
PPAG clinic	50	79	80
Private maternity centre	40	74	61
Any sterilisation (hospital)[3]	**33**	**73**	**84**
Female sterilisation (hospital)[3]	**33**	**73**	**84**
Male sterilisation (hospital)[3]	**12**	**33**	**19**

u = Unknown (information not available)
[1] Information on the monthly injectable and two- to three-month injectable was available only in the 1993 and 2002 surveys.
[2] Information on the implant method was available only in the 1996 and 2002 surveys.
[3] Sterilisations were rarely offered in other types of facilities.

Table A.3 Availability of family planning commodities in facilities offering family planning methods

Percentage of health facilities offering specific family planning methods, and the method was available the day of the survey, by type of facility and year of survey, Ghana 1993-2002

Family planning commodity and type of facility	Percentage of facilities		
	1993[a]	1996[a]	2002[b]
Combined pill	**92**	**92**	**82**
Hospital	98	92	83
Health centre	94	92	84
PPAG clinic	95	100	100
Private maternity centre	86	87	77
Condom	**85**	**93**	**87**
Hospital	89	92	90
Health centre	86	92	86
PPAG clinic	81	97	100
Private maternity centre	86	92	86
All injectables	**94**	**90**	**93**
Hospital	100	92	92
Health centre	93	81	93
PPAG clinic	84	97	100
Private maternity centre	96	91	94
Spermicides	**85**	**91**	**74**
Hospital	93	92	81
Health centre	87	84	71
PPAG clinic	82	100	93
Private maternity centre	79	90	72
Progesterone-only pill	**62**	**86**	**75**
Hospital	75	85	77
Health centre	65	82	78
PPAG clinic	30	97	40
Private maternity centre	56	82	73
IUD	**89**	**89**	**76**
Hospital	96	94	77
Health centre	88	84	71
PPAG clinic	82	93	92
Private maternity centre	84	88	84
Implant	u	**85**	**74**
Hospital	u	94	66
Health centre	u	50	80
PPAG clinic	u	75	80
Private maternity centre	u	u	87

u = Unknown (not available)
[1] Indicates facility had no stock-out during preceding six months
[2] Indicates facility had no stock-out on the day of the survey