REPUBLIC OF GHANA

Ghana Family Planning Costed Implementation Plan

2016–2020

GOVERNMENT OF GHANA

Ministry of Health

September 2015

Funding and technical support provided by

Suggested citation: Government of Ghana. 2015. Accra: Ghana Health Service. 2015. Washington, DC: Futures Group, Health Policy Project. Ghana Family Planning Costed Implementation Plan.

Ghana Family Planning Costed Implementation Plan

2016-2020

SEPTEMBER 2015

[1] Ghana Ministry of Health [2] Ghana Health Service

CONTENTS

TABLE OF FIGURES

ACKNOWLEDGEMENTS

The Government of Ghana would like to express its appreciation to the many partners and groups who supported the development of the Ghana Family Planning Costed Implementation Plan, 2016–2020 (GFPCIP). This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, development partners, implementing partners, professional associations, and for-profit organisations working in aligned areas.

This publication is made possible through the funding and technical support from the United States Agency for International Development, through the Health Policy Project (HPP), with particular acknowledgement of the contributions of Dr. Nichole Zlatunich, Dr. Tewodros Bekele, and Jasper Sablah, who provided technical support throughout the development of the GFPCIP.

In addition to the organisations and projects named above that provided financial support, a variety of government agencies, development partners, implementing partners, professional associations, and for-profit organisations also provided valuable inputs and feedback throughout the process via in-person meetings and ongoing electronic communications. These organisations include:

- Adventist Relieve Agency;
- African Women's Development Foundation;
- Alliance for Reproductive Health Rights;
- Christian Health Association of Ghana;
- Christian Coalition of NGOs in Health;
- Community Practice Pharmacists' Association;
- Curious Minds;
- DKT International;
- Food and Drugs Authority;
- Family Planning 2020 (FP2020);
- Ghana AIDS Commission;
- Ghana Education Service – School Health Education Programme;
- Ghana Health Service – Family Health Division Health Promotion Unit; Regional Health Directorate; Supplies, Stores and Drugs Management; Policy Planning Monitoring & Evaluation Division;
- Ghana Registered Midwives Association;
- Ghana Adolescent Reproductive Health Project;
- Health Keepers Network;
- Human Rights Advocacy Centre;
- JHPIEGO;
- Korle-Bu Teaching Hospital- Reproductive Health Unit;
- Management Systems International;
- Marie Stopes International Ghana;
- Ministry of Education;

- Ministry of Finance;
- Ministry of Gender, Children and Social Protection- Department of Gender;
- Ministry of Health- Policy Planning Monitoring and Evaluation Division; Procurement & Supplies Unit;
- National AIDS Control Programme;
- National Health Insurance Authority;
- National Population Council;
- National Youth Authority;
- Palladium;
- Parliament of Ghana- Parliamentary Select Committee on Health;
- Planned Parenthood Association of Ghana;
- Population Action International;
- Population Council;
- Regional Health Directorate: Ashanti Region, Central Region, Eastern Region, Greater Accra Region, Volta Region;
- Ridge Hospital- Family Planning Unit;
- School of Public Health, University of Ghana;
- Society of Private Medical and Dental Practitioners;
- UKAID;
- United Nations Population Fund;
- USAID;
- USAID Communicate for Health, implemented by FHI 360;
- USAID | DELIVER, implemented by John Snow Inc.;
- USAID Evaluate for Health, implemented by Management Sciences Intl;
- USAID Health Policy Project, implemented by Palladium;
- USAID Systems for Health, implemented by University Research Corp; and
- World Health Organization.

The development process was led by a Task Force under the joint leadership of the National Population Council (NPC) and Ghana Health Service (GHS). Special appreciation is also made to the Task Force for steering this process, namely: Ms. Marian Kpakpah, NPC, Dr. Patrick Aboagye, FHD/GHS; Marcia Halm, African Women's Development Foundation; Jacqueline Sfarijlani, Ghana AIDS Commission; David Logan, GHARH Project; Dr. Gloria Quansah Asare, GHS; Mavis Apatu, Regional Health Directorate/GHS; Nana Yaw Yankah, Ministry of Finance; Caroline Adonadaga, National AIDS Control Programme; Dr. Stephen Ayisi-Addo, National AIDS Control Programme; Dr. Zana Somda, Palladium; Albert Wuddah-Martey, PPAG; Dr. George Amofah, School of Public Health, University of Ghana /Private Consultant; Prof. Augustine Ankomah, School of Public Health, University of Ghana; Archie Laing, UKAID; Mammah Tenii, UNFPA; Dr. Kareem Mumuni, University of Ghana Medical School; Afua Aggrey, USAID | DELIVER; Irene Agyemang, USAID | DELIVER; Egbert Bruce, USAID | DELIVER; Dr. Nicholas Kanlisi, USAID Systems for Health; Nora Maresh, USAID; Felix Osei-Sarpong, USAID; Juliana Pwamang, USAID; Vandana Stapleton, USAID; and Dr. Roseline Doe, World Health Organization.

We also acknowledge Dr. Afisah Zakariah and Dr. Emmmanuel Ankrah Odame of the Ministry of Health for assisting with the review.

In addition, Ms. Joyce Amedoe, Ms. Esther Cofie, and Mr. Isaac Sopelle of National Population Council, and Dr. Yaa Asante of Ghana Health Service, manned the Secretariat that coordinated the whole development process of the GFPCIP, and should be recognised for their continuous efforts and ongoing engagement throughout the process.

FOREWORD

Ghana has made impressive gains in economic growth and social development, elevating the country to lower middle-income status. However, the socioeconomic development and progress made over recent decades has not been inclusive, leaving some sectors lagging behind with respect to progress, and some key sectors, especially improvements in maternal health. As a result, maternal mortality was declared to be a national emergency in 2008. The high maternal mortality ratio is associated with a weak health system and low access to quality health services, including low access to skilled birth attendance, human resource shortages, and high unmet need for family planning (FP).

FP services have been expanding in Ghana for the last 50 years through public and private service providers. Our government-led public education programs on family planning have been successful in creating awareness and addressing misconceptions; however, changes in attitudes and practices have not been encouraging, as there are still high rates of unwanted and mistimed births amongst Ghanaian women, and both men and women still prefer large families.

Cognizant of the low coverage and utilisation of FP services, the Government of Ghana (GOG) has made commitments to reach more women, youth, and adolescents by making these services affordable, accessible, and equitable for all population groups. The government has put in place a comprehensive multisector FP programme to increase demand for and use of family planning as priority interventions in the Millennium Development Goals (MDG) Acceleration Framework (MAF). This Costed Implementation Plan (CIP) is being developed as part of the comprehensive multisectoral strategy to reposition FP programs in Ghana and translate policy intent into realistic actionable programme targets and activities.

The CIP calls for a concerted action amongst public, private, civil society, faith-based, and nongovernmental organisations to expand family planning services and strengthen our health system to meet the bold commitments the GoG made at the London Summit in July 2012. This bold and ambitious but realistic plan is the blueprint to which all stakeholders will refer when working on family planning in Ghana. It has been crafted through an evidence-based, extensive consultative process encompassing globally proven interventions contextualised to our local realities.

Real ownership begins with decisive leadership and meaningful engagement in the planning process; in this respect, I believe that the painstaking work and extensive consultations involved in preparing for the CIP have effectively consolidated the strong collective ownership needed to ensure its successful implementation.

I believe government commitment and leadership will be key drivers of progress in this regard, and I want to assure all our partners and FP stakeholders throughout the sector that our government's resolve has never been stronger; we are committed to continue playing a strong leadership role to reach the bold but achievable targets set out in this CIP document. The strong partnerships we have built up over the last years inspires great optimism. We should all be proud of the important progress we have made together, and derive from these achievements renewed optimism about the continued gains we stand to make over the coming years. Therefore, let us continue to work together to ensure the health and wealth of women, our communities, and our nation.

Hon. Alex Segbefia, Minister of Health

PREFACE

The firm resolve of the Government of Ghana to advance family planning services has been reflected in the National Population Policy and the MDG Acceleration Framework (MAF) documents. The MAF has put reduction of maternal morbidity and mortality as one of its foremost objectives. The recent momentum in advancing family planning services in Ghana is motivated by proof that it is one of the most effective ways to prevent maternal, infant, and child mortality and provide additional social and economic benefits to women, their families, communities, and our nation.

Initiated by the Government of Ghana in November 2014, the preparation of the Ghana Family Planning Costed Implementation Plan (GFPCIP) has gone through iterative processes of programme assessment and landscaping, activity planning, and costing. The plan builds on the key achievements, best practices and lessons learnt of various reproductive health and family planning strategies and plans implemented in Ghana. The GFPCIP is a particularly significant document not only because it is the last five-year plan that will get us through our final 'sprint' to the FP2020 goals, but also because it constitutes a key component of our government's improved momentum to address equity, and access to reproductive, maternal, newborn and child health services.

The CIP focuses on the following key strategic priorities that will help us reach our goals:

1. Priority # 1: Promote and nurture change in social and individual behaviour to address stigma, myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies through correct, consistent, and targeted social and behaviour change communications (SBCC) that focuses on rights-based family planning
2. Priority # 2: Increase age-appropriate and rights-based information, access, and use of contraception amongst young people, ages 10–24 years
3. Priority # 3: Improve availability and access to a full method mix, quality of client-provider interactions, with a particular focus on improving counselling on delaying, spacing, and limiting for all clients of all ages and population groups
4. Priority # 4: Improve distribution and ensure full financing for commodity security in the public and private sectors
5. Priority # 5: Strengthen advocacy to build political will for rights-based family planning amongst community leaders, religious and cultural institutions, and policymakers at all levels to lead to higher budget and expenditure levels for family planning from domestic sources and ensure implementation and accountability
6. Priority # 6: Strengthen the provision of FP services and information through Community-based Heath Planning and Services (CHPS) to expand access to hard-to-reach-communities (e.g., increase capacity of CHPS community health workers (CHWs)

We have deliberately set ambitious but realistic, targets that we believe can be achieved over the coming five years. Working together as one, we believe we can realise these goals for the following compelling reasons: first; we are building up on the encouraging momentum attained since the London Summit in 2012. Second, the renewed focus on the untapped potential of CHPS structure can be game-changing. We can maximise the gains from the community based platforms by broadening and deepening the engagement of local communities, particularly women and youth in every village. Third, the steadfast support and commitment of our diverse partners is has been a strength. Tackling the challenges ahead will no doubt require the continued concerted efforts of our government, the private sector, non-governmental organisations, and multilateral and bilateral development partners. We believe that our joint efforts will lead to a decline in the unmet need for family planning to a level of impact by 2020 by increasing the modern contraceptive prevalence rate for married and unmarried sexually active women.

Finally, we would like to express our profound appreciation to all those who have been involved in the development of this important document. Its successful completion and publication would not have been possible without the committed efforts and vital contributions of a wide range of stakeholders. We also want to thank all of our partners for endorsing this document as our common guiding reference for our operations for the coming five years. We would like to encourage all stakeholders to commit to this important scale-up plan to reach our goals so that we can continue to save lives, and women and families can continue to fully enjoy the benefits of family planning.

Marian Kpakpah
Ag. Executive Director
National Population Council

Dr. Appiah Denkyira
Director-General
Ghana Health Service

Dr. Sylvester Anemana
Chief Director
Ministry of Health

EXECUTIVE SUMMARY

The Government of Ghana (GoG) has committed to increasing the modern contraceptive prevalence rate (CPR) to 30 per cent amongst married and 40 per cent amongst unmarried, sexually active women by 2020. Full implementation of the Ghana Family Planning Costed Implementation Plan, 2016–2020 (GFPCIP) by the GoG and partners will enable Ghana to reach its ambitious but realistic goals.

Figure 1: CIP Operational Objectives

- Increase the modern contraceptive prevalence rate amongst currently married women from 22.2 per cent[i] in 2014 to 29.7 per cent by 2020 (33% all methods CPR in 2020).
- Increase the modern CPR amongst unmarried sexually active women from 31.7 per cent[1] in 2014 to 40 per cent by 2020 (50% all methods CPR in 2020).

Comprehensive sexual and reproductive health and rights care, including family planning, is not only a health and rights issue. It is a developmental necessity, as it also improves livelihoods and promotes economic growth. Therefore, providing quality reproductive health services to women, men, and adolescents and ensuring consistent CPR growth is a priority for the GoG. Improving CPR and increasing the uptake of long-term family planning will provide multiple benefits to Ghana by accelerating development and reducing pressure on the nation's resources.

Ghana can realise a boost in economic growth and productivity that can raise incomes and allow families and governments to improve the well-being of future generations. Ghana's population dynamics can be turned into a valuable demographic dividend only if investments are made in FP and reproductive health (RH) programmes to promote population change through a lower fertility rate and more balanced age structure, as well as in multisectoral social and development programs that enable economic growth and quality-of-life improvements. Voluntary FP programmes play an important role in enabling couples to realise their reproductive preferences, thereby shaping a country's demographic path while simultaneously improving health and increasing savings across development sectors.[ii] However, the demographic dividend is only possible when fertility rates decline sharply and significantly, leading to a lower dependency ratio.[iii]

Therefore, to improve the ability of women, men, and young people to fulfil their fertility intentions, leading to improved health and increased wealth at the individual, community, and national levels, the GFPCIP analyses key issues and barriers to family planning and provides a technical strategy to guide investments over the next five years. The GFPCIP is structured around six main thematic areas:

1. Demand creation;
2. Service delivery;
3. Contraceptive security;
4. Policy and enabling environment;
5. Financing; and
6. Stewardship, management, and accountability.

Each theme is further separated into strategic outcomes and specific activities that have been identified as necessary to achieve those outcomes. The GFPCIP includes an activity matrix that illustrates the relationship between the strategic outcomes and the activities planned to achieve them. It further articulates the inputs required to fully implement each activity and the public sector cost of those inputs.

Full implementation of the GFPCIP will increase the number of women in Ghana currently using modern contraception from approximately 1.5 million users in 2015 (baseline) to 1.9 million in 2020 (see Figure).

Figure 2: Total FP Users, Married and Unmarried 2015 Baseline, Projected, 2016–2020

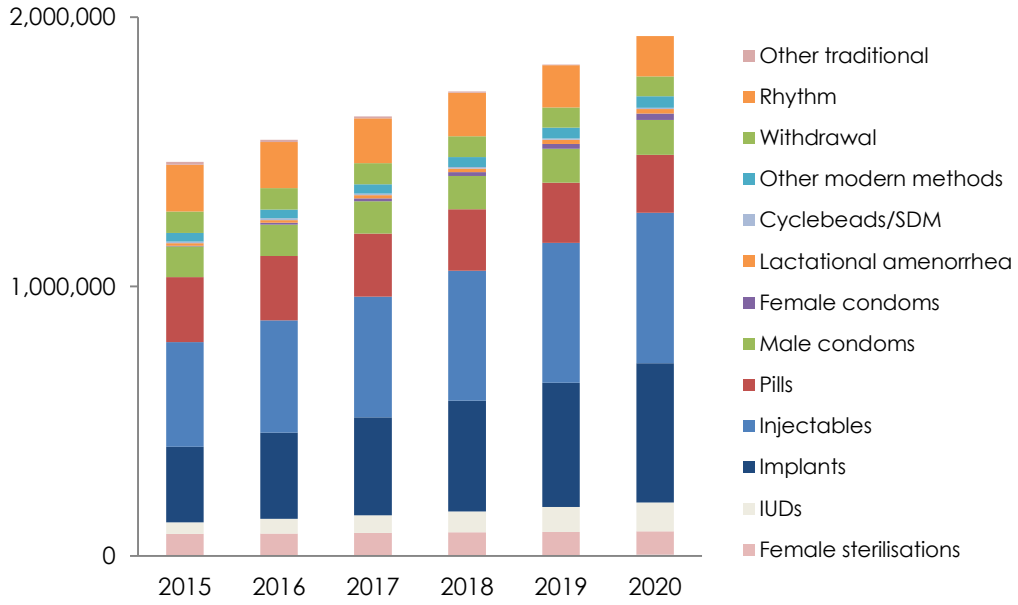
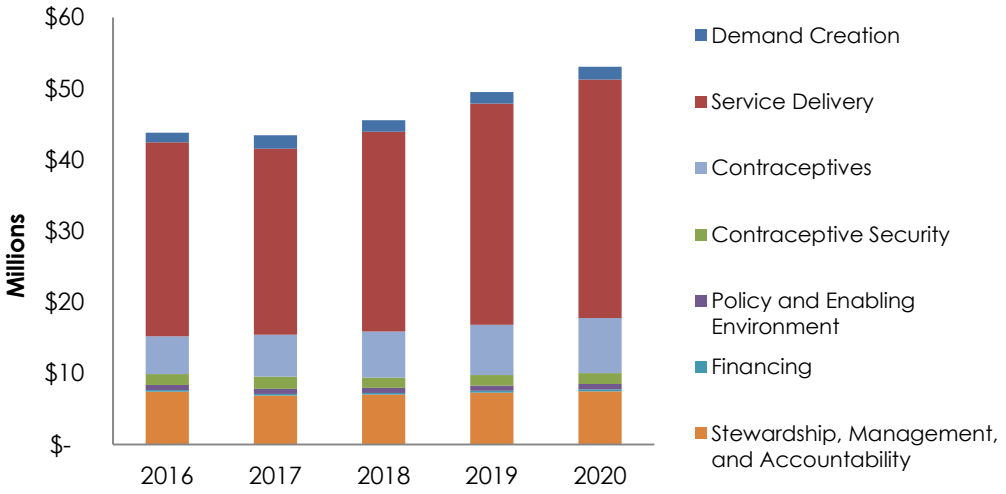


Figure 3: Costs by Thematic Areas and Contraceptive Costs, in Millions USD shows the annual costs of fully implementing the GFPCIP, including both activity and contraceptive commodity and consumable costs. The total costs of the plan from 2016–2020 are $235 million USD (906 million Ghanaian cedis). Between 2016 and 2020, the annual cost of the plan will average about $47 million USD. This amounts to a cost of about $40.5 million USD per year in activity costs, or $5.52 USD per woman of reproductive age per year, and $6.5 million USD per year in contraceptives and direct consumables, or $3.74 USD per FP user per year. A total of $32.5 million USD, or 14 per cent of the overall costs, are in commodities, including contraceptives and consumables. Another 3 per cent of the costs are in demand creation; 62 per cent in service delivery; 3 per cent in programming for contraceptive security; 1.6 per cent in policy and enabling environment; less than 1 per cent in financing; and 15 per cent in stewardship, management, and accountability.

Figure 3: Costs by Thematic Areas and Contraceptive Costs, in Millions USD



Making these investments in family planning in Ghana and achieving the desired CPR goals will avert more than 2.3 million unintended pregnancies, more than 800,000 abortions, almost 30,000 child deaths, and more than 5,000 maternal deaths between 2016 and 2020. Additionally, the intervention will avert expenditures of almost $115 million USD on maternal and infant healthcare costs alone

during the five-year plan period.[iv] In addition, other sectors, including public health, education, and infrastructure, will also experience significant cost savings due to increased FP use.

Ghana's FP goals and the activities and results detailed to achieve them in the GFPCIP are ambitious and must therefore be matched with commensurate support in the areas of human resources, financing, and political commitment from national to regional to district to community levels throughout the country.

ABBREVIATIONS

AYFHS	Adolescent and Youth-Friendly Health Services
CBO	Community-Based Organisation
CMS	Central Medical Stores
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-Based Health Planning and Services
CHV	Community Health Volunteer
CHW	Community Health Worker
CIP	Costed Implementation Plan
CMS	Central Medical Stores
CPE	Continuing Professional Education
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
CSO	civil Society Organisation
CYP	Couple years of protection
DALYs	Disability-Adjusted Life Years
DC	Demand Creation
DFID	Department for International Development (UK)
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EC	Emergency Contraceptives/Contraception
FBO	Faith-Based Organisation
F	Financing
FDA	Food and Drugs Authority
FHD	Family Health Division
FP	Family Planning
FSP	Financial Sustainability Plan
GES	Ghana Education Service
GFPCIP	Ghana Family Planning Costed Implementation Plan
GHS	Ghana Health Service
GoG	Government of Ghana
GSA	Ghana Standards Authority
HPP	Health Policy Project
HMIS	Health Management Information System
HRDD	Human Resource and Development Division
HW	Health Worker
ICC/CS	Inter-agency Coordination Committee for Contraceptive Security
ICPD	UN International Conference on Population and Development
IEC	Information, Education, and Communication
IPC	Interpersonal Communication
IUD	Intrauterine Device
IVR	Interactive Voice Response
LAPM	Long-Acting and Permanent Methods
LARC	Long-Acting Reversible Contraceptive
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MAF	MDG Acceleration Framework
MCH	Maternal and Child Health
MCPR	Modern Contraceptive Prevalence Rate
MDAs	Municipal and District Assemblies
MDBS	Multi-donor Budget Support

MDG	Millennium Development Goal
ME	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MOU	Memorandum of Understanding
NDPC	National Development and Planning Commission
MP	Member of Parliament
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
NMC	National Medical Council
NPC	National Population Council
NYA	National Youth Authority
OPD	Outpatient Department
PEE	Policy and Enabling Environment
PLHIV	People Living With HIV
PLS	Procurement, Logistics, and Supply
PLWHA	People Living With HIV/AIDS
PMA2020	Performance, Monitoring, and Accountability 2020
PMTCT	Prevention of Mother-To-Child Transmission
PPAG	Planned Parenthood Association of Ghana
PPME	Policy, Planning, Monitoring, and Evaluation
PPP	Public-Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHMT	Regional Health Management Team
RMS	Regional Medical Store
SBCC	Social and Behaviour Change Communication
SD	Service Delivery
SDG	Sustainable Development Goal
SDP	Service Delivery Point
SHEP	School Health Education Programme
SMA	Stewardship, Management, and Accountability
SMO	Senior Medical Officer
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SSDM	Supplies, Stores and Drug Management Directorate
TFR	Total Fertility Rate
TMA	Total Market Approach
TOR	Terms of Reference
TOT	Trainer of Trainers
TWG	Technical Working Group
USD	U.S. dollar
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

PROCESS AND FORMULATION OF THE GFPCIP

Ghana began developing the Ghana Family Planning Costed Implementation Plan, 2016–2020 (GFPCIP) in February 2015, with support initiated by the Health Policy Project (HPP), funded by USAID, which assembled a Technical Support Team to provide expertise.

Working from February through September 2015, the team worked under the direction of the National Population Council (NPC) and Ghana Health Service (GHS) to conduct a comprehensive situational analysis, including a desk review and consultations; identify strategic priorities; solicit for strong stakeholder input (through group consultations, in-person meetings, and electronic communications); develop and refine activities; and estimate costs. The team was guided throughout the process by the CIP Task Force, a group of high-level experts drawn from the government, development partners, implementing partners, civil society, and advocates.

The Technical Support Team, in consultation with expert groups, and under the guidance of the Task Force, developed the technical strategy through an inclusive, country-driven process that included situation analysis, goal setting, results formulation, and activity planning. The GFPCIP technical strategy was built on a comprehensive understanding of the family planning (FP) issues, gaps, and opportunities at the service delivery (SD), programme, and policy levels in Ghana, and follows the fundamental elements of sound FP programme design. The team conducted a situation analysis to gather information and data—comprising a desk review, secondary analysis of statistical data, and stakeholder consultations—to gather information. In addition to holding formal meetings with the Task Force and four Strategic Advisory Groups (SAGs) addressing Service Delivery, Social Behaviour Change, Contraceptive Security, and Youth, respectively, the team conducted consultations and key informant interviews with more than 25 partners, donors, and other government sectoral ministries and bodies, including five Regional Health Directorates, to ensure that they assessed the perspectives of various stakeholders. The team took in to account their inputs on current ongoing activities and potential activities to address barriers at the national, regional, district, and community levels.

The technical strategy was informed by the country goal of increasing the contraceptive prevalence rate (CPR). The CPR targets for married and unmarried women were vetted and selected through a consultative Reality Check meeting.

The plan and activity matrix was presented in various forms to expert groups throughout the process, including the CIP Task Force; the four SAGS; and the Inter-agency Coordination Committee for Contraceptive Security (ICC/CS). The plan was refined based on their feedback and input at these meetings and via electronic communications.

A list of key issues and associated causal factors was developed from the detailed situation analysis and stakeholder consultation work. The Technical Support Team then conducted a root-cause analysis of the issue list to identify the context and interrelationship of problems and develop a comprehensive list of inter-connected causal factors for each key issue, and discrete issues that could be addressed by various interventions. This information was then organised, classified, and entered into an issue-solution matrix. The strategic priorities were developed from data gathered during this consultation process and desk review, and proposed again to stakeholders for vetting, refinement, and approval.

The team next converted issues into results (strategic outcomes), drafted an implementation framework detailing the strategic results; activities; sub-activities; outputs, including targets; and timeline. This framework was then circulated to stakeholders (including the Task Force) for additional feedback and edits. The matrix was further detailed and refined through stakeholder meetings. At these meetings, participants assigned prioritisation rankings for the impact and feasibility of the success of various interventions in the local context. In addition, stakeholders provided additional feedback through various iterations of the framework through one-on-one and small group consultations and electronic communications.

In addition, the team identified and considered global best and high-impact practices,[v] analysed them for applicability in Ghana, and included relevant intervention activities in the GFPCIP for consideration (including activities for piloting and evaluation before larger scale-up), as appropriate to the country context and according to stakeholders' expert opinions.

The costing was developed based on international best practices and customised to the Ghana context to include local costs (refer to 3.1, Costing Assumptions section for further information and details). Finally, the Government of Ghana (GoG) circulated the draft version of the complete GFPCIP to its partners and stakeholders before the plan was finalised and approved.

During execution, further refinement of the technical strategy will become necessary as information is generated from performance monitoring of the GFPCIP. After the mid-term review, but before the final evaluation is completed, the process for developing a new GFPCIP for 2021–2026 should commence. This process for developing a revised plan should be informed by the mid-term review and by preliminary results from the final evaluation.

LANDSCAPE ASSESSMENT

Introduction

The Ghana Family Planning Costed Implementation Plan, 2016–2020 (GFPCIP) details the country's plans to achieve its vision and goals to improve the health and well-being of its population and the nation through providing high-quality, rights-based family planning (FP) information and services.

In addition, this document serves as the blueprint for Ghana to achieve the following consensus-developed targets:[vi]

- To increase the modern contraceptive prevalence rate (CPR) amongst currently married women from the current 22.2 per cent[vii] to 29.7 per cent by 2020 (33% all methods CPR in 2020)
- To increase the CPR amongst unmarried sexually active women from the current modern CPR of 31.7 per cent to 40 per cent by 2020 (50% all methods CPR in 2020)

Ghana's commitments to family planning and the Costed Implementation Plan (CIP) align with the most recent medium-term development policy framework: the Ghana Shared Growth and Development Agenda (GSGDA II, 2014–2017). Thus, the GFPCIP contributes to Ghana's developmental goals of ensuring and sustaining macroeconomic stability; enhancing the competitiveness of Ghana's private sector; accelerated agriculture modernisation and sustainable natural resource management; oil and gas development; infrastructure and human settlements development; human development, productivity and employment; and transparent, responsive, and accountable governance.[viii]

At the global level, the July 2012 London Summit on Family Planning renewed enthusiasm and commitment to family planning and led to a number of countries developing CIPs with the aim of accelerating progress in FP goals. The GFPCIP was developed to facilitate fulfilment of Ghana's FP2020 pledges (refer to Figure 4) and aligns with key FP, population, health, and other sectoral policies and strategies in Ghana, including the National HIV and AIDS, STI Policy; National Gender and Children Policy; National Health Policy; Ghana Adolescent Reproductive Health Policy; National Population Policy, Revised Edition, 1994; and the National Reproductive Health and Service Policy and Standards. Others include the Reproductive Health Strategic Plan 2007–2011; Ghana Health Sector Medium-term Development Plan 2014–2017; Ghana National Condom and Lubricant Programming Strategy 2014; Health Commodity Supply Chain Master Plan; The Ghana National Reproductive Health Commodity Security Strategy 2011–2016; and Ghana Strategic Plan for the Health and Development of Adolescents and Young People, 2009–2015. These are detailed further in Table 5: Key Policies and Strategies in Ghana.

In addition, access to family planning and contraception is a fundamental dimension of sexual and reproductive health and reproductive rights, as clearly stated in the UN International Conference on Population and Development (ICPD) Programme of Action (PoA), held in Cairo, Egypt in 1994. ICPD's consensus framework aimed directly at a goal of comprehensive sexual and reproductive health and rights (SRHR), based on a human rights framework and inclusive of family planning, maternal health, prevention of STIs, and adolescent reproductive health.[ix]

In line with these goals, Ghana's National Reproductive Health and Service Policy and Standards defines a rights-based approach to reproductive health and sexual rights, "The Government of the Republic of Ghana adopts and adapts the reproductive health definition from the 1994 Cairo ICPD . . . Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services . . ."[x]

However, despite international and national policy instruments supportive of sexual and reproductive health services and rights, many Ghanaians, particularly girls and women, are unable to access these services due to a number of hindering factors, including, but not limited to early marriage, low socioeconomic status, low levels of education and literacy, and poor access to healthcare. These factors affect the lives and productivity of women and girls who, in turn, cannot fulfil their rights to education, health, and work due to the lack of information and services that could enable them to delay motherhood and plan their family size.

Operating under this context, the GFPCIP was designed to align to the 10 components of the FP2020's *Rights and Empowerment Principles for Family Planning*: agency and autonomy; availability; accessibility; acceptability; quality; empowerment; equity and non-discrimination; informed choice; transparency and accountability; and voice and participation.[xi]

Rational For and Use of the GFPCIP

The GFPCIP is the guide for all FP programming for the government across all sectors, development partners, and implementing partners. The GFPCIP details the necessary programme activities and costs associated with achieving national goals, providing clear programme-level information on the resources the country must raise domestically and from partners. The plan gives critical direction to Ghana's FP programme, ensuring that all components of a successful programme are addressed and budgeted for by government, donors, implementing partners, and all actors.

More specifically, the GFPCIP will be used to do the following:

- **Ensure that one unified country strategy for family planning is followed by government, development partners, and implementing partners:** The GFPCIP articulates Ghana's consensus-driven priorities for family planning—derived through a consultative process—and thus becomes a social contract for donors and implementing partners. The plan will help ensure that all FP activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their FP investments and programmes. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the Ministry of Health (MoH) must hold development and implementing partners to account for their planned activities and realign funding to the country's needs identified as priorities. At the same time, the GFPCIP details commitments, targets, actions, and indicators to make the MoH ultimately accountable for their achievement. All other sectoral ministries should work in tandem with the MoH to implement the GFPCIP and coordinate efforts.
- **Define key activities and an implementation roadmap:** The GFPCIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's FP goals by 2020.
- **Determine impact:** The GFPCIP includes estimates of the demographic, health, and economic impacts of the FP programme, providing clear evidence for advocates to use to mobilise resources.
- **Define a national budget:** The GFPCIP determines detailed commodity costs and programme activity costs associated with the entire FP programme. It provides concrete activity and budget information to inform the MoH budget requests for FP programmes aligned with national goals between 2016 and 2020. It also provides guidance to the MoH and partners to prioritise the funding and implementation of strategic priorities.
- **Mobilise resources:** The GFPCIP should also be used by the GoG and partners to mobilise needed resources. The plan details the activities and budget required to implement a comprehensive FP programme; as such, the MoH and partners can systematically track the currently available resources against those required as stipulated in the GFPCIP, and conduct

advocacy to mobilise funds from development partners to support any remaining funding gaps.

- **Monitor progress:** The GFPCIP's performance management mechanisms measure the extent of activity implementation and help determine that the country's FP programme is meeting its objectives, ensuring coordination, and guiding any necessary course corrections.
- **Provide a framework for inclusive participation:** The GFPCIP and its monitoring system provide a starting point to address and improve the participation of stakeholders within and outside of government; in addition, where appropriate and feasible, activities strive for inclusiveness of relevant groups and representatives from key populations in the implementation and monitoring of the plan.[xii]

The Global Context

Scaling up FP services is one of the most cost-effective interventions to prevent maternal, infant, and child deaths globally. Furthermore, FP interventions aid in lowering mortality, contributing to the Millennium Development Goals (MDGs) and the proposed Sustainable Development Goals (SDGs). Through a reduction in the number of unintended pregnancies in a country, it is estimated that one-quarter to one-third of all maternal deaths could be prevented. Family planning is linked indirectly as a contributor to positive health outcomes. For example, FP interventions contribute to reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unwanted teenage pregnancies, and lowering infant deaths.[xiii] Additionally, each dollar spent on FP initiatives on average results in a $6 saving on health, housing, water, and other public services.[xiv] Universal access to sexual and reproductive health (SRH) services by 2030 and the elimination of unmet need for modern contraception by 2040 has been calculated to have annual costs of $3.6 billion USD, and annual benefits of $432 billion USD, thus resulting in $120 of benefits for every dollar spent.[xv]

Lack of access by adolescent girls to family planning, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. In low- and middle-income countries, complications of pregnancy and childbirth are the leading causes of death amongst adolescent girls ages 15–19.[xvi]

As of 2014, amongst women of reproductive age in developing countries, 877 million need access to contraceptive methods because they are sexually active but do not want a child in the next two years. Of these women, 652 million (74%) are using modern methods of contraception; however, the remaining 225 million (26%) desire to space or limit pregnancies but are not using modern contraception, resulting in significant unmet need for modern FP methods.[13]

FP2020

The UK government, through the Department for International Development (DFID), and the Bill & Melinda Gates Foundation partnered with the United Nations Population Fund (UNFPA) to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups to renew and revitalise the global commitment to ensuring the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.[xviii] The resulting event was the London Summit on Family Planning, held on 11 July 2012. At the summit, implementers, governments, and FP stakeholders united to determine priorities and set forth commitments. The GoG made several significant commitments (see Figure 4).

Figure 4: Ghana Country Commitments to FP2020[xvii]

Policy and Political Commitments

1. In 2011, Ghana's MoH and its National Population Council put in place an MDG 5 Acceleration Framework, also known as the MAF Plan.
2. The country commits to revising its national health insurance benefits package to include FP services and supplies, which will make them free of charge everywhere.

Financial Commitments

3. Ghana is committed to increasing the government contribution to buying FP commodities. The government currently directly purchases about one- quarter of all commodities; this percentage will increase after 2015.
4. Ghana will commit an additional $3 million USD annually for the MAF Plan for 2012–2015.

Programme and Service Delivery Commitments

5. Use community-based nurses to deliver FP services in rural areas.
6. Eliminate user fees for FP services in all public health facilities.
7. Increase demand for FP, including advocacy and communications, to improve male involvement (such as the "Real Man" campaign).
8. Improve workforce training and options for task shifting.
9. Improve counselling and customer care.
10. Improve postpartum and postabortion care, including postpartum and postabortion FP services.
11. Offer expanded contraceptive choices, including a wider range of long-acting and permanent methods.
12. Provide adolescent-friendly services for sexually active young people (through youth promoters and adolescent friendly services).
13. Support the private sector in providing services.

The summit aimed to "mobilise global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020."[xix] Achieving this ambitious target would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 childbirth-related and maternal deaths, and 3 million infant deaths.[xx]

The London Summit on Family Planning called on all stakeholders to work together on various areas,[xxi] including the following:

- Increasing the demand and support for family planning;
- Improving supply chains, systems, and service delivery models;
- Procuring the additional commodities countries need to reach their goals;
- Fostering innovative approaches to FP challenges; and
- Promoting accountability through improved monitoring and evaluation (M&E).

Sustainable Development Goals

Building on the commitments of the MDGs, the global SDGs[xxii] have been newly proposed by the United Nations to address domestic and global inequalities by 2030. Proposed Goals 3 and 5 include direct and indirect outcomes related to family planning. Proposed Goal 3 specifies "Ensure healthy lives and promote well-being for all at all ages." Further, the sub-activities state the following:

- 3.1—By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- 3.7—By 2030, ensure universal access to SRH services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Further, proposed Goal 5, "Achieve gender equality and empower all women and girls," includes sub-activity 5.6: "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences."[xxiii] Given the focus areas in family planning and equitable access, if the necessary resources, political will, advocacy, and in-country priorities are provided, the SDGs are set to achieve substantial impact outcomes.

The Regional Context

The total fertility rate (TFR) is high for many of countries in West Africa due to low contraceptive prevalence rates. In addition, maternal and infant mortality remain high (see Table 1).

Table 1: Reproductive Health Indicators for Selected Countries in West Africa, Latest Available Data[xxiv]

Country	TFR[xxv]	MCPR, Married Women[xxvi]	Maternal Mortality Rate per 100,000 Live Births (2013) [xxvii]	Infant Mortality Rate per 1,000 Live Births (2013) [xxviii]
Benin	4.9	7.9	340	56.2
Burkina Faso	6	15	400	64.1
Ghana	**4.2**	**22.2**	**380**	**52.3**
Guinea	3.7	18.4	650	64.9
Liberia	5.1	4.6	640	53.6
Mali	4.7	19.1	550	77.6
Niger	6.1	9.9	630	59.9
Nigeria	7.6	12.2	560	74.3
Senegal	5.5	9.8	320	43.9
Sierra Leone	5	12.1	1100	107.2

Although Ghana has indicators that are better than many neighbouring West African countries, it does not compare as favourably to other successful developing countries, such as Egypt, Brazil, and Thailand, which have lower fertility rates and higher modern CPRs (MCPRs) (see Table 2.)[xxix]

Table 2: Reproductive Health Indicators for Selected Middle-Income Countries, Latest Available Data[xxx]

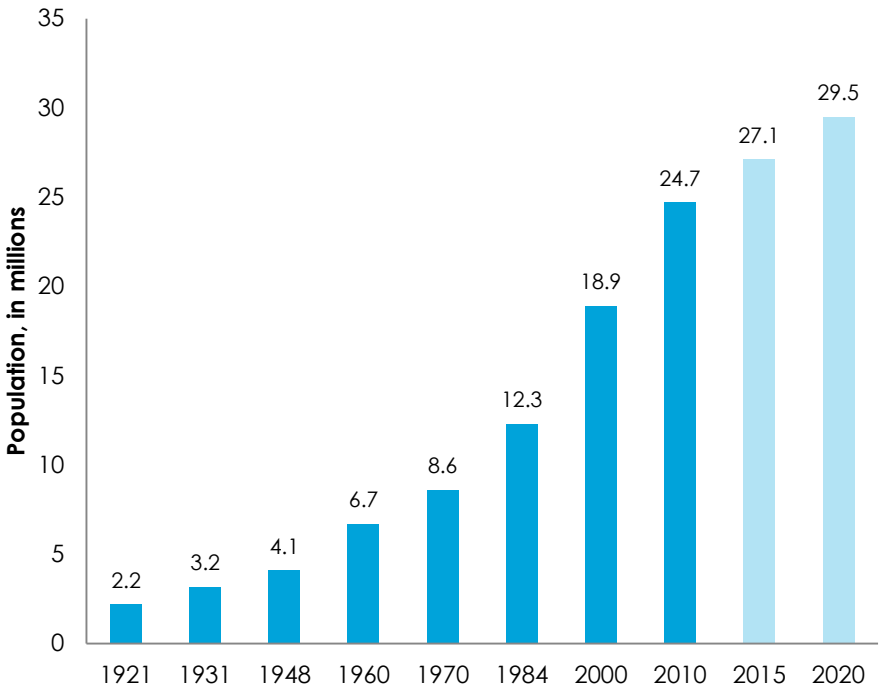
Country	TFR[xxxi]	MCPR, Married Women[xxxii]	Maternal Mortality Rate per 100,000 Live Births (2013) [xxxiii]	Infant Mortality Rate per 1,000 Live Births (2013) [xxxiv]
Brazil	2.5	70.3	69	12.3
Egypt	3.5	56.9	45	18.6
Ghana	**4.2**	**22.2**	**380**	**52.3**
Thailand	2.2	63.6	26	11.3

The Ghanian Context

Population

Ghana's population is growing rapidly, as indicated in 5. Its population has increased more than tenfold over the last 90 years, from 2.3 million in 1921 to 24.7 million in 2010. Over the last 30 years, the population doubled, and with an annual growth rate of 2.5 per cent, the population of Ghana is expected to double again in 28 years. This would lead to a population of almost 50 million people by 2038.[xxxv]

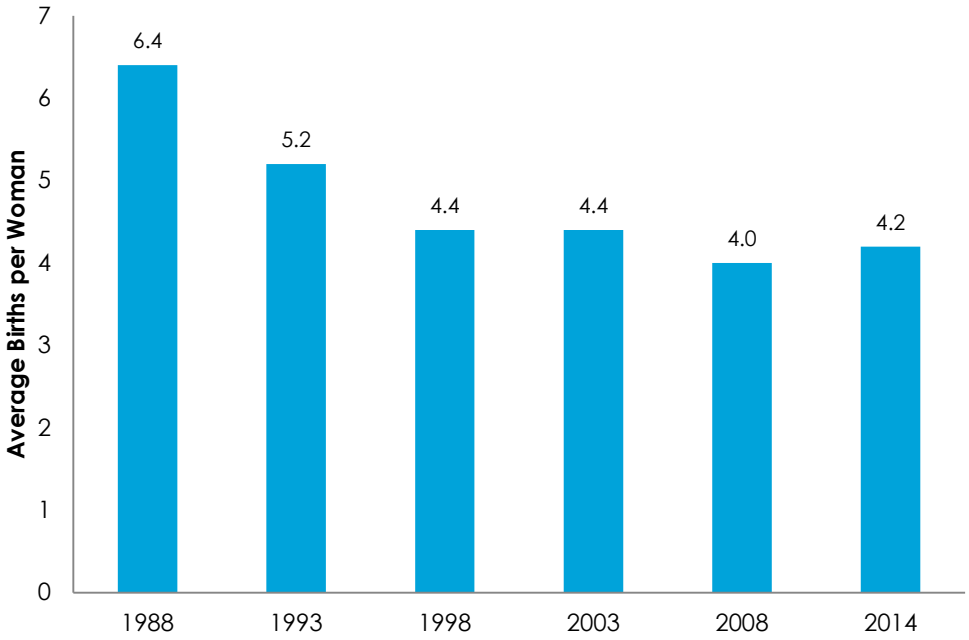
Figure 5: Population Growth Trend, 1921-2010, and Projected Growth, 2015-2020[xxxvi]



Due to the high population growth rate, Ghana's population is young—38 per cent of the population is under 15 years of age. More than half of Ghana's population lives in urban areas.[xxxvii] This urbanisation has had a dramatic impact on the population structure since 1960, when only 23 per cent of the population lived in urban areas. The rapid and continuing high rate of Ghana's urbanisation

strains the ability of the government to provide social services, including sanitation, water, housing, and general infrastructure such as schools and hospitals.[xxxviii]

Figure 6: Trends in Total Fertility Rate in Ghana, for the Three-Year Period Preceding the Surveys[xxxix]



A high child dependency ratio resulting from a high fertility rate (see Figure 6 for TFR trends) and population growth rate is a major barrier to social transformation and development.[xl] Despite advances in socioeconomic indicators, Ghana faces key health and developmental challenges in achieving its strategic goals. The high rate of population growth strains the country's natural resources, which in turn drives up the poverty rate and threatens future development gains.

Therefore, Ghana's population dynamics can be turned into a valuable "demographic dividend" only if investments are made in FP and reproductive health (RH) programmes to promote population change through a lower fertility rate and more balanced age structure, as well as in multisectoral social and development programmes that enable economic growth and quality-of-life improvements. The demographic dividend refers to the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents. The dividend is not automatic—it depends on investments and reforms in three sectors: family planning, education, and economic policy. Voluntary FP programmes play an important role in enabling couples to realise their reproductive preferences, thereby shaping a country's demographic path while simultaneously improving health and increasing savings across development sectors.[xli]

Unmet Need

Unmet need is the percentage of women who want to space their births or do not want to become pregnant but are not using contraception.[xlii] Thirty per cent of currently married women have an unmet need for family planning and 27 per cent of married women are currently using a contraceptive method. This means that only 47 per cent of the potential demand for family planning is being met. Thus, if all married women who have an unmet need for family planning were to use FP methods, the CPR would increase from 27 per cent to 57 per cent.[xliii] Forty-two per cent of unmarried sexually active women have an unmet need for family planning and 45 per cent are currently using a contraceptive method, meaning that the total demand for family planning amongst unmarried sexually active women is 87 per cent, with only 51 per cent of the potential demand for family planning currently being satisfied. Furthermore, if all of the unmarried sexually active women who have an

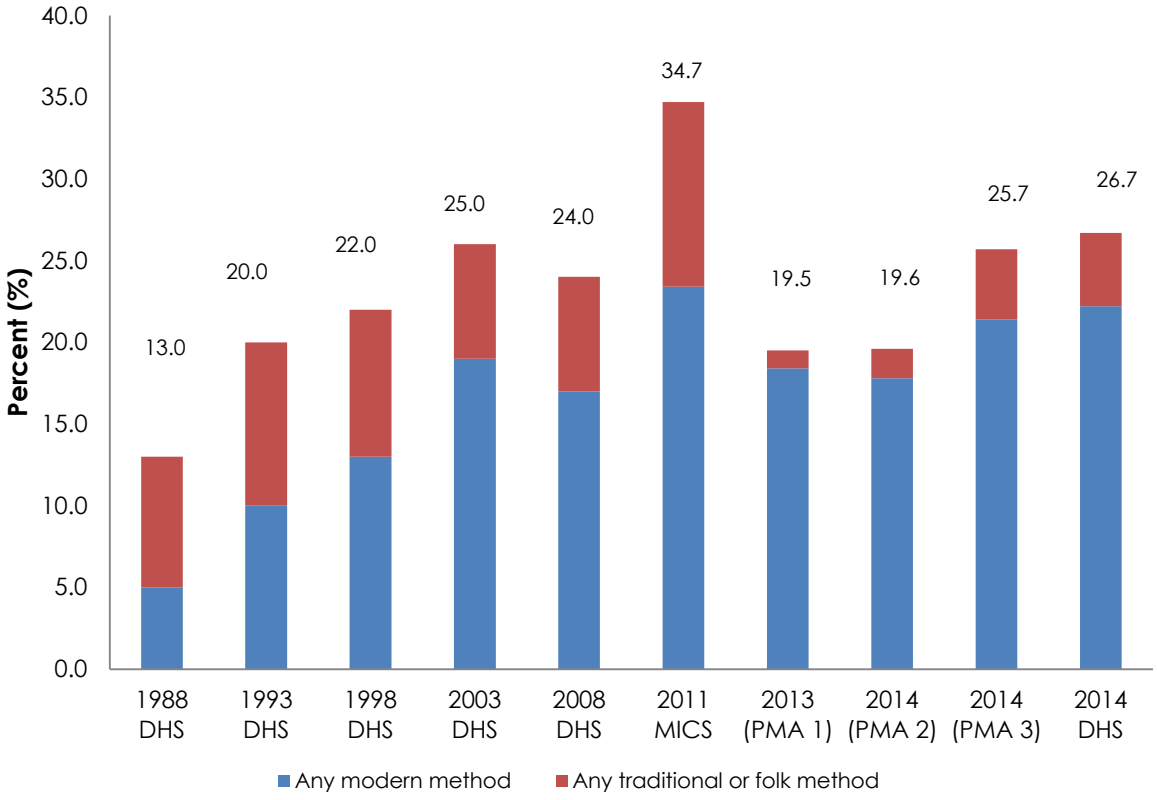
unmet need for family planning were to use contraceptive methods, the CPR would increase from 45 per cent to 87 per cent.[xliv]

Poor access to quality FP services—characterised by few skilled providers and inadequate commodities that give the client little or no choice of methods of family planning and undermine the ability of men and women to freely decide on the number and spacing of their children—contributes to high levels of unmet need in the country. In turn, high unmet need contributes to unplanned pregnancies—2008 Ghana Demographic and Health Survey (GDHS) data indicate that unplanned pregnancies are still common in Ghana, with 14 per cent of births in Ghana unwanted, and 23 per cent mistimed (wanted later).[xlv] In addition, women in lower wealth quintiles have higher levels of unmet need compared to women in the highest wealth quintile, whose need for family planning is more likely to be met.[xlvi]

Contraceptive use

Rapid population growth is fuelled by the high fertility rate in Ghana. High fertility, as discussed earlier, is due to various causal factors, including early marriage and unintended pregnancies as a result of low contraceptive use.

Figure 7: Contraceptive Use Trends Amongst Married Women, 1988–2014[xlvii]



In 2014, more than 25 per cent of married women of reproductive age (15–49 years) were using FP methods, as shown in Figure 7; however, modern method use has stagnated in recent years, and remains below the target goals set in policy documents.[xlviii]

Figure 8: Contraceptive use Amongst Married Women, 2008–2014[xlix]

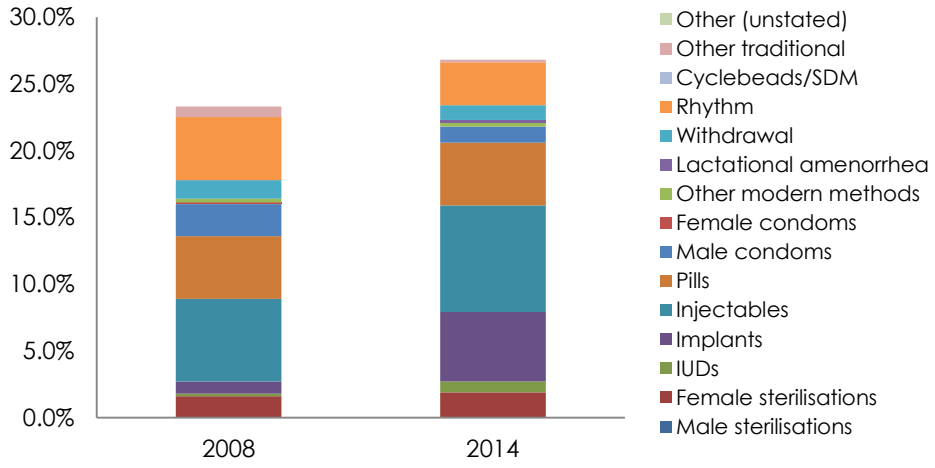
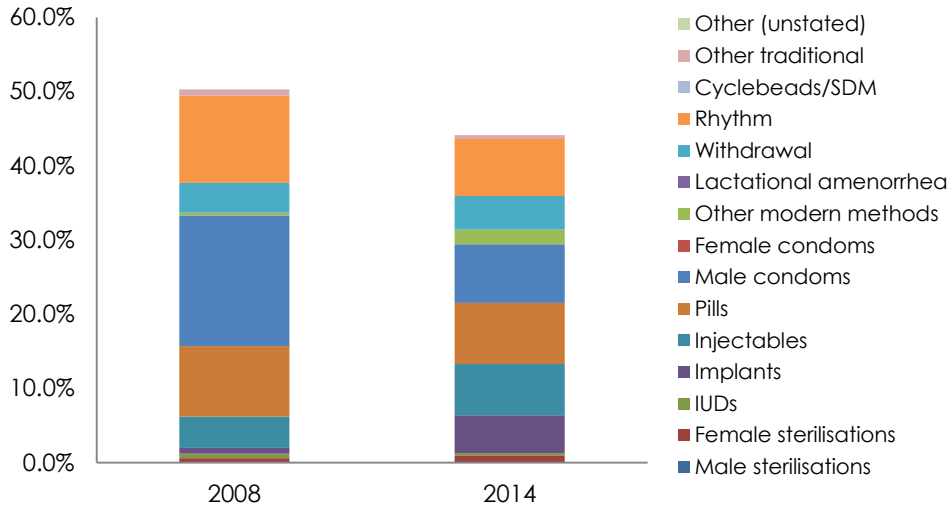
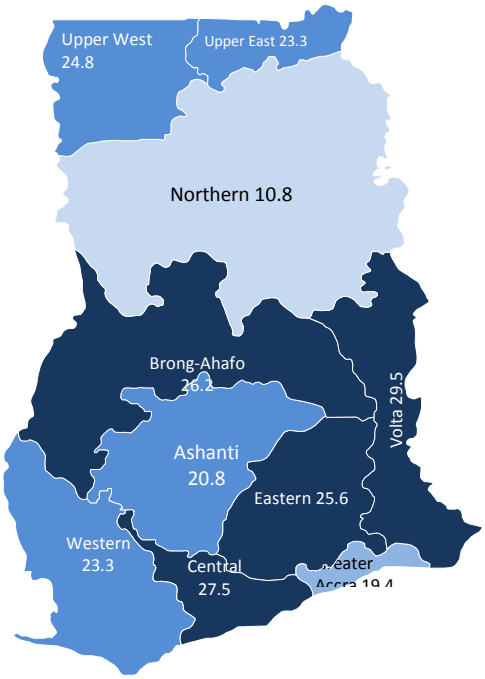


Figure 9: Contraceptive Use Amongst Unmarried Sexually Active Women, 2008–2014[l]



Disparities in contraceptive use exist by age, marital status, education, socioeconomic status, and rural-urban geographic location. Unmarried women of reproductive age have higher use of contraceptive methods compared to married women.li However, as illustrated in Figure 8: Contraceptive Use Amongst Married Women, 2008-2015 and Figure 9: Contraceptive Use Amongst Unmarried Sexually Active Women, 2008-2014. While CPR for married women increased between 2008 and 2014, increasing by 3.2 per cent for all methods and 5.6 per cent for modern methods, the CPR for unmarried sexually active women decreased during this period, by 5.9 per cent for all methods and 2.1 per cent for modern methods. Of particular concern is the significant decline in male condom use, from 17.6 per cent of unmarried sexually active women relying on male condoms in 2008 to a 7.9 per cent rate amongst unmarried sexually active women in 2014.

Figure 10: Modern Method Use by Sub-Region, Percentage of Currently Married Women Using Any Modern Contraceptive Method, 2014[lii]



	MCPR, married women
	*10–14.9
	*15–19.9
	*20–24.9
	*25–30

CPR is higher amongst women with more years of education; married women with secondary or higher education are almost twice as likely (34.3%) as women with no education to use any method of contraception (18.6%). The poorest women have the lowest levels of use; 28.5% per cent of married women in the highest wealth quintile use any method of family planning compared to those from the lowest wealth quintile, who have a lower CPR rate of 22.2 per cent. Married women in rural areas have a higher contraceptive prevalence rate (CPR of 27% for all methods and 24.2% for modern methods) compared to their counterparts in urban areas (26.3% for all methods and 20.3% for modern methods). There are also clear regional differences, as shown in Figure 10.[liii] Lower CPR in rural areas among both married and unmarried women is also exacerbated by the clustering of health personnel, particularly doctors and university-trained nurses, in the two major metropolitan areas of Accra and Kumasi at a much higher proportion to the population living there, leading to inadequate numbers of health staff in rural areas.[liv]

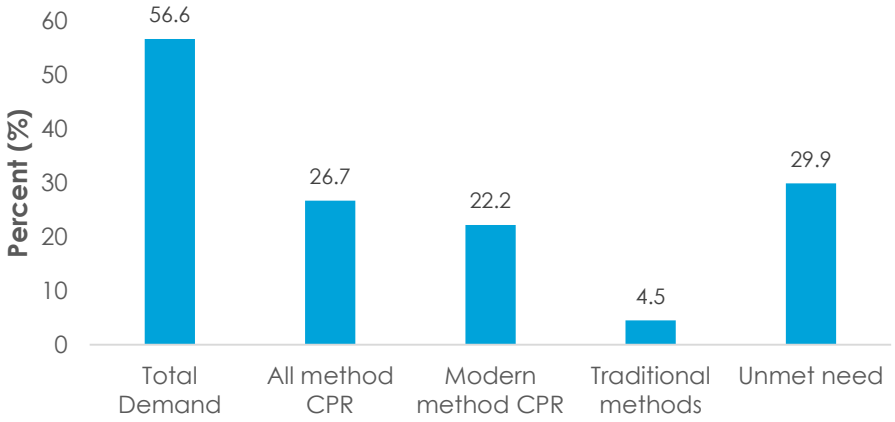
Key Issues and Challenges

Over the years, Ghana has enhanced the capacity of institutional and social structures at national and subnational levels to mobilise communities and deliver FP services. The FP programme, however, continues to face a number of challenges and constraints that must be addressed to meet the country's FP goals.

Demand Creation (DC)

Ghana has been successful in reducing the high fertility rate from 6.4 births per woman in 1988 to 4 births per woman in 2008, with a slight uptick to 4.2 births per woman in 2014.[lv] However, total demand and utilisation of FP services remain low. According to the 2014 DHS, 56.6 per cent of married women ages 15–49 want to avoid pregnancy and therefore need contraceptives, whereas only 22.2 per cent are using modern contraceptives and 4.4 per cent using traditional family planning methods, meaning that almost 30 per cent of married women want to avoid pregnancy yet are not using any method of family planning (see Figure 11).

Figure 11: Demand and Use of Family Planning, Currently Married Women[lvi]

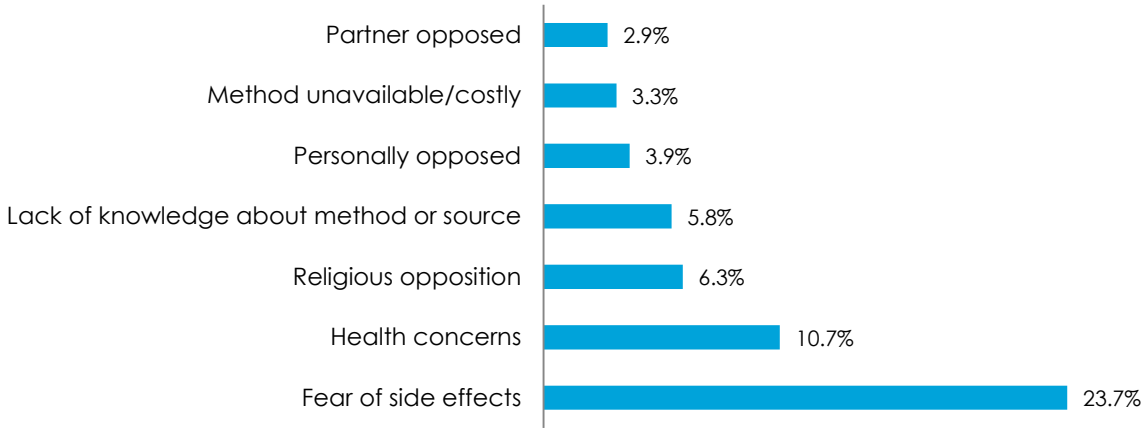


Women's knowledge of FP methods and services has significantly improved over time. Knowledge of contraceptive methods amongst Ghanaian women has been historically high since the early 1990s, with 90.6 per cent of women reporting knowledge of at least one method of family planning in the 1993 DHS survey.[lvii] More recent data from 2008 show that about 98 per cent of women knew at least one modern method of family planning.[lviii] However, knowledge of long-acting reversible or permanent methods was lower, with only 43, 64, and 63 per cent of women knowledgeable about intrauterine devices (IUDs), implants, and sterilisation, respectively.[lix]

However, the high level of knowledge and awareness about FP methods has not translated into an equivalent high use of FP services. In 2014, only 22.2 per cent of married women in the reproductive age group (or their partners) were using modern contraceptive methods.[lx] An additional 29.9 per cent of women had an unmet need for family planning.

A number of studies have assessed the barriers to demand and use of FP services in Ghana. Sociocultural factors remain the major demand-side constraint to such services in Ghanaian communities. The low socioeconomic status of women, religious beliefs, educational level, misinformation about family planning, high child mortality, patriarchal nature of household decision-making processes, and fear of potential side effects are important factors that contribute to low demand and use of contraception in Ghana.[lxi, lxii]In addition, the tradition of having large family sizes is deeply rooted in Ghanaian households.[lxiii] In a culture where polygamy is also common, women tend to gain a sense of security by bearing more children for their husbands.[lxiv]

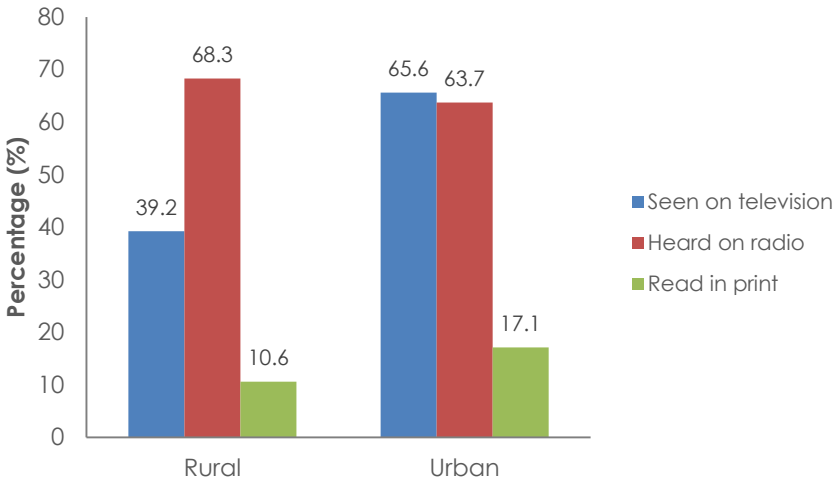
Figure 12: Reasons for Not Using Family Planning Services[lxv]



Fear of side effects (23.7%) and health concerns (10.7%), are amongst the top reasons for women's non-use of contraception (see Figure 12).[lxvi] In addition, lack of knowledge and knowing no source for FP services are common reasons reported for not using such services in population groups with low levels of education.

In young women ages 15 to 19, total demand for contraceptives increased from 66 per cent to 75 per cent between 2003 and 2008 and remained high, at 69.3 per cent in 2014.[lxvii] However, only 16.7 per cent of young women in this age group are using modern contraceptives, leaving 50 per cent of married women in this young age group with an unmet need.[lxviii] Young people are thus the most under-served population age group. The significant difference between CPR and unmet need in the 15- to 19-year-old age group is likely related to increased awareness and generation of demand for contraceptives that is not being met.

Figure 13: Percentage of Women Ages 15–49 Reporting Exposure to FP Messages, by Residence[lxix]



Demand creation activities implemented by the Ghana Health Service (GHS) and its partners target community mobilisation through use of media and national and local campaigns. A wide range of information, education, and communication (IEC) interventions aimed at social behaviour change are being implemented to address widespread myths, rumours, and misconceptions about family planning. Demand creation efforts through mass media (billboards, newspaper/magazine ads, radio/TV spots) (see Figure 13) and community mobilisation using community dramas, community rallies and women groups sessions, and production and distribution of IEC materials have led to a

significant increase in exposure to FP messages via the media.[lxx] National campaigns like "Life choices: It's your life, it's your choice" have brought about a shift from seeing family planning as a way of limiting family sizes to viewing it as a way to empower women and improve the health of women and children.[lxxi] However, there are also misconceptions amongst many young people that family planning is an issue only for married couples and not so relevant for adolescents. Experts suggest that demand creation and behaviour change interventions targeting young people need to improve and be creatively contextualised to this age group.[lxxii]

Service delivery

FP service delivery in Ghana has advanced through a number of developments since the introduction of modern FP activities as a public welfare service by the Christian Council of Ghana in 1961. Following the opening of the first Family Advice Centre in Accra in 1961, the Planned Parenthood Association of Ghana (PPAG) later expanded FP services through branches at various centres throughout the country in 1967.[lxxiii] Currently, a wide range of FP services are offered at government hospitals and clinics, private for-profit facilities, and facilities operated by nongovernmental organisations (NGOs). The National Reproductive Health and Service Policy and Standards stipulates that outreach services, static services, and social marketing service delivery approaches shall be used to make FP services accessible, available, and affordable to all eligible individuals and couples.[lxxiv] See Table 3 for the distribution of facilities.

Table 3: Distribution of Health Facilities by Type, Ghana, 2013[lxxv]

	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper East	Upper West	Volta	Western	Total-national
CHPS	70	186	169	422	81	151	189	126	158	181	**1,733**
Clinic	152	115	54	118	257	49	45	12	72	114	**988**
District Hospital	19	18	12	14	6	11	5	3	17	11	**116**
Health Centre	141	83	64	84	20	83	44	68	146	59	**792**
Hospital	89	11	14	18	62	15	1	6	11	17	**244**
Midwife/Maternity	97	42	32	24	80	9	1	2	21	41	**349**
Mines	0	0	0	0	0	0	0	0	0	3	**3**
Polyclinic	0	0	1	1	10	5	0	0	2	2	**21**
Psychiatric Hospital	0	0	1	0	2	0	0	0	0	0	**3**
Total	**568**	**455**	**347**	**681**	**518**	**323**	**285**	**217**	**427**	**428**	**4,249**

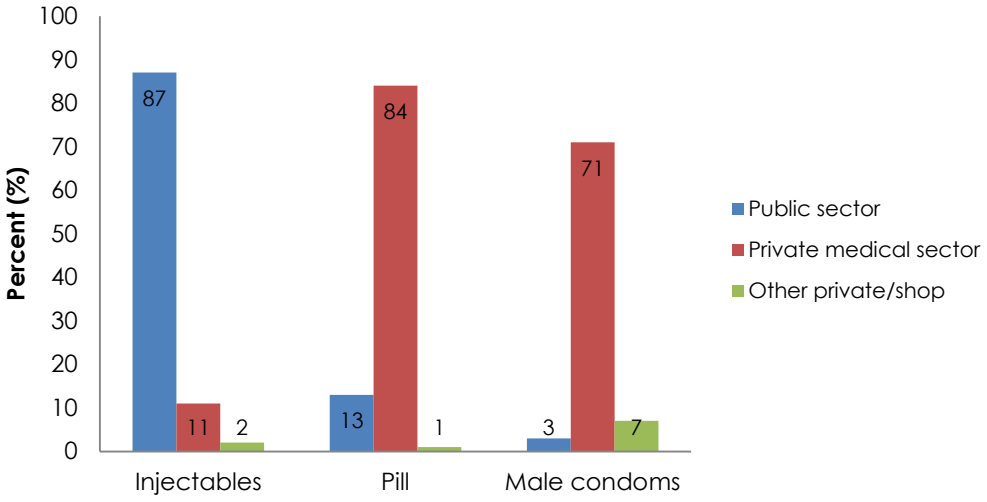
The main suppliers of contraceptives in Ghana are the MoH/GHS public health facilities, followed by pharmacies (including chemists and drug stores), private clinic facilities, and NGOs such as the PPAG and Marie Stopes International Ghana (MSIG). Although there is a growing reliance on the private sector as source of contraceptives, the public sector currently provides about 47 per cent of these commodities, whereas the private sector delivers about 46 per cent. [lxxvi] The public sector mainly provides injectables and implants, whereas the private sector mainly supplies pills and condoms—

methods that require more resupply. Pharmacies (43 per cent) and other sources (29 per cent) are accessed more frequently by the 15- to 19-year-old age group than any other age group.[lxxvii] See Figure 14 for the sources of contraception.

In both public and private sectors, method choice availability has expanded through the introduction of combined injectables (1992), implants (1996), the female condom (2000), and emergency contraception (EC) (2003).[lxxviii] Overall, infrastructure and service availability have improved, with almost all public facilities (96%) offering FP services five or more days a week as well as improved privacy for clients.[lxxix]

Women in rural areas (55%) rely on the public sector more than those in urban areas (41%).The private sector provides more than half of the modern contraceptives for the Brong Ahafo, Greater Accra, Eastern, and Western regions. The Northern, Upper East, and Upper West regions rely on the public sector for the majority of their contraceptives (between 63% and 88%).[lxxx]

Figure 14: Sources of Contraception[lxxxi]



The number and capacity of human resources also remains a challenge, with inadequate health personnel staffing the health clinics and facilities. There is a critical shortage and uneven distribution of key health personnel across the country.[lxxxii] Table 4 gives the latest data on service providers available to provide FP/RH services in Ghana, by region.

Table 4: Distribution of RCH Health Personnel, by Type, Ghana, 2013[lxxxiii]

	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper East	Upper West	Volta	Western	Total
OB/GYN	14	0	10	6	28	2	1	0	9	8	**78**
Clinicians/ Physicians	92	55	43	54	95	54	15	22	41	68	**540**
Paedriatric	5	3	3	4	16	0	1	0	2	2	**34**
Public Health Nurses	37	17	20	32	128	10	14	10	44	16	**327**
Practicing midwifes	446	147	131	320	440	50	124	60	263	242	**2,223**
Community health nurses (CHNs)	1,236	560	484	960	1,369	188	484	252	928	749	**7,211**
Total practicing RCH personnel	**1,828**	**782**	**692**	**1,375**	**2,076**	**304**	**639**	**345**	**1,286**	**1,086**	**10,413**

The lack of capacity of some personnel cadres to deliver certain methods also prevents clients from accessing them.[lxxxiv] The Community-based Health Planning and Services (CHPS) programme, initiated in 1999 to place health officers in communities to provide health information and service was laudable and made a significant impact. The 2007–2011 Human Resources Strategic Plan emphasised the strengthening and expansion of this programme.[lxxxv] The attrition rate is also quite high; in particular, nurses trained in family planning experience higher turnover rates; thus, new nurses must be trained continuously.[lxxxvi]

According to the DHS 2008, injectables and pills are the most popular modern methods in urban and rural areas across almost all age groups and income quintiles. Condoms are used at higher rates by urban, wealthier women from 20 to 34 years of age and those with most education, constituting 27 per cent of the method mix for women with higher education. Rural women more commonly rely on long-acting and permanent methods (LAPMs). LAPMs constitute 13 per cent of the method mix for rural women versus 8 per cent for urban women. In addition, women age 40 and older are more likely to be LAPM users.[lxxxvii, lxxxviii]

Figure 15: The Role of Community-Based Health Planning and Services (CHPS)

In The 1970s And Early 1980s, FP Services In Ghana Were Mainly Limited To Clients Visiting A Clinic To Get Contraceptive Pills. However, Over The Past Decade, GHS And Its Partners Have Been Trying To Move Deeper Into Communities To Provide Access To Basic FP Education, Promotion, And Choices Of Contraceptive Methods. In 1974, The PPAG Pioneered The Introduction Of A Small Community-Based Distribution (CBD) Programme, Which Continued To Expand Access And Reorient The Concept Of Contraceptive Distribution To Community-Based Services (Cbss).[lxxxix]

CHPS Is Ghana's Flagship Community-Based Programme; It Relies On Community Health Officers (Chos) And Community Health Volunteers (Chvs) Based In Service Delivery Stations Known As Community Health

Compounds. Chos Provide A Range Of Door-To-Door Services, Including Antenatal And Postnatal Care, Emergency Delivery, Immunisation, Nutrition Education, Treatment And Counselling For Home Disease Management, And Family Planning (Pills, Injectables, Condoms), Whereas Chvs Mobilise Communities And Provide Condoms And FP Information, Referring Clients To Chos For Other FP Services.[xc]

Similarly, Since Chvs' Tasks Are Determined By The Chos, Their Focus Can Also Shift From Family Planning To Other Services.[xci]

While Chos Are Expected To Conduct At Least 10 Home Visits Each Day For Preventive Health Education, They Instead, Conduct Only One Home Visit Per Week, On Average.[xcii] This Average Is Very Low As Community Health Workers (Chws) Are Expected To Be In Closer And More Frequent Contact With Households. While CHPS Was Intended To Be Mobile With Services Designed To Be Provided Primarily Through House-To-House Visits, Clients Still Go To CHPS Compounds To Access Services, And Often There Are Long Queues Within CHPS Compounds. The Policy Also Is Based On Chos Living Within Their Subdistricts And Commuting For Outreach Activities, But This Approach Has Not Been Carried Out Well Due To Logistical Limitations In Coordinating Outreach Effectively, Thus Affecting Community Mobilisation And Demand Creation Activities. The Current CHPS Operational Plan Mandates A Population Of 1,500 For A CHPS Zone Instead Of The Original 5,000, Which Would Allow CHPS To Better Serve Potential FP Clients. In Addition, There Is A Need For Continued Refresher Training For Chos And Chvs, And Strengthening Monitoring And Supervision To Improve Poor FP Promotion And Access Through CHPS. Inadequate And Interrupted Commodity Supply Also Poses A Challenge For The Functioning Of CHPS To Its Full Potential.

Another factor contributing to low usage of modern contraceptive methods is lack of availability of all choices of contraceptives in health facilities due to the shortage of trained staff mentioned above, particularly those skilled in providing long-acting reversible and permanent methods.[xciv] In addition to ensuring that these methods are available at health facilities, it is also essential that providers are adequately trained to provide LAPM contraceptives. The quantity and competencies of health workers (HWs) skilled in providing the whole range of FP methods has improved progressively over the years but falls short of the WHO-recommended standards per population.[xcv] Until recently, implant services were provided primarily by trained midwives. Recently, community health nurses (CHNs) have been allowed to provide implants to ensure access to a wide range of contraceptive methods.[xcvi] Implementing partners are currently supporting GHS in training CHNs in implant insertion and removal skills.[xcvii]

FP service delivery has yet to satisfactorily address the needs of under-served and disadvantaged groups. Young people in particular feel intimidated in seeking services and fear the idea that they will be considered promiscuous if they raise issues about contraceptives.[xcviii] Clients also complain that HWs' motivation is weak, especially in public health facilities, and some of them are biased and have a negative attitude towards certain type of contraceptives—especially long-acting methods.[xcix] In most private facilities and PPAG-supported areas, contraceptive uptake is high. Apart from a shortage of skilled workers, the lack of necessary equipment and logistical constraints limit the capacity of public facilities to provide quality and comprehensive FP services.[c] The MoH is developing national staffing norms and standards to address quantity and quality gaps in human resources. However, the government's recent freeze in hiring HWs has also contributed to capacity limitations in health facilities. Over the past 10 years, GHS has given particular attention to training providers in counselling and interpersonal communication skills. Many HWs believe there is need to improve interpersonal communication with clients to address deep-rooted misperceptions.[ci] One of the good practices in this regard is the use of "satisfied clients." GHS and its partners also train "satisfied clients" in public speaking and communication so they can conduct health education activities in their communities.[cii]

Contraceptive Security

Ghana's supply chain supporting public health facilities has evolved significantly over the last few decades through decentralisation in the 1980s, the creation of GHS in 1996, and the Procurement Act of 2003.[ciii] Contraceptive commodity supply chain management is structured and led under the broader RH commodity security system (see Figure 16). To ensure long-term security of reproductive health supplies, the MoH developed a National Reproductive Health Commodity Security (RHCS) Strategy for 2011–2016 with a detailed action plan and budget. The main objectives of the RHCS

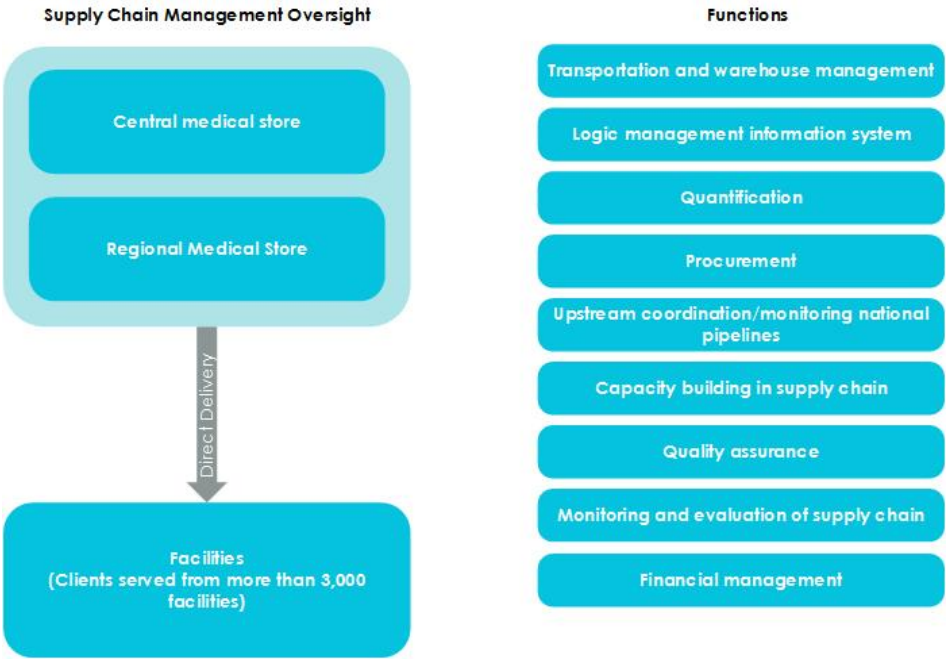
Strategy are to improve the policy environment, strengthen commitment and capacity, strengthen coordination and information sharing, ensure adequate financing, create demand and increase utilisation, ensure service availability and contraceptive access in all sectors, and strengthen the logistics system. The Inter-agency Coordinating Committee for Commodity Security (ICC/CS), a multistakeholder body chaired by National Population Council (NPC) and GHS, plays a significant role in contraceptive security, as it brings together health partners working on reproductive health and family planning, donors, government agencies and relevant state bodies, and civil society.[civ]

The ICC/CS provides general oversight of commodity security in the country, mobilises financial resources, coordinates amongst donors and partners, and follows up implementation of activities to strengthen commodity security. Since the establishment of the ICC/CS as one of the first CS initiatives in the country in 2002, the GoG has assumed some of the costs of FP commodities, and there are continued efforts by civil societies, donors, and the public sector to advocate for the government to increase the budget for these commodities in the future.[cv]

While the government currently contributes to funding for FP commodities, the amount is inadequate to the current need, and therefore, there is a high dependence on donors for commodity procurement.[cvi] Greater investment by government and development partners is necessary to address these challenges and accelerate progress. Many experts have identified the need for diversification of the contraceptive financing base towards one more sustainable and gradually self-reliant. In addition, there are gaps in the logistics system. Many experts agree that supply shortages reported by health facilities are often "artificial"—a stockout experienced at facility level due to misdistribution while the central level or regional stores have adequate stock available. Encouraging the private commercial sector to become more involved in FP commodity procurement, distribution, sales, and promotion has been identified as a promising approach to improving commodity security.[cvii, cviii]

The MoH's strategy to improve the supply chain states that the National Health Commodity Supply Agency shall manage the main categories of commodities: programme commodities, such as vaccines, antiretroviral, and tuberculosis (TB) medicines; FP and malaria commodities; special and critical commodities, such as cancer medicines and commodities with huge supply risks; and commodities for which the Focused Public Sector Model can provide significant "value-added" benefit to the supply chain.[cix] The ICC/CS meets regularly and its partners actively participate in the forecasting and planning of the procurement of commodities. Quantification and forecasting to develop the commodity procurement table (CPT) is completed in February and reviewed in August every year.[cx] However, there is a major gap in the timing of contraceptives arriving. Also, the flow of contraceptive information and data from downstream through the system is weak. At the national level, stock monitoring is consistent, but information coming from lower levels on stock status is incomplete, unreliable, and delayed.[cxi]

Figure 16: Supply Chain Management (programmes and selected commodities)[cxii]



In addition, routine reporting of stock levels and performance monitoring of the supply chain are weak, and there are gaps in accountability and responsibility across agencies. The traditional pull system of delivering commodities to public facilities is weak, leading to health facilities and lower levels (districts and facilities) collecting commodities when stockouts become inevitable. However, most private vendors deliver directly to facilities; the facilities prefer private vendors for this reason. In addition, although multiple stakeholders are involved in supply chain activities, there is weak coordination and sharing of information and data on contraceptive supply. Moreover, Logistics Management Information System designs exist for some public sector commodities, but they are not integrated and comprehensively addressed.[cxiii, cxiv]

Quantification and commodity needs are not well aligned. Some partners and private sector organisations are not active participants in the quantification exercise, resulting in the importing and distribution of commodities not reflected in the quantification and procurement plan. The private sector is not actively engaged in quantification and forecasting; however, it plays a significant role in providing FP access. The level of engagement by regional directors of health services during the quantification and forecasting process is also inadequate. Data coming from lower levels to support quantification and forecasting are also limited in completeness and timeliness, and lower-level administrators such as the directors of district health offices are not sufficiently engaged in warehousing and logistics issues, resulting in major communication and coordination gaps.[cxv]

According to the Ghana National Condom and Lubricant Programming Strategy, the supply of condoms[cxvi] to the end user through the supply chain faces a number of challenges related to inefficiencies in the distribution system. Monitoring and reporting of data on male condoms has been a challenge. In addition, the district health information management system (DHIMS) does not disaggregate the information collected on female condoms. Non-traditional distribution channels, such as vending machines, are underutilised for male and female condoms, and female condom distribution is limited to public facilities in urban areas. Storage conditions are not optimal for condoms, as warehousing, particularly at the facility level, was not originally designed to support the storage of bulk items, such as condoms.[cxvii]

The Food and Drug Authority (FDA) of Ghana is a member of ICC/CS and participates in regular meetings. The FDA works to ensure that commodities entering the country meet international standards; it also is responsible for ensuring that products on the market are registered. However,

delays in the FDA registration process for contraceptives remain a major challenge. For example, facilities have faced artificial shortages due to an inability to finish the formal paperwork processes in a timely manner between the start of the process and completion; in some cases, completing paperwork for various processes within FDA has taken up to two years. In addition, taxation on FP commodities is a challenge—some donors use diplomatic exemptions to bring in contraceptives free from tax, but not all importers can take advantage of this exemption or the tax-free status of donors and UN agencies; thus, this issue remains a policy barrier.[cxviii]

Social marketing programmes are widely promoted across Ghana, and are currently growing in their contributions to expanding access to contraceptives and FP services. Social marketing networks mainly include pharmacies and chemical sellers; private clinics and maternity homes; and NGOs and civil society organisations (CSOs), such as the PPAG. The two main social marketing entities and programmes currently operating in Ghana are GSMF International (formerly known as the Ghana Social Marketing Foundation) and DKT International. GSMF International is the largest private sector supplier of contraceptives in Ghana and has a wide distribution network; it delivers products to more than 4,000 outlets nationwide (its methods include pills, male and female condoms, vaginal foaming tablets, and injectable contraceptives).[cxix]

Policy and enabling environment

Ghana's 1969 Population Policy was one of the first in sub-Saharan Africa; this policy was later revised in 1994 to incorporate new developments and emerging issues related to population and the environment, children, youth and the elderly, as well as persons with disabilities and HIV/AIDS.[cxx] Article 37(4) of the 1992 Constitution, which enjoined the State to maintain a population policy consistent with the aspirations and development needs and objectives of Ghana, also provided the basis for revising the 1994 population policy. To coordinate implementation of policy objectives, the Ghana National Family Planning Programme was launched in May 1970 as a department within the Ministry of Finance and Economic Planning. Alongside the revision of population policy in 1994, the NPC was established as the highest statutory body to advise the government on population issues and serve as a secretariat.[cxxi]

The National Population Policy, Revised Edition 1994 affirms the commitment of the GoG to population issues and incorporates the emerging issues of the time, including HIV/AIDS, teenage pregnancy, pollution, degradation of the environment, and others. The main targets for the policy were to reduce the TFR from 5.5 to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020. The policy also aimed at achieving a CPR of 15 per cent for modern methods by 2000, 28 per cent by 2010, and 50 per cent by 2020. The policy also set the target of reducing the present annual population growth rate of about 3 per cent to 1.5 per cent by 2020.[cxxii] Table 5 cites the multisectoral policy documents of relevance to the GFPCIP.

Table 5: Key Policies and Strategies in Ghana

Policies	Description
Ghana Health Sector Medium-term Development Plan 2014–2017[cxxiii]	The Health Sector Medium-term Development Plan (HSMTDP) is the sector's blueprint, spelling out the role of the health sector in government priorities and its contribution to human development, productivity, and employment. The objectives of HSMTDP focus on the need for improved leadership and accountability, increased access to healthcare for the poor, and bridging inequities in the distribution of health services.
National Health Policy: Creating Wealth Through Health[cxxiv]	The policy declares a paradigm shift from curative action to health promotion and the prevention of ill health. The policy states that the national vision for health is to create wealth through health and contribute to the national vision of attaining middle-income status by 2015. The priority strategic areas of the policy include ensuring access to quality health, population and nutrition services, promoting healthy lifestyles, strengthening health system and capacity development, promoting use of evidence for decision making, building the health industry, sustaining health financing, and strengthening governance and partnership in health.
Reproductive Health Strategic Plan 2007–2011[cxxv]	The overall goal of the strategic plan is to improve the health and quality of life of persons of reproductive age and newborn children by providing high-quality RH services. Its strategic objectives focus on reducing maternal and neonatal morbidity and mortality, promoting and increasing access to quality RH services, and increasing contraceptive prevalence and access.
National Reproductive Health and Service Policy and Standards[cxxvi]	This document provides the rules and regulations governing RH services and training, components of these services, and the target groups for services and information. The Service Standards component of the document sets out the minimum acceptable level of performance and expectations for each component of RH services, expected functions of service providers, and the basic training content required for the performance of these functions, including task shifting.
National HIV and AIDS, STI Policy[cxxvii]	The policy aims to provide guidance to other HIV-related policies, interventions, and programme designs, and their implementation in Ghana. The overall goal of the policy is to halt and reverse the spread of HIV infection in the general population and in key and vulnerable populations.
Ghana National Condom and Lubricant Programming Strategy. 2015.[cxxviii]	The aim of a national condom programming strategy is to ensure that all sexually active populations can be motivated to choose to use condoms if they need to, and that they have sufficient access to condoms and lubricants meeting the required quality standards whenever necessary. The objectives of the strategy are to improve the environment for condom and lubricant programming, increase the demand for these products, ensure an uninterrupted supply and sustainable funding, and put in place a national mechanism for comprehensive programming.
Health Commodity Supply Chain Master Plan[cxxix]	The priority objectives included in the master plan are as follows: • Improving regular communications and formal coordination amongst and between supply chain actors; • Ensuring that the public sector supply chain adds value in support of health commodity availability at all facilities; • Building the human capacity of the supply chain; • Putting in place regular supportive supervision as a key "maintenance" tool for data reliability and accuracy; and • Strengthening the monitoring process and involving clients and supporting partners in this process.

Policies	Description
Meeting the Commodity Challenge: The Ghana National Reproductive Health Commodity Security Strategy 2011–2016[cxxx]	The goal of the strategy is "To ensure that every woman, man, and youth can choose, obtain, and use the quality contraceptives and condoms they need for family planning and prevention of sexually transmitted infections, and that commodities required for emergency obstetric and neonatal care are available to prevent morbidity and mortality due to pregnancy and childbirth." The main objectives are as follows: 1. Improve the policy environment; 2. Strengthen commitment and capacity; 3. Ensure adequate funding; 4. Strengthen coordination and information sharing; 5. Create demand and increase utilization; 6. Ensure availability and access in all sectors; and 7. Strengthen the logistics system.
National Gender and Children Policy[cxxxi]	The goal of the policy is to mainstream gender and children's concerns in the national development process to improve the social, legal/civic, political, economic, and cultural conditions of the people of Ghana, particularly women and children.
Ghana Strategic Plan for the Health and Development of Adolescents and Young People, 2009-2015. Healthy Young People: Better Future[cxxxii]	The goal of the plan is to contribute to the improvement of adolescents and young people's health status by implementing realistic interventions that aim to bring appropriate solutions for their major health problems. The strategic objectives prioritise access to appropriate health information and utilisation of quality services by adolescents and young people, improvement in the legal and sociocultural environment and programme management, and improvement in community participation and engagement.
Ghana Adolescent Reproductive Health Policy[cxxxiii]	The goal is "To contribute to the improvement of adolescents and young people's health and provide comprehensive health services and other complementary programmes, such as self-care and life and livelihood skills to adolescents and young people." The strategic objectives aimed at adolescents and young people include the following: 1. Improve their access to appropriate health information 2. Improve their access to and utilisation of quality health services 3. Enhance their social, legal, and cultural environment for health 4. Improve community participation (adolescents, parents, community leaders, traditional and religious leaders) in targeted health programme implementation to increase the demand and utilisation of services 5. Improve the management of targeted health programmes, including resource mobilisation
National Population Policy, Revised Edition 1994[cxxxiv]	The main targets for the policy are to reduce the TFR to 3.0 by 2020, achieve a CPR of 50 per cent by 2020, and reduce the population growth rate to 1.5 per cent by 2020. The policy's areas of work include the following: maternal and child health; FP and fertility regulation; health and welfare; food and nutrition; education; empowerment of women; the role of men in family welfare; children and youth; the aged and persons with disabilities; population and law; population information, education, communication, and motivation; internal migration and spatial distribution of the population; international migration; environmental programmes; housing strategies; poverty alleviation; labour force and employment; data collection and analysis, research, monitoring, and evaluation; training and institutional capacity building; and resource mobilisation.

Although Table 5 above clearly shows that the policy environment is positive towards promoting health, reduction in population growth, reproductive health, family planning, and commodity security in Ghana, there are also ongoing efforts to expand access and back such initiatives with legislative actions. To expand access to FP services, legislation on National Health Insurance Scheme (NHIS) reform, passed in 2012, requires the NHIS to include family planning in its package of services.[cxxxv] According to the reform measure, FP education and services will be part of the package of free maternal healthcare provided under the NHIS.

Ghana has adopted many useful policies; many guidelines, manuals, commitments, and strategies have been developed and endorsed by high-level government officials or organisations. However, policies and guidelines are at times out of date, vaguely worded, or inconsistent and overlapping.[cxxxvi] While pioneering in adopting some policies on family planning and population, often there is a gap between the statements in the written document and implementation in practice.[cxxxvii] In addition, previous policies, such as the 1969 population policy, were not successful mainly because only minimal support came from political leadership.[cxxxviii]

Although policy elements are very clearly articulated in documents and service standards, the standards are often not practiced, due to lack of awareness or neglect of enforcement.[cxxxix] For example, the *National Reproductive Health Service Standards and Protocol* mentions that, for couples, consent of a partner for contraceptive use is not required. The protocol also states that EC shall not be promoted as a regular FP method.[cxl] However, providers' actions often are not in alignment with these standards in practice. Most experts believe that government commitment is not lacking, based on the large number of policies and strategies.[cxli] Family planning is considered a priority by health sector officials and the government; thus, policy itself is not a major barrier. It is mainly the implementation of the policies that remains a challenge. It is generally believed that policies and commitments are also not fully implemented because of weak monitoring mechanisms at lower levels of the system.[cxlii] Thus, the gap lies in the dissemination and implementation of the policies and guidelines; in particular, there is a need to train lower-level health personnel on the use of policies and guidelines.[cxliii]

Financing

Despite the 2001 Abuja Declaration commitment to allocate at least 15 per cent of national budgets to the health sector,[cxliv] GoG expenditures on health generally remain low, as the current health budget constitutes less than 7 per cent of the national budget.[cxlv] The allocation as a percentage of the national budget declined from 16.23 per cent in 2006 to 11.04 per cent in 2010, and to less than 7 per cent in 2015, although there has been an increasing budgetary allocation (in nominal value) over the years (see Table 6).

Table 6: National and Health Budgets, in Billions of Ghana Cedis[cxlvi]

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
National budget	2.95	3.87	5.06	6.46	6.58	7.93	13.53	31.84	36.21	44.00
MoH budget	0.48	0.56	0.75	0.92	0.73	0.99	1.80	3.53	3.35	3.07
Total share for health, as % of the national budget	16.24%	14.57%	14.87%	14.27%	11.04%	12.46%	13.3%	11.08%	9.26%	6.97%

Financing is a critical component of the FP programme. Until 2001, the MoH relied fully on donor support for procurement and technical assistance to the programme until it was able to draw financial resources from health sector basket funds (mainly World Bank funding) to contribute to some contraceptive procurement requirements.[cxlvii] Although the current government financial commitments to RH commodities are increasing, they have not translated into full disbursements. GoG funds budgeted for RH commodities purchase through MoH are sometimes not released, and the funds eventually released are usually significantly less than originally budgeted.[cxlviii, cxlix] In addition, GoG expenditures for RH commodity purchases have been very volatile over recent years, ranging from a high of $1.4 million USD in 2009 to a low of $55,517 in 2011.[cl] Also, currently there is no budget line item for FP contraceptive procurement.[cli] Funding for FP programming is inadequate commensurate to the need.[clii] Thus, more domestic funding support is needed. Lack of funds at the subregional level for FP programming also remains a huge challenge; even raising funds to pick up commodities from the regions to transport to the districts and health facilities is often a struggle.[cliii]

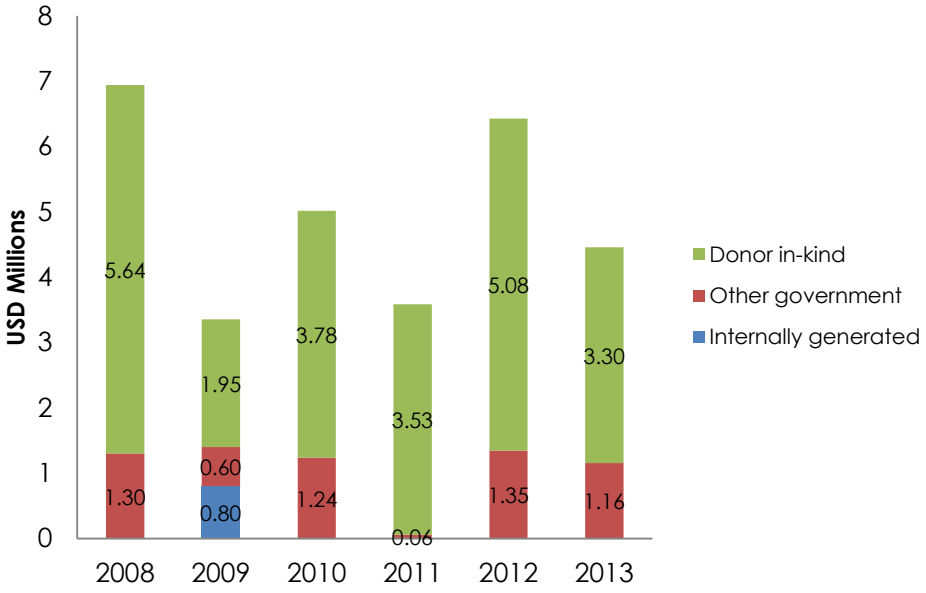
Even with the current contribution of GoG health sector funds to RH commodity procurement, the FP programme remains highly dependent on donor support (see Table 7 and Figure 17). About 75 per cent of commodities are currently procured through donor funds.[cliv] UNFPA, USAID, and DFID are the major funders for Ghana's procurement of commodities.[clv] Donor fatigue has been identified as a huge threat to achieving FP goals, especially if there is not a considerable improvement in GoG contributions.[clvi] Even when donors contribute sizeable amounts to state agencies that lack adequate budgetary support from the GoG (e.g., such as for the School Health Education Programme, SHEP), the programme activities of these agencies become highly dependent on donors and thus directed by donor interests and their districts of activity.[clvii]

The Financial Sustainability Plan (FSP) was developed to cover the period 2007–2011, to coincide with the Health Sector Programme of Work (POW) timeframe; however, this document has since not been reviewed or updated.[clviii] Funding for commodities is a significant and continuing challenge, and indefinite commitments from government and donors on the procurement of contraceptives have created funding gaps and an inadequate supply of commodities, resulting in rationing across virtually all facility levels.[clix] Thus, the financing of contraceptives, services, and operations remains a challenge in the medium to long term.

Table 7: Reproductive Health Commodity Procurement Financing in the Public Sector, 2008–2013, Contributions in Percentages and USD Millions [clx,clxi, clxii,clxiii, clxiv,clxv]

	2008	2009	2010	2011	2012	2013	2014
Total GoG funds allocated for procurement (USD millions)	$1.91 million[clxvi]	$2.49 million	$1 million	$2 million	$2.24 million	$3 million	-
GoG expenditure contribution (USD millions)	$1.3 million	$1.4 million	$1.24 million	$55,517	$1.35 million	$1.16 million	$2.39million
% of GoG budget released	68%	56%	124%	3%	60%	39%	-
Donor funding (USD millions)	$5.64 million	$1,95 million	$3,78 million	$3.53 million	$5.08 million	$3.3 million	$6.81million
Total expenditure on commodities (USD millions)	$6.94 million	$3.35 million	$5.02 million	$3.58 million	$6.43 million	$4.46 million	$9.20million
GoG contribution (%)	19%	41.8%	25%	2%	21%	26%	26%
Donor contribution (%)	81%	58.2%	75%	98%	79%	74%	74%
Total expenditure on contraceptives as a percentage of the amount needed to be procured (%)	not available	not available	48%	89%	112% [clxviii]	214% [clxix]	160% [clxx]

Figure 17: Reproductive Health Commodity Procurement Financing for the Public Sector, 2008–2013, in USD Millions[clxxi]



In addition, a cost challenge remains for many beneficiaries in accessing family planning; it is hoped that the implementation of the free FP service under the NHIS will help bridge this gap and reduce the unmet need. The total cost of running the FP programme in 2010 (operational, programme, and commodity costs) was estimated to be around $41 million USD.[clxxii] This estimate would see a significant increase should the free FP service be implemented under the NHIS, and the CPR rate would increase dramatically.[clxxiii]

Stewardship, Accountability, and Management

To effectively reposition family planning to achieve programme objectives by 2020, it is essential to prioritise and improve stewardship, accountability, and management (SMA). The quality of supervision in health facilities is variable, and often does not occur at all due to a lack of funds to support it.[clxxiv] Supervision at community and primary care levels is weak; performance reviews are done without recourse to any actions or recommendations based on their outcomes.[clxxv] Health facility managers appear not to be really interested in the FP programme, as it basically does not contribute to the internally generated funds (IGF) of the facilities.[clxxvi]

There is good collaboration and communication amongst CSOs, NGOs, and development partners in the FP and RH sectors. Coordination amongst partners has been strengthened and largely achieved by the functioning of the ICC/SC.[clxxvii] The ICC/SC meets once every quarter and comprises representatives from the MoH, GHS/Family Health Division (FHD), UN agencies, donors, NGOs, senior medical officers (SMOs), Ministry of Finance, FDA, and other MoH agencies. Coordination amongst state agencies such as the SHEP of the Ghana Education Service (GES), NPC, Department of Gender, and the FHD is also functional. There is adequate coordination and collaboration amongst these and other multisectoral agencies in implementing their activities relating to RH and family planning; however, this work can further be strengthened. Integration of family planning into other health services and activities, such as antenatal care and postpartum care, immunisation programmes, and advocacy outreach, has shown considerable improvement and progress.

Providing services jointly rather than separately will likely present financial savings to health systems and improve efficiency. For example, offering FP information and services at antenatal and postnatal clinics provides a wide audience of potential beneficiaries and increases access to family planning; some of these beneficiaries can be difficult to contact later on.[clxxviii]

Another disabling challenge is the lack of involvement of and collaboration with the private for-profit sector. This sector is not actively engaged in the quantification and forecasting process, yet it plays a significant role in increasing access, as about 85 per cent of pills and 78 per cent of condoms are obtained in the private sector.[clxxix,clxxx] A challenge remains in obtaining data on services and commodities supplied and used through this sector.[clxxxi] In addition, the Society for Private Medical and Dental Practitioners (SPMDP) has not been properly engaged as a group and can play a useful and complementary role in providing quality FP services.[clxxxii]

Better collaboration is needed between GHS/FHD and FDA to improve on acceptable messaging of advertisements for ECs to prevent or reduce misuse and abuse. In addition, the FDA may be unaware of the full extent of the import of condoms and lubricants into the country, as they are captured under a broader customs and trade category in the Ghana Community Network Services Limited (GCNet) platform.[clxxxiii] Currently, condoms are included in the broader class of rubbers and lubricants for health, grouped into a larger reporting category encompassing all types of lubricants, including auto lubricants. There are also challenges in registration of some commodities with the FDA, with the processes of registration and importation extending beyond planned timelines even when the commodities fall under expedited review procedures. Commodities such as condoms are often kept in warehouses for extended periods, as the FDA's policy requires them to test each batch that arrives in country; however, it often takes months to complete the evaluation of the commodity samples.[clxxxiv]

COSTED IMPLEMENTATION PLAN

The GoG developed the GFPCIP to clearly define the country vision, goal, strategic priorities, interventions, and inputs, and present the estimated cost to achieve them. The GFPCIP details the strategic priorities that will drive government and nongovernment sectors in increasing FP access to meet the ambitious national targets for increasing CPR and reducing unmet need by 2020, as well as generally in increasing knowledge of and access to family planning in a rights-based manner.

GFPCIP aligns with broader health plans and related strategic plans for RH commodity security, reduction of maternal and neonatal mortality, and adolescent health policies, as well as HIV/AIDS strategies, including those for condoms and lubricants. However, the specific aim of the GFPCIP is to specify the interventions and activities to be implemented, and itemise the financial and human resources needed to meet the comprehensive national FP goals to help women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing; and support the achievement of gender equality. More broadly, voluntary family planning reduces preventable maternal mortality and morbidity, decreases unwanted teenage pregnancies, improves child health, facilitates educational advances, reduces poverty, and is a foundational element for the economic development of a nation.

CIP Operational Objectives

CPR objectives are as follows (see Tables 8 and 9):

- Increase the modern CPR185 amongst currently married women from the current 22.2 per cent186 to 29.7% per cent by 2020 (33% all methods CPR in 2020)
- Increase the modern CPR amongst unmarried sexually active women from the current 31.7 per cent187 to 40 per cent by 2020 (50% all methods CPR in 2020)

To facilitate the monitoring of the plan's success, the national objectives for 2020 have been translated into yearly progress objectives for CPR for married and women in union; and unmarried, sexually active women.

The overall annual growth rate needed for Ghana to increase its modern CPR from 22.2 per cent (married women) in 2014 (23.3 projected in 2015) to 29.7 per cent (married women) in 2020 is 1.3 per cent a year, on average, for modern CPR and a 1.1 per cent growth in total CPR per year.

The recent declining trend in CPR use for unmarried women between 2008 and 2014 will be reversed. The overall annual growth rate needed for Ghana to increase its modern CPR from 31.7 per cent (unmarried sexually active women) in 2014 (32.8 projected in 2015) to 40 per cent (unmarried sexually active women) in 2020 is 1.4 per cent a year on average for modern CPR and a 1.1 per cent growth in total CPR per year.

Table 8: Objectives for CPR for Married and In-Union Women in Ghana, by Year

	2015	2016	2017	2018	2019	2020
Yearly objectives – all methods	27.8%	28.7%	29.7%	30.8%	31.9%	33.0%
Yearly objectives – modern methods	23.5%	24.6%	25.8%	27.0%	28.3%	29.7%

Table 9: Objectives for CPR for Unmarried, Sexually Active Women in Ghana, by Year

	2015	2016	2017	2018	2019	2020
Yearly objectives – all methods	45.2%	46.0%	46.9%	47.9%	47.8%	50.0%
Yearly objectives – modern methods	32.8%	34.1%	35.4%	36.9%	36.7%	40.0%

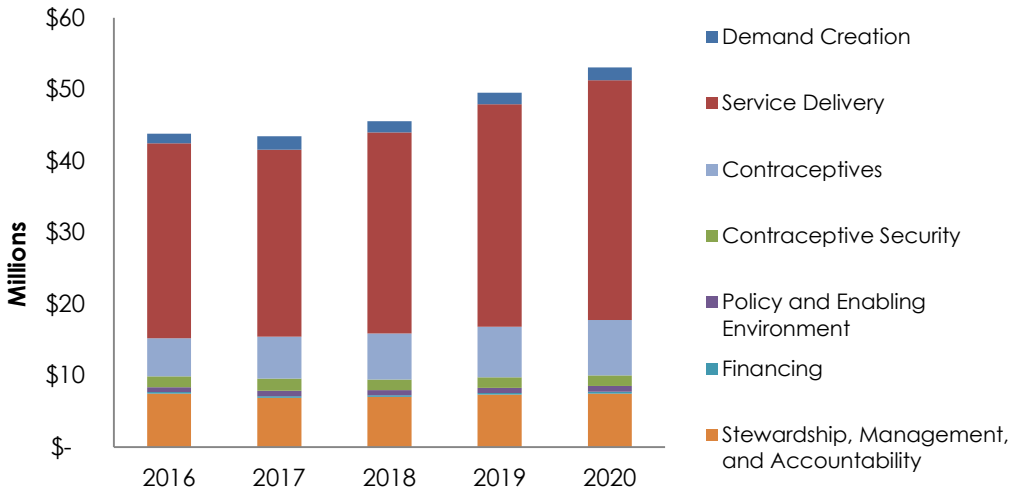
To achieve the desired CPR scenario, the number of FP users in Ghana must increase from 1.46 million in 2015 to 1.93 million by 2020. To reach this pace, almost 500,000 users need to be added between 2016 and 2020; this is almost 200,000 more than would be needed if the CPR growth rate seen between 2008 and 2014 continues at the same pace.

Thematic Areas

Across the six thematic areas, there are 80 total strategic results for implementing a full FP strategy in Ghana. Each area is further detailed by activities, sub-activities, inputs, output indicators, and timeline information (refer to Annex A. Implementation Framework with Full Activity Detail). Many of the strategic results listed in the framework map to strategic priorities.

The total cost for implementing the GFPCIP is $235 million USD (906 million Ghanaian cedis). Overall, $32.5 million USD, or 14 per cent of the overall costs, is in commodities, including contraceptives and consumables. Another 3 per cent of the costs is in demand creation; 62 per cent in service delivery; 3 per cent in programming for contraceptive security; 1.6 per cent in policy and the enabling environment; less than 1 per cent in financing; and 15 per cent in stewardship, management, and accountability (see Figure 18).

Figure 18: Costs by Thematic Areas and Contraceptive Costs, in Millions USD



Strategic Priorities

The strategic priorities in the GFPCIP represent key areas for financial resource allocation and implementation performance. Strategic priorities reflect issues and/or interventions that must be acted on to reach the country's goals. The strategic priorities ensure that the limited available resources are directed to areas that have the highest potential to increase the CPR in Ghana. In the case of a funding gap between resources required and those available, the strategic priority activities should be given precedence to ensure the greatest impact and progress towards the objectives laid out. Priority

activities allow the GoG to focus resource and time investments on coordination and leadership for GFPCIP execution. However, all of the components necessary for a comprehensive FP programme (all of the activities that support, complement, and complete it) have been detailed with their activities and costs; the strategic priorities of the plan will be used to guide the use of current and new funding and programme development.

Six Strategic Priorities

- Priority # 1: Promote and nurture change in social and individual behaviour to address stigma, myths, misconceptions, and side effects; and improve acceptance and continued use of family planning to prevent unintended pregnancies through correct, consistent, and targeted social and behaviour change communications that focus on rights-based family planning.
- Priority # 2: Increase age-appropriate and rights-based information, access, and use of contraception amongst young people ages 10–24 years.
- Priority # 3: Improve availability and access to a full method mix, quality of client-provider interactions, with a particular focus on improving counselling on delaying, spacing, and limiting for all clients of all ages and population groups.
- Priority # 4: Improve distribution and ensure full financing for commodity security in the public and private sectors.
- Priority # 5: Strengthen advocacy to build political will for rights-based family planning amongst community leaders, religious and cultural institutions, and policymakers at all levels, to leading to higher budget and expenditure levels for family planning from domestic sources and ensure implementation and accountability.
- Priority # 6: Strengthen the provision of FP services and information through CHPS to expand access to hard-to-reach-communities (e.g., increase capacity of CHPS CHWs).

Intervention and Activity Mapping to Strategic Priorities

The activities in the GFPCIP are structured around six essential components or thematic areas of an FP programme:

1. Demand creation
2. Service delivery
3. Contraceptive security
4. Policy and enabling environment
5. Financing
6. Stewardship, management, and accountability

The six strategic priorities are addressed through various activities under these six thematic areas. As not all activities are strategic priority activities, the total strategic priority costs amount to only a portion of the total CIP costs (see Figure 19 and Table 10).

Figure 19: Costs for Strategic Priorities, by Area, in Millions USD

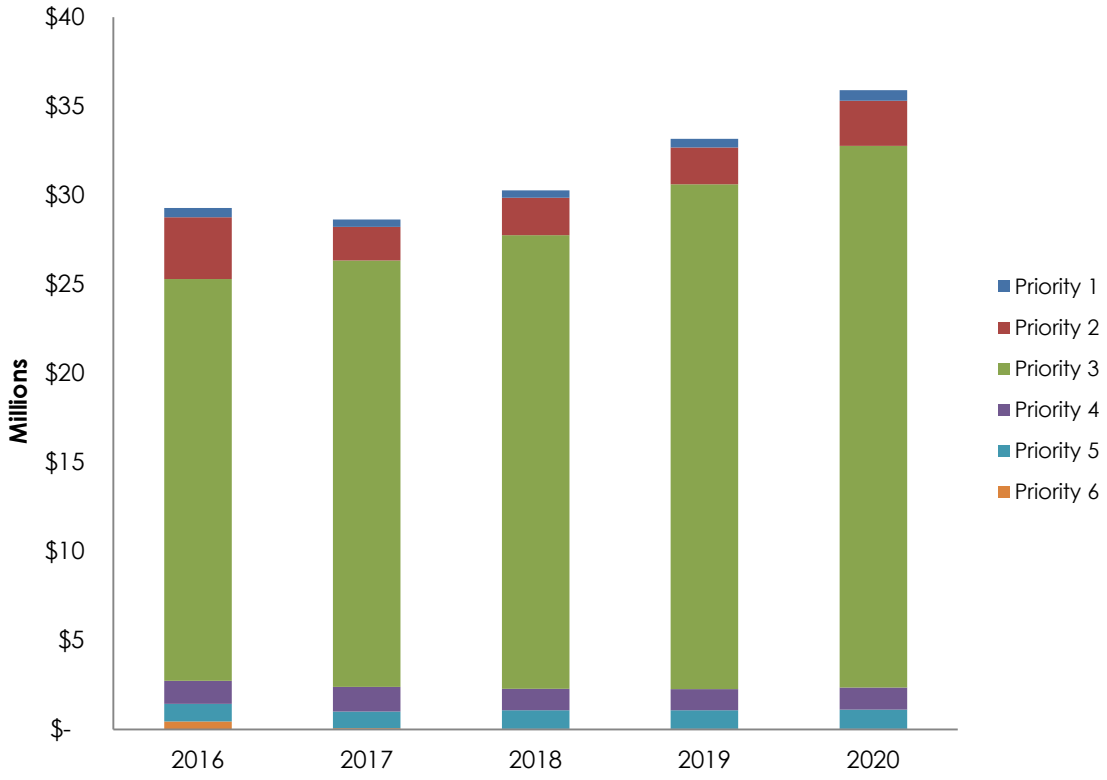


Table 10: Costs for Strategic Priorities, by Area, in USD

	2016	2017	2018	2019	2020	Total
Priority # 1: Promote and nurture change in social and individual behaviour to address stigma, myths, misconceptions, and side effects; and improve acceptance and continued use of family planning to prevent unintended pregnancies through correct, consistent, and targeted social and behaviour change communications that focus on rights-based family planning	$516,853	$406,810	$410,221	$475,604	$587,712	**$2,397,199**
Priority # 2: Increase age-appropriate and rights-based information, access, and use of contraception amongst young people ages 10–24 years	$3,476,981	$1,889,525	$2,099,139	$2,069,857	$2,541,279	**$12,076,781**
Priority # 3: Improve availability and access to a full method mix, quality of client-provider interactions, with a particular focus on improving counselling on delaying, spacing, and limiting for all clients of all ages and population groups	$22,550,974	$23,942,809	$25,463,282	$28,340,216	$30,416,132	**$130,713,412**
Priority # 4: Improve distribution and ensure full financing for commodity security in the public and private sectors	$1,295,671	$1,393,137	$1,208,741	$1,193,397	$1,240,958	**$6,331,903**
Priority # 5: Strengthen advocacy to build political will for rights-based family planning amongst community leaders, religious and cultural institutions, and policymakers at all levels to lead to higher budget and expenditure levels for family planning from domestic sources and ensure implementation and accountability	$997,041	$931,363	$1,050,537	$1,042,974	$1,077,223	**$5,099,137**
Priority # 6: Strengthen the provision of FP services and information through CHPS to expand access to hard-to-reach-communities (e.g., increase capacity of CHPS CHWs)[clxxxviii]	$444,658	$72,999	$33,850	$34,696	$35,563	**$621,767**
Total Strategic Priority Costs	**$29,282,177**	**$28,636,642**	**$30,265,769**	**$33,156,745**	**$35,898,866**	**$157,240,199**

Details on Thematic Areas

Demand Creation

Justification

Demand for and uptake of family planning can be increased by expanding knowledge and addressing myths and misconceptions through public campaigns and community-level mobilisation activities. Dissemination of accurate information about FP methods and their availability, and encouragement of FP use to promote the health of women and their families will increase knowledge of, and demand for, family planning. Champions and advocates can increase demand for family planning within communities—producing a supportive environment; reducing social, cultural, and religious barriers; and mobilising community support.

Strategy

The wide gap between knowledge about contraceptives and utilisation in Ghana indicates a clear need for implementing an evidence-based, targeted social and behaviour change communication (SBCC) programme to promote more widespread contraceptive usage amongst all groups. By designing and implementing such an SBCC campaign, along with on-the-ground community mobilisation, demand will increase as awareness rises, leading to increased rates of adoption. The design of the campaign will be harmonised across interventions, so communications to the public about family planning are targeted accurately with evidence-based slogans and messages and include target market segmentation to increase demand.[clxxxix] High-impact demand generation activities will be included to close the knowledge-use gap by addressing cultural and religious beliefs that affect FP uptake and utilisation, myths and misinformation, and fear of side effects and health concerns that impede its adoption and continuous use. Innovative technology and multiple media outlets, such as mobile health platforms, will be piloted and evaluated.

Ghana's SBCC campaign will use formative and assessment research to inform the appropriate community-based strategy and methodology. It is important to create campaigns that are adaptable for different cultural audiences.[cxc] Multiple media outlets—including mass media, IEC materials, interpersonal communications, advocacy campaigns, and champions—will increase demand and uptake of services.[cxci] The formative research will outline the knowledge, attitudes, and practices of the audience so that the campaign addresses the actual needs of the target population.[cxcii] Successful campaigns can result in increased demand, open acceptance of family planning in the home, increased knowledge and access to FP services, and advocacy amongst users for FP methods.[cxciii] Further, the integration of services and improved counselling at the service delivery level, included in thematic area # 2, Service Delivery, are strategies shown to successfully increase demand for family planning. The SBCC campaign will holistically incorporate rights-based FP messages to educate clients on their SRH rights.

Specific demand creation efforts will be targeted at men and youth. While men share responsibility for reproductive health, lack of focus on them might imply that family planning is not their concern. Male involvement is crucial to a successful demand creation campaign.[cxciv] Barriers for uptake include power and gender dynamics that inhibit women from making open decisions on family planning in their households. Dispelling myths and misconceptions amongst men is important for ensuring their support of family planning.[cxcv] To address the specific needs of youth, contraceptive education will be incorporated into the classroom setting, and teachers will be equipped to adequately support the SRH needs of youth. Peer educators will be trained to help with information dissemination and linking young people to service delivery.

Strategic Results

DC1. A multipronged rights-based SBCC strategy is developed based on evidence and a situational assessment of current SBCC interventions, to improve the sociocultural environment for reproductive health and family planning, including behavioural factors and social and gender norms. Evidence and data will be gathered to inform an SBCC strategy. Materials

will be used that ensure honest, accurate, clear, and consistent FP messaging reflecting reproductive rights and targeting various audiences, and including revised branding and messaging, as well as the use of new communication channels, such as social media.

DC2. There is improved use of tailored media and communication materials for FP education. A mass-media campaign will be developed from the SBCC strategy to include context-specific communication materials, Q&As, flyers, audio visuals, posters, brochures, billboards, and so on in English and four local languages. Messaging will specifically target under-served and marginalised groups of young people (including those with disabilities) and men, and will address social, cultural, and regional variation. Journalists will be oriented on FP topics, including sexual and RH and rights and development for young people. In addition, local information systems and mobile vans in the communities will disseminate FP information.

DC3. Innovative media initiatives are used to create demand for FP services. Social media and other innovative and locally appropriate communication and media channels will be used to create demand for family planning.

DC4. Ethical use of media and advertisement on family planning are practiced. Guidelines on the ethical and appropriate use of media for FP promotion by the public and private sectors will be developed and implemented to discourage promotion of single FP methods and unethical messaging.

DC5. All CHPS CHNs, CHOs, and community volunteers are trained on rights-based FP demand creation and supplied with materials to improve CHPS capacity this demand creation. All CHPS CHNs, CHOs, and CHVs will be trained through in-service training on rights-based FP demand creation so they understand FP rights and can correct myths and misconceptions and host community dialogues. All CHPS compounds will be supplied with job aids, communication materials, and necessary supplies for community education on family planning.

DC6. Mhealth technology is piloted for household level use. Mhealth technology for household-level use will be piloted and evaluated as a communication tool by CHNs, CHOs, and CHVs in selected CHPS compounds. The Mhealth technology will then be scaled up in later years.

DC7. Role of champions, faith-based organisations (FBOs), religious leaders, CSOs, and opinion makers is strengthened to create an enabling environment for increased demand for FP services and products. FP champions and satisfied clients will be selected, cultivated, and engaged in national campaigns and demand creation activities. The institutional capacity of community-based religious and faith-based organisations and CSOs will be built based on their needs to promote the reduction of stigma and raise awareness of FP and RH rights.

DC8. FP/contraceptive education is included and fully implemented as part of the life skills teaching curriculum provided in junior and senior high schools, with improved capacity of relevant teachers to deliver FP/contraception education. The FP component of the life skills education curriculum will be reviewed and updated, and the capacity of relevant GES staff, SHEP coordinators, and teachers will be built to implement it in all colleges of education and higher learning institutions per the revised content. The capacity of SHEP coordinators and teachers will be built, including their ability to address myths, misconceptions, and bias towards young people regarding FP/contraception education and on rights to family planning. In addition, teachers and schools implementing best practices on FP/contraception education will be rewarded and motivated through a national recognition process.

DC9. FP/contraception education through a peer-to-peer approach is scaled up. A peer-to-peer FP/contraception education approach will be developed; it will target young people and adults, including through the use of men's and mother's support groups, and satisfied clients based on evidence and best practices, and then it will be implemented. The capacity of young people to be peer educators will be built through technical and leadership training; peer education in schools and communities will be strengthened through organised groups at schools and in communities in

collaboration with local health facilities. In addition, districts will be assisted to integrate youth programming into the existing health budget and put in place a system of incentive packages for peer educators. Awareness amongst parents and communities to improve access to information, skills, and service utilisation by young people will be increased through quarterly meetings facilitated by nurses, teachers, and counsellors from schools, and HWs.

DC10. Male involvement in FP demand creation is improved. Men's groups will be used for FP awareness raising and will be provided with the necessary aids and targeted communications materials. National campaigns to mobilise men in support of family planning will be conducted.

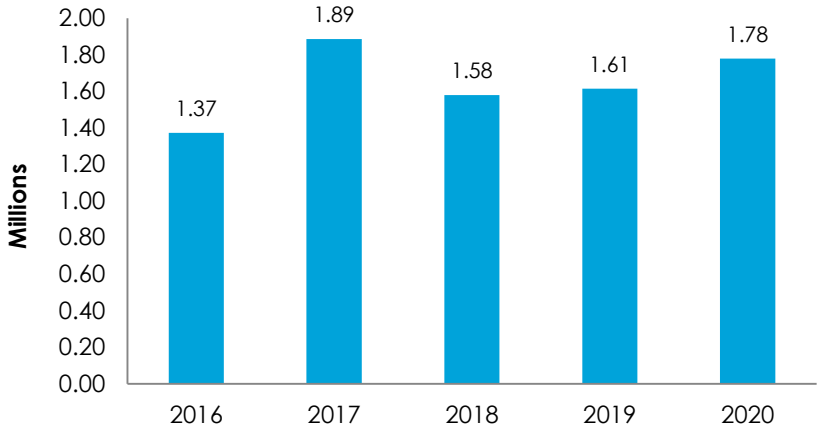
DC11. Increased awareness of FP benefits by communities and groups is facilitated through community mobilisation events. Community durbars and festivals will be held, and other relevant occasions will be used to strengthen and dialogue on family planning, including for young people. Family Planning Week will be celebrated annually at the national, regional, district, and community levels. CHPS compounds will organise local FP days in their communities.

DC12. Educated community members and clients who know and are empowered to demand their rights to FP/contraception information and services are engaged to promote FP availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation. The SBCC campaign will engage with human rights advocates to ensure that communications materials include rights-based FP messages to educate clients on SRH rights. In addition, the capacity of the Health Promotion Department at GHS will be built to disseminate information on a client charter and rights.

Costing Summary

As shown in Figure 20, the total cost for demand creation activities will be $8,230,609 USD between 2016 and 2020.

Figure 20: Demand Creation Costs, in Millions USD



Service Delivery

Justification

As discussed in the situation analysis, the current staffing, skill levels, and service structure within the Ghanaian healthcare system does not promote quality client-provider interactions. Without adequate training, time, supplies, and equipment to provide services, HWs struggle to perform their duties and adequately counsel clients on contraceptive methods. It is necessary to bolster the current delivery system to improve access through CHPS, continuous outreach, and the private sector. HWs, like many clients, are not adequately informed about the rights of clients to contraceptive information and services, resulting in less-than-optimal availability, accessibility, quality, equity and non-

discrimination, informed choice, transparency, accountability, and voice and participation for all clients.

Strategy

As defined in the National Reproductive Health and Service Policy and Standards, Ghana uses a rights-based approach to service availability for reproductive health and sexual rights, "The Government of the Republic of Ghana adopts and adapts the reproductive health definition from the 1994 Cairo ICPD . . . Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services . . ."[cxcvi] It later details a definition of sexual rights.[cxcvii]

To improve the FP service delivery capacity in Ghana's resource-constrained setting, several strategies will be employed. Community-based FP/contraception services will be expanded in all CHPS facilities to improve access to them; CHNs will implement house-to-house visits to ensure that they conduct outreach per the standard to deliver FP services.

Task shifting will be instituted so that FP methods are available from the lower levels of the health system, thus relieving the burden at higher levels of care. Task shifting has been shown to help mitigate the human resource crisis in many countries, including Ghana. The cascading of implant insertion and removal training to CHNs will be completed to implement task-shifting/sharing for long-acting reversible contraceptives (LARCs).

Access to facility-based FP services will be improved through implementation of an FP service scale-up plan in areas with the greatest unmet need and poor access. Strengthened pre-service training will be complemented by necessary in-service training and supportive supervision at all levels, including the private sector, to ensure that all providers have quality counselling skills, promote client rights, can conduct client follow-up, can provide LARCs (including implant removal) and permanent methods as appropriate to their cadres, and complete proper record keeping and reporting. An innovative eight-week mLearning system refresher training course will be piloted, evaluated, and scaled up if effective; it will cover the management of contraceptive side effects and misconceptions; will be for nurses, midwives, and community volunteers; and will use interactive voice response (IVR) and text messaging. To address quality issues, the FP quality of care in clinics, health centres, and hospitals will be improved by establishing FP quality improvement (QI) teams in health facilities to follow up on proper use of FP guidelines and protocols.

In addition, the GoG's policy of providing integrated RH/HIV care indicates that even when not addressed explicitly, FP programming addresses HIV prevention through the dual protection provided by male and female condoms.[cxcviii] This is in addition to specific activity efforts to integrate FP services into other outpatient and inpatient services, including maternal and child health (MCH) services; antiretroviral therapy (ART) clinics; and client-initiated HIV testing and counselling rooms in HIV centres, immunisation units, outpatient departments (OPDs), and inpatient wards.

The rights of all groups to receive equitable services will be emphasised in programming. HWs will be trained and provided with job aids to address the needs of vulnerable and key population groups, including people with disabilities. Improved participation of communities in service delivery will address issues of rights of participation by including young people, women, men, and people with disabilities in management and service delivery teams. Friendly services for young people in health facilities will be expanded to ensure privacy and confidentiality in corners for them. In addition, programmes to allow clients and community members to voice their concerns about rights issues in health facilities will be initiated, including complaint filing mechanisms such as feedback/suggestion boxes for FP services.

Strategic Results

SD1. Community-based FP/contraception services are expanded in all CHPS facilities to improve access to comprehensive FP services. The availability of FP services in all CHPS facilities will be monitored and corrective measures taken to address health worker absence and logistics. Regular supervision of CHN house-to-house visits will be implemented to ensure that CHNs conduct outreach per the standard for delivering FP services. Supplies and tools (bags, gowns, stationery, and medical supplies) will be provided for CHNs for community visits.

SD2. Access to facility-based FP/contraception services is improved. FP services will be available during off-work hours and weekends, depending on local needs and context, to provide expanded access to services. A facility assessment survey will be conducted to assess the range of FP services provided, stockouts, and service delivery challenges faced by health facilities. An FP services scale-up plan will be developed in areas with the greatest unmet need and poor access. HWs will be trained and provided with job aids to address the needs of vulnerable and key population groups, including people with disabilities. There will be improved participation of communities in service delivery, including young people, women, men, and people with disabilities, through including them in management teams and service delivery teams. Health worker training on postpartum family planning will be cascaded through supportive supervision to health facilities.

SD3. FP access through outreach services is improved. Outreach sites for FP services will be integrated with MCH services, including FP education and counselling.

SD4. Quality of FP/contraception services in CHPS compounds, clinics, health centres, and all facilities is improved. A supportive supervision manual for FP services in CHPS compounds will be developed; CHPS will implement monthly mentorship of FP services, starting with an onsite orientation for midwives and CHNs on the mentorship program.

SD5. There is improved FP/contraception quality of care in clinics, health centres, and hospitals. FP QI teams in health facilities will be established to follow up on proper use of FP guidelines and protocols. A system to reward best-quality service delivery points (SDPs) in FP/contraception services will be established based on quality services adhering to rights-based service delivery standards and not numbers. FP guidelines and protocols will be provided to all CHPS health centres, clinics, and hospitals.

SD6. FP/contraception services are integrated with other outpatient and inpatient services. FP services will be integrated in other outpatient and inpatients services, including ART clinics, client-initiated HIV testing and counselling rooms in HIV centres, immunisation units, OPDs, and inpatient wards.

SD7. "Lost to follow-up" for FP services is minimised. A "lost to follow-up" client tracking mechanism to address missed opportunities will be implemented; health facilities will be facilitated in following up with clients.

SD8. Task shifting/sharing for LARCs to the lower cadre of HWs is implemented to build human resource capacity for FP service delivery. The cascading of implant insertion and removal training to CHNs will be completed. The quality of training will be monitored to ensure that minimum requirements are met by CHNs and CHPS for implant insertion counselling and follow-up. Flow charts, communication materials, and job aids to facilitate LARC service provision will be provided to CHNs.

SD9. Continuous refresher training and capacity building are provided to HWs. Cascaded rights-based refresher training will be provided to HWs (midwives, nurses, doctors, and so on) on comprehensive FP service delivery (counselling skills, promoting client rights, ensuring that all clients have access, implant removal skills, client follow-up, LARC, record keeping and reporting). An eight-week mLearning system refresher training course will be piloted, evaluated, and scaled up; it

will be for nurses, midwives, and community volunteers; will cover the management of contraceptive side effects and misconceptions; and will use interactive IVR and text messaging.

SD10. FP/ contraception pre-service training for doctors, midwives, and nurses is strengthened. The pre-service training curriculum will be reviewed; additional topics such as LARC, health of young people, rights elements, logistics management, and health worker attitude and behaviour change issues will be addressed in the revised pre-service FP training curriculum. Course content and instructional plans will be developed and rolled out. Training materials, equipment, and medical supplies for colleges to strengthen FP pre-service training will be provided.

SD11. Improved skills of current HWs are facilitated to improve availability and access to FP services. Collaboration with health education institutions will be strengthened to improve availability and access to FP services. Training on permanent FP methods will be expanded.

SD12. FP clinic staff are motivated. A national- and regional-level health worker motivation scheme will be implemented for good performers who provide high-quality rights-based services. An assessment of health worker demotivation will be conducted and recommendations implemented.

SD13. There are improved access and quality of FP services in the private sector. Short- and long-term method availability in private facilities will be expanded; HWs at private facilities will be included in refresher and other FP training courses.

SD14. There are improved access to and utilisation of FP/contraception services by young people. Friendly services for young people in health facilities will be expanded and special times for them will be designated. The privacy and confidentiality in corners for young people will be ensured. Regional resource teams will be trained in youth-focused FP services; service providers will be trained on the topic through supportive supervision. Non-health worker support staff will be oriented on friendly FP services for young people. Discussion forums for young people will be organised in youth corners.

SD15. HWs are educated so they know about client rights to FP/contraception information and services, including availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation. HWs will be educated about the rights of clients—including the rights of people living with HIV (PLHIV)—to use other methods of contraception in addition to male and female condoms. Rights-based adolescent and youth-friendly health services (AYFHS) in public and private sector health facilities will be improved. In addition, programmes to allow clients and community members to voice their concerns about rights issues in health facilities will be initiated, including complaint-filing mechanisms such as feedback/suggestion boxes for FP services.

SD16. Service delivery points are equipped with the necessary HWs and supplies to provide rights-based FP services. All direct and indirect costs will be supported at SDPs to provide a full method mix of FP services (see Table 11).

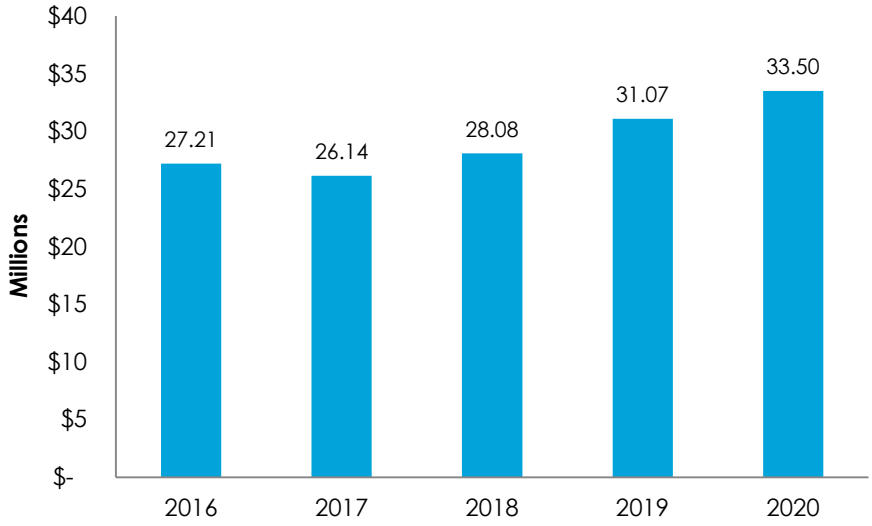
Table 11: Costs for Result SD16: Direct and Indirect Service Delivery Costs (Excluding the Cost of FP Commodities and Direct Consumables)

	2016	2017	2018	2019	2020	Total
Direct costs	16,435,635	18,009,649	19,743,219	21,654,927	23,740,781	**99,584,211**
Indirect costs	4,135,294	4,457,216	4,808,034	5,190,439	5,602,477	**24,193,460**
TOTAL	**20,570,928**	**22,466,866**	**24,551,253**	**26,845,366**	**29,343,258**	**123,777,671**

Costing Summary

As shown in Figure 21, the total cost for service delivery activities is projected to be $145,998,418 USD between 2016 and 2020.

Figure *21*: Service Delivery Costs, in Millions USD



Contraceptive Security (CS)

Justification

Maintaining a robust and reliable supply of contraceptive commodities to meet clients' needs, prevent stockouts, and ensure contraceptive security is essential to achieving the goals of the FP programme. It is crucial to ensure that contraceptive commodities and related supplies are adequate and available to meet the needs and choices of FP clients. The activities of this strategic priority will be implemented in line with other commodity security plans and strategies. Providing a full method mix of FP methods to meet the changing needs of clients throughout their reproductive lives not only increases overall levels of contraceptive use, it also ensures their ability to fully exercise their rights and meet their reproductive goals. Modern method use will increase and traditional methods use will decrease as an overall percentage of the total method mix; shifting users from less effective to more effective methods while maintaining the widest possible range of method choices gives women and families the ability to best fulfil their reproductive intentions.

Strategy

Maintaining a robust and reliable supply of contraceptive commodities to meet clients' needs, prevent stockouts, and ensure contraceptive security is a priority for the programme to achieve its goal. This thematic area also addresses the sustainable supply of contraceptive commodities and related consumables. It is aimed at ensuring that contraceptive commodities and supplies are adequate and available to meet the needs and choices of FP clients.[cxcix] The activities of this strategic priority will be implemented in line with other commodity security plans and strategies.

Because central-level supply is currently not a significant challenge for FP commodities, forecasting, quantification, and procurement will continue through biannual meetings at the national level as they have in recent years. The capacity of the FP sub-quantification team at the national level will be built, along with training at the subnational level for forecasting. Warehousing infrastructure and logistics capacity and efficiency will be improved through training supply chain officers in warehousing and logistics, advocating for full refurbishment of warehouses, and refurbishing selected warehouses. In addition, Regional Health Directorates will be engaged to advocate for integration of family planning with general facility stores at facility levels or at least ensure oversight for all stores, including those for family planning.

The current distribution system will be reviewed, and alternatives, including the push system, will be considered. The capacity of districts and facilities to implement timely pick-up of commodities will be improved through providing funding for transportation and conducting joint pick-ups with other programmes and general hospitals from regional stores. Pilot testing, evaluation, and scale-up of alternative supply and distribution mechanisms (e.g., public-private partnership [PPP] ventures) will be conducted and lessons learnt from the private sector supply and distribution system. There will be increased availability of FP commodities through distribution by a social marketing organisation to non-traditional outlets such as bars, night clubs, and hotels.

Strategic Results

CS1. Forecasting, quantification, and procurement plans are developed. Forecasting and quantification meetings will be held biannually and a full method mix included. The capacity at the subnational level for forecasting will be built. The capacity of the FP sub-quantification team will be built through structured regular training with various software and forecasting methods, and necessary equipment procured.

CS2. FP commodities are procured per the quantification and procurement plan. Follow-up will help improve the timely initiation of procurement purchase orders.

CS3. Emergency contraceptives are procured per the quantification and procurement plan. ECs will be procured per the quantification and procurement plan as a life-saving commodity.

CS4. Timely delivery of shipments is ensured. The government and all development partners will implement procurement and shipment per the procurement plan.

CS5. Warehousing capacity and efficiency are improved. Warehousing infrastructure and logistics capacity and efficiency will be improved through training supply chain officers in warehousing and logistics, advocating for full refurbishment of warehouses, and refurbishing selected warehouses.

CS6. Distribution of protocols is set/revised to improve distribution channels, commodity supplies, and systems. The distribution protocol/standard operating procedures (SOPs) will be revised as part of revision of the general SOP.

CS7. Distribution system is improved. The current distribution system will be reviewed and alternatives, will be considered, including the push system. The capacity of districts and facilities to implement timely pick-up of commodities will be improved through providing funding for transportation and conducting joint pick-ups with other programmes and general hospitals from regional stores. Pilot testing, evaluation, and scale-up of alternative supply and distribution mechanisms (e.g., PPP ventures) will be conducted. There will be increased availability of FP commodities through distribution by a social marketing organisation to non-traditional outlets such as bars, night clubs, and hotels.

CS8. Government and development partner workplans are aligned to the supply chain master plan. Recommendations from warehousing and distribution optimisation studies/reports will be implemented and workplans aligned to the supply chain master plan.

CS9. Supply and distribution of commodities are improved through systemic and innovative changes. The private sector supply chain systems will be assessed, and best practices for adoption or adaptation will be identified. Best practices from private sector supply and distribution systems will be applied.

CS10. Commodity regulatory practices are improved through addressing regulatory challenges currently resulting in delayed distribution of commodities and commodity supply. Regular coordination meetings with FDA will be held.

CS11. Regulatory bodies are actively engaged in regular monitoring and testing of FP/RH commodities in the public and private sectors, and resolve resource constraints for post-market quality assurance (QA). Regulatory bodies will be actively engaged in post-market surveillance and testing of FP/RH commodities in the public and private sectors, including post-market surveillance.

CS12. Theft is prevented and appropriate action taken when it occurs. Theft prevention and management strategies/guidelines will be adopted, including using batch numbers to track distribution and use, and conducting proper follow-up to ensure that appropriate actions are taken when commodity theft occurs.

CS13. Commodity procurement is improved through revision of procurement guidelines. The current procurement guidelines will be reviewed and revised by committee.

CS14. Facility stock management is improved for commodities at the facility level. Regional Health Directorates will be engaged to advocate for integration of FP stores with general facility stores at facility levels or at least ensure oversight for all stores, including those for family planning.

CS15. Detection and disposal of damaged/expired FP commodities is improved. National guidelines/protocols for the detection and disposal of damaged/expired commodities, including FP commodities, will be updated; during scheduled refresher trainings, HWs will be oriented on observing expiry dates of commodities before providing them to clients.

Costing Summary

As shown in Figure 22, the total cost for programming for contraceptive security will be $7,652,603 USD between 2016 and 2020. Figure 23 shows that the total costs for FP commodities and direct consumables will be $32,480,278 USD between 2016 and 2020. Figures 24 and 25 show the method mix to reach specific targets for CPR; Figure 26 shows the total number of all contraceptive users, by method.

Figure 22: Contraceptive Security (Program) Costs, in Millions USD

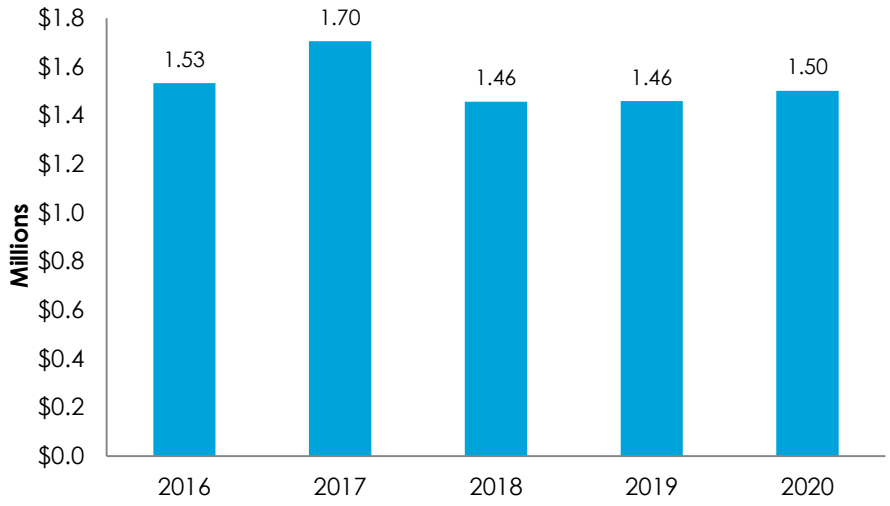


Figure 23: Contraceptive and Direct FP-Consumable Commodity Costs, in Millions USD

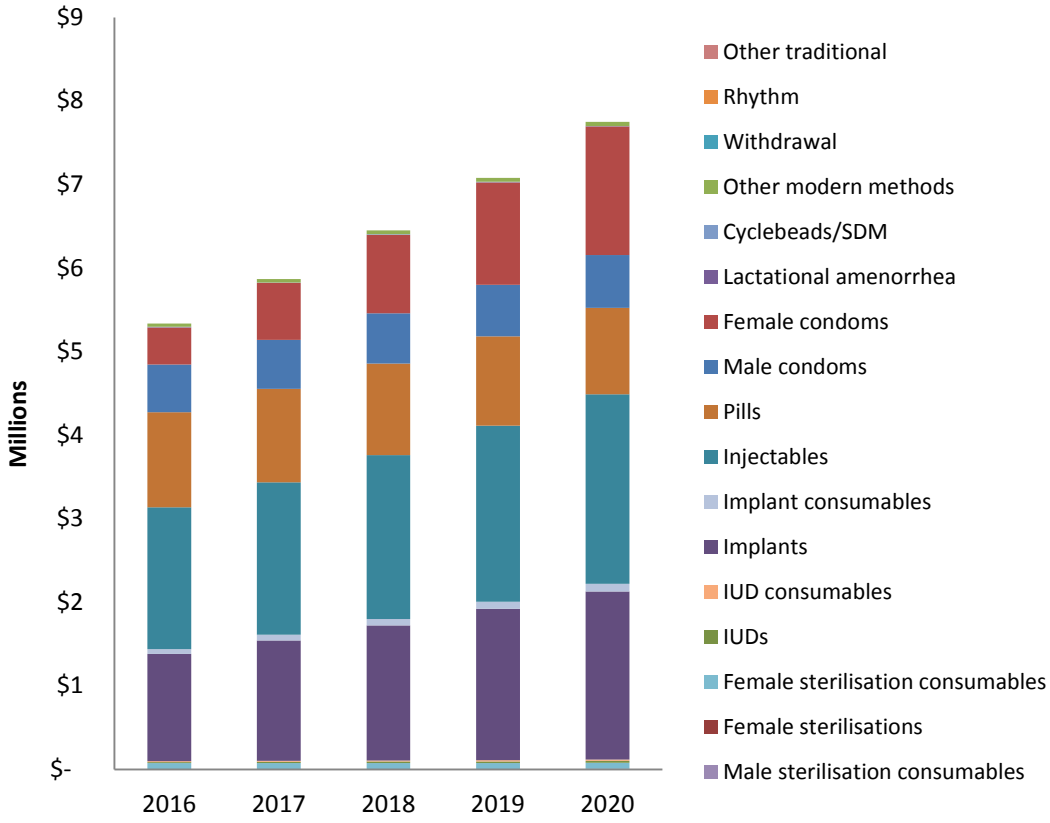


Figure 24: 2015 Baseline and Projected Method Mix, 2016–2020, Married Women and Women in Union, To Reach 33 Per Cent Target CPR

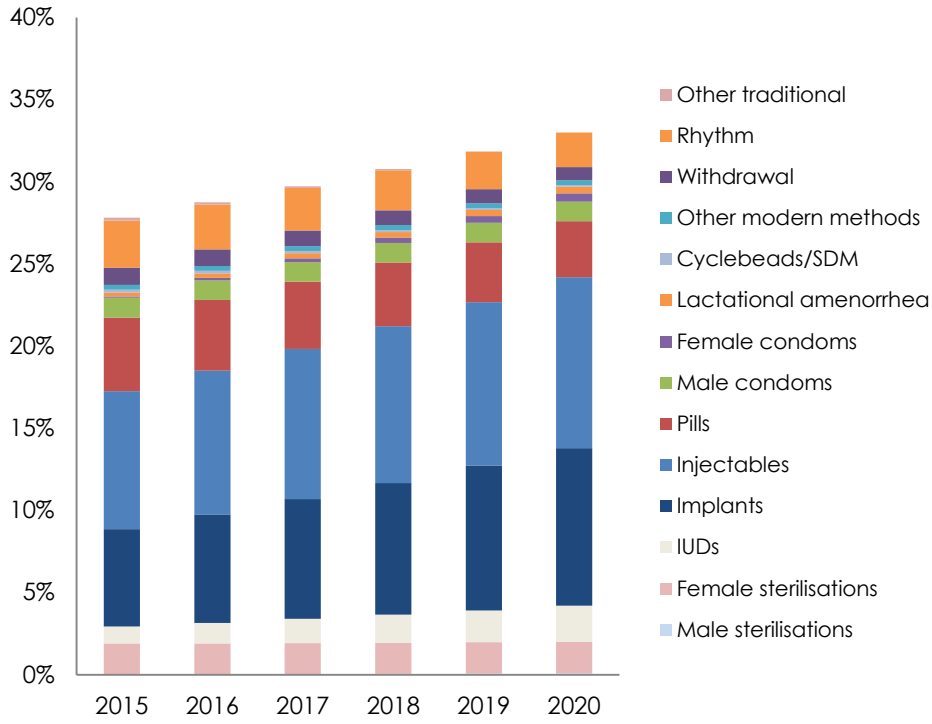


Figure 25: 2015 Baseline and Projected Method Mix, 2016–2020, Unmarried Sexually Active Women, to Reach 50 Per Cent Target CPR

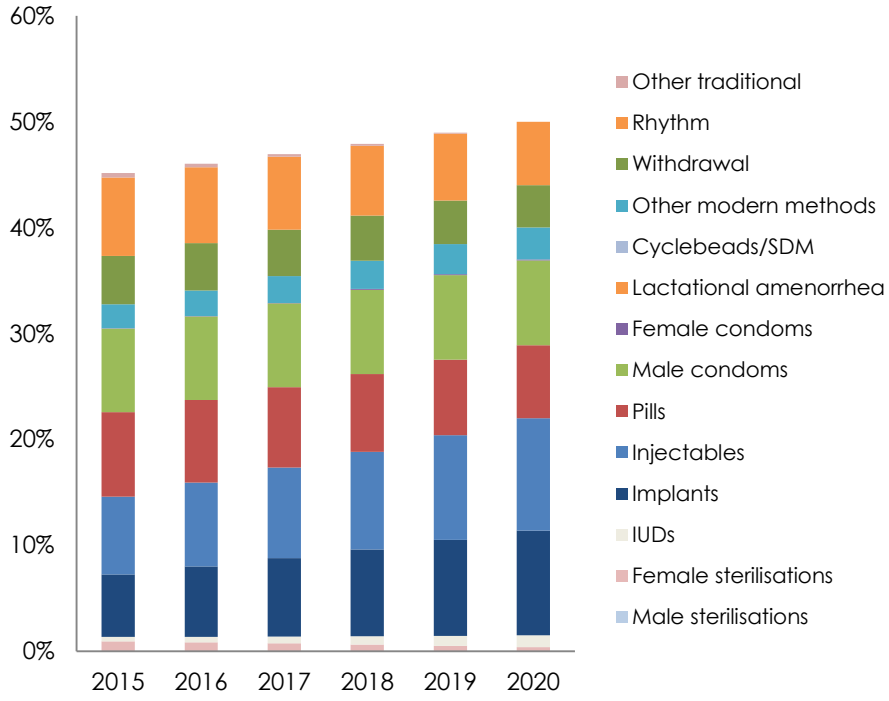
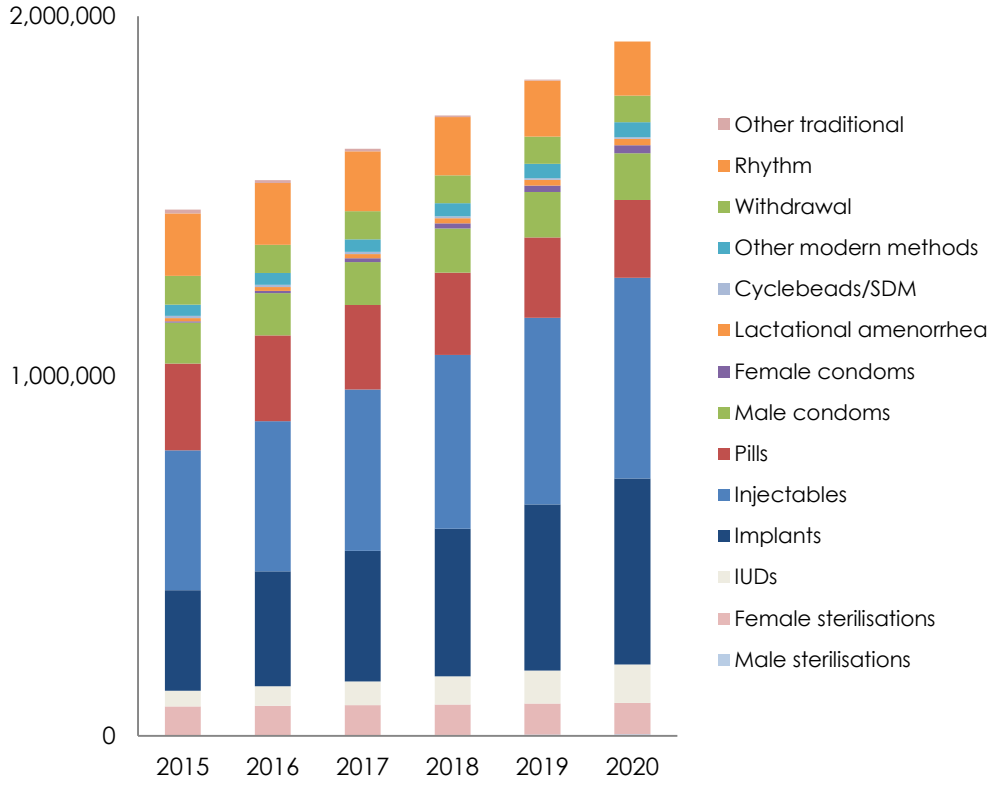


Figure 26: Total Contraceptive Users, Married and Unmarried, by Method



Policy and Enabling Environment (PEE)

Justification

Although family planning has been recognised in policy as a key element in improving national health and development, and creating a supportive environment for a demographic dividend to be reaped, the enabling environment needs to be further strengthened. Lack of political will, commitment, and clear messages from leaders has hampered policy implementation. In addition, key stakeholders and implementers are often unaware of the policy implications of their work because policy dissemination is often inadequate, especially to lower-level HWs.

Strategy

Multisectoral coordination will ensure that FP and population goals and objectives are appropriately integrated with other health and development initiatives (including finance, social welfare, education, women's affairs, and so on) as a cross-cutting intervention for national development. Senior leadership in all sectors will engage in reviewing progress towards the country's FP goals and increase political support for family planning by making the "financial" case for it as a strategy for social and economic development. They will achieve this goal by holding high-level ministerial briefings and producing advocacy materials targeting policymakers at national and regional levels.

General advocacy efforts will be improved through developing a national coalition of FP champions drawn from Parliament and local, cultural, and religious leaders. Key policymakers (members of Parliament, local political leaders, and others) will be sensitised on FP rights, and any misconceptions will be corrected.

In addition, because a lack of clarity has prevented full implementation of various policies, efforts will be made to harmonise statutory roles and official stances. New policies and guidance will be developed and implemented, including putting family planning in NHIS. The roles and responsibilities for the FP QA protocol (including condoms) between the FDA and the Ghana Standards Authority (GSA) will be rationalised. Specific advocacy will also be conducted to ensure that policies and guidelines for family planning promote access to FP services rather than hamper access for often-marginalised groups, such as youth, and ensure the provision of FP services in accordance with human rights and quality-of-care standards. The official stance on access to FP for youth will be clarified for HWs; official policies will be disseminated to service providers. GES policies on provision of contraceptives in schools will also be clarified and strengthened. Specific advocacy efforts will also be made to eliminate taxation of contraceptives.

To improve policy knowledge, all MoH, GHS, and NPC FP policies will be printed and uploaded online, and briefs for HWs will be developed biennially to update them on current policies and the implications for their work.

Strategic Results

PEE1. Family planning is seen as a critical element of the national development agenda and a critical component for achieving the demographic dividend in Ghana, along with simultaneous investments in education, healthcare, and governance. Senior leadership in all sectors will be engaged in reviewing progress towards the country's FP goals and increase political support for family planning by making the "financial" case for it as a strategy for social and economic development; they will achieve this goal by holding high-level ministerial briefings and producing advocacy materials targeting policymakers at national and regional levels.

PEE2. Multisectoral coordination ensures that FP and population goals and objectives are appropriately integrated with other health and development initiatives (including finance, social welfare, education, women's affairs, and so on). A multisectoral approach will be advocated so that each ministry includes FP and population issues, as appropriate, in their national policy documents, strategic plans, and budget allocations through developing and disseminating technical briefs. Non-health ministries and department directors will be engaged to include FP and

population issues, as appropriate, as part of their policy development process. Relevant projects will be encouraged to have their interpersonal communication (IPC) agents working in non-health sectors to integrate FP SBCC into their programmes.

PEE3. There is improved ability of key policymakers to ensure that FP rights are protected in policy and programme design. Policymakers (members of Parliament, local political leaders, and others) will be sensitised on FP rights and any misconceptions corrected. The Commission on Human Rights and Administrative Justice of Ghana will be encouraged to incorporate family planning efforts in its annual reports.

PPE4. A national coalition of advocates/champions drawn from Parliament and local, cultural, and religious leaders is established and supported to support rights-based family planning. FP advocates/champions will be coordinated and supported to carry out FP advocacy activities.

PEE5. Policymakers are able to advocate for bills related to family planning. Policymakers will be trained and oriented on how to advocate for bills on RH and rights policies, including family planning. The National Coalition of Advocates will also engage policymakers.

PEE6. Young people in schools receive improved FP/RH information and access to services due to clarified policies on FP/RH interventions for them. GES policies on provision of contraceptives in schools will be clarified and strengthened. The school curricula will be improved, and enforcement of examinable comprehensive family planning and reproductive health in life skills curricula will be encouraged.

PEE7. Policy on access for young people to FP services in clinical and community settings is clarified; service providers are knowledgeable about official policies affecting access by young people. Official policies on access to FP for young people will be clarified for HWs; official policies will be disseminated to service providers.

PEE8. FDA and GSA have harmonised roles as statutory bodies. The roles and responsibilities in the FP QA protocol (including condoms) between the FDA and GSA will be rationalised. In addition, the Minister of Health and parliamentary and/or legal bodies will resolve the current impasse between FDA and GSA.

PEE9. There is a collaborative relationship with the FDA to support timely, and a quality-driven contraceptive approval processes is improved. Collaboration with the FDA will be improved to reduce time delays in approval of registering new contraceptives, and reduce time delays in sampling and analysis during post-shipment inspection procedures before distribution is allowed.

PEE10. Removal of taxation on contraceptives is achieved. Advocacy efforts will be made for a policy change to remove taxes from all essential maternal health medicines and commodities, including contraceptives, with the goal of removing the barriers of having to rely on diplomatic exemptions.

PEE11. Inclusion of family planning in NHIS is operationalised. The legislative instruments for FP inclusion in the NHIS will be finalised; advocacy will target approval by Parliament and lawmakers.

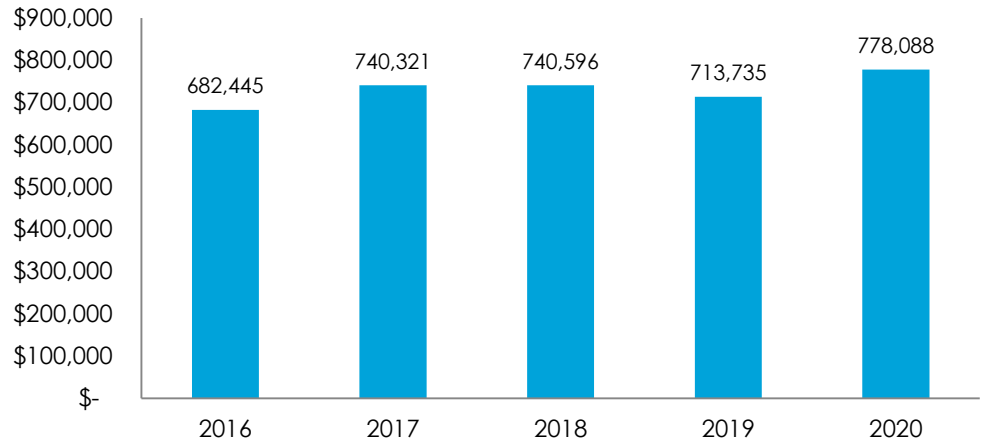
PEE12. Access to policy information is improved, with FP policies widely disseminated and available on the MoH, GHS, and NPC websites. All MoH, GHS, and NPC FP policies will be printed and uploaded online.

PEE13. HWs are informed of key policies and implications for their work. Briefs for HWs will be developed biennially to update them on current policies and implications for their work.

Costing Summary

As shown in Figure 27, the total cost for policy and enabling environment activities will be $3,655,184 USD between 2016 and 2020.

Figure 27: Policy and Enabling Environment Costs, in USD



Financing (F)

Justification

To address the distance between the generally supportive official policy environment for family planning and the low allocation of national financial resources to fully meet the need for FP services, advocacy and monitoring will be a key driver for increasing government allocations. Improving financing from development partners, along with domestic resource allocations and funding from the private sector, will also support sustainability for the FP programme.

Strategy

To address the limited financial commitment to family planning commensurate with need, advocacy for increased funding within national budgets, in addition to funding secured from development partners and the private sector, is essential. New financing will be cultivated from traditional development partners and the Global Fund. In addition, non-traditional donors (e.g., corporations and the media) from the private sector will be educated about the benefits of investing in family planning to improve sustainability.

A resource mobilisation plan, with a focus on first identifying and financing gaps for priority activities, will be designed and implemented. An annual FP gap analysis will be conducted and annually reviewed by stakeholders to align development and implementing partners' available funding and workplans with the GFPCIP.

Budget advocacy to be undertaken will include the creation of a budget line item for FP commodities (under RH commodities) to ensure that allocations for family planning are ring-fenced—not grouped with RH generally—as well as ensure the creation of an official budget line for FP programmes (separate from RH) in the MoH budget. A budget line item for FP programming will be created (including human resources, infrastructure, and management of health systems for family planning, including supportive supervision), and FP expenditure tracking will monitor expenditures against pledged annual budgets for the government and partners. In addition, consistent technical assistance and advocacy will be provided to help subnational levels make evidence-based decisions related to programming, budgeting, and tracking expenditures for family planning to ensure that it is fully integrated.

To address direct cost barriers and improve access to FP services for all, not just those covered by NHIS (addressed under PEE11), advocacy efforts will be made for all regions to adopt the scheme

started in the Upper East region to implement a free FP programme to address access issues for populations including rural women, under-served communities, people living with HIV/AIDS (PLWHA), young people, and others.

Strategic Results

F1. Financing gaps for family planning are identified; available funding information is disseminated to ensure transparency and accountability for financing and results, and avoid duplication of efforts. An annual FP gap analysis will be conducted and annually reviewed by stakeholders to align development and implementing partners' available funding and workplans with the CIP. A resource mobilisation plan will be designed and implemented, with a focus on identifying and financing gaps for priority activities first.

F2. An official budget line for FP commodities (separate from RH) is created in the MoH and Ministry of Finance (MoF) budgets to improve financial sustainability by increasing national GoG funding for family planning. A budget line item for FP commodities (under RH commodities) will be created to ensure that allocations for family planning are ring-fenced, not grouped with RH generally. Advocacy efforts will be made with the GoG/MoH to ensure a secure and timely commitment and release of funds to contraceptive and other RH commodities.

F3. An official budget line for FP programmes (separate from RH) is created in the MoH budget. A budget line item for FP programming (including human resources, infrastructure, and management of health systems for family planning, including supportive supervision) will be created, and FP expenditure tracking will monitor expenditures against pledged annual budgets for the government and partners.

F4. Subnational budgets prioritise financing for family planning, leading to improved sustainability of programmes. Sound policy directives, guidelines, and tools will be developed to assist subnational levels to allocate resources to family planning. Consistent technical assistance and advocacy will be provided to help subnational levels make evidence-based decisions related to programming, budgeting, and tracking expenditures for family planning to ensure that it is fully integrated and that subnational budgets continuously reflect increased finances for family planning.

F5. Level of FP support from development partners is increased through targeted advocacy. FP development partner meetings will be organised to invite new and increased FP financing commitments from them, in line with the resource mobilisation plan and funding gaps identified; resource mobilisation efforts will be made, including developing and submitting proposals for funding. Resources from the Global Fund will be mobilised to procure contraceptives so as to expand access to services, including prevention of mother-to-child transmission (PMTCT) of HIV, and improve infrastructure and systems for logistics management.

F6. Non-traditional donors (e.g., corporations and media) from the private sector are educated about the benefits of investing in family planning to improve sustainability. FP advocacy meetings will be organised with various corporate officers on corporate social responsibility investments in family planning. Joint plans between FHD, CSOs, and corporate organisations will be developed to advance family planning (talk shows, community events) as part of organisations' corporate social responsibility.

F7. Improved financing mechanisms for FP/RH services are implemented. The National FSP for contraceptives will be updated and expanded to cover other RH commodities. Clear policy guidelines will be developed on use of FP commodities (including condoms) funding; full cost recovery and other financial mechanisms will be piloted for some commodities in the NGO and social marketing sectors.

F8. Direct cost barriers to FP access are removed, thus improving access to FP services for all, not just those covered by NHIS. Advocacy will be done for all regions to adopt the scheme started in the Upper East region to implement a free FP programme (with or without the implementation of

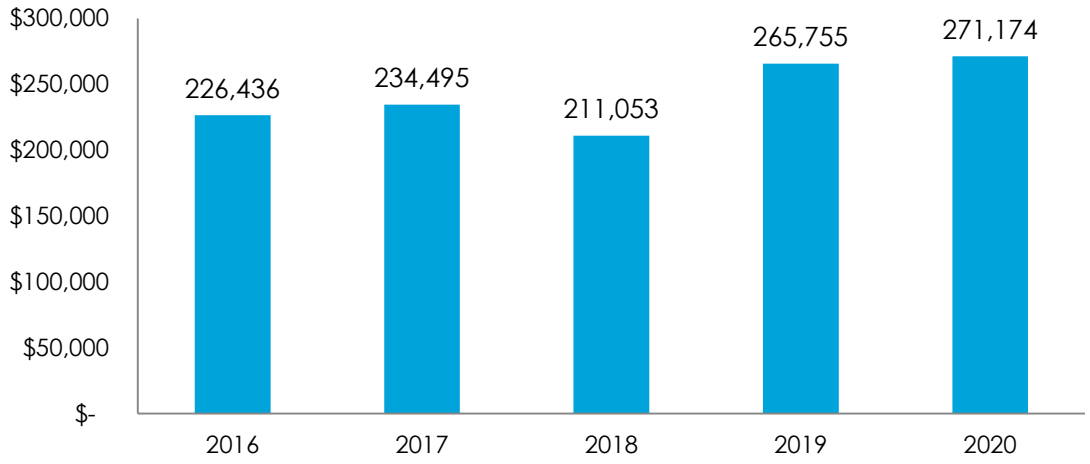
the free service under NHIS) to address access issues for such populations as rural women, under-served communities, PLWHA, young people, and others, to improve accessibility, affordability, and availability.

F9. A strong evidence base exists for increasing the government's and development partners' investments in family planning in Ghana. The evidence base will be built to increase financial support for family planning, including in NHIS. This will include commissioning evidence-based research and modelling to inform advocacy efforts so as to increase funding from government and development partners for family planning.

Costing Summary

As shown in Figure 28, the total cost for financing activities will be $1,208,913 USD between 2016 and 2020.

Figure 28: Financing Costs, in USD



Stewardship, Management, and Accountability (SMA)

Justification

To meet the targeted increase in MCPR by 2020, strong monitoring, management, leadership, and accountability are necessary. Effective management and governance of FP activities at all levels is needed to ensure that FP goals are reached. Improved coordination is essential to improve collaboration amongst partners and government bodies and ensure that activities are implemented as a harmonised national effort.

Strategy

With the increased range of activities, energy, and focus needed to meet the FP goals in the GFPCIP, it is essential that stewardship, management and accountability efforts are strengthened. Improved government capacity is critical to effectively lead, manage, and coordinate implementation of the FP CIP. A committee comprising NPC, GHS, and MoH FP experts on staff will be established to facilitate monthly internal coordination meetings. Senior staff of partners/consultants will also be seconded to NPC and GHS to support government staff and build on-the-job capacity through skill transfers.

Regional GFPCIP dissemination events will be held and 10 costed regional FP workplans for 2016–2020 will be developed, aligned to the national GFPCIP. Improved coordination with regions will ensure that national-level goals and plans reflect regional objectives, and vice versa. Annual regional FP plans will be developed that detail the regional health offices' and local partners' responsibilities. Regional and district focal persons will coordinate services and NGO activities and CIP

implementation in each region and district, respectively. National annual workplans for the GFPCIP and the National Condom and Lubricants Implementation plan will be developed.

ICC/CS's coordination and effectiveness will be improved through a broadened mandate and strengthening of subcommittees. Young people and community members will be included in the monitoring of policy and design of programmes by joining ICC/CS and other subcommittees so as to improve accountability to clients and marginalised populations. To further increase accountability and participation, community monitoring tools such as FP scorecards will be made available, and HWs, volunteers, NGOs, and community-based organisations (CBOs) will use them in public community activities.

A total market approach to all FP commodities will be taken to clarify the role of the public, non-profit, and for-profit sectors by a thorough market segmentation analysis. An enabling environment for the private sector in FP service provision will also be fostered, and opportunities for additional public-private partnerships will be explored.

Mentorship and supportive supervision are key strategies for improving the quality of implementation. The capacity of district managers to coordinate, monitor, supervise, and manage the programme will be built. In addition supportive supervision using all FP protocols and logistics tools, including standard operating procedures (SOPs) on privacy and confidentiality of services and the Standards and Tools for Monitoring Adolescent & Youth Friendly Health Services (AYFHS) in Ghana, will be implemented. In addition, consultants will carry out medical site visits to monitor FP activities. To improve the quality of rights-based FP services in the public and private sectors, FP programme management protocols will be reviewed to ensure they have a guidance section for districts; this will in turn ensure that healthcare facilities and trained providers are respectful of medical ethics and individual preferences, sensitive to gender and life-cycle requirements, and include SOPs on privacy and confidentiality of services.

Quality data reporting will be improved in the DHIMS and logistics management information system (LMIS); tools for reporting will be provided and HWs in both public and private facilities will be trained and refreshed on DHIMS and other data collection tools. Advocacy for systems strengthening for the LMIS will be conducted. M&E capacity will also be improved to support GFPCIP implementation, with government personnel trained on revised M&E tools and the Policy, Planning, Monitoring, and Evaluation (PPME)/GHS Division equipped with adequately trained M&E staff.

Regular annual performance review mechanisms will be developed, and a mid-term review and end-of-plan evaluation of the GFPCIP conducted. Collaboration with research institutions and implementing partners will be improved to support learning from operational research so as to inform future evidence-based decision making. These combined efforts will result in stronger management and accountability regarding FP goals in Ghana.

Strategic Results

SMA1. There is improved annual planning for family planning. Annual workplans for the GFPCIP and the National Condom and Lubricants Implementation plan will be developed.

SMA2. There is improved national coordination, partnership, and integration of family planning between the government and all stakeholders, including government and nongovernmental organisations and development partners. ICC/CS's coordination and effectiveness will be improved through a broadened mandate and strengthening of subcommittees: SBCC; Access/Quality care; Finance and advocacy; Procurement, logistics, and supply (PLS, formerly Logistics); M&E; Youth reproductive health; and Condoms and lubricants. Regular meetings will be held of the ICC/CS and all subcommittees. Young people and community members will be included in the monitoring of policy and design of programmes by their joining ICC/CS and other subcommittees.

SMA3. There is improved coordination with the private sector to better leverage resources in FP service provision. A total market approach to all FP commodities will be taken to clarify the role of the public, nonprofit, and for-profit sectors through a thorough market segmentation analysis. The contraceptive market analysis will be aligned with the total market approach (TMA) strategy, leading to growth towards market segmentation, with the private sector taking on contraceptive brands. An enabling environment for the private sector in FP service provision will be fostered and opportunities for additional PPPs will be explored.

SMA4. Coordination between national and regional levels, and within regions is improved. Coordination with regions will ensure that national-level goals and plans reflect regional objectives, and vice versa. Annual regional FP plans will be developed detailing the regional health offices' and local partners' responsibilities. Regional and district focal persons will coordinate services, NGO activities, and CIP implementation in each region and district, respectively.

SMA5. Knowledge to inform policy and programming is improved. Collaboration with research institutions and implementing partners will be improved to support learning from operational research to inform evidence-based decision making.

SMA6. FP/contraceptive use indicators are reported accurately from public and private facilities to improve the quality of data entry. Tools for reporting will be provided, and HWs in both public and private facilities will be trained and refreshed on DHIMS and other data collection tools. The DHIMS tool will be reviewed and edited to address data quality and reduce incorrect data entry. Data collection processes will also be monitored and data will be analysed for quality and validity.

SMA7. National LMIS for FP and other RH commodities at all levels is strengthened to provide the required information for decision making in a timely manner. Advocacy will be conducted for systems strengthening for the LMIS.

SMA8. FP/contraceptive use monitoring and supervision tools are reviewed for quality and effectiveness. M&E tools, manuals, and guidelines will be reviewed and updated.

SMA9. M&E capacity is improved to support GFPCIP implementation. Relevant government personnel will be trained on the revised M&E tools.

SMA10. Community monitoring tools are provided and used to enhance accountability of services. FP scorecards will be made available, and HWs, volunteers, NGOs, and CBOs will use them in public community activities.

SMA11. PPME department M&E capacity is strengthened. The PPME/GHS Division will be equipped with adequate trained M&E staff, and regional refresher training will be held for regional M&E officers.

SMA12. NPC/MoH/GHS capacity to lead, manage, and coordinate implementation of the GFPCIP effectively is improved. A committee comprising NPC, GHS, and MoH FP experts on staff will be established to facilitate monthly internal coordination meetings. Senior staff of partners/consultants will be seconded to NPC and GHS to support government staff and build on-the-job capacity through skill transfers.

SMA13. District capacity to manage the FP/contraception programme is strengthened and protocols adhered to through regular supportive supervision, leading to an improved quality of rights-based FP services in the public and private sectors. FP programme management protocols will be reviewed to ensure they have a guidance section for districts, which in turn will ensure that healthcare facilities and trained providers are respectful of medical ethics and individual preferences, sensitive to gender and life-cycle requirements, and include the SOPs on privacy and confidentiality of services at all health facilities. The capacity of district managers will be built to

coordinate, monitor, supervise, and manage the programme; supportive supervision will be implemented, using all FP protocols and logistics tools, including these SOPs and the Standards and Tools for Monitoring Adolescent & Youth Friendly Health Services (AYFHS) in Ghana. In addition, consultants will carry out medical site visits to monitor FP activities.

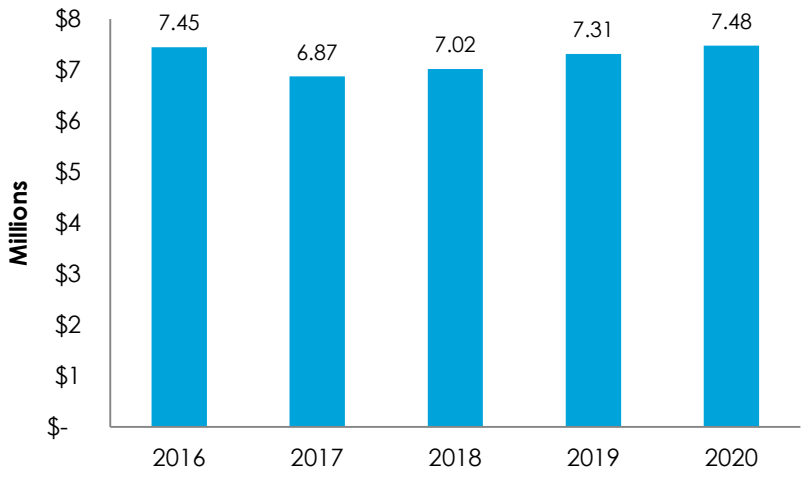
SMA14. Key FP regional and district planners and implementers are knowledgeable about the GFPCIP and have developed regional workplans for family planning based on the national GFPCIP. Regional GFPCIP dissemination events will be held, and 10 costed regional FP workplans for 2016–2020 aligned to the national GFPCIP will be developed.

SMA15. GFPCIP is regularly assessed and evaluated to guide future FP strategy development and programming. Performance review mechanisms will be developed and internal reviews to assess progress will be held annually. A mid-term review and end-of-plan evaluation of the GFPCIP will be conducted.

Costing Summary

As shown in the Figure 29, the total cost for stewardship, management, and accountability activities will be $36,131,843 USD between 2016 and 2020.

Figure 29: Stewardship, Management, and Accountability Costs, in Millions USD



COSTING

Costing Assumptions

Costing elements are described and costed based on specific data collected from government rate documents, vendors in Ghana, and partners implementing programmes. Each source for each input is cited in the costing tool; all inputs are also editable in the tool. In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g., the specific input costs for producing a radio programme, the number of programmes to be produced, the cost of broadcasting the programme, the number of times it will be broadcast, and so on). When specific costs for items were not available (e.g., if an activity has yet to be implemented in Ghana), the costing data are drawn from a regional African or international source and noted as such in the costing tool.

Contraceptive costs are calculated from 2016 to 2020 using the 2014 Ghana Demographic and Health Survey (DHS) CPR and method mix as a baseline for the 2015 method mix, assuming the same rate of change between 2014 and 2015 for each commodity, as averaged between the 2008 and 2014 DHS reports. The 2020 objective CPRs were then extrapolated for each intermediate year between 2016 and 2020 using an S-curve, as it is assumed that CPR growth will be closer to the slower rates seen in recent years and then speed up as the plan, including improvements in demand creation and service delivery, is implemented further.

Unless otherwise noted, all consumable costs (e.g., salaries, per diem rates, conference package rates, and so on) are based on current costs as of August 2015 and have been automatically adjusted for a base rate of inflation of 2.5 per cent every year. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in U.S. dollars and converted to local currency.

The Excel costing tool with complete data for Ghana is available from GHS and NPC for review, updating, or modification for other programmes.

Costing Summary

The costs of this plan have been calculated using a tool developed specifically for this purpose, with methodology borrowed from the costing of other FP plans in the region. The tool allows for a calculation of the overall costs of the plan, as well as a disaggregation of the costs by activity area and year. It includes both initial (investment) costs and ongoing or sustainability costs for the duration of the plan. [cc]

The methodology used is a "bottom-up" or "ingredients-based" approach, whereby each resource required for each programme activity is identified and valued.

Direct and indirect service delivery costs at the facility level were taken from a 2013 study "Cost of Family Planning Services in Ghana,"[cci] updating the 2012 costs with a standard inflation rate of 2.5 per cent between 2012 and 2015 and with the CPR rates for 2016–2020 for each method, as set in the Reality Check meeting and presented in the GFPCIP. The results of the GFPCIP show lower projected annual costs than presented in the 2013 study, as the annual number of users projected for each method is significantly lower. In addition, commodity costs are presented separately in the GFPCIP, rather than as a component of service delivery costs. These service delivery costs at the facility level include direct costs (staff time for providing FP services, including counselling and clinic visits; other consumables, mainly medical supplies; and laboratory testing) and indirect costs (administrative staff time, supervision from the regional or central level, office equipment, medical equipment, vehicles used for programme administration, physical infrastructure for administering the programme/service, transport costs for administration, public utilities, maintenance and repair, staff training, and other administrative costs such as office supplies and legal and audit costs). The GFPCIP costing does not include costs to clients, such as client time, transport, meals, out-of-pocket payments, user fees for services or drugs, costs incurred by local communities, programme negative externalities

(to the extent that they exist), and non-specified administrative and overhead costs incurred by external agencies such as development and implementing partners.

The total cost for implementing the GFPCIP is estimated at $235 million USD (906 million Ghanaian cedis).

Overall, $32.5 million USD, or 14 per cent of the overall costs, is for commodities, including contraceptives and consumables. Another 3 per cent of the costs are for demand creation; 62 per cent for service delivery; 3 per cent for programming for contraceptive security; 1.6 per cent for policy and enabling environment; less than 1 per cent for financing; and 15 per cent for stewardship, management, and accountability.

Costs are spread over the duration of the plan, with commodity costs increasing over time as more women are reached. In addition to commodities, the biggest cost drivers are service delivery and stewardship, management and accountability activities, at $146.0 million and $36.1 million USD, respectively.

The costs of the plan (exclusive of FP commodities and direct consumables) are comparable to other countries' similar FP costed implementation plans, which range from about $2–$5 USD per user per year.[ccii] The cost per woman of reproductive age for activity costs is $5.52 USD per year—higher than costs in many other countries, as the Ghana costs include all direct point-of-service and indirect costs (based on Ghanaian costing for each FP method), which are not fully included in most other countries' CIPs.

The cost per user for FP commodities and direct consumables would average $3.74 USD between 2016 and 2020; this average is slightly lower than the range of costs of $4–$6.95 USD seen in other countries, due to the current method mix's high rate of lower-cost methods compared to other countries, as well as the growing emphasis on LARCs.[cciii] The costs in Ghana are derived from actual national rather than international estimate costs and include a variety of additional loaded costs for each commodity (e.g., freight, insurance, customs and clearing charges, warehousing, and distribution fees to the last mile), which were not included in the standard costing for commodities for some of the other CIPs with lower average yearly costs. The value-added tax (VAT) has not been included in these loaded costs, as the majority of FP commodities are procured by development partners able to use diplomatic exemptions. Like the costs for other inputs, the loaded costs were determined by gathering data from a sample of the main organisations procuring FP contraceptives and direct consumables in Ghana. Figure 30 shows summary costs by thematic areas and the total; Table 12 shows costs by thematic area.

Figure 30: Costs by Thematic Areas and Contraceptive Costs, in Millions USD

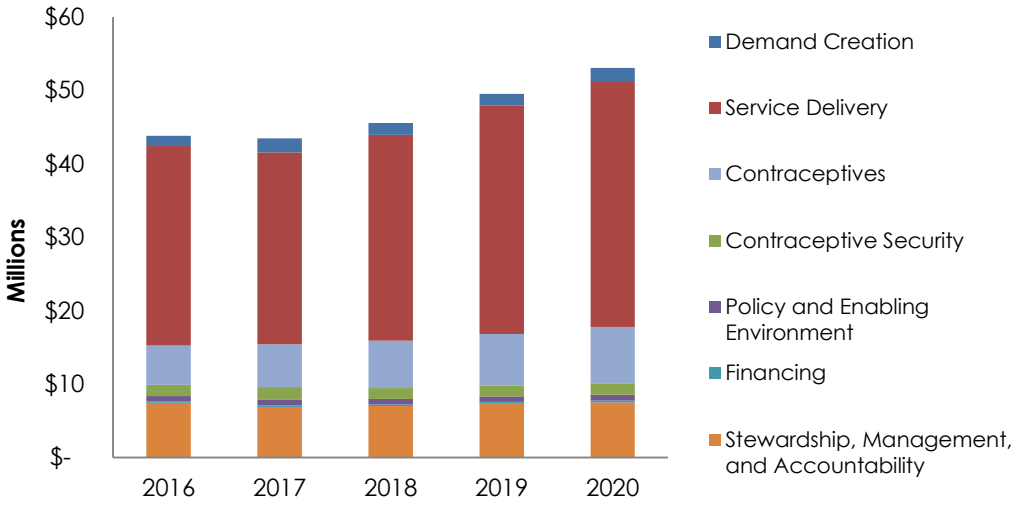


Table 12: Costs, by Thematic Areas, in USD

	2016	2017	2018	2019	2020	Total
Demand creation	$1,372,026	$1,886,222	$1,579,885	$1,613,628	$1,778,848	**$8,230,609**
Service delivery	$27,206,329	$26,136,719	$28,080,209	$31,070,438	$33,504,723	**$145,998,418**
Contraceptives (commodities)	$5,334,815	$5,868,612	$6,448,583	$7,077,877	$7,750,392	**$32,480,278**
Contraceptive security (programmes)	$1,531,807	$1,704,803	$1,456,358	$1,458,525	$1,501,111	**$7,652,603**
Policy and enabling environment	$682,445	$740,321	$740,596	$713,735	$778,088	**$3,655,184**
Financing	$226,436	$234,495	$211,053	$265,755	$271,174	**$1,208,913**
Stewardship, management, and accountability	$7,447,692	$6,874,137	$7,019,294	$7,313,867	$7,476,854	**$36,131,843**
Total	**$43,801,549**	**$43,445,308**	**$45,535,977**	**$49,513,824**	**$53,061,190**	**$235,357,848**

PROJECTED METHOD MIX AND CONTRACEPTIVE NEEDS

Assumptions

The current CPR for all women for all methods in 2015 was calculated from 2014 DHS data (assuming that the same incremental yearly change that occurred between 2008 and 2014 was sustained for 2015).[204] The total number of women of reproductive age was calculated from the 2010 census data, based on the official population growth rate of 2.5 per cent.[205] The percentage of married and unmarried women of reproductive age was also derived from the 2010 census. The percentage of unmarried sexually active women of reproductive age was extrapolated from the 2008 DHS data.[206]

A target method mix for 2020 was projected for the GFPCIP, with input from the May 2015 Reality Check meeting,[207] and in consultations with the Task Force and Contraceptive Security Strategic Advisory Group. The method mix projections consider various factors, including availability of infrastructure, provider capacity, and historical trends. These projections are to be understood as the best-guess projections for a future method mix, and are not to be interpreted as reducing user choice for any particular method. For this reason, the actual forecasting and procurement for FP commodities should be regularly reviewed and adjusted based on new and emerging data, including information on user preference and choice, as well as actual commodity use in the public and private sectors, which will be increasingly valuable as the quantity and quality of these data improve. The projections are based on the following assumptions, which were guided by best practices and recommendations made by members of the consultation groups:

1. The CIP will be fully implemented by the government and partners, including specific emphasis on reaching under-served women, such as rural populations, the urban poor, and youth, and creating demand and improving access for LARCs.
2. LARCs will rise at a rate similar to those of other countries in the region, based on similar data for demand and access,[208] once LARCs are available at more SDPs and demand-creation activities for them have begun. The greatest rise in LARCs is projected for implants, accompanied by an increased demand for IUDs at a slightly lower rate.
3. Injectable use will increase in line with similar rises in other countries in the region due to increased access resulting from planned scale-up of task shifting for injectable provision by CBDs, and in line with the historical increase in injectable uptake.
4. Pill use will decrease slightly as a percentage of all methods used (and mainly for married women), due to improved access to injectables and LARCs.
5. Condom use amongst both married and unmarried sexually active women decreased between the 2008 and 2014 DHS; there will be efforts to reverse this trend, particularly targeting unmarried women.
6. Unmarried sexually active women are increasingly relying on withdrawal use, as shown in the increasing trend of withdrawal between the 2008 and 2014 DHS. Demand Creation and counselling at service delivery facilities will be targeted to address this issue, with the goal of decreasing reliance on withdrawal as an FP method.
7. The method mix quantification for the GFPCIP varies from the national quantification projections because it is based on variably adjusting CPR method mixes for married and unmarried women based on DHS data and desired CPR targets, rather than past historical use, which is factored into the national quantification projections.209
8. In addition, for the GFPCIP, male and female condoms were included only in the method mix and costed for the amount required for FP usage alone—condoms used for the prevention of HIV and other sexually transmitted infections in addition to the use of another method by women are not included in this GFPCIP costing, although these projections and costs should be included in the larger national quantification projections for RH commodities.

9. EC is not included as a percentage of the method mix, as it is not promoted as a regular or consistent method of family planning. It will be procured for public and private sector use as a lifesaving commodity—a method to be used when other primary methods are not used or fail. Due to the planned SBCC and service delivery activities to better educate clients on the purpose of ECs, the quantities of them to be procured annually has been projected to remain level after 2017. Although the population of women of reproductive age will increase due to population growth momentum, the rate of use of EC has been projected by stakeholders to decline at a similar rate, reversing the increasing rate of its use in Ghana in recent years. Thus, the procurement of EC per historical trends in the national quantification plan is included in the programme costs under contraceptive security.

The interventions of this GFPCIP will lead to reaching a total CPR of 33 per cent for married women and 50 per cent for unmarried women of reproductive age in 2020. This will lead to a total of more than 1.9 million women users of contraception in 2020.

The 2015 baseline method mix and the 2020 objective method mix assumptions for all women are detailed in Table 13 for married women and Table 14 for unmarried sexually active women.

Table 13: 2015 Baseline Method Mix and Projected Method Mix for 2020, for Married Women and Women in Union

Contraceptive method	Method mix	
	2015 baseline[210]	2020 Projections
Male sterilisations	0.00%	0.10%
Female sterilisations	1.90%	1.90%
IUDs	1.03%	2.20%
Implants	5.93%	9.60%
Injectables	8.40%	10.40%
Pills	4.48%	3.40%
Male condoms	1.20%	1.20%
Female condoms	0.08%	0.50%
Lactational amenorrhea	0.23%	0.40%
Cyclebeads/SDM	0.17%	0.10%
Other modern methods	0.30%	0.30%
Withdrawal	1.05%	0.80%
Rhythm	2.87%	2.10%
Other traditional	0.17%	0.00%
CPR, all methods	**27.8%**	**33.0%**
Modern CPR	**23.5%**	**29.7%**

Table 14: 2015 Baseline Method Mix and Projected Method mix for 2020, for Unmarried Sexually Active Women

Contraceptive method	Method mix	
	2015 baseline[211]	2020 Projections
Male sterilisations	0.0%	0.00%
Female sterilisations	1.0%	0.40%
IUDs	0.4%	1.10%
Implants	5.9%	9.90%
Injectables	7.4%	10.60%
Pills	8.0%	6.90%
Male condoms	7.9%	8.00%
Female condoms	0.0%	0.10%
Lactational amenorrhea	0.0%	0.00%
Cyclebeads/SDM	0.0%	0.00%
Other modern methods	2.3%	3.00%
Withdrawal	4.6%	4.00%
Rhythm	7.4%	6.00%
Other traditional	0.4%	0.00%
CPR, all methods	**45.2%**	**50.0%**
Modern CPR	**32.8%**	**40.0%**

Details of the annual method mix, services/commodities, and contraceptive prevalence by method and demographic and health impacts for married women and those in union; unmarried, sexually active women; and total FP users, married and unmarried, for 2015 and projected for 2016–2020 are shown in Figures 31, 32, and 33, respectively. Standard units needed for one year of use rather than couple years of protection (CYP) factors were used for these calculations.[212]

Figure 31: Contraceptive Prevalence by Method, Married Women and Women in Union, 2015 Baseline, Projected 2016–2020

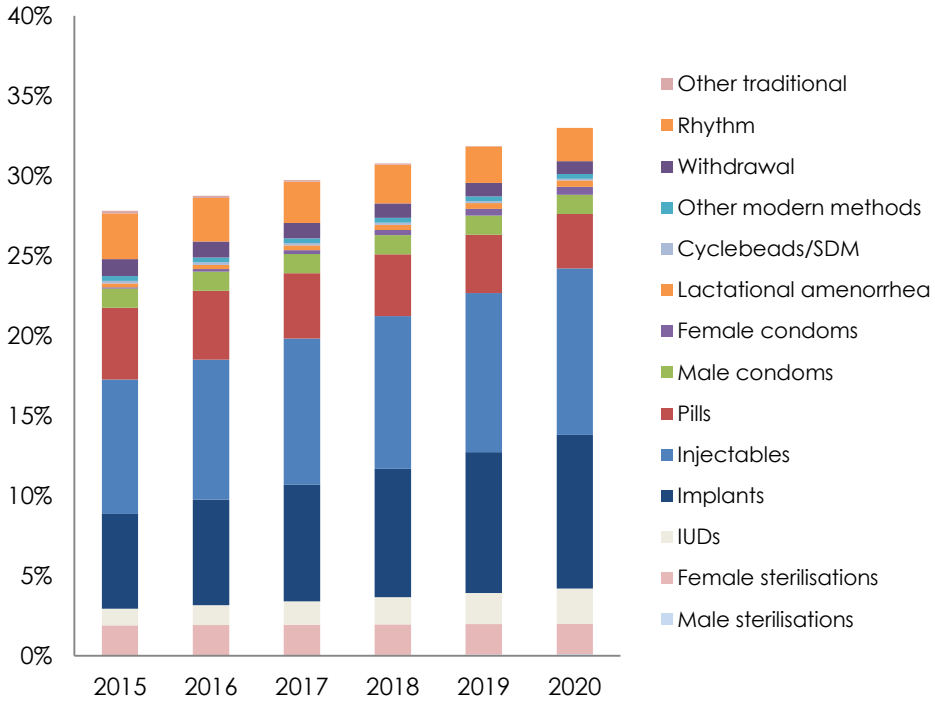


Figure 32: Contraceptive Prevalence by Method, Unmarried, Sexually Active Women, 2015 Baseline, Projected 2016–2020

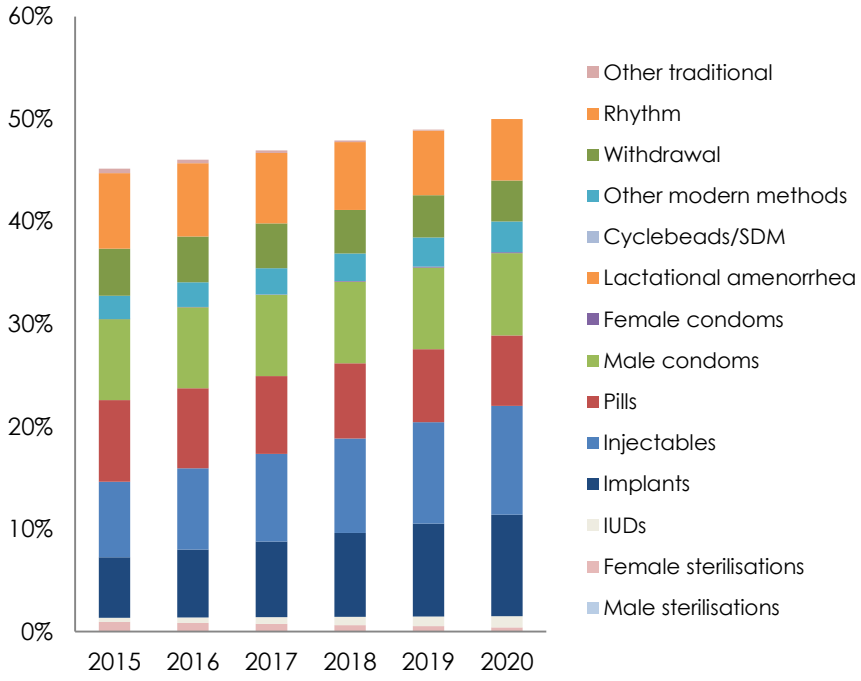


Figure 33: Total FP Users, Married and Unmarried, 2015 Baseline, Projected 2016–2020

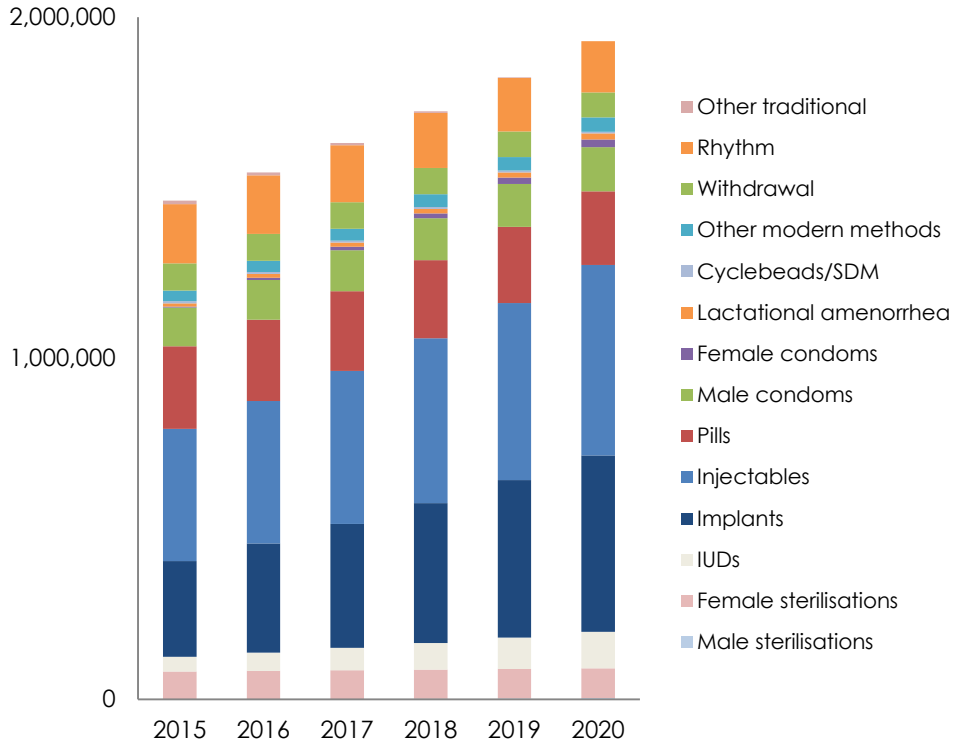


Table 15: Number of FP Users Provided With Services or Commodities gives the total estimated number of FP users that need to receive each method each year. The number of users is lower in this figure than that in Table 16, as users of long-acting methods (sterilisation, IUDs, and implants) do not need to be provided with services each year to be considered an FP user. Table 16 details the total number of current FP users for each method, by year, which corresponds to the method mix targets for married and unmarried sexually active women.

Table 15: Number of FP Users Provided With Services or Commodities[213]

	2016	2017	2018	2019	2020
Male sterilisations	715	846	988	1,141	1,305
Female sterilisations	7,513	7,515	7,557	7,565	7,641
IUDs	19,998	23,303	26,913	30,856	35,022
Implants	127,214	143,094	160,440	179,392	199,333
Injectables	417,323	448,760	482,641	519,249	558,264
Pills	238,411	234,146	228,968	222,768	215,641
Male condoms	116,745	119,862	123,073	126,385	129,787
Female condoms	6,566	10,096	13,979	18,240	22,888
Lactational amenorrhea	10,461	12,011	13,703	15,543	17,539
Cyclebeads/SDM	6,144	5,782	5,370	4,905	4,385

	2016	2017	2018	2019	2020
Other modern methods	32,879	34,949	37,170	39,583	42,093
Withdrawal	79,059	78,108	76,903	75,399	73,663
Rhythm	170,859	166,817	162,017	156,348	149,957
Other traditional	8,415	6,627	4,636	2,412	0
Total	**1,242,300**	**1,291,915**	**1,344,356**	**1,399,786**	**1,457,518**

Table 16: Total FP user mix, projected 2016–2020[214]

	2016	2017	2018	2019	2020
Male sterilisations	715	1,507	2,379	3,337	4,385
Female sterilisations	82,912	84,049	85,140	86,155	87,169
IUDs	53,986	65,553	78,215	92,068	107,075
Implants	319,763	362,931	409,955	461,236	516,433
Injectables	417,323	448,760	482,641	519,249	558,264
Pills	238,411	234,146	228,968	222,768	215,641
Male condoms	116,745	119,862	123,073	126,385	129,787
Female condoms	6,566	10,096	13,979	18,240	22,888
Lactational amenorrhea	10,461	12,011	13,703	15,543	17,539
Cyclebeads/SDM	6,144	5,782	5,370	4,905	4,385
Other modern methods	32,879	34,949	37,170	39,583	42,093
Withdrawal	79,059	78,108	76,903	75,399	73,663
Rhythm	170,859	166,817	162,017	156,348	149,957
Other traditional	8,415	6,627	4,636	2,412	0
Total	**1,544,237**	**1,631,197**	**1,724,148**	**1,823,628**	**1,929,279**

IMPACTS

The ImpactNow model[215] was used to calculate the impacts from which the GoG will benefit by increasing the CPR. These demographic, health, and economic impacts include the following:

- Unintended pregnancies averted
- Abortions averted
- Unsafe abortions averted
- Maternal deaths averted
- Child deaths averted (due to improved birth spacing)
- Healthcare costs averted (in USD)

These calculations estimate that the FP interventions in Ghana will avert more than 2.3 million unintended pregnancies, more than 800,000 abortions, and more than 5,000 maternal deaths between 2016 and 2020 if the CIP is implemented fully. Additionally, the intervention will avert almost $115 million USD just for maternal and infant healthcare costs during the five-year plan period.[216]

Table 17 forecasts the impacts of increases in FP demand, use, and priorities for 2016–2020 in Ghana. The baseline numbers are drawn from the 2014 DHS and projected outward based on full implementation of the GFPCIP and reaching the stated CPR targets for married and unmarried sexually active women of reproductive age; they show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Ghana.

Demographic impacts. "Unintended pregnancies" averted refers to the number of births that will not occur, including live births, abortions, miscarriages, and stillbirths. The number of pregnancies averted, including abortions, also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions decline due to increased FP use and fewer unintended pregnancies, maternal deaths will decline.[217]

Health impacts. As a result of full implementation of the GFPCIP, significant numbers of maternal and child deaths will be averted, as well as unsafe abortions, contributing to a healthier population.[218]

Economic impacts. Given the priority on realising the demographic dividend in Ghana, these numbers hold particular significance. Increased FP use, reduced unmet need for family planning, and increased contraceptive prevalence will result in government savings and economic impacts on the whole, but Table 17 shows the specific impacts on maternal and infant healthcare costs only.

Table 17: Annual and Total Impacts of the GFPCIP

	2016	2017	2018	2019	2020	Total
Demographic impacts						
Unintended pregnancies averted	399,266	429,265	460,598	493,417	527,706	**2,310,252**
Abortions averted	143,736	154,535	165,815	177,630	189,974	**831,690**
Health impacts						
Maternal deaths averted	920	967	1,014	1,061	1,108	**5,070**
Child deaths averted	5,142	5,529	5,932	6,355	6,797	**29,755**
Unsafe abortions averted	64,681	69,541	74,617	79,934	85,488	**374,261**
Disability-adjusted life years (DALYs)[219] averted	490,958	526,514	563,515	602,136	642,341	**2,825,464**
Economic impacts						
Maternal and infant healthcare costs averted (USD)	19,831,396	21,321,423	22,877,727	24,507,861	26,210,973	**114,749,380**

INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

As espoused in the National Health Policy, the MoH will provide stewardship and leadership, including mobilising support and resources from domestic sources, and from partners and private sector players, to successfully implement the plans outlined in this document.[220] Ownership in implementing the CIP will be driven by the government through GHS, its responsible agency. However, implementation of this broad-based plan calls for a multisectoral approach and coordination and partnerships at various levels, including with relevant ministries, national government agencies, municipal and district assemblies (MDAs), CSOs, NGOs, development partners, academia, media, the private sector, traditional authorities, and communities, to realise the great benefits and goals stated in this document.

The common objective of stakeholders to achieve GFPCIP objectives by 2020 calls for government leadership and functional processes to track and ensure performance assessment and accountability. This section illustrates a proposed management structure, defines roles, and describes institutional coordination arrangements crucial to achieving results. The proposed structure is flexible and should be adapted and modified as necessary to achieve utmost output as it is rolled out operationally.

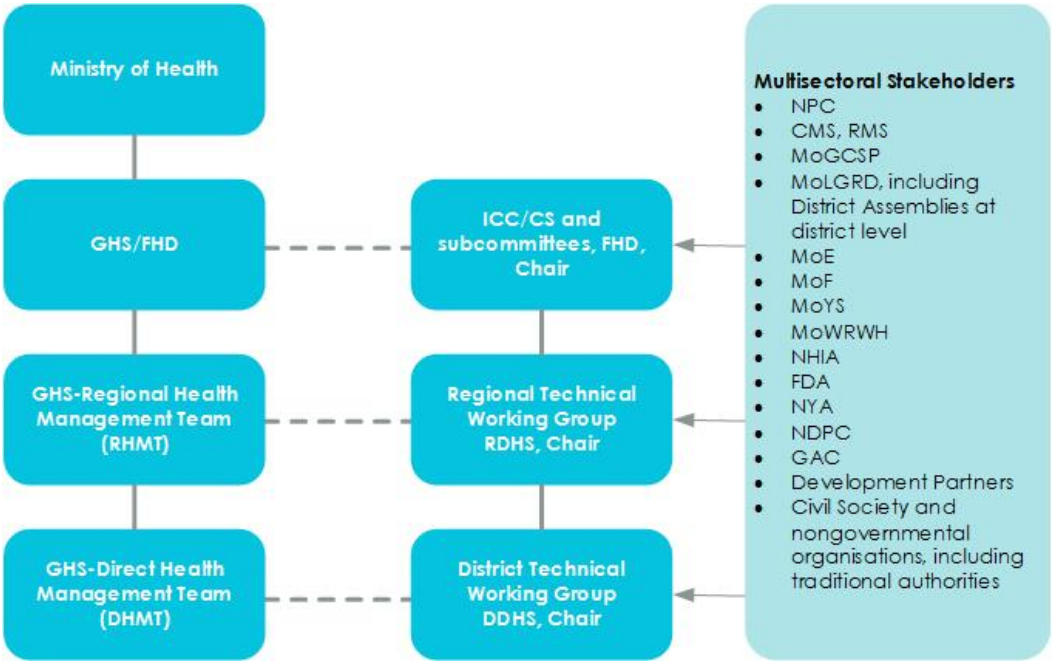
Management, Coordination, and Accountability Structure

The GFPCIP is the common master workplan for 2016–2020, based on which subnational workplans will be developed to help achieve the set targets of the FP programme. The GFPCIP encompasses all sectors within the FP landscape, including the private sector. To lead the implementation of the CIP, a streamlined management, coordination, and accountability structure will be adopted, as proposed in Figure 34: Proposed Coordination Structure.

The structure includes the following:

- Recognises that the MoH is the overarching body responsible for health and will be the steward to steer the planning, resource mobilisation, financing, implementation, and performance monitoring of the GFPCIP, leveraging existing government structures in collaboration with other key stakeholders
- Validates the high priority attached to family planning within government and the critical role it plays in harnessing demographic dividends for development and accelerating socioeconomic growth as the nation progresses towards achieving its medium- to long-term development goals
- Leverages existing FP operational structures such as the Regional Resource Teams to implement the activities in the GFPCIP
- Shows the broad-based approach needed for implementation of the GFPCIP, involving multisectoral stakeholders such as CSOs, CBOs, professional associations, FBOs, the private sector, development partners, and related ministries and agencies, amongst others
- Shows that the implementation of the GFPCIP will be decentralised to achieve results, with multisectoral stakeholders constituting regional and district-level management teams.

Figure 34: Proposed Coordination Structure



Roles and Responsibilities of Key Actors

Ministry of Health (MoH)—The MoH is responsible for ensuring oversight of the effective and efficient implementation of the GFPCIP. The MoH will perform its core functions in the GFPCIP through the PPME Directorate. The functions include executing performance management processes; ensuring accountability of resources provided for the roll-out of the GFPCIP; managing, coordinating, and monitoring implementation of the plan to ensure achievement of performance targets by national and international stakeholders; mobilising, monitoring, and ensuring efficient use of resources; developing policy frameworks and regulations that create an enabling environment to improve service delivery and access and ensure that policies are widely disseminated and implemented; setting guidelines and standards for programme operations and service delivery; and recruiting the necessary staff needed for implementation of the plan and providing capacity-building mechanisms.

Ghana Health Service (GHS)—GHS is an autonomous executive agency responsible for implementing approved policies for health delivery within the country. GHS will have direct oversight of implementation of the GFPCIP through its FHD and will mobilise resources for execution of the plan and monitor the progress of its implementation against targets set. GHS will also ensure better coordination capacity with other stakeholders, such as the mission hospitals, SMOs, and the private sector, to harness activities, leverage resources, and realise the multisectoral approach of the plan through enhanced partnerships.

National Population Council (NPC)—The NPC was set up by Act 485 of Parliament in 1994 as the highest statutory body to advise the government on population and related issues and ensure proper coordination and implementation of all population policies and programmes, including that of reproductive health. In 1994, a revised population policy was formulated. NPC was instrumental in the development of the GFPCIP. NPC will be responsible for coordinating FP stakeholders—including government agencies, donors, NGOs, and private sector players—in planning and reviewing implementation of CIP activities and harmonising resources mobilisation efforts.

Central Medical Stores (CMS) and Regional Medical Stores (RMS)—The CMS will ensure proper warehousing and storage of contraceptive commodities and other RH commodities and equipment for the MoH, GHS, and SMOs in line with its core mandate. The RMS will serve as the major suppliers

of contraceptive commodities for regions, districts, and health facilities by linking the CMS with the Regional Health Directorates and District Health Offices of GHS.

Ministry of Gender, Children and Social Protection (MoGCSP)—The MoGCSP has ministerial responsibility for formulating policies and directives to improve gender issues and the rights of children, and promote the protection of the marginalised and disadvantaged. The MoGCSP will ensure an enabling environment for agencies and departments involved in implementation of the plan, such as the Department of Gender, to perform their activities and also make available the resources for their functioning.

Ministry of Local Government and Rural Development (MoLGRD)—The MoLGRD will play a critical role in enabling effective and efficient implementation of the plan at the decentralised level. Cooperation and coordination of district implementation teams with district assemblies and local authorities will help to harness resources at the subregional level to enhance the efficient use of limited resources. The MoLGRD will also facilitate the use of social welfare staff at the district offices to support the FP programme through advocacy and information dissemination.

Ministry of Education (MoE)—The MoE provides policy direction for education of the youth and school children, and is a major stakeholder in the implementation of the plan. The MoE will foster strong interlinkages between its agencies and departments with those of MoH and other stakeholders involved in execution of the GFPCIP. It will create an enabling environment by clarifying grey areas in its policies regarding adolescent RH and monitor to ensure that its agencies and cross-linked departments, such as the GES and SHEP, implement approved policies to promote the rights of youth to information and services.

Ministry of Finance (MoF)—The MoF is responsible for mobilising funds and resources for government operations. It allocates funds to the various sector ministries according to priorities set by the GoG. Improved and enhanced engagement and coordination between MoH and MoF will ensure timely disbursement of funds for implementation of the GFPCIP. It will also enable the MoH to advocate for increased funding to support the plan by placing emphasis on the role of family planning in ensuring the achievement of the Medium- to Long-term Development Plan.

Ministry of Youth and Sports (MoYS)—The MoYS is responsible for developing policies to protect youth and the enabling environment for their development. Youth are a critical group covered in the GFPCIP; coordination and partnership with MoYS and its agencies, including the National Youth Authority, is essential to leveraging resources to implement the plan.

Ministry of Water Resources, Works, and Housing (MoWRWH)—The MoWRWH has responsibility over the building and housing sector. It will provide resources to strengthen its programming on housing deficit responses, linking it to population and engaging FP managers to collaborate and propagate FP information to help reduce future housing deficits.

Ministry of Food and Agriculture (MoFA)—The MoFA is responsible for oversight of the agriculture sector and food security, and provides policies and regulations to increase agriculture produce and make the country self-sufficient in its agriculture requirements. It will strengthen population-agriculture programming and disseminate information to communities about overpopulation, agriculture needs, and family health. Agriculture extension officers will play a valuable role in dissemination of information on family planning and managing a healthy family, and its benefits to farming activities and farming communities.

National Health Insurance Agency (NHIA)—The NHIA secures and regulates the implementation of the national health insurance policy and implements the NHIS, which will provide insurance for registered members to access free FP services when the scheme includes family planning in its outlay of benefits. It will also maintain good cooperation with service providers and deliver timely reimbursements to ensure uninterrupted FP service delivery and realise greater access to family planning.

Food and Drugs Authority (FDA)—The FDA will provide regulatory oversight to ensure that quality contraceptives and other reproductive commodities are marketed and made available for use by clients. It will also improve engagement with programmes to ensure better cooperation, resulting in the timely registration of commodities.

National Youth Authority (NYA)—NYA is mandated to support the development and implementation of policy frameworks for the youth of the country. It is also involved in ensuring that their rights are protected. The NYA can support dissemination of FP information and an integrated approach to activities, which will help in realising some of the outputs of the plan.

National Development and Planning Commission (NDPC)—NDPC was established in 1987 and ensures the effective implementation of approved national development plans and strategies, coordinates economic and social activities countrywide, and works with sector ministries to integrate family planning into annual programmes and budgets. NDPC understands the important role of family planning in harnessing demographic benefits and can prioritise it in its Long-term Development Plan for Ghana, currently under development.

Ghana AIDS Commission (GAC)—The GAC is a supra-ministerial body, under the Office of the President, mandated to develop HIV/AIDS policy and lead the national response. It guides and coordinates donors, NGOs, FBOs, and CSOs involved in the national response against HIV/AIDS. The GAC also mobilises resources for condoms procurement for HIV prevention.

All other ministries, government agencies, enterprises, and corporations will also play active roles in mainstreaming the youth reproductive health and population-related agenda in their workplaces, as outlined in the GFPCIP document, and contribute to improvement in access to FP/RH information, education, and services in Ghana.

The Ghana Coalition of NGOs in Health (GCNH)—GCNH fosters networking and information sharing amongst CBOs/NGOs in the health sector in Ghana as well as amongst international partners, and provides a forum to carry out evidence-based advocacy and campaigns for health. This coalition is active in providing advocacy for family planning at the regional and district levels. It has members across the country and can be leveraged to expand awareness creation.

Christian Health Association of Ghana (CHAG)—CHAG is a coalition of FBOs having mission facilities, a number of which provide FP services. They are critical in the health delivery sector—in many districts they are patronised as much as public institutions. They need to be engaged further to improve integration of FP services, particularly in Catholic facilities.

Parliamentarians—Parliamentarians will foster general awareness on population issues at all levels in the country and lobby for the inclusion of family planning in government priority programmes. The Parliamentary Select Committee on Health will advocate for an enabling environment, including promoting increased investments in FP projects, and advocate for members of Parliament to speak on FP issues in their constituencies. This committee can also provide oversight of GFPCIP implementation, review progress reports, and lead in advocating for reduced or removal of taxes on FP commodities and supplies.

Research and academia—Research and academic institutions play an integral role in efforts to increase the awareness and use of FP services through technical guidance, research, and training of future health professionals. Academic institutions will integrate family planning into a wide range of programmes, especially in pre-service institutions for service providers. Research institutions will be encouraged to generate new research evidence to improve operational performance and quality-of-service delivery, and disseminate research upon which policymakers can make evidence-based decisions.

Professional associations and councils—Through various professional regulatory bodies and technical agencies, the MoH will monitor compliance with the laws and set standards guiding health

professionals to work ethically and uphold the tenets of their profession. These bodies include the Medical and Dental Council (MDC), Pharmacy Council, Nurses and Midwives Council, Allied Health Professional Council, Ghana Medical Association, Society of Private Medical and Dental Practitioners, Pharmaceutical Society of Ghana, Community Practice Pharmacists Association, Ghana Registered Nurses Association, and Public Health Nurses Association, amongst others. These councils can incorporate learnings on FP education in their continuing medical education sessions. These professional associations and practice groups can also organise lectures or invite resource persons to provide information on family planning so they can be educated to provide informed awareness to the public.

Development partners—Development partners and UN agencies are key pillars of the successful implementation of the GFPCIP, as they are critical to providing the necessary financial resources, technical support, and commodity supplies. Development partners and UN agencies will collaborate closely with the government and take a keen interest in monitoring the progress of GFPCIP implementation. Key roles and responsibilities include supporting the modalities of the national response that government partners see as priority challenges in the absence of insufficient resources and/or technical expertise; they will make firm commitments to support areas of the GFPCIP in line with their scope and workplans. Key development partners and donors supporting FP activities include USAID, UNFPA, DFID, and the West African Health Organisation (WAHO), amongst others.

Civil society—Civil society includes a diverse group of organisations, including NGOs; FBOs; cultural, local, and international organisations; traditional authorities; media; private sector organisations; and academia. Collectively, civil society plays an instrumental role in advocacy to drive awareness and demand creation, accelerate access to FP services, and provide various levels of services. These groups will be particularly valuable in supporting community-level activities; thus, coordination and partnership, particularly at the subnational level, is needed to harness resources to implement the plan. Another important role will be to serve as ombudsmen, to ensure social accountability and responsibility in implementation of the GFPCIP so limited resources are utilised judiciously and efficiently. Civil society can also advocate for the amendment of laws and policies, such as harmonising the roles of the FDA and the GSA to avoid duplication of regulatory activities and reduce undue bureaucratic delays.

Coordination Framework

The diversity and multisectoral complexity of the GFPCIP calls for critical harmonisation of resources and activities. A coordination framework should critically align roles and responsibilities so as to result in improved outputs, the ability to better track progress and milestones, and improve overall programme efficiency; this will also prevent duplication of efforts and the waste of human and capital resources.

Since the GFPCIP has adopted a decentralised approach, the coordination structures at the national, regional, and district levels must be clarified. The strategic priorities and activities of the GFPCIP will guide the development of regional and district plans based on the national one. The GFPCIP should be integrated and harmonised with other health and non-health sector programmes. The coordination management at the district level should also involve resource mobilisation to support the subnational plan budget, identifying funding gaps and advocating for increased funding from donors and central government for the gaps while focusing the limited resources available on priority results.

National Level

Inter-agency Coordinating Committee for Commodity Security (ICC/SC)—The ICC/CS was created to provide a platform to bring together stakeholders and organisations to coordinate and manage commodity security and quantify contraceptives requirements. Through the ICC/CS, an annual national (excluding the commercial sector) quantification exercise on contraceptives, including condoms, is undertaken and reviewed biannually with key stakeholders. Quantification is done for

public and SMO-sector commodities. The ICC/CS meets quarterly, in addition to specific quantification meetings held biannually. The ICC/CS, through its subcommittees, will play a crucial role in implementation of the GFPCIP.

The ICC/CS principally will be responsible for reviewing regular reports on GFPCIP progress from the working group, in addition to its functions of providing a platform for FP dialogue and ensuring that commodity security remains within national requirements to prevent stockouts and gluts. It will continue to lead quantification, but its subcommittees will play instrumental roles in implementation of the GFPCIP. The ICC/CS will work to achieve efficiencies and the collective effectiveness of different stakeholders by clarifying roles and responsibilities for implementation, including donor commitment areas, creating stronger synergies amongst implementing partner efforts, optimising the flow of information across different stakeholders, and requiring accountability for performance and results from all partners and implementers for the overall success of GFPCIP implementation.

Subcommittees of the ICC/CS—As detailed in the activity matrix, the following subcommittees of the ICC/CS will be reinvigorated or formed: SBCC; Access/Quality care; Finance and advocacy; PLS (formerly Logistics); M&E; Youth reproductive health; and Condoms and lubricants. Based on terms of reference (TORs), the subcommittees will meet monthly or quarterly, in addition to specific ad-hoc meetings detailed in the GFPCIP.

Subnational Implementation

The implementation framework of the GFPCIP emphasises decentralised plan implementation; thus, subnational managers and others need to be capacitated to manage the programme effectively and efficiently at the lower levels. Regions will have increased responsibilities for scaling up family planning through better planning, resource allocation, implementation, monitoring, and evaluation with local government authorities at the district and community levels. The MoH and GHS will work with partners to provide guidance and technical assistance to regions and districts to facilitate the translation of GFPCIP activities at the regional and district levels. Specific planning and engagement will happen at the regional level to develop costed regional workplans for 2016–2020 aligned to the national GFPCIP. Engagement of District Chief Executives and local authority departments, such as planning and education, and coordination with other sector players will be essential to the subnational implementation of the GFPCIP.

Regional Level

A similar coordination structure to the ICC/CS will be replicated at the regional level with a Regional Technical Working Group (TWG) chaired by the Regional Director of Public Health. The Regional Resource Team will provide guidance and training of lower-level staff and will work with the Regional FP coordinator to implement the CIP. TORs for the Regional TWG will be developed, as detailed in Annex A. Implementation Framework with Full Activity Detail. The coordinator will send monthly reports to the working group, which will in turn submit reports to the national level on regional activities and progress.

District Level

A similar coordination structure will also be developed at the district level. There will be a District Technical Working Group (TWG), chaired by the District Director of Public Health. TORs for the district TWG will be developed, as detailed in Annex A. Implementation Framework with Full Activity Detail. The district FP coordinator will coordinate activities and implementation of the CIP based on the modified plan for the district, with support and guidance from the district TWG. The coordinator will send monthly reports to the district steering committee, which then will forward the reports to the region.

Resource Mobilisation

Resource mobilisation will be key to the effective and successful implementation of the CIP. Before the start period of the GFPCIP in early 2016, a forum will be held for key stakeholders and partners to

make commitments for responsibility and implementation of GFPCIP activities. During this meeting, government agencies and development and implementing partners will agree to their roles and responsibilities for various results and activities, and complete the column headed "Lead and Collaborating Organisations" in Annex A.

Additionally, as described in the financing section of the GFPCIP, an annual gap analysis will be conducted, starting in early 2016, to identify unfunded gaps. A plan will be developed to raise resources, categorising results according to level of priority. The framework will explore a number of strategies, which may include developing proposals to new donors for support, increasing advocacy at the district level for increased allocation of funds to family planning, engaging CSOs to support advocacy for parliamentary support for increased funding, mobilising resources and support from the private sector, harnessing resources from other sectors or programmes and leveraging ongoing activities, and increasing the efficient use of funds.

Performance Monitoring and Accountability

The effective implementation of FP services requires putting in place a systematic performance M&E mechanism to set programme targets, track performances, evaluate achievements, and provide information for timely decision making. In addition to supporting evidence-based decision making, M&E systems also provide health institutions with an opportunity to benefit from supportive supervision by upper-level institutions to assess areas for improvement, train staff on the job, and jointly solve identified issues.

To support successful implementation and achievements of CIP goals and objectives, the following four interlinked M&E components will be implemented systematically:

- Routine data collection through DHIMS
- Performance review and quality improvement
- Integrated supportive supervision
- Evaluation and operations research

The four components of the FP M&E process will be integrated into the overall health sector M&E systems. The **routine data collection** and aggregation process will utilise DHIMS to provide a summary of key FP programme performance indicators and analytical reports. Routine data collection and aggregation will serve as an input for performance review and quality improvement, during which priorities that need more emphasis during supportive supervision will be identified. Service utilisation data collected through DHIMS and administrative reports will be supplemented by data from the Track20 and Performance, Monitoring and Accountability 2020 (PMA2020) initiatives and from the expected 2019 DHS.

FP programme **performance review and quality improvement** will track and analyse performance against the detailed CIP implementation activity matrix. Based on the matrix, the performance review process will review the adequacy of achievements against the activities and targets set for the period under review. The performance review will be conducted regularly on a quarterly and annual basis in the form of review meetings at the health facility, district, regional, and national levels. The process will include review of achievements on priority activities, sub-activities, and performance indicators to identify root causes of performance gaps and take improvement actions regularly at the health facility level and all levels of health management. QI in health facilities includes using locally available data to improve the provision of quality FP services through a continuous process of measurement, assessment, and improvement.

Integrated supportive supervision of the FP programme will entail guiding, training, and encouraging staff to improve their performance to provide high-quality FP services. The supervision sessions will aim to assess and provide support on the major components of rights-based FP services

and the health system in a structured manner. It will be cascaded from national to regional, district, and facility levels using trained subject matter specialists and programme experts.

FP programme **evaluation and operations research** will complement other components of routine monitoring by systematically collecting, analysing, and interpreting data about FP programme activities and the impact and outcome of the programme to answer specific evaluation questions. FP programme evaluations may be conducted as process evaluations to examine the appropriate execution of CIP components or as outcome evaluations to assess the overall impact of the FP programme.

Several categories and levels of key FP programme outcome and output indicators will be collected to track implementation of the CIP. A comprehensive list of output-based indicators is included in Annex A. Implementation Framework with Full Activity Detail. A summary list of the key outcome indicators to use as a monitoring dashboard is included in Table 18: List of Key Outcome Indicators.

The key performance indicators are based on the strategic priorities and activity results. The process indicators will show when and if activities have been completed. These indicators will help assess implementation progress and will be presented in a dashboard format to make for easy viewing and interpretation, and provide a clear snapshot view of the programme's status. The data sources for these key outcome indicators are listed in Table 18: List of Key Outcome Indicators; during data collection and monitoring, the preference will be to use local data sources wherever possible.

The MoH and GHS will organise biannual performance review meetings with representatives of the regions in attendance and a select number of District FP Coordinators (including some who have made great progress on dashboards and others who have fallen below their targets). These meetings will be held to assess progress and obtain information on challenges, proffer solutions, and share best practices, as well as agree on priorities for next six-month period. The performance review meeting will also help to assess planning and programming, and incorporate recommendations into the next annual plan.

A mid-term review of the CIP implementation will also be conducted midway into the process; a stakeholder forum will be held to review the report and recommendations so changes can be made to make improvements for the remaining implementation period.

Table 18: List of Key Outcome Indicators

Category	Indicators	Data Source
Programme outcome indicators	TFR	DHS, PMA2020, Track20
	CPR, total	DHS
	CPR, modern methods	DHS, PMA2020, Track20
	Adolescent birth rate	DHS, PMA2020, Track20
	Teenage pregnancy rate	DHS
Demand creation	Mean desired family size	DHS
	Total demand for family planning • Demand for limiting • Demand for spacing	DHS, PMA2020, Track20

Category	Indicators	Data Source
	Percentage of women with an unmet need for modern methods of contraception	DHS, PMA2020, Track20
	Percentage of women reporting exposure to FP messages on radio, television, or in print in the past 12 months	DHS, PMA2020, Track20
	Percentage of the population who know of at least one source of contraceptive services and/or supplies	DHS, PMA2020
	Percentage of births in the past 5 years to women who report that the pregnancy was mistimed (wanted later) or unwanted	DHS, PMA2020
Service delivery	Number of acceptors new to modern contraception (New acceptors)	Administrative report, DHIMS
	Percentage of women whose demand is satisfied with a modern method of contraception	DHS, PMA2020, Track20
	Percentage distribution of users, by modern method of contraception	DHS, PMA2020, Track20
	CYP	Administrative report, DHIMS
	Source of supply (by method)	DHIMS, DHS, PMA2020, Track20
	Number of contraceptive methods available at a specific health facility	DHS, PMA2020
	Proportion of health facilities that provide an all-contraceptive method mix	DHS, PMA2020, Track20
	Number of CHWs and providers trained on FP service delivery, by district, region, and methods	Administrative report, DHIMS
	Percentage of women who were provided with information on family planning during their last visit to a health service provider	DHS, PMA2020, Track20
	Contraceptive discontinuation, switching, and failure rates in last 12 months	DHS, PMA2020, Track20
Contraceptive security	Medical stores that experienced contraceptive stockouts in the last 12 months • Central medical store • Regional medical stores	DHIMS, PMA2020, Track20
	Percentage of facilities that experienced a stockout in the last 12 months	DHIMS, PMA2020, Track20
	Percentage of key personnel trained in contraceptive logistics	DHIMS, PMA2020, Track20
Policy and enabling environment	Proportion of districts that have disseminated and provided the latest population policy document addressing fertility and family planning	Administrative report

Category	Indicators	Data Source
	Proportion of regions that have a regular quarterly FP coordination meeting	Administrative report
	Number of ministries and agencies that established and implemented a regular multisectoral coordination structure to promote and advance FP policy	Administrative report
	Number of FP best practices documented and disseminated	Administrative report
Financing	Expenditure on family planning from government domestic budget	Administrative report, Track20, NHA/SHA
	Expenditure on family planning as a percentage of total health expenditure	Administrative report, Track20, NHA/SHA
	Expenditure on contraceptive commodities from government domestic budget	Administrative report, Track20, NHA/SHA
	Public sector resources allocated to family planning as percentage of GDP	Administrative report, Track20
	Public sector share of resources allocated for contraceptive procurement	Track20, Administrative report
	Percentage of recent/current users who have paid any fees for FP services in the past 12 months	DHS, PMA2020, Track20
Stewardship, management, and accountability	Number of government-led multisectoral FP coordination meetings conducted annually • National level • Regional level	Administrative report
	Number of FP best practices identified, documented, and scaled up to improve programme management and outcomes	Administrative report
	Number of civil society organisations that received technical and logistic support to advance the FP programme at the national, regional, and community levels	Administrative report
	Number of FP accountability mechanisms designed and implemented at all levels	Administrative report

ANNEX A. IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL[221]

Area 1: Demand Creation (DC)

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
DC1. Multipronged rights-based SBCC strategy developed based on evidence and situational assessment of current SBCC to improve the sociocultural environment for reproductive health and family planning, including behavioural factors and social and gender norms	SP 1	DC1.1 Gather evidence and data to inform an SBCC strategy and materials to ensure honest, accurate, clear, and consistent FP messaging that reflects reproductive rights and targets various audiences (including, but not limited to the following: rural/urban young people, married youth, adolescent girls and young women, men, PLHIV, people with disabilities, FBOs, sex workers, male-focused interventions targeting non-paying partners of female sex workers (FSWs) (not as appendages of existing sex worker interventions), young people in mining areas, internally displaced persons (IDP)—youth, young people with disabilities, commercial sex workers, young people in and out of school, HIV-positive young people, and other vulnerable groups (including key population groups, and others), with the full participation and	Engage a research team to do the following: Conduct assessment and analysis of DC initiatives implemented to date Identify best practices on FP mobilisation and SBCC Conduct assessment and analysis of existing myths and misconceptions about family planning Identify which SBCC initiatives worked well in addressing myths and misconceptions so far and which ones did not Assess people's knowledge of their rights to family planning Evaluate why the current messaging is not resonating with all groups of people Develop scale-up plan and scale up best practice communication initiatives	• Assign 5 government or implementing partner staff, 30 days each • Facilitate transport and daily allowance for 5 people, 15 days each • Hold 4 stakeholder meetings to review findings, best practices, and scale-up plans, 50 people • Print research report evaluating current messaging and existing myths and misconception on family planning, 100 pages, 100 copies	Report of the assessment and best practices completed	2016	GHS* (Health Research Division and FHD), NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		consultation of these communities[222] Assess existing myths and misconceptions about family planning amongst young people, people with disabilities, commercial sex workers, young people in and out of school, other vulnerable groups and key population groups					
		DC1.2 Develop one evidence-based national comprehensive SBCC strategy to give direction to rights-based FP DC activities, including revised branding and messaging; use new communication channels such as social media[223]	Engage a small team to guide the SBCC subcommittee to review the previous communications strategy, develop an SBCC strategy, and develop and test key communication messages for all audiences (this will include the public sector, leading a generic condom promotion campaign and the relaunch of Be Safe, and a re-branding of generic condoms to counter effects of product recall in 2013)	• Assign 3 implementing partner staff, 60 days each • Hold 4 SBCC subcommittee meetings, 30 people • Hold 20 message-testing workshops in regions,15 participants • 12 days of travel for 3 people to conduct message-testing workshops	FP SBCC strategy developed and approved	2016	GHS,* NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		DC1.3 Disseminate the comprehensive SBCC strategy[224]	Print and disseminate SBCC strategy to orient stakeholders	• Print SBCC strategy, 50 pages, 500 copies • Hold 2 full-day national dissemination meetings, 50 people each (segmentation of participants for dissemination: (1) partners and stakeholders; Regional Health Promotion Officers, Regional Public Health Nurses, and Deputy Directors of Public Health; (2) participants conduct a downstream dissemination at the regional level for Health Promotion Officers/Health Promotion focal persons, District Public Health Nurses, and Municipal/District Directors of Health Services • Hold 10 half-day regional dissemination meetings, 20 participants	SBCC strategy printed, distributed, and posted to GHS website (target: 500) National and regional dissemination meetings for SBCC strategy held (target: 2 national, 10 regional)	2016	GHS,* NPC, SBCC subcommittee, development partners, NGOs
DC2. Improved use of tailored media and communication materials for FP education	SP 1	DC2.1 Collaborate with partners to develop a mass media campaign on family planning based on SBCC strategy[225]	Develop context-specific communication materials, Q&As, flyers, audio visuals, posters, brochures, billboards, etc. in 4 local languages	• Hire a media production firm to create and produce materials, 60 days in 2016 and 60 days in 2018 • Hold 6 1-day stakeholder meetings, 30 people (3 meetings in 2016 and 3 in 2018)	Communication materials, drama, Q&A, audio visuals, flyers, posters, brochures, billboards, etc. in 4 local languages developed	2016 2018	GHS,* NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		DC2.2 Design FP messaging targeting under-served and marginalised groups of young people (including those with disabilities)	Develop awareness creation and communication materials that address the needs of under-served and marginalised groups of young people—addressing needs of vulnerable and key populations	• Assign a government or implementing partner staff to develop FP messages that address the needs of under-served and marginalised young people, 30 days • Hold 3 consultations with marginalised young people to receive feedback at initiation stage to review FP messages, and final materials, 20 people • Hold 2-day SBCC and youth subcommittee meetings to review and finalise messages, 30 people	Awareness creation and communication materials that address the needs of under-served and marginalised young people developed	2016	GHS,* NPC, Youth subcommittee, SBCC subcommittee, development partners, NGOs
		DC2.3 Design FP messaging targeting men, aligned with ongoing gender programming	Develop awareness creation and communication materials targeting men – messages that encourage male involvement in family planning, male partners accompanying women to FP clinics, discourage men's desire for large family size and unprotected sex, initiating discussions on family planning, etc.	• Assign government or implementing partner staff to develop FP messages that address men, 30 days • 2-day SBCC subcommittee meetings to review and finalise messages, 30 people	Awareness creation & communication materials that address the needs of men developed	2016	GHS,* NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		DC2.4 Ensure that all SBCC materials address social, cultural, and regional variation	Conduct regional workshops to review and adapt SBCC materials Translate relevant SBCC materials into local languages	• Hold 10 regional workshops biannually to adapt to local social/cultural norms and local language, ensure inclusion of community representatives, including young people, 40 people • Translate and print select materials in 4 local languages, 4 fliers, 10,000 copies each per language; 2 posters, 1,000 copies each per language	Number of regional workshops to review and adapt communications materials (target 10 biannually)	2017 2019	GHS,* NPC, development partners, NGOs
		DC2.5 Pre- and post-test all FP materials	Conduct regular pre- and post-test of all FP media and communication materials before dissemination	• Assign 2 FHD/NPC staff to pre- and post-test materials, 40 days annually • Transport and daily allowance for field pre- and post-test by 2 staff from FHD/NPC (4 days for each test, 10 materials tested each year)	Communication materials pre- and post-test report (target: 10 annually)	2016 2017 2018 2019 2020	GHS,* NPC, development partners
		DC2.6 Disseminate materials[226]	Disseminate context-specific communication materials	• Print fliers, 200,000 annually • Print posters, 50,000 annually • Post billboards, 15 annually	Number of communication materials: flyers, posters, and billboards disseminated (target: 200,000 fliers; 50,000 posters; 15 billboards annually)	2016 2017 2018 2019 2020	GHS,* NPC, development partners, NGOs, CSOs, media, private sector
			Purchase media space for FP mass media message dissemination[227]	• Buy 2-minutes of ad space on radio and TV to play during prime time, quarterly • Buy 30 minutes of air time	Number of radio and TV spots purchased and aired (target: 5 radio spots and 3 TV	2016 2017 2018	GHS,* NPC, development partners, NGOs, CSOs, media, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				to host quarterly discussion sessions on radio and TV	spots quarterly, 1 longer discussion on radio and TV quarterly)	2019 2020	
			Orient journalists (including TV and radio presenters) on selected FP thematic topics, including SRH and rights and development for young people[228]	• Hold a meeting to develop material to train journalists on family planning, 20 people • Print 100 pages, 20 copies • Annual full-day workshops for journalists, 50 people per meeting • Print 50 pages, 50 copies	Materials developed to train journalists Number of journalists oriented on rights-based family planning (target: 200)	2016 2017 2018 2019 2020	GHS,* ICC/CS, NPC, development partners, NGOs, media
		DC2.7 Promote use of local information system and mobile vans in communities to disseminate FP information	Allocate budget to cover the cost of air time for local information system and rent mobile vans to promote FP messages	• Buy 2 minute ad space on local radio to play during prime time, three times quarterly, 20 districts in year 1, 50 in year 2, 100 in year 3, 216 in year 4 • Rent mobile van time, 10 days/year, 20 districts in year 1, 50 in year 2, 100 in year 3, 216 in year 4	Number of districts using local information system to disseminate FP information (target: 216 by year 4) Number of districts using mobile vans to deliver messages (target: 216 by year 4)	2017 2018 2019 2020	GHS,* Regional Health Management Team (RHMT), District Health Management Team (DHMT), development partners, NGOs, CSOs, media
DC3. Innovative media initiatives used to create demand for FP services	SP 1	DC3.1 Use social media and other innovative and locally appropriate communication and media channels to create demand for family planning[229]	Develop social media platforms	• Assign implementing partner staff to develop social media platform and train staff, 60 days	Social media platform developed Staff trained	2016	GHS,* NPC, SBCC subcommittee, development partners, NGOs
			Disseminate tailored FP information using social media and regularly conduct discussion forums	• Assign NPC and GHS experts to provide FP information weekly to social media coordinator, 2 hours, weekly • Social media coordinator	Weekly social media forum conducted (tweet chats, Google hangouts, Facebook	2016 2017 2018 2019	GHS,* NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				to host weekly forum and post daily messages, 100 days annually • Procure 1 laptop, 1 smartphone	discussions, etc.) FP messages posted on social media pages daily	2020	
			Design and test other innovative communication and media initiatives	• Hold 1-day SBCC subcommittee meeting to brainstorm on innovations, 30 people • Hire IT consultant to develop innovative media, 30 days each for 3 years	Number of innovative communication and media systems designed (target: 2 annually)	2018 2019 2020	GHS,* NPC, SBCC subcommittee, development partners, NGOs
DC4. Ethical use of media and advertisement on family planning practiced		DC4.1 Develop and implement guidelines on ethical and appropriate use of media for FP promotion	Develop a guideline on use of media for FP promotion by the public and private sectors to discourage promotion of single FP methods and unethical messaging	• Assign government or implementing partner staff to develop media use guidelines for FP messaging, 30 days • Hold 2-day guideline development consultation workshop, 30 people • Print and disseminate copies of the guidelines, 50 pages, 200 copies	Media use guideline developed Number of copies printed and distributed (target: 200)	2016	GHS,* NPC, Media Commission, FDA, SBCC subcommittee, development partners, NGOs
			Enforce and monitor implementation of the guidelines in collaboration with FDA	• FDA, NPC, and GHS to assign focal people to follow up implementation of the guidelines, 3 days each annually	Biannual reporting to ICC/CS on implementation of the guidelines	2017 2018 2019 2020	GHS,* NPC, FDA
		DC4.2 FHD, Health Promotion Department (HPD), and FDA to collaborate to review guidelines for approval of SBCC materials	Hold a workshop to create shared consensus from HPD policy and FDA policy on approval of FP advertisements	• Hold 1 2-day workshop, 15 participants	Policy synergy on FP advertisements and materials	2016	GHS,* FDA, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			FP/RH materials review committee to meet to review and make recommendations on FP materials to ensure that marketing slogans and messages in media campaigns are accurate and appropriate	• Review committee (FDA, NPC, FHD, media agency) to meet for 1 day every quarter to review materials and make recommendations, 10 participants	Number of review committee meetings (target: 20) Number of communication materials reviewed and approved or declined (target: at least 10 annually)	2016 2017 2018 2019 2020	GHS,* FDA, development partners, NGOs
			Train private and public sector media professionals (print, audio-visual, etc.) on ethically appropriate use of media for FP promotion	• Hold 1 national orientation meeting, 50 participants • Hold 3 zonal dissemination meetings, 50 participants	Number of media oriented (target: 200 people annually, 2 years)	2016 2019	GHS,* NPC, development partners, NGOs, media
			Orient relevant organisations, HWs, and stakeholders to disseminate information through media and other channels	• Hold national orientation workshop, 50 people • Cascade training to all 10 regions, 50 people per region	Number of people trained (50 nationally, 500 regionally)	2017	
DC5. All CHPS CHNs, CHOs, and CHVs are trained on rights-based FP DC and supplied with materials to improve CHPS capacity for rights-based FP demand creation	SP 6	DC5.1 Complete training of all CHPS CHNs, CHOs, and CHVs on rights-based FP DC so they understand FP rights and can correct myths and misconceptions	Identify areas of skill gaps and unfavourable attitudes of FP service providers that inhibit demand for FP commodities, (e.g., inability to properly address issues of client myths and misconceptions)	• Assign 2 government or implementing partner staff, 20 days each • Facilitate transport and daily allowance for travel to regions, 2 people, 10 days each	Report on assessment of knowledge and skill gaps of HWs	2016	GHS,* development partners, NGOs
			Engage qualified and experienced communication experts to design training approach to contextualise in-service refresher training (ensure	• Assign 2 government or implementing partner staff, 30 days each • Hold 1-day meeting, 30 participants • Print 50-page	Revised and updated DC training guide	2016	GHS,* MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			that patients' charter and RH rights issues are included)	document, 15,000 copies			
			Provide in-service training on rights-based FP DC for all CHNs, CHOs, and CHVs, including on how to host community dialogues	• Hold 3-day central training workshops for Regional Resource Teams and other HWs, 100 people trained in total • Regional Resource Teams to conduct in-service training on rights-based FP DC to train 1,000 people annually (cost included in regular supportive supervision visits)	Number of CHNs, CHOs, and CHVs trained on rights-based FP DC (target: 5,000)	2016 2017 2018 2019 2020	GHS,* RHMT, development partners, NGOs
		DC5.2 Supply all CHPS compounds with job aids, communication materials, and necessary supplies for community education on FP	Develop standard FP folder/communication tool for use by CHWs and CHVs	• Assign government or implementing partner staff to develop community-level FP messages for CHNs, CHVs, and households, 20 days, • 1-day SBCC subcommittee meeting to review messages, 30 people	Communication tools and community- level FP messaging developed	2016 2017	GHS,* development partners, NGOs
			Print and distribute FP communication materials and job aids to all CHPS compounds	• Print standard FP folder/communication tool for use by CHWs and CHVs, 10,000 copies • NPC and GHS to organise distribution mechanism, including utilising partners to support dissemination	Number of materials printed and distributed to all CHPS compounds (target: 10,000 copies)	2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
DC6. Mhealth		DC6.1 Pilot Mhealth	Design locally appropriate	• Assign government or	Mhealth messages	2017	GHS,* NPC, SBCC

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
technology piloted for household-level use		technology at household level for use as a communication tool by CHNs, CHOs, and CHVs	Mhealth messaging on family planning	implementing partner staff to develop Mhealth FP messages, 20 days • 1 full-day SBCC subcommittee meeting to review messages, 30 people	developed		subcommittee, development partners, NGOs
			Pilot test in select CHPS compounds	• GHS and NPC to select pilot region • Hold half-day initial training in 4 areas, 50 participants per training • 1 server, 2 GSM modems, 3 laptops, 125 phones • Assign implementing partner staff to function as project coordinator, 1 technical staff, IT coordinator, 1 year each • Airtime for texting and calls	Mhealth FP messaging pilot tested in 4 selected districts	2017	GHS,* NPC, SBCC subcommittee, development partners, NGOs
			Evaluate pilot test	• Hire a consultant to conduct a rigorous evaluation with a comparison group, including examination of FP knowledge and practices, to assess the programme, 60 days • Facilitate transport and daily allowance for 2 people, 30 days each		2018	GHS,* NPC, SBCC subcommittee, development partners, NGOs
			Scale up Mhealth technology for FP messaging and DC	• Assign implementing partner staff to function as project coordinator, 2 technical staff, IT coordinator, annual salaries • Airtime for texting and	National-level scale-up	2018 2019 2020	GHS,* NPC, SBCC subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				calls • Establish toll-free number			
DC7. Strengthen role of champions, FBOs, religious leaders, civil societies, & opinion makers to create enabling environment for increased demand for FP services and products	SP 5	DC7.1 FP champions and satisfied clients cultivated and engaged in national campaigns and DC activities[230]	Identify national and local FP champions and other key public figures drawn from Ministry of Chieftaincy Affairs, National Commission for Civic Education (NCCE), Information Services, chiefs, queen mothers, youth leaders, and women leaders, etc.	• SBCC subcommittee led by NPC and GHS to vet the national ambassadors, regularly scheduled meeting	2 national champions; 1 local champion for each region mentored	2016 2019	NPC,* GHS, MoH, National House of Chiefs, Parliament, SBCC subcommittee, RHMT, development partners, NGOs
			Develop specific responsibilities and activities[231]	• SBCC subcommittee to develop TOR, regularly scheduled meeting	TOR/scope developed	2016 2019	NPC,* SBCC subcommittee
			Organise national and local events to officially appoint national and local FP champions and ambassadors	• Hold national events, 70 participants	Number of national champions appointed (target: 10) Number of local champions appointed (target: 10, 2 per region)	2016 2018	NPC,* GHS, MoH, National House of Chiefs, Parliament, SBCC subcommittee, RHMT, development partners, NGOs
			Provide technical support, monitor roles, and mentor champions regularly, with a focus on including knowledge of RH rights [232]	• Hold 2-day biennial review and capacity-building update training meeting with champions, 50 participants • Print training documents, 50 pages, 50 copies • Print certificates of appreciation, 30 copies	Number of biennial review meetings Capacity- building update training held biannually Number of certificates issued (target: 30)	2017 2019	NPC,* GHS, MoH, National House of Chiefs, Parliament, SBCC subcommittee, RHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		DC7.2 Build institutional capacity of community-based religious & faith based organisations & CSOs, based on their need to promote the reduction of stigma & raise awareness on FP and RH rights	Assess institutional capacity and needs of local religious and faith based organisations to provide FP education and prioritise those that need support	• FHD and NPC to do rapid assessment of capacity of local organisations and prioritise those needing strategic support, assign 2 staff, 20 days	A report and recommendation of the assessment of local organisations	2016	GHS,* NPC, development partners, NGOs, FBOs
			Update and print audio-visual communication materials to build capacity	• Assign 4 government or implementing partner staff to develop updated communication materials for local religious FBOs and CSOs, 40 days each • Print communications document, 20 pages, 2,000 copies biennially • Print posters, 1,000 copies	Local organisations supported and supplied with office supplies, audio-visual materials, guidelines, and manuals	2017 2019	GHS,* NPC, development partners, NGOs
			Provide continuous mentorship and monitor performance	• Hold national biannual review meeting with local organisations being supported, 30 participants • Hold 10 regional workshops biennially, 30 people	Number of review meetings annually (target: 2) Number of regional workshops conducted (target: 30)	2016 2017 2018 2019 2020	GHS,* NPC, development partners, NGOs
DC8. FP/contraceptive education included and fully implemented as part of the life skills teaching curriculum provided in junior and senior high schools, with improved capacity of relevant teachers	SP 2	DC8.1 Review and update FP component of life skills education curriculum and build capacity of relevant GES staff, SHEP coordinators, and teachers, and implement in all colleges of education and higher learning institutions per the	Review and update the complementary modules for life and livelihood skills education in schools, using infusion and integration methodology and targeting specific age groups (pre-adolescents, younger adolescents, youth), focusing on gender and power dynamics in the	• Coordinate with PEE advocacy activities; coordinate with academia • Hire consultant to facilitate review and update modules and materials, focusing on gender and power dynamics in the content, 90 days	Modules reviewed and updated Curriculum updated to include use of infusion and integration approach	2016	GES,* GHS, NPC, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
to deliver FP/contraception education		revised content[233]	content,[234] and based on identified gaps following the evaluation of the levels of integration in existing modules or curriculum	• Hold 3 1-day consultative meetings with stakeholders, 50 participants			
			Engage relevant stakeholders and engage and support SHEP coordinators in directing RH education in schools	• Hold 5 meetings at GES office • Included in other sub-activities	Relevant stakeholders active in process	2016	GES,* GHS, NPC, development partners, NGOs
			Orient school management committees (SMC)/parent-teacher associations (PTA) executive members	• Hold district orientations for SMC/PTA executive members, 50 people per meeting, to cover 900 secondary high schools and 13,082 junior high schools[235]	Number of SMC/PTA executive members oriented (target: 27,844)	2016 2017 2018 2019 2020	GES,* GHS, NPC, development partners, NGOs
			Build capacity of SHEP coordinators and teachers to address myths, misconceptions, and bias towards young people regarding FP/contraception education and on rights to family planning[236]	• Hold 1 national 3-day meeting with regional training teams (40 people, 4 per region) and 20 national trainers from SHEP & guidance & counselling units • Hold district trainings to train district SHEP coordinators & teachers, 25 participants per district (5,400 total)	Number of people and coordinators trained (target: 60 trainers; 5,400 trainees)	2016 2017	GES,* GHS, NPC, development partners, NGOs
			Introduce and roll out the modules on SRH and rights for young people in all colleges of education and higher learning institutions[237]	• Print modules on SRH for young people, 100 pages, 5,000 copies • Facilitate transport and daily allowance for distribution of copies to all colleges of education and higher learning institutions, 1 person, 7 days	Number of colleges of education using the modules (target: 38 public colleges of education)	2016	GES,* GHS, NPC, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Supply schools and school health clubs/peers with FP/ contraception education materials	• District SHEP coordinators and teachers to distribute education materials to schools (100 brochures, 3 posters per school) to 10,800 schools	Number of schools provided with guidelines, and FP/ contraception education materials (target: 10,800)	2016	GES,* GHS, NPC, development partners, NGOs
			Award and motivate teachers and schools implementing best practices on FP/contraception education through national process of nomination and application by regions and districts, and evaluation by national team of those applications submitted	• GES to include nomination procedures in regular materials disseminated to regions and districts • Prepare and print award certificates, 50 copies • Hold an annual award event, 100 participants, 50 regional	Number of best-performing schools and teachers awarded every year (target: 50)	2017 2018 2019 2020	GES,* GHS, NPC, development partners, NGOs
			Facilitate experience-sharing visits between schools/teachers	• Facilitate transport and daily allowance for 12 teachers (4 visits of school teams of 3), 5 days each	Number of experience- sharing visits organised annually (target: 4)	2017 2018 2019 2020	GES,* GHS, NPC, development partners, NGOs
			Ensure that monitoring and supportive supervision of teachers includes FP component	• Send briefing letters to national monitoring team and regional and district monitoring teams to have monitoring teams ascertain that teachers are effectively infusing and integrating FP issues in their lessons during regular supportive supervision visits	Annual briefing letters sent to monitoring teams (target: 4; 1 per year)	2017 2018 2019 2020	GES,* GHS
DC9. FP/ contraception education through peer-to-	SP 2	DC9.1 Develop and implement a peer-to-peer FP/contraception education approach	Draw experience from existing peer education programmes and design a peer-to-peer FP/	• Assign government or implementing partner staff to compile experience from existing	Report on existing practice of peer-to-peer FP/ contraception	2016 2017	GHS,* GES, NPC, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
peer approach scaled up		targeting young people and adults, including through the use of men's and mother's support groups, satisfied clients, etc.	contraception education initiative with modules for peer education[238]	peer-to-peer FP/ contraception education initiatives, 20 days • Assign government or implementing partner staff to develop modules and job aids for peer education, 40 days	education compiled Number of modules developed (target: 20)		
			Train associations and networks of young people and implement peer-to-peer education program	• Hold 3-day training workshops, total of 3, 50 participants each • Print modules and job aids for peer education, 100 pages, 200 copies	Number of participants trained (target: 150)	2017	GHS,* GES, NPC, RHMT, development partners, NGOs
		DC9.2 Build the capacity of young people to be peer educators and strengthen peer education in schools and communities	Build the capacity of young people at the regional level to educate others as peer educators through technical and leadership training[239]	• Hold 3-day regional training workshops to train 200 people annually • Print modules and job aids for peer education, 100 pages, 200 copies annually	Number of young people trained to be peer educators (target: 800)	2017 2018 2019 2020	GHS,* GES, NPC, RHMT, development partners, NGOs, FBOs
			Organise peer education at schools under the leadership of school nurses, teachers, and professional counsellors[240]	• Print job aids and FP materials for peer education groups, 10,000 copies of 100 pages • Honorarium for 2 nurses, teachers, or counsellors per school, 1,000 schools	Number of schools with peer education (target: 1,000)	2017 2018 2019 2020	GHS,* GES, NPC, RHMT, development partners, NGOs
			Organise peer education in communities in collaboration with local health facilities[241]	• Print job aids and FP materials for peer education groups, 10,000 copies of 100 pages • Honorarium for 1,000	Number of peer educators operating in communities in collaboration with health facilities	2017 2018 2019	GHS,* NPC, RHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				HWs	(target: 10,000)	2020	
			Help districts to integrate youth programming in the existing health budget and put in place a system of incentive packages for peer educators[242]	• Assign government or implementing partner staff to develop remuneration package guidelines, 20 days • Guidelines to be reviewed by Youth Subcommittee and National Youth Authority • Regions to work with districts through regular supportive supervision visits to encourage the implementation of remuneration package guidelines for peer educators	Remuneration package guidelines developed Number of peer educators receiving incentive package	2018 2019 2020	GHS,* GES, NPC, RHMT, DHMT, development partners, NGOs
		DC9.3 Increase awareness amongst parents and communities to improve access to information, skills, and service utilisation by young people[243]	Build capacity of parents and communities on SRH and development issues for young people and intergenerational communication	• Nurses, teachers, and counsellors from schools and HWs receive honorarium to organise parent and community meetings quarterly to build capacity, and provide refresher orientation on FP and AYRH issues (costed in DC9.2)	Number of training sessions for parents and communities on young people's FP/ contraceptive needs	2017 2018 2019 2020	GHS,* GES, NPC, RHMT, development partners, NGOs
DC10. Male involvement in FP DC improved	SP 1	DC10.1 Use men's groups for FP awareness raising	Establish men's groups in communities and put in place a community dialogue programme on FP	• Develop a guiding TOR for men's groups and send to regions and districts	All districts establish men's groups for FP awareness raising	2016	GHS,* development partners, NGOs
			CHNs, CHOs, and CHVs to provide technical support and regularly monitor performance of men's groups	• CHPS facilities to report to districts quarterly on the performance of men's groups; districts to compile reports and	Percentage of CHPS facilities submitting quarterly reports on performance of men's groups	2017 2018 2019	GHS,* Ministry of Local Government and Rural Development (MLGRD), NPC, Metropolitan, (MMDAs), development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				submit to regions and GHS • GHS to compile, analyse, and provide feedback; assign government staff, 20 days annually	(target: 90%)	2020	partners, NGOs
			Provide men's groups with necessary aids and communication materials on family planning	• Distribute job aids and communication materials to all districts (included in DC distribution of materials)	Number of districts supplied with job aids and communication materials addressing men (target: 216)	2017 2018 2019 2020	GHS,* MLGRD, NPC, MMDAs, development partners, NGOs
		DC10.2 Conduct national campaigns to mobilise men in support of family planning	Integrate national *Men for Family Planning* campaigns into annual National FP Week	• Campaign implementation plan developed and monitored by SBCC subcommittee during regular meetings • Include in National FP Week	Annual *Men for Family Planning* campaign conducted for 1-week period	2017 2018 2019 2020	GHS,* MLGRD, NPC, SBCC subcommittee, development partners, NGOs
DC11. Communities and groups have increased awareness of FP benefits through community mobilisation events	SP 1	DC11.1 Encourage the use of community durbars, festivals, and other relevant occasions to strengthen and dialogue on family planning, including for young people[344]	Messages and materials disseminated at durbars, festivals, and other relevant events	• Material production included in other DC activities; promotion included in SMA activities	Number of community durbars and festivals featuring FP messages (target: 20 per year)	2016 2017 2018 2019 2020	GHS,* NPC, development partners, NGOs, CSOs, religious institutions, media, traditional authorities, academia, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		DC11.2 Celebrate FP Week annually at national, regional, district, and community levels[245]	Organise national launching event of FP Week and ensure media coverage	• Hold planning committee meetings at national and regional levels (national: 5 meetings for 20 people; regional: 8 meetings for 15 people) • Hold launch and activities at a venue in a regional capital; hire tent, sound system, etc. • Provide transport allowance and per diem to staff and partners from outside the region, 20 people • Provide transport allowance to media personnel, 30 journalists • Provide soda and snacks to attendees, 500 people • Buy 2-minutes of ad space on radio and TV to play during prime time, daily for one week	Number of celebrations of FP Week held (target: 5)	2016 2017 2018 2019 2020	GHS,* NPC, development partners, NGOs, media
		DC11.3 Encourage CHPS compounds to organise local FP days in their communities	CHPS compounds to organise local community event on the first day of FP Week	• Print and disseminate posters (1,000 posters; 10,000 flyers) • Q&A sessions conducted and certificates given to 10 best-performing families	Number of CHPS compounds organising community event during FP Week (target: 500)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
DC12. Educated community members and clients who know and are empowered to demand their rights to FP/contraception information and services, including availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation	SP 1	DC12.1 Educate clients on sexual and RH rights	Engage with human rights advocates to ensure communication materials include rights-based FP messages	• Hold 2-day workshops with FP rights advocates and community representatives, including young people, to discuss FP rights and review communications materials, 50 participants	Number of workshops to review communication messages from a rights-based perspective (target: 3)	2016 2018 2020	GHS,* NPC, RHMT, development partners, NGOs
			Develop communication materials that clearly state the FP-related rights of clients	• Rights-based message development included in SBCC strategy and material development	Percentage of SBCC campaign materials with rights-based FP messages (target: at least 50% of materials explicitly address one or more of the following: agency and autonomy, availability, accessibility, acceptability, quality, empowerment, equity and non-discrimination, informed choice, transparency and accountability, and voice and participation)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, development partners, NGOs
			Disseminate FP rights information to clients,	• Dissemination to clients is included in DC message	Estimated number of people reached	2017	GHS,* NPC, RHMT, development partners,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			providers, and HWs	dissemination • Dissemination to providers and HWs is included in DC and SD	with rights-based FP messages (target: 8 million)	2018 2019 2020	NGOs, CSOs, religious institutions, media, traditional authorities, academia, private sector
			Build capacity of HPD to disseminate information on the client charter and rights	• Hold training workshop, 20 participants • Hire a seconded technical staff to Health Promotion Unit of GHS to build capacity, 1 year	Health promotion staff trained and supported by TA seconded for one year	2016 2017	

Area 2: Service Delivery

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SD1. Community-based FP/ contraception services expanded in all CHPS facilities to improve access to comprehensive FP services	SP 6	SD1.1 Monitor the availability of FP services in all CHPS facilities and report sites where services are not provided due to absence of HWs, logistics, or other reasons, and take corrective measures	Identify CHPS sites that do not have two CHNs or CHOs trained in family planning	• FHD to assign 2 staff, 20 days, to work with regions to compile the information and write assessment report • Include on agenda at regular SD subcommittee meeting	Assessment report of CHPS compounds' FP SD status	2016	GHS,* NPC, SD subcommittee, RHMT, DHMT, development partners, NGOs
			Provide feedback to district health directorate in areas where there are no adequate CHNs or CHOs or there is lack of logistics to provide FP services	• FHD to send feedback letter to regions and districts	All identified districts notified by letter	2016	GHS*
			Ensure that trained CHNs or CHOs are deployed and necessary logistics, such as stationery, basic medical equipment, etc., are available in all CHPS compounds	• GHS to advocate for deployment of CHNs CHOs and necessary logistical equipment and supplies to provide quality rights-based FP services • Hold annual meetings to advocate with decisionmakers, 30 people	Percentage of CHPS compounds with CHNs and necessary supplies (target: 95%)	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, RHMT, DHMT, development partners, NGOs
		SD1.2 Ensure that CHNs provide house-to-house visits per the standard to deliver FP services	Implement regular supervision of CHN house-to-house visits	• Included under monthly supportive supervision of FP services—transport for health centre midwives and senior nurses to conduct monthly CHPS visits	Number of CHPS zones receiving monthly supervision to ensure CHN house-to-house visits (target: 3,000)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners
			Provide supplies and tools (bags, gown, stationery, and medical supplies) for CHNs for community visits	• Procure 3,000 bags, gowns, stationery, and medical supplies kits to supply CHPS zones	Percentage of CHPS zones supplied with all materials and supplies (target:	2016 2017 2018	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				• Resupply stationery and medical supplies as needed (commodities included under CS, stationery resupplied annually)	95%)	2019 2020	
		SD1.3 Advocate for construction of CHPS and deployment of CHNs in remote areas where clinics and hospitals are not available, as per CHPS policy goals	Encourage regions and districts to construct CHPS (during review meetings and through official communications)	• Hold annual advocacy meetings with relevant policymakers and decisionmakers, 10 people • Conduct ongoing dialogue with relevant policymakers and decisionmakers	Targeted advocacy meetings and dialogues conducted	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
SD2. Access to facility-based FP/ contraception services improved	SP 3	SD2.1 Ensure that FP services are available during off-working hours and weekends, depending on local needs and context, to provide services (opening time should be tied to activity; e.g., market day; time should suit the community—flexible working hours based on community context, including a priority to expand access to young people)	Negotiate with regional directors of health, health providers, etc., and agree on a mechanism for flexible scheduling to make services available during times of highest demand and greatest accessibility to clients	• Hold a meeting between GHS and partners to draft guidelines for more accessible scheduling for FP services, 50 people • GHS to officially communicate to regions and districts to review SD time and address needs and demands of communities	Regions that revised their SD time to accommodate demands of communities	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT
			Implement weekend and off-working hours FP service provision at FP/RH clinics	• GHS to follow up with regional directors of health to ensure that scheduling guidelines are being implemented • Regular meetings to include review of the status of the implementation of flexible scheduling at all facilities			GHS,* NPC, RHMT, DHMT

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		SD2.2 Conduct Facility Assessment Survey to assess the range of FP services provided, stockouts, and SD challenges faced by health facilities (tertiary, senior, junior, and primary levels)	Conduct Facility Assessment Surveys through which evidence is gathered on the range of FP services being provided at various classes of SDPs, stockouts, quality of FP services, etc., to inform programming	• Assign implementing partner staff to conduct health facility assessment survey, 120 days • Facilitate transport and daily allowance, 30 days	Facility Assessment Survey conducted and report compiled	2017	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD2.3 Identify areas with greatest unmet need and poor access, and provide targeted support	Identify areas with greatest unmet need and poor access (e.g., Northern and Upper East regions) Align with market segmentation analysis to create holistic picture	• Determine areas of greatest unmet need and poor access at regular SD subcommittee meeting • Market segmentation analysis conducted in SMA3	Regions with highest unmet need and poor FP SD identified	2016	GHS,* NPC, RHMT, DHMT, development partners, NGOs
			Develop FP service scale-up plan in these regions	• Assign 3 government staff, 20 days • Hold 3 regional meetings with partners to develop plan, 30 people per region • Facilitate transport and daily allowance	Scale-up plan developed	2017	GHS,* NPC, RHMT, DHMT, development partners, NGOs
			Advocate with GHS to implement service scale-up plan (e.g., including training HWs, providing logistics and supplies, and monitoring progress)	• Hold annual small meetings to advocate with GHS to implement scale-up plan, 10 people	Number of meetings to advocate with GHS to implement scale-up plan (target: 4)	2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD2.4 Ensure accessibility of FP services to vulnerable and key population groups, including people with	Create job aids for HWs to address the needs of vulnerable and key population groups, including people with disabilities	• Assign government or implementing partner staff, 60 days • Hold 2-day workshop for SD subcommittee and representatives from	FP job tool created to address needs of vulnerable and key population groups, including people	2016 2018 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		disabilities		communities to review and finalise tool, 60 participants • Hold two 2-day review meetings to review progress and other guidelines and tools, 60 participants	with disabilities		
			Advocate and provide continuous support to make MCH clinics accessible for people with disabilities	• FHD to advocate continuously to provide support to ensure accessibility	MCH clinics supported	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
			Train HWs and provide materials that aid SD to vulnerable and key population groups, including people with disabilities	• Hold national training workshop, 5 days, 40 participants • Cascade training to all supervisors in regions, 25 participants per training, to provide on-the-job training for all HWs • Print job aids, 50 pages, 10,000 copies	Number of supervisors trained (target: 115) HWs trained through on-the-job training Number of facilities and CHPS outreach zones provided with job aids (target: 4,250 facilities; 3,000 CHPS zones)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD2.5 Improved participation of communities in SD, including young people, women, men, people with disabilities, etc.[246]	Advocate for service institutions to include community representatives, including young people, on management teams and SD teams	• GHS to assign staff to prepare advocacy messages, send letters, and conduct follow-up, 10 days • Included as an agenda item in annual review meetings of facility governance	Percentage of facilities that engage young people and other community representatives in their governance structures (target: 90%)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD2.6 Expand postpartum FP programme in health centres and hospitals to address missed	Train HWs on postpartum FP methods and cascade through supportive supervision to health	• Hold training workshops, 3 days, 5 workshops, 20 participants trained as trainers of trainers (TOTs) per	HWs trained on postpartum family planning (PPFP) Facilities initiated	2016 2017	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		opportunities	facilities	workshop • Cascade training through supportive supervision (costed in other SD and SMA activities)	PPFP services	2018 2019 2020	
SD3. FP access through outreach services improved	SP 3	SD3.1 Map sites eligible for outreach services and set up regular FP outreach services integrated with MCH services in marketplaces, social centres for young people, and other public areas	Identify sites eligible for outreach FP services integrated with MCH services. Mapping will identify communities needing improved service provision and facilities within the vicinity that can then provide the outreach services	• Assign government staff to work with regions to identify sites and prepare a report, 20 days	A report on sites eligible for outreach support	2016	GHS,* NPC, RHMT, DHMT, development partners, NGOs
			Set up outreach sites for FP services integrated with MCH services, including FP education and counselling	• Logistics (commodities, supplies, consumables, equipment) costed under FP commodity costs • Procure 200 bags for FP supplies for outreach services • Assign trained HWs, no additional staffing cost • Provide HWs with transportation allowance, 3 days per week	Number of outreach sites started (target: 20 new sites in year 1, 50 in year 2, 100 in year 3, 200 in years 4 and 5)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
SD4. Quality of FP/ contraception services in CHPS compounds, clinics, health centres, and all facilities improved	SP 6	SD4.1 Implement monthly onsite FP supportive supervision of CHPS by supervisors and ensure availability of supplies	Develop a supportive supervision manual for FP services in CHPS compounds and ensure availability of supplies	• Hold 2 3-day SD subcommittee meetings, 30 people • Hold 2-day consultation workshop, 30 people	FP supportive supervision manual developed	2016	GHS,* NPC, SD subcommittee, RHMT, DHMT, development partners, NGOs
			Implement monthly mentorship of FP services provided by CHPS, starting	• Facilitate transport for health centre midwives and senior nurses to conduct monthly	Percentage of CHPS sites receiving at least 10 visits	2016 2017	GHS,* RHMT, DHMT, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			with an onsite orientation for midwives and CHNs on the mentorship program	CHPS visits to 3,000 CHPS outreach zones, included in SMA costing	annually (target: 90%)	2018 2019 2020	partners
SD5. Improved FP/ contraception quality of care in clinics, health centres, and hospitals	SP 3	SD5.1 Establish FP QI teams in health facilities to follow up on proper use of FP guidelines and protocols	Establish FP QI teams in health centres and hospitals	• FHD to issue official letter • District management to follow up establishment of QI teams, assign government staff, 216 districts, 10 days	FP QI team established	2016 2017	GHS,* RHMT, DHMT, development partners, NGOs
			Institutionalise a system to reward best-quality SDPs in FP/ contraception services, based on quality services adhering to rights-based SD standards, not on numbers	• GHS to establish award committee • Committee to review performance of SDPs based on official annual report FP data • Hold a national event to award best-performing SDPs, 200 people	Best-performing SDPs awarded	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
			Make FP guidelines and protocols available in all CHPS health centres, clinics, and hospitals	• Print FP guideline and protocol, 10,000 copies • Facilitate transport and daily allowance for distribution of copies to regions to distribute to all facilities, 1 person, 7 days	Number of health facilities and CHPS outreach zones provided with guidelines and protocols (target: 4,250 facilities; 3,000 CHPS zones)	2016	GHS,* RHMT, DHMT, development partners, NGOs
			Conduct quarterly meetings of FP QI teams to review FP SD standards and provide support for improvement (QI teams to emphasise all aspects of quality, including infection prevention, counselling skills, privacy, confidentiality, etc.)	• FP QI quarterly team meetings in health facilities utilising quality checklist • Regions to compile report of active quarterly team meetings and submit to national level for follow-up	Percentage of health facilities conducting quarterly FP QI team meetings (target: 90%)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SD6. FP/ contraception services integrated with other outpatient and inpatient services	SP 3	SD6.1 Integrate FP services in other outpatient and inpatient services, including ART clinics, client-initiated HIV testing and counselling rooms in HIV centres, immunisation units, OPDs, and inpatient wards	Make FP services/contraceptive commodities (e.g., condoms) available through outpatient clinics, PMTCT services, HIV/immunisation/postnatal care, etc.	• Hold 2-day meeting with Heads of Nursing at Regional Health Directorates to issue a policy statement and ensure that integration is implemented in each district, 30 people • Facilities to make requests for adequate commodities for outpatient, HIV, immunisation, and postnatal-visit clinics (included in FP commodity costing)	Percentage of relevant facilities integrating FP services (target: 60%)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
			Provide logbooks, monitoring charts, and referral slips for outpatient and inpatient clinics	• Print and distribute logbooks, monitoring charts, and referral slips to 4,250 facilities and 3,000 CHPS zones	Percentage of facilities integrating FP services supplies with adequate record-keeping forms (target: 95%)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
			Provide basic FP orientation and refresher trainings to HWs in other clinics Conduct sensitisation of HWs on importance of integration (including during in-service training)	• On-the-job orientations facilitated by FP clinic	HWs trained Facilities integrating FP services	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
SD7. "Lost to follow-up" for FP services minimised		SD7.1 Implement "lost to follow-up" client-tracing mechanism to address missed opportunities	Develop "lost to-follow-up" client-tracing form and attach to client's medical record	• Regular SD subcommittee meetings to develop form and procedures • Print 10,000 copies of 50-page form, distribute copies to 4,250 facilities	"Lost to-follow-up" client- tracing form developed Mhealth system developed and implemented to trace "lost to follow-up" clients	2016 2017 2018 2019 2020	GHS,* SD subcommittee, RHMT, DHMT, development partners, NGOs
			Facilitate health facilities in	• Provide budget line to 4,250 health facilities to pay for	Number of health facilities with	2016	GHS,* RHMT, DHMT,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			following up with clients	airtime for client follow-up appointments • Provide mobile phones to 4,250 health facilities to make and receive phone calls and texts to facilitate client follow-up	budget line for client follow-up (target: 4,250)	2017 2018 2019 2020	development partners, NGOs
			Secure support from telecommunication companies	• Advocate with corporate social responsibility units at telecommunication companies to support free and/or discounted airtime to allow HWs to trace missing clients and remind clients about follow-up (activities and cost included in financing)	Value of free or discounted airtime donated (target: $100,000 annually)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs, private sector
			Encourage HWs to see client follow-up as part of their regular job	• Supportive supervision to encourage HWs to see follow-up as part of their regular job(activities and costs included in SMA)	Percentage of supervisors encouraging HWs to include client follow-up in their regular work (target: 90%)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
SD8. Implement task shifting/sharing for LARCs to lower cadre of HWs to build human resource capacity for FP SD	SD8.1 Complete cascading of implant insertion and removal training to CHNs		Identify areas that have not trained CHNs on implant insertion and removal	• Regions identify districts and report to FHD	Untrained CHNs identified	2016	GHS,* RHMT, DHMT
			Cascade training of all remaining CHNs on implant insertion and removal	• Use Regional Resource Teams to cascade training to 500 additional CHNs via supportive supervision visits	Number of CHNS/HWs trained in implant insertion (target: 500	2016 2017	GHS,* RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				annually • Facilitate transport and daily allowance, 2 trainers, 5 days per training session	annually, 2,500 total)	2018 2019 2020	
			Monitor quality of training and ensure that minimum requirements are met by CHNs and CHPS for implant insertion counselling and follow-up	• Facilitate transport and daily allowance for quality monitoring team, 3 people, 3 days per region	Number of trainings monitored (10 annually)	2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
			Provide flow charts, communication materials, and job aids to facilitate LARC service provision by CHNs	• Print flow charts, communication materials, and job aids on LARC, 2,500 copies of each • Materials disseminated during CHN trainings	Number of CHPS facilities supported with materials to provide LARC (target: 2,000)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
SD9. Continuous refresher training and capacity building provided to HWs	SP 3	SD9.1 Provide cascaded rights-based refresher training to HWs (midwives, nurses, doctors, etc.) on comprehensive FP SD (emphasise counselling skills, promoting client rights, ensuring all clients have access, implant-removal skills, client follow-up, LARCs, record-keeping and reporting)[247]	Develop training database at regional and central levels to compile data on HW training status	• Assign 3 government staff from FHD and HR department to communicate to regions, collect data, develop and input data to training database, and train regions, 60 days each • Hire IT expert, 30 days	Training database developed for GHS and regions	2017	GHS,* RHMT, DHMT, development partners, NGOs
			Use database information to assess training needs and staff attrition, and plan for providing refresher trainings	• Compiled report and training plan presented at SD subcommittee meetings (included in regular meeting costs)	Quarterly plan based on database information	2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Provide on-the-job refresher trainings annually for HWs already trained on comprehensive FP service package, per the guideline for in-service refresher training	• Hold annual refresher training for TOT, 3 days, 100 participants • TOT to cascade training via on-the-job refresher trainings during normal supportive supervision visits	Number of HWs receiving annual refresher training on comprehensive FP package (target: 5,000)	2016 2017 2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs
			Develop and pilot test an 8-week mLearning system refresher training course for nurses, midwives, and CHVs on the management of contraceptive side effects and misconceptions, using IVR and text messaging on simple mobile phones to provide in-service training without interrupting health services; the system will allow trainees to respond to audio recordings using their telephone keypads	• Hold half-day initial training in 4 areas, 50 participants per training • 1 server, 2 GSM modems, 3 laptops • Assign implementing partner staff to function as project coordinator, technical staff to design training, IT coordinator, 80 days each • Airtime for texting and calls to participants	Pilot test conducted	2017	GHS,* RHMT, DHMT, development partners, NGOs
			Evaluate pilot test	• Hire a consultant to conduct a rigorous evaluation with a comparison group, including examination of HW practices and quality of health services, to assess the training, 60 days • Facilitate transport and daily allowance for 2 people, 30 days each	Pilot test evaluated	2018	GHS,* RHMT, DHMT, development partners, NGOs
			Scale up mLearning system refresher training course for nurses, midwives, and CHVs	• Assign implementing partner staff to function as project coordinator, 2 technical staff, IT coordinator, annual salaries • Airtime for texting and calls • Establish a toll-free number	National-level scale-up	2018 2019 2020	GHS,* RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SD10. FP/ contraception pre-service training for doctors, midwives, and nurses strengthened	SP 3	SD10.1 Review pre-service training curriculum and suggest areas of improvements (such as LARC, health of young people, rights elements, logistics management, etc.); [248] include topics that address HW attitude and behaviour change issues in pre-service FP training curriculum (including raising awareness about patients' charter and RH rights of clients)	Review pre-service training curriculum and identify areas for improvement	• FP and adolescent health and development (ADHD) programmes to review and revise curriculum in collaboration with National Medical Council (NMC), 3 government staff, 30 days each • Hold 2-day review workshop, 30 people	Report on recommendations for review	2020	GHS,* NPC, MoE, GES, Human Resource and Development Division (HRDD)-MoH, NMC, MDC, training institutions, development partners
			Dialogue with the MoE, GES, MoH, GHS, and stakeholders on the operationalisation of the revision to the pre-service training curriculum	• Hold 4 small consultation meetings between GES, MoE, MoH, GHS, 10 people	Agreement reached on the need and operationalisation of curriculum revision/update	2020	GHS,* NPC, MoE, GES, training institutions, development partners
		SD10.2 Develop course content and instructional plans[249]	Include new priority areas in the curriculum for all levels of HWs (doctors, midwives, and nurses)	• Hold 3-day meeting to revise curriculum, 50 participants	Revised/updated HW training curriculum and instructional plans for CHNs, CHOs, RCH staff, nurses, midwives, and doctors	2020	GHS,* NPC, MoE, GES, HRDD-MoH, NMC, MDC, training institutions, development partners
		SD10.3 Roll out course content and instructional plans	Introduce and roll out course content and instructional plans for CHNS, CHOs, RCH staff, nurses, midwives, and doctors	• Print course content and instructional plans, 200 pages, 500 copies • Facilitate transport and daily allowance for distribution of copies to all institutions, 1 person, 7 days	Number of institutions using the course content and instructional plans (target: 75)	2016 2017	GHS,* NPC, MoE, GES, HRDD-MoH, NMC, MDC, training institutions, development partners

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Provide training materials and equipment and medical supplies for colleges to strengthen FP pre-service training[250]	• Procure training materials, equipment and supplies, 75 colleges/universities o Gynaecologic simulators, contraceptive implant simulators, general equipment, instruments, linens, FP methods, forms and guidelines • Facilitate transport and daily allowance for distribution, 1 person, 7 days, twice • Procure replacement equipment and supplies after 3 years	Number of colleges/universities provided with equipment (target: 75)	2016 2019	GHS,* NPC, MoE, GES, HRDD-MoH, NMC, MDC, training institutions, development partners
SD11. Improved skills of current HWs to improve availability and access to FP services	SP 3	SD11.1 Strengthen collaboration with health education institutions to improve availability and access to FP services[251]	Collaborate with medical professional councils to include FP topics in their continuing professional education (CPE) programmes	• 5 small advocacy meetings with professional council leadership to include FP continuing medical education topics, 5 people • Hold 1-day national workshop to update/develop FP content to be included in continuing medical education, 30 participants	FP topics included in CPE programmes Number of CPE sessions conducted in family planning per each health professional category	2016 2017	GHS,* NPC, MoE, GES, HRDD-MoH, NMC, MDC, training institutions, development partners
		SD11.2 Expand training on permanent FP methods	Expand training of higher and mid-level HWs (doctors, health officers) on permanent methods	• Hold 4 national training workshops, (20 HWs trained per 5-day workshop)	HWs trained biennially (target: 440; 220 annually)	2017 2019	GHS,* NPC, training institutions, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SD12. FP clinic staff motivated		SD12.1 Implement national- and regional-level HW motivation scheme for good-performing HWs providing high-quality, rights-based services	Provide certificate and/or award for HWs that have shown dedication and discipline to providing high-quality rights-based services	• GHS to assign staff to work with regions and districts to nominate and vet HWs for annual awards, 10 days • Print 500 certificates to be distributed at district level	Number of HWs given annual awards (target: 500)	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, development partners, NGOs
			Assess HW demotivation and propose solutions	• Hire consultant to conduct an assessment, 30 days	Report of assessment and recommendations	2016	GHS,* NPC, SD subcommittee, development partners, NGOs
			Implement recommendations of assessment of staff demotivation	• Human resource and FHD teams to implement recommendations • Provide resources and staff time, 20 days annually, for implementation	Recommendations implemented	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, development partners, NGOs
SD13. Improved access and quality of FP services in the private sector	SP 3	SD13.1 Expand short- and long-term method availability in private facilities	Encourage expansion and availability of all FP methods in private facilities through memorandum of understanding (MOU) signed with GHS	• Identify private facilities' varying levels of capacity and plan for phased approach of engaging them to make all FP methods available • 15 MOU signing ceremonies annually at GHS or Regional Health Directorates with private facilities, 10 participants	Number of private facilities that signed MOUs (target: 15 per year)	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, development partners, NGOs, private sector
			Include HWs at private facilities in refresher and other FP training courses	• Hold 1 national and 10 regional TOT training workshops for supervisors, 5 days, 10 TOTs trained per workshop • Reach 1,000 HWs in the	Number of HWs from private facilities trained (target: 1,000 annually)	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, development partners, NGOs, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				private sector through supportive supervision visits • Facilitate transport and daily allowance for supportive supervision visits, 100 days annually			
			Provide monitoring log books and reporting formats for private facilities	• Provide logbooks, monitoring charts, and referral slips to 500 facilities annually	Number of health facilities supplied with logbooks, monitoring charts, and referral slips (target: 500)	2016 2017 2018 2019 2020	GHS,* NPC, SD subcommittee, development partners, NGOs, private sector
SD14. Improved access to and utilisation of FP/contraception services by young people	SP 2	SD14.1 Expand friendly services for young people in health facilities and designate special times for young people	Supply health facilities with necessary materials and supplies for corners targeting young people	• For each youth corner, procure facility supplies and equipment: youth standards and tools for monitoring; television set-LCD digital; DVD player; table top refrigerator; sign board; examination couch; tables; chairs; benches; games—Ludo, oware, cards, draft, scrabble; bookshelves • For each youth corner, procure medical supplies and equipment: injection tray, thermometers, digital blood pressure apparatus, mercury blood pressure apparatus, weighing scale, penis model, anatomical models, human reproductive models, STI kits; steriliser-stove top autoclave, examination screen—4 folds, sink/veronica bucket, trash bin, examination gloves, hand sanitisers, parazone, liquid soap, Savion detergents, hand towels; include equipment delivery charge per facility	Number of health facilities supported with new equipment in corners for young people (target: 287 youth corners/centres in 2016, 350 in 2017, 450 in 2018, 550 in 2019, and 687 by 2020)	2017	GHS,* NPC, SD subcommittee, development partners, NGOs
			Ensure privacy and confidentiality in corners for young people	• Included in sub-activity above	Number of health facilities supported with equipment to ensure privacy and	2016 2017 2018	GHS,* NPC, SD subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
					confidentiality in corners for young people (target: 287 youth corners/centres in 2016, 350 in 2017, 450 in 2018, 550 in 2019, and 687 by 2020)	2019 2020	
			Train regional resource teams on youth-focused FP services Train service providers on youth-focused FP services	• Hold central training workshops for Regional Resource Teams and other HWs, 100 participants total • Hold 10 regional trainings, 50 HWs per region • Remaining service providers to be trained through supportive supervision, including in SMA costing	Number of HWs trained in youth-focused FP services (target: 600)	2016 2017 2018	GHS,* NPC, SD subcommittee, development partners, NGOs
			Orient other support staff who are non-HWs on friendly FP services for young people	• Hold half-day on-site orientation per facility, 4,250 facilities by 2020	Number of facilities that provided on-site orientation to support staff (target: 4,250)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Facilitate discussion forums for young people and conduct weekly discussions	• Hold weekly discussion forum for young people in each youth corner and provide refreshments to those in attendance, 287 youth corners/centres in 2016 and 687 by 2020 • Honorarium for HWs included in DC costing	Number of facilities conducting weekly discussion forums for young people (target: 287 youth corners/centres in 2016, 350 in 2017 450 in 2018, 550 in 2019, and 687 by 2020)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
SD15. Educated HWs who know about clients' rights to FP/ contraception information and services, including availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation	SP 3	SD15.1 Educate HWs about the rights of clients, including the rights of PLHIV to use other methods of contraception in addition to male and female condoms	Review rights-based tools and develop additional tools needed	• Assign government or implementing partner staff, 30 days • Hold a 1-day stakeholder meeting, 50 people • Hold 3 working group meetings, 3 days each, 15 people • Hold a finalisation meeting, 50 people • Print 2 rights-based tools, 50 pages, 10,000 copies each	Number of rights-based tools developed or updated (target: 2)	2016	GHS,* NPC, RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Educate HWs on clients' rights, including the rights of PLHIV to use other methods of contraception in addition to condoms	• Hold onsite orientation meetings in health facilities for HWs, costing included in regular supportive supervision	HW in facilities oriented on client rights	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD15.2 Improved rights-based AYFHS in health facilities[252]	Establish and strengthen AYFHS in existing public and private sector facilities	• Print 2 posters to illustrate the rights of clients and young people, 10,000 copies • Counselling job aids and protocols to be distributed under other SD activities, include illustration of rights of clients and young people • Training of service providers on rights-based AYFHS, included in other SD activities	Facilities fully equipped to provide rights-based AYFHS services with trained providers and adequate supplies	2017 2019	GHS,* NPC, RHMT, DHMT, development partners, NGOs
		SD15.3 Initiate programmes to allow clients and community members to voice their concerns about rights issues in health facilities	Put in place complaint filing mechanisms, including feedback/suggestion boxes for FP services	• Provide feedback/suggestion boxes in all health facilities by 2020 • All health facilities to include review of feedback/suggestion box data in management meetings, no additional cost • All health facilities to hold quarterly community meetings for community members to voice their concerns about rights issues in health facilities and ideas for improvements, no additional cost	Percentage of facilities with feedback mechanisms in place (90%)	2016 2017 2018 2019 2020	GHS,* NPC, RHMT, DHMT, development partners, NGOs
SD16. SDPs equipped with the necessary HWs and supplies to provide rights-	SP 3	SD16.1 Support all direct and indirect costs to provide a full method mix of FP services	Support direct costs for SDPs to provide a full method mix of FP services	• Support direct costs for all FP services, including staff time for providing FP services—counselling and clinic visits; FP commodities, included under	Direct and indirect costs at the facility level supported	2016 2017 2018	GHS,* RHMT, DHMT, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
based FP services				"Commodities"; medical consumables, included under "Commodities"; other consumables, mainly medical supplies; laboratory testing		2019 2020	
			Support indirect costs for SDPs to provide a full method mix of FP services	• Support indirect costs for all FP services, including administrative staff time, supervision from regional and central levels, office equipment, medical equipment, vehicles used for programme administration, physical infrastructure for administering the programme/service, transport costs for administration, public utilities (electricity, water, etc.), maintenance and repair, staff training, and other administrative costs (office supplies, legal costs, audit)			

Area 3: Contraceptive Security

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
CS1. Forecasting, quantification, and procurement plans developed	SP 4	CS1.1 Hold forecasting and quantification meetings biannually, and ensure that a full method mix is included (at minimum including all of the contraceptives on the WHO essential medicines list [oral hormonal contraceptives, injectable hormonal contraceptives, IUDs, condoms, diaphragms, implantable contraceptives, intravaginal contraceptives];[253] natural and permanent contraceptive methods for both men and women are planned for and made available at appropriate facility levels)[254]	Hold quantification meetings (include commercial distribution data, as available, in national quantification exercises) Circulate forecasting, supply plans, and procurement plan to stakeholders Conduct biannual review and make adjustments in line with GoG budgeting schedule	• Assign 2 government or implementing partner staff to prepare and finalise quantification plan, 20 days • Biannual 5-day national quantification meeting, 30 participants	Number of quantification meetings (target: 2 annually) Forecasting, quantification, and procurement plans developed, including CPT tables	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
			Build capacity at subnational level for forecasting, including holding assumption-building workshops and capacity building for data collation to guide forecasting	• 2-day training workshop for regional ICC/CS, 50 people • Hold 10 in-person regional trainings, 15 people	Regional capacity built for forecasting and data collection	2017	GHS,* NPC, MoH, ICC/CS, regions, development partners, NGOs
		CS1.2 Build capacity of FP sub-quantification team through structured regular training using various software and forecasting methods[255]	Conduct training	• Hold 3 5-day training workshops, 20 people	Number of trainings held	2016 2018 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		CS1.3 Procure necessary equipment (computers/software) and strengthen GHS/FHD coordination of procurement process[256]	Obtain quotations and procure equipment	• Procure equipment: 2 computers, 5 laptops, 5 tablets, 1 network printer	Equipment procured	2016	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS2. FP commodities procured per the quantification and procurement plan	SP 4	SS2.1 Conduct timely procurement[257]	Follow up timely initiation of procurement purchase orders per the schedule by the procurement unit	• FHD to submit procurement plan to MoH procurement unit • Hold 5 procurement follow-up meetings annually, 10 people	Procurement purchase orders initiated per the schedule on quantification and procurement plan Percentage of requirement procured	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS3. ECs are procured per the quantification and procurement plan		CS3.1 Procure ECs per the quantification and procurement plan	Ensure that ECs are procured as a life-saving commodity Improved education about the use of EC to clients including under DC and for HWs under SD	• Include ECs in standard RH quantification and procurement plan	ECs procured and distributed, along with other FP commodities and essential life-saving commodities	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS4. Timely delivery of shipments ensured		CS4.1 Ensure that government and all development partners implement procurement and shipment per the procurement plan	Regularly review implementation of procurement plan and shipment pipelines during ICC/CS meetings and take action	• Development partners provide briefings on shipment timelines at regular ICC/CS meetings, no additional cost • Ensure continuous dialogue of relevant partners and implementers, no additional cost	Adequate levels of commodities based on consumption to prevent gluts or stockouts	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
CS5. Warehousing capacity and efficiency improved	SP 4	CS5.1 Advocate for improvement of warehousing infrastructure and logistics capacity and efficiency	Train supply chain officers in warehousing and logistics Advocate for full refurbishment of warehouses Refurbish selected warehoses	• Hold 10 3-day regional trainings for district-level supply chain officers on warehousing and logistics, 30 people per training • Advocacy for full refurbishment of warehouses, no additional cost • Refurbishment of 3 warehouses with closed-circuit television (CCTV), refrigerator for warehouses, and temperature monitors	Number of supply chain officers trained on warehousing and logistics (target: 300) Number of warehouses refurbished (target: 3)	2016 2018	GHS,* NPC, MoH, ICC/CS, CMS, RMS, development partners, NGOs
CS6. Distribution of protocols set/revised to improve distribution channels, commodity supplies, and systems	SP 4	CS6.1 Support revision of distribution protocol/SOP as part of revision of the general SOP	Hold meeting to develop/revise distribution protocols Train regions on appropriate requisition-making of all medical products	• Assign 2 government or implementing partner staff to develop distribution protocol and work with committee, 30 days • Hold 3-day meeting, 20 participants, including 5 regional participants • 2-day orientation for regions on the new SOP/protocol (2 participants from each region) • Hold district-level half-day training for staff that handle requisitions	Protocol developed/revised Number of staff trained on requisition making (target: 20)	2016	MoH,* GHS,* NPC, ICC/CS, development partners, NGOs
CS7. Distribution system improved	SP 4	CS7.1 Review current distribution system and consider alternatives, including the push system[258]	Review current distribution system and mechanisms and conduct options analysis, including financial analysis, to identify alternative transportation strategies	• Assign implementing partner staff to assess current distribution system and conduct options analysis, 20 days • Hold 1 ICC/CS meeting to review distribution system, 60	Distribution system report completed	2016	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Hold national-level review meeting of commodity distribution system Develop and implement recommendations for strengthening distribution system	people • Hold national review meeting, including regional representatives, 100 people			
		CS7.2 Improve the capacity of districts and facilities to implement timely pick-up of commodities	Provide funding for transportation Conduct joint pick-ups with other programmes and general hospitals (integrated transportation of commodities) from regional stores	• Fund fuel and repairs for district trucks to make monthly commodity pick-ups, 216 districts • Conduct advocacy for joint pick-up with other programmes from regional stores, no additional cost	Commodities are picked up in a timely manner to prevent stockouts Integrated transportation implemented	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, CMS, RMS, development partners, NGOs
		CS7.3 Pilot test alternative supply and distribution mechanisms, e.g., PPP venture[259]	Advertise for PPP proposals Pilot outsourcing of delivery of commodities in one region	• Place 4 half-page advertisements in print media for call for proposals • Hold a half-day meeting of a committee to evaluate proposals, 30 people • Fund outsourcing of delivery of commodities in 1 region for 1 year	PPP proposal selected and approved	2016 2017	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
			Evaluate pilot test of outsourcing of delivery of commodities in 1 region	• Hire a consultant to conduct a rigorous evaluation, 60 days • Facilitate transport and daily allowance for 2 people, 30 days each	Report on pilot implementation completed	2018	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		CS7.4 Increased availability of FP commodities through distribution to non-traditional channels (especially for condoms)[260]	Conduct targeted distribution to expand condom availability beyond the traditional channels (health facilities) to non-traditional outlets such as bars, night clubs, and hotels Expand distribution channels targeting key populations through non-traditional outlets Review and assess impact of programme with SMO after 1 year and renew if effective	• Assign government or implementing partner staff to develop strategy to expand distribution to non-traditional channels, 20 days • Partner 1 SMO for a year to roll out programme to expand distribution to non-traditional channels, based on report • Hold review meeting for programme impact assessment, 30 people	New and targeted programmes developed	2017	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS8. Government and development partner workplans aligned to the supply chain master plan	SP 4	CS8.1 Support education on and alignment to the supply chain master plan[261]	Implement recommendations from warehousing and distribution optimisation studies/reports and align workplans to the supply chain master plan	• Hold 2 PLS subcommittee meetings, 30 people • Present at regular ICC/CS meeting	Number of subcommittee meetings held (target: 2)	2017	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS9. Improved supply and distribution of commodities through systemic and innovative changes	SP 4	CS9.1 Assess private sector supply chain systems and compile best practices for adoption or adaptation Apply best practices from private sector supply and distribution systems	Conduct rapid assessment of private sector best practices in supply chain for FP commodities Discuss with private sector representatives and adopt/adapt useful lessons from private sector supply and distribution system ICC/CS subcommittee meets representatives and makes recommendations to strengthen distribution system	• Hire consultant to conduct assessment and compile best practices for adoption, 30 days • Print assessment report, 50 pages, 100 copies • Have private sector representatives attend ICC/CS meeting and share best practices regarding distribution system, no additional cost • Hold 1 meeting of the PLS subcommittee, 30 people	Assessment report of best practices from private sector supply and distribution system completed Number of best practices from private sector supply and distribution system applied to public system (target: 5)	2016	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
CS10. Improved commodity regulatory practices through addressing regulatory challenges currently resulting in delayed distribution of commodities and delays in commodity supply		CS10.1 Hold regular coordination meetings with FDA	Establish regular meetings with regulatory authority and FDA	• Hold biannual meetings with FDA, 10 people • Assign permanent contact person designated to handle FP issues at FDA and GHS/FHD, and ensure that ICC/CS action points are implemented, 20 days annually	Biannual meeting with FDA conducted Coordination improved	2016 2017 2018 2019 2020	GHS,* NPC, MoH, FDA, ICC/CS, development partners, NGOs
			FDA representative(s) to attend ICC/CS meetings regularly FDA contact person to be updated on issues of previous meeting and responses	• Invitation and reminders sent to FDA about ICC/CS meetings, no additional cost	Percentage of ICC/CS meetings attended by FDA representative(s) (target: 80%)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, FDA, ICC/CS, development partners, NGOs
CS11. Regulatory bodies actively engaged in regular monitoring and testing of FP/RH commodities in the public and private sectors, and resolving resource constraints for post-market QA		CS11.1 Actively engage regulatory bodies in post-market surveillance and testing of FP/RH commodities in the public and private sectors, including post-market surveillance[262]	Identify and earmark resources to strengthen post-market QA surveillance by FDA and GSA Assess regulatory challenges that FDA, GSA, and stakeholders are facing and make recommendations to improve testing, monitoring, and overall regulation Develop guideline/protocol for regulation of FP commodities, including testing procedures Advocate for government and partner support for increased resources for FDA activities	• Hold a stakeholders meeting with FDA/GSA/GHS to identify needed resources to strengthen post-market surveillance, 20 people • Assign government or implementing partner staff to review challenges and make recommendations, 30 days • Transport and daily allowance for 2 staff for post-market surveillance activities, 50 days annually	Robust QA plan developed and disseminated Number of monitoring visits conducted Number of tests conducted on commodities in each sector	2016 2017 2018 2019 2020	GHS,* NPC, MoH, FDA, GSA, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
CS12. Theft prevented and appropriate action taken when theft occurs		CS12.1 Adopt theft prevention and management strategies/guidelines	Use batch numbers to track distribution and use Follow up and ensure that appropriate actions are taken when commodity theft occurs Develop theft prevention and management guidelines and circulate to regions and districts, including: staff to crosscheck batch numbers; regions to make record of batches received and distributed, and facilities make record of batches received; Collaborate with FDA/ central and regional warehouses to have all batches recorded to reduce cross-sector theft	• Assign 2 government or implementing partner staff to develop theft prevention and management guidelines, 20 days • Print theft prevention and management guidelines, 20 pages, 7,000 copies • Orient facility management staff on guidelines for theft prevention and management in regions through regular supportive supervision visits	Commodities tracked Theft minimised Appopriate action taken when FP commodities are stolen	2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
CS13. Commodity procurement improved through revision of procurement guidelines		CS13.1 Review and revise current procurement guidelines	Form committee to review procurement guidelines	• Hold 3 committee meetings to review and edit procurement guidelines, 20 participants • Assign 1 government staff to complete edits to procurement guidelines, 20 days • Print procurement guidelines, 100 pages, 200 copies	Guidelines reviewed and circulated	2017	MoH,* GHS, NPC, ICC/CS, development partners, NGOs
CS14. Improved facility stock		CS14.1 Advocate for the integration of FP stores	Engage Regional Health Directorates to advocate for	• GHS and Supplies, Stores and Drug Management	Number of facilities with integrated	2016	GHS,* SSDM, RHMT, DHMT,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
management for commodities at the facility level		within the general facility stores for other health supplies[263]	integration of FP stores with general facility stores at facility levels, or at least ensure oversight for all stores, including family planning	Directorate (SSDM) to hold 10 regional consultative meetings with regional health directorates to advocate for integration at facility levels, 10 people	stores (target: 10)		development partners, NGOs
CS15. Improved detection and disposal of damaged/expired FP commodities		CS15.1 Update national guidelines/protocols for the detection and disposal of damaged/expired commodities to include FP commodities	Assign government or implementing partner staff to update guidelines/protocols for detection and disposal of damaged/expired commodities Circulate protocols to all regions and districts (full document) and facilities (abridged version) During scheduled refresher trainings, orient HWs on observing expiry dates of commodities before providing to clients	• Assign government or implementing partner staff to update and present guidelines/protocols and abridged version for wide circulation, 20 days • Hold PLS subcommittee meeting to review guidelines/protocols and adopt abridged version for circulation, 30 people • Print copies of abridged version for circulation to all facilities, 20 pages, 10,000 copies • Print copies of complete protocol, 100 pages, 300 copies	Guidelines/protocols developed and circulated	2016 2017	MoH,* GHS, NPC, PLS subcommittee, development partners, NGOs

Area 4: Policy and Enabling Environment

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
PEE1. Family planning is seen as a critical element of the national development agenda and a critical component in achieving the demographic dividend in Ghana, along with simultaneous investments in education, healthcare, and governance	SP 5	PEE1.1 Engage senior leadership in all sectors in reviewing progress towards the country's FP goals and increase political support for family planning by making the "financial" case for it as a strategy for social and economic development[264]	Hold high-level ministerial briefings to discuss FP issues with policymakers and stakeholders to build a case for family planning as an integral component of all sustainable development	• Hold annual half-day ministerial-level briefings, 60 people	Number of briefings held (target: 5) Number of sector ministers and chief directors in attendance at briefings (target: at least 5 per briefing)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs, media
			Produce advocacy materials targeting policymakers at national and regional levels; include success stories[265]	• Assign government or implementing partner staff to document success stories and produce 1 report and 2 briefs for advocacy audiences (1 for political leaders and another for development partners), 60 days • Print report, 50 pages, 200 copies • Print 2 advocacy briefs, 2 pages, 5,000 copies each	Number of reports and briefs produced (target: 3)	2017 2019	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
PEE2. Multisectoral coordination ensures that FP and population goals and objectives are appropriately integrated with other health and		PEE2.1 Advocate for a multisectoral approach so that each ministry includes FP and population issues, as appropriate, in their national policy documents, strategic plans, and budget allocations through developing and disseminating technical briefs	Prepare technical briefs to advocate for budget framework papers to include family planning as a strategy to improve maternal and newborn health Support the collection and	• Facilitate transport and daily allowance for 2 MoH/GHS staff members to travel to 5 places to collect data annually, 5 days • Assign 2 GHS and NPC staff to develop technical briefs, 10 days each	Number of technical briefs disseminated (target: 1,000 annually)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
development initiatives (including finance, social welfare, education, women's affairs, etc.)			use of information on cost, cost-effectiveness, and cost savings, including for national health accounts and reproductive health sub-accounts	• Print technical briefs, 6 pages, 1,000 copies annually			
		PEE2.2 Engage non-health ministries and department directors to include FP and population issues, as appropriate, as part of their policy development processes	Hold 2-day workshops with ministries and partner staff about how to introduce family planning into their workplans	• Hold biennial meetings, 50 people	Number of stakeholders engaged in FP policy discussions (target: 50)	2016 2018 2020	NPC,* MoH, GHS, development partners, NGOs
			Hold meeting with 5 ministries biennially to review their strategic plans and guide their FP issues	• Hold 5 biennial small meetings, 20 people • Print strategic plans, 100 pages, 20 copies	Ministry staff review strategic plans (target: 5 sectoral ministries)	2016 2018 2020	NPC,* MoH, GHS, development partners, NGOs
		PEE2.3 Advocate with relevant projects to have IPC agents working in non-health sectors integrate FP SBCC into their programmes	Hold series of advocacy meetings on non-health sector projects to integrate FP SBCC into programmes	• Hold biannual advocacy meetings each year, 20 people	Number of non-health sector stakeholder organisations engaged in integrating SBCC into their programmes (target: 10)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, development partners, NGOs
			Disseminate SBCC tools to support non-health sector IPC agents and orient them	• SBCC tools developed under DC, no additional cost • Facilitate transport and daily allowance for 2 MoH/GHS staff members to travel to 10 public institutions annually to conduct on-the-job orientations, 30 days	Job aid developed Number of non-health sector IPC agents oriented (target: 200 annually)	2016 2017 2018 2019 2020	GHS,* MoH, NPC, development partners, NGOs
PEE3. Improved ability of key	SP	PEE3.1 Sensitise policymakers (members of	Orient MPs, policymakers, and health and FP focal	• Hold 1-day national meetings	Number of MPs, political leaders,	2017	NPC,* MoH, GHS, Finance and

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
policymakers to ensure that FP rights are protected in policy and programme design	5	Parliament [MP], local political leaders, etc.) on FP rights and correct any misconceptions	persons at national and subnational levels on SRH rights	in 2017 and 2019, 150 people • Hold 10 1-day regional meetings in 2018 and 2020, 50 people per meeting • Facilitate transport and daily allowance for 2 expert facilitators to regional meetings	and health officers at national and subnational levels oriented on SRH rights (target: 200)	2018 2019 2020	Advocacy subcommittee, Parliament, regions, development partners, NGOs, media
		PEE3.2 Work with Commission on Human Rights and Administrative Justice of Ghana to incorporate family planning into its annual reports	Hold meetings to brief Commission on Human Rights and Administrative Justice of Ghana on FP rights and potential human rights violations	• Hold annual small meetings, 10 people per meeting	Commission on Human Rights and Administrative Justice of Ghana includes family planning in its annual reports	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
PPE4. A national coalition of advocates/ champions drawn from Parliament, local, cultural, and religious leaders to support rights-based family planning is established and supported	SP 5	PEE4.1 Coordinate and support FP advocates/champions and scale up FP advocacy, including on RH rights	Coordinate nationally prominent FP advocates to share best practices in advocacy and lessons learnt from FP advocacy	• Hold annual 2-day meetings, 200 people, 150 from regions • Hold 4 national preparatory meetings, 12 people per meeting	Number of advocates coordinated to share best practices (target: 200 annually)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
			Provide support to prominent FP champions to carry out FP advocacy activities	• Facilitate transport and daily allowance, 3 days quarterly, 350 champions	Number of FP champions supported (target: 350)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, development partners, NGOs
			Support prominent FP champions to attend	• Facilitate transport and daily allowance, 1 international trip	Number of prominent FP	2016	NPC,* MoH, GHS, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			advocacy meetings with government, development, and implementing partners internationally, nationally, provincially, and at the local level	annually, 7 days, 2 people • Facilitate transport and daily allowance, 20 trips within Ghana annually, 5 days, 2 people	champions supported to travel internationally and nationally (target: 2 international trips annually; 40 domestic trips annually)	2017 2018 2019 2020	partners, NGOs
			Support specific activities of prominent FP advocates, including providing technical support on FP issues, including supporting relevant parliamentary committees that advocate for maternal and neonatal health issues/family planning, the First Lady, business leaders, and relevant councils	• Include technical support in annual workplans of NPC, GHS, and partners; assign 5 government and implementing partner staff, 20 days each • Hold 20 small meetings in regions and districts, 15 people per meeting	Number of FP champions provided with technical assistance [target: 50 annually]	2016 2017 2018 2019 2020	NPC,* MoH, GHS, development partners, NGOs
PEE5. Policymakers are able to advocate for bills related to family planning	SP 5	PEE5.1 Train and orient policymakers on how to advocate for bills on RH and rights policies, including family planning	Hold workshops to orient policymakers on how to advocate for bills	• Assign government or implementing partner staff to conduct trainings, 10 days • Hold 2 trainings, 1 day each, 25 people per meeting	Number of policymakers oriented on how to advocate for bills (target: 30)	2017 2019	NPC,* MoH, GHS, Parliament, development partners, NGOs
		PEE5.2 National Coalition of Advocates to engage policymakers	Provide information and policy briefs to National Coalition of Advocates and hold working technical meetings	• Hold annual meetings with National Coalition of Advocates, 30 people per meeting • Printing of policy brief included in other PEE activities, no additional cost	Number of meetings held (target: 5)	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Parliament, National Coalition of Advocates, development partners, NGOs
PEE6. Young people in schools receive improved FP/RH information and access to	SP 2	PEE6.1 Clarify and strengthen GES policies on provision of contraceptives in schools	Hold meetings with GES to clarify official positions on providing contraceptives to young people in schools, and whether girls who	• Hold biannual meeting with GES, 20 people • Other specific advocacy activities included in other PEE	Number of meetings held (target: 10)	2016 2017 2018	NPC,* GES, MoE, MoH, GHS, Finance and Advocacy subcommittee,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
services due to clarified policies on FP/RH interventions for them			become pregnant can remain in school If policy is against providing contraceptives, develop campaign to target key decisionmakers, using the approach detailed in the Advance Family Planning (AFP) Advocacy Portfolio[266] Advocate for universal policy to allow for contraceptive demonstrations in junior and senior schools	activities, no additional cost	Clear policy guidelines from GES on provision of contraceptives in school	2019 2020	development partners, NGOs
		PEE6.2 Improve school curricula and encourage enforcement of examinable comprehensive FP/RH in life skills curricula[267]	Review school curricula at junior and senior high school levels to ensure that FP issues are explicitly covered in examinable curricula materials	• Assign government or implementing partner staff to review curricula and recommend updates, 30 days • Hold 3 meetings with GES, 15 people	GES staff review relevant school curricula; recommendations are generated on modifications Report of the review and recommendations	2016 2017	NPC,* GES, MoE, MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
			Hold advocacy meetings before next curricula review period with relevant officials and mobilise advocacy support for inclusion of basic FP/contraception education into the curricula as examinable questions	• Hold advocacy workshop, 30 people • Hold 10 meetings with GES and other influential officials, 15 people	Advocacy workshop conducted Number of meetings with officials (target: 10)	2017	NPC,* GES, MoE, MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Support GES to enforce proper implementation of curricula	• Hold biannual meetings for follow-up, 15 people	Number of meetings held (target: 6)	2018 2019 2020	NPC,* GES, MoE, MoH, GHS, development partners, NGOs
PEE7. Policy on access for young people to FP services in clinical and community settings is clarified; service providers are knowledgeable about official policies affecting access by young people	SP 2	PEE7.1 Official policies on access for young people to family planning clarified for HWs	Orient HWs on official policy on providing contraceptives to young people in clinical and community settings	• Hold 10 1-day meetings with Regional Resource Teams, 25 people per meeting • Hold 10 downstream meetings for district representatives, 30 people per meeting	GHS releases official policy statement on access to contraceptives by young people	2017	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
		PEE7.2 Disseminate policies	Dissemination to service providers of policies affecting young people's access to family planning	• Included in other PEE activities, no additional cost	Dissemination to service providers of policies affecting young people's access to family planning completed	2016 2017 2018 2019 2020	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
PEE8. FDA and GSA have harmonised roles as statutory bodies		PEE8.1 Rationalised roles and responsibilities on FP (including condoms) QA protocol between the FDA and GSA[268]	A workable agreement on organisational roles and working arrangements developed ahead of permanent legal resolution Institutional guidelines on working arrangements developed to clarify roles	• Hold 5 meetings to develop a workable agreement on organisational roles and working arrangements, 30 people	Number of meetings held (target: 5) Institutional guidelines developed	2016	FDA,* GSA,* NPC, MoH, GHS, Finance and Advocacy subcommittee
		PEE8.2 The Minister of Health and parliamentary and/or legal bodies resolve the current impasse between the 2 statutory bodies (FDA and GSA)[269]	MoH submits a paper with recommendations for parliamentary action	• Hold 5 meetings with MoH, technical experts, , Ministry of Trade and Industry (MOTI), etc. to develop consensus and list of recommendation for MoH to submit to	MoH recommendation submitted to Parliament	2017	MoH,* FDA, GSA, NPC, GHS MOTI, Finance and Advocacy subcommittee

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				Parliament, 40 people			
PEE9. Improved collaborative relationship with the FDA to support timely and quality-driven contraceptive approval processes		PEE9.1 Improve collaboration and working relationship with FDA with the goals of reducing time delays in approval of registration of new contraceptives and delays in the sampling and analysis during post-shipment inspection procedures before distribution is allowed	Hold meetings with FDA to access policy, human, and financial barriers causing time delays in registration for contraceptives and post-shipment inspection	• Hold 3 meetings with FDA to access policy, human, and financial barriers causing time delays in registration for contraceptives and post-shipment inspection, and develop recommendations to improve the system, 20 people	Recommendations developed	2016 2017	FDA,* MoH, GSA, NPC, GHS, MOTI, Finance and Advocacy subcommittee
PEE10. Removed taxation of contraceptives	SP 5	PEE10.1 Advocate for policy change to remove taxes from all essential maternal health medicines and commodities, including contraceptives, to remove barrier of reliance on diplomatic exemptions	Hold advocacy meetings with stakeholders to develop strategy to position maternal health medicines and commodities as a right and essential medicine Implement strategy through holding a high-level policy meeting and developing an advocacy brief	• Finance and Advocacy subcommittee of the ICC/CS to hold 5 meetings to develop an action plan for policy change to remove taxes and develop an advocacy brief, 20 people • Assign 2 government or implementing partner staff to conduct research, 25 days each • Conduct research to inform strategy and brief by facilitating transport and daily allowance for 2 staff, 10 days • Hold 1 high-level policy meeting, 30 people • Develop and print brief, 2 pages, 1,000 copies	Number of meetings (target: 6) Number of briefs disseminated (target: 1,000)	2016 2017	NPC,* MoH, GHS, Finance and Advocacy subcommittee, development partners, NGOs
PEE11. Inclusion of family planning in NHIS is	SP 5	PEE11.1 Legislative instruments for family planning finalised and advocated for approval by	NPC and GHS to attend legislative instruments finalisation team meetings	• Hold a 1-day meeting of the Finance and Advocacy subcommittee of ICC/CS to design and implement	Advocacy strategy completed	2016	NPC,* MoH, GHS, Finance and Advocacy subcommittee,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
operationalised		Parliament and lawmakers[270]	Advocate for approval by lawmakers	advocacy strategy to ensure full method mix availability in the NHI package (At minimum, including all of the contraceptives on the WHO essential medicines list [oral hormonal contraceptives, injectable hormonal contraceptives, IUDs, condoms, diaphragms, implantable contraceptives, intravaginal contraceptives],[271] natural, and permanent contraceptive methods for both men and women are available), 20 people • Attend 5 legislative instruments finalisation team meetings and advocate for the full package of contraceptive methods to be included in the NHI package, and accessibility is increased	Number of legislative instruments meetings attended by relevant staff or partners (target: 100%)		development partners, NGOs
PEE12. Improved access to policy information, with FP policies widely disseminated and available on MoH, GHS, and NPC websites		PEE12.1 Upload and print all MoH, GHS, and NPC FP policies[272]	MoH, GHS, and NPC to upload all FP polices and print copies for distribution	• Print 10 documents, 100 pages each, 2,000 copies • Assign MoH, GHS, and NPC staff to upload all FP policies online for public access, 10 days annually per organisation	Number of policies uploaded and printed (target: 5 policies printed in 2016, 5 printed in 2017; ongoing uploading electronically)	2016 2017 2018 2019 2020	NPC,* MoH,* GHS,* development partners
PEE13. HWs are informed of key policies and implications for their work	SP 5	PEE13.1 Plan for policy/strategy dissemination to include targeted briefs designed for HWs, etc., that will clearly tell them about what the policies mean for	Develop briefs for HWs biennially to update them on current policies and implications for their work	• Assign government or implementing partner staff, 20 days biennially • Hold 5 1-day biennial meetings, 25 people each	Number of meetings held (target: 15) 10-page briefs	2016 2018 2020	GHS,* NPC, MoH, Finance and Advocacy subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		their work			developed for HWs		
			Print and distribute briefs	• Print 10-page brief, 30,000 copies biennially • Hold 3 zonal dissemination meetings biennially, 50 people per zone	Number of briefs printed and disseminated to 10 regions and posted to the MoH website (target: 90,000)	2016 2018 2020	GHS,* NPC, MoH, Finance and Advocacy subcommittee, development partners, NGOs

Area 5: Financing

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
F1. Financing gaps for family planning are identified, and available funding information is disseminated to ensure transparency and accountability for financing and results, and to avoid duplication of efforts	SP 5	F1.1 Conduct an annual FP gap analysis to align development and implementing partners' available funding and workplans with the CIP	Support gap analysis, including data gathering, analysis, synthesis, validation, and reporting of data	• Hire 2 consultants, 60 days each in year 1, 30 days each in years 2–5 • Hold annual meeting with government, partners and development partners, 50 people	Gap analysis conducted annually	2016 2017 2018 2019 2020	GHS,* NPC,* MoH, Finance and Advocacy subcommittee, development partners, NGOs
			Conduct annual review of gap analysis by stakeholders	• Hold 1-day meeting, 80 people • Print 50 pages, 80 copies	Number of participants at gap analysis meeting (Target: 80)	2016 2017 2018 2019 2020	GHS,* NPC,* MoH, Finance and Advocacy subcommittee, development partners, NGOs
		F1.2 Design and implement a resource mobilisation plan, with a focus on identifying and financing gaps for priority activities first	Develop a resource mobilisation plan	• Assign 1 government staff and 1 implementing partner staff, 30 days each; review and editing by 8 other staff, 5 days each • Print 50 pages, 100 copies	Resource mobilisation plan developed	2016	GHS,* NPC,* MoH, Finance and Advocacy subcommittee, development partners, NGOs
			Present and review resource mobilisation plan at regular ICC/CS meetings	• Review included in regular ICC/CS meetings, no additional cost	Number of times the resource mobilisation plan is presented/reviewed at ICC/CS meetings (target: 5)	2016 2017 2018 2019 2020	GHS,* NPC,* MoH, ICC/CS, Finance and Advocacy subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
F2. An official budget line for FP commodities (separate from reproductive health) is created in the MoH and MoF budgets to improve financial sustainability by increasing national GoG funding for family planning	SP 4	F2.1 Create a budget line item for FP commodities separate from RH to ensure that allocations for family planning are ring fenced and not grouped with RH generally	Host annual meetings with MPs and ministry officials to advocate for increased funding	• Hold an annual 1-day meeting, 50 people	Number of meetings held a year with parliamentarians and ministry officials annually (target: 1 meeting held annually, 30 MPs and officials per meeting)	2016 2017 2018 2019 2020	NPC,* GHS, MoH, Parliament, development partners, NGOs
		F2.2 Advocate with the GoG/ MoH to ensure secure and timely commitment and release of funds to contraceptive and other RH commodities	Develop policy briefs advocating for increases in and timely delivery of the FP line items, aimed at MPs and key decisionmakers	• Assign 4 government or implementing partner staff, 15 days each, to develop briefs: 1 in 2016, 1 in 2018, 1 in 2020 • Review and finalise at regular Finance and Advocacy subcommittee meetings, no additional cost • Print and disseminate 3 policy briefs, 2 pages, 1,000 copies each year	Number of copies of policy briefs printed and disseminated (target: 2,000)	2016 2018 2020	NPC,* GHS, MoH, Parliament, development partners, NGOs
F3. An official budget line for FP programmes (separate from reproductive health) is created in the MoH budget	SP 5	F3.1 Create a budget line item for FP programming (including human resources, infrastructure, and management of health systems for family planning, including supportive supervision)	Implement FP expenditure tracking to monitor expenditures against pledged annual budgets for the government and partners	• Assign 1 government and 1 implementing partner staff, 30 days each, annually • Review FP expenditure tracking report annually at a regular ICC/CS meeting, no additional cost • Print expenditure tracking report, 20 pages, 500 copies	Annual expenditure tracking report available	2016 2017 2018 2019 2020	NPC,* GHS, MoH, Parliament, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Advocate for a separate line item for FP programming at annual meetings with MPs and ministry officials to advocate for increased funding	• Activities included under other Financing activities, no additional cost	Separate line- item advocacy arguments presented at annual meetings with MPs and ministry officials	2018 2019 2020	NPC,* GHS, MoH, Parliament, development partners, NGOs
			Develop a policy brief advocating for a separate line item for FP programming aimed at MPs and key policymakers	• Assign 4 government or implementing partner staff to develop brief, 15 days each • To be reviewed and finalised at a regular Finance and Advocacy subcommittee meeting, no additional cost • Print and disseminate policy brief, 2 pages, 1,000 copies	Number of copies of policy brief printed and disseminated (target: 1,000)	2019	NPC,* GHS, MoH, Parliament, ICC/CS, development partners, NGOs
F4. Subnational budgets prioritise financing for family planning, leading to improved sustainability of programmes	SP 5	F4.1 Develop sound policy directives, guidelines, and tools to assist subnational levels to allocate resources to family planning	Advocate with MoH to issue policy directive to Regional Health Directorates mandating that a portion of regional health budgets are allocated to family planning	• Hold 4 meetings with MoH to advocate for issuance of policy directive, 15 people	Policy directive issued	2017 2018 2019 2020	NPC,* GHS, MoH, development partners, NGOs
		F4.2 Provide consistent technical assistance and advocacy to help subnational levels make evidence-based decisions related to programming, budgeting, and tracking expenditures for family planning to ensure that it is fully integrated and that subnational budgets continuously reflect increased finances for family planning	Advocate with and provide technical support to Regional Health Directorates to programme, budget, and track expenditures for family planning	• Assign 2 staff from NPC and GHS, 60 days annually • Facilitate transport and daily allowance for teams of 2 staff from NPC and GHS to travel to regions biannually (starting with 6 in 2016 and 10 in 2017–2020) to conduct advocacy and provide technical support to Regional Health Directorates, 5 days per region per trip	Number of technical assistance visits provided by staff Number of Regional Health Directorates funding family planning as a separate line item	2016 2017 2018 2019 2020	NPC,* GHS, MoH, regions, development partners, NGOs
F5. Level of FP support from development partners is		F5.1 Organise FP development partners meetings to invite new and increased FP	Hold annual 1-day advocacy meeting with key FP development partners Invite key partners previously	• Hold annual 1-day meetings, 80 people	Number of participants at partner meeting (target: 80)	2016 2017	NPC,* GHS, MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
increased through targeted advocacy		financing commitments from partners in line with the resource mobilisation plan and funding gaps identified	identified as potential FP development partners		Documentation of number and value of commitments made	2018 2019 2020	
		F5.2 Identify new FP development partners that are major funders of family planning globally, develop FP resource mobilisation proposals, and submit proposals to solicit support	Identify traditional and new FP development partners known globally Use FP gap analysis document and prepare proposal documents Submit and follow up for funding approval	• Hold a biennial Finance and Advocacy subcommittee meeting to create a development partner list and prioritise outreach, 30 people • Assign 2 government staff to prepare and submit proposals documents, 30 days annually	Development partner list created Number of proposals submitted (target: 3 annually, 1 of which should be to a new development partner)	2016 2017 2018 2019 2020	NPC,* GHS, MoH, Finance and Advocacy subcommittee, development partners, NGOs
		F5.3 Mobilise resources from the Global Fund (GF) to procure contraceptives to expand access to services, including PMTCT of HIV, and improve infrastructure and systems for logistics management[273]	Leverage opportunities from the next GF grant proposal development and mobilise resources Identify key investment areas and include those in GF concept note and proposals, including the following: Funds for the procurement of condoms and other contraceptives to expand access to FP services, including PMTCT of HIV Prioritise improvements in warehouse management processes and LMIS	• Hold 3 meetings of the Finance and Advocacy subcommittee of the ICC/CS to plan for how to increase FP resources in the next GF application, no additional cost	Quantity of condoms procured with GF support Quantity of other contraceptives procured with GF support Amount of funding for infrastructure logistics management improvement Number of meetings held (target: 3)	2016 2017 2018 2019 2020	NPC,* GHS, MoH, Finance and Advocacy subcommittee, development partners, NGOs
		F5.4 Advocate with the Multi-donor Budget Support (MDBS) in its	Map contributors to MDBS Invite MDBS contributors to	• Invite MDBS contributors to FP advocacy meetings, costing included under other activities	Number of advocacy meetings with MDBS	2016 2017	NPC,* GHS, MoH, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		funding cycle to specifically earmark funding for contraceptives within the next POW budget period	FP advocacy meeting and make a case for FP investments Hold one-on-one advocacy meetings with MDBS contributors to increase their FP investment MoH, NPC, and GHS attend MDBS meeting (organised by MoF) and advocate for increased FP investments	in PEE and Financing • Hold 5 small meetings with MDBS contributors annually, 10 people • MoH, NPC, and GHS to participate at regular MDBS meetings, no additional cost	contributors in attendance (target: 2 large and 5 small meetings annually)	2018 2019 2020	partners, NGOs
F6. Non-traditional donors (e.g., corporations and media) from the private sector are educated about the benefits of investing in family planning to improve sustainability		F6.1 Organise FP advocacy meetings with various corporate officers on corporate social responsibility investments for family planning[274]	Hold a series of FP lunch briefings or cocktails for chief executive officers, executives, and corporations and utilise advocacy tools such as RAPID and Ghana Arise; have high-level officials, including the Minister of Health, host the advocacy briefings	• Hold a series of 3 briefings biennially, 50 people per meeting	Number of corporate representatives briefed on corporate social responsibility investments for family planning (target: 30) Documentation of number and value of commitments made	2017 2019	NPC,* GHS, MoH, ICC/CS, Finance and Advocacy subcommittee, development partners, NGOs
			Track and participate in business forums of private companies to highlight importance of family planning to socioeconomic development[275]	• Finance and Advocacy subcommittee to track private business forums and request invitations, no additional cost • Facilitate 3 staff to attend 3 business forums annually and present on the importance of family planning to socioeconomic development	Number of companies with supportive FP policies Private sector contributions to family planning	2016 2017 2018 2019 2020	NPC,* GHS, MoH, Finance and Advocacy subcommittee, development partners, NGOs, private sector
			Develop joint plans between FHD, CSOs, and corporate organisations to advance family planning (talk shows,	• Facilitate 3 staff to attend 6 meetings annually of CSOs and corporate organisations to strengthen family planning in	Joint plans in place and implemented Number of activities	2016 2017	NPC,* GHS, MoH, Finance and Advocacy

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			community events) as part of organisations' corporate social responsibility[276]	their corporate social responsibility programmes, including media donation of airtime, etc.	carried out on FP awareness creation by the private sector	2018 2019 2020	subcommittee, development partners, NGOs, private sector
F7. Implement improved financing mechanisms for FP/RH services	SP 5	F7.1 National FSP for contraceptives is updated and expanded to cover other RH commodities[277]	Update and implement the national FSP for contraceptives and expand plan to cover other RH commodities	• Hold 3 meetings to review and update the national FSP for contraceptives, 50 people	Updated and expanded FSP Percentage of FSP plan activities under implementation (target: 90%)	2017	NPC,* GHS, MoH, development partners, NGOs
		F7.2 Develop clear policy guidelines on use of FP commodities income (including from condoms)[278]	Develop a clear reinvestment plan for improving resource mobilisation and allocation for FP commodities supply (including condoms)	• Assign 2 GHS staff to draft policy guidelines on use of income, 30 days each • Hold 3 joint meeting between Finance and Advocacy subcommittee; PLS; and condoms and lubricants subcommittee of ICC/CS, 90 people • ICC/CS to conduct advocacy to finalise policy guidelines on use of income, no additional cost	Policy guidelines on use of condom income in effect	2017	NPC,* GHS, MoH, Finance and Advocacy subcommittee, PLS subcommittee, condoms and lubricants subcommittee, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		F7.3 Full cost recovery and other financial mechanisms are piloted for some commodities in the NGO and social marketing sectors[279]	Pilot full cost recovery for some commodities in the NGO and social marketing sectors and other financing mechanisms	• Hire consultant to conduct cost-recovery research and produce feasibility study with projected cost-benefits, 60 days • Align with market segmentation analysis, included under SMA activities, no additional cost • Hold 3 dialogue meetings with NGOs and social marketing organisations to plan for piloting of full cost recovery schemes for appropriate commodities, 40 people	Number of financing mechanisms implemented	2017 2019 2020	NPC,* GHS, MoH, development partners, NGOs
F8. Direct cost barriers to FP access are removed, thus improving access to FP services for all, not just those covered by NHIS	SP 5	F8.1 Advocate for all regions to adopt the scheme started in the Upper East region to implement a free FP programme (with or without implementation of the free service under NHIS) to address access issues for certain populations, including rural women, under-served communities, PLWHA, young people, etc., to improve accessibility, affordability, and availability	Advocate for free access to FP services for all populations, including those without NHIS, to ensure access to rights-based FP services	• Advocate at all relevant regional meetings for the creation of a non-insured budget line item for FP services at all public health facilities in the other 9 regions (e.g., invite Upper East region to make a presentation on the scheme, etc.), no additional cost	Number of regional events with advocacy for the creation of a non-insured budget line item for FP services (target: 1 annually)	2016 2017 2018 2019 2020	NPC,* GHS, MoH, regions, development partners, NGOs
			Relevant policymakers, including regional directors, undertake a study tour to see the Upper East free FP scheme in effect	• Upper East Region to host a 5-day study tour for GHS regional directors from the other 9 regions and relevant policymakers to see the benefits of the scheme in the region, 25 people	Number of policymakers attending study tour (target: 25)	2018	NPC,* GHS, MoH, regions, development partners, NGOs
F9. A strong evidence base exists for increasing the government's	SP 5	F9.1 Continue to build the evidence base to increase financial support for family planning, including family	Commission evidence-based research and modelling to inform advocacy efforts to	• Hire 3 consultant teams of 3 people each to conduct 3 evidence-based research and modelling, projects;	Number of evidence-based research and modeming projects	2016 2018 2019	NPC,* GHS, MoH, regions, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
and development partners' investments in family planning in Ghana		planning in NHIS; e.g., determining the return on investment in family planning; examining the economic rate of return from scaling up access to contraception; willingness-to-pay study; identify, test, and implement innovative new financing mechanisms for family planning using computer models	increase funding from government and development partners for family planning	e.g., determining the return on investment in family planning; examining the economic rate of return from scaling up access to contraception; willingness-to-pay study; identify, test, and implement innovative new financing mechanisms for family planning using computer models such as the Goals, Allocate, and Resource Needs model; 60 days each • Print 3 study reports, 50 pages each, 200 copies • Print 3 briefs, 4 pages each, 1,000 copies	to build the evidence base for family planning funding (target: 3)		partners, NGOs

Area 6: Stewardship, Management, and Accountability

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SMA1. Improved annual planning for family planning		SMA1.1 Develop relevant annual workplans	Develop detailed annual workplans for the GFPCIP	• Hold an annual 2-day workshop with stakeholders to develop the annual workplan for the GFPCIP, 50 people • Assign 2 government or implementing partner staff to prepare and finalise workplans, 20 days each	Annual FP workplans developed, reviewed annually, and disseminated electronically to all stakeholders	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Develop an annual National Condom and Lubricants implementation workplan to increase overall condom and lubricants use with a TMA approach[280]	• Hold an annual 2-day workshop, 50 people • Assign 2 government or implementing partner staff to prepare and finalise workplan, 20 days each	National Condom and Lubricants implementation workplan developed, reviewed annually, and disseminated electronically to all stakeholders	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs
SMA2. Improved national coordination, partnership, and integration of family planning between government and all stakeholders, including government organisations, NGOs, and development partners	SP 5	SMA2.1 Improve coordination and effectiveness of ICC/CS through a broadened mandate and strengthening of subcommittees[281]	Review and update the mandate and composition of the ICC/CS Reinvigorate existing and create new subcommittees with the appropriate TOR developed; review existing TOR and identify current membership: SBCC Access/Quality care Finance and Advocacy PLS (formerly Logistics) M&E Youth Reproductive Health Condoms and Lubricants	• Hold ICC/CS meeting to establish new subcommittees, no additional cost • GHS and NPC to work with subcommittees to develop and review/revise TOR, assign 2 government staff, 20 days • Nominate 1 "patron" to galvanise political will at higher levels, especially related to financing of family planning and provide facilitator honorarium, 5 days annually • Hold meeting to review composition of ICC/CS and TOR, 10 people	Report on review and updates Report on establishment of subcommittees	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
		SMA2.2 Hold regular meetings of ICC/CS and its subcommittees of[282]	Conduct regular meetings of ICC/CS and subcommittees	• Hold regular quarterly meetings of ICC/CS, 60 people • Hold monthly or quarterly regular meetings for each subcommittee based on TOR, 30 people (in addition to ad-hoc meetings specified in other areas of the GFPCIP)	Number of ICC/CS meetings held (target: 20) Number of subcommittee meetings held	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, all subcommittees, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				• Assign 2 government staff to gather information on ICC/CS membership, mandates, and activities, and track progress of action points using database, 20 days annually			
		SMA2.3 Improved participation of community members, including young people and other key groups, in policy monitoring, advocacy, and coordination[283]	Support young people and community members to be included in the monitoring of policy and design of programmes by inviting them to ICC/CS and other subcommittees	• Issue invitations to ICC/CS and other subcommittees, no additional cost	Number of young people and community members supported to attend and participate in ICC/CS and other decision-making meetings	2016 2017 2018 2019 2020	GHS,* NPC, MoH, ICC/CS, development partners, NGOs
		SMA2.4 Support leadership training of young people and community members to participate in policy monitoring, advocacy, and coordination activities	Identify and select participants Develop guidelines on leadership training for young people and community members—to include elements of training, etc.	• Hold 10 5-day training workshops for selected participants in regions, 25 people per region	Number of young people and community members with leadership and technical capacity built	2016 2019	GHS,* NPC, MoH, regions, development partners, NGOs
		SMA2.5 Improve reporting to FHD on activities for all partners involved in FP activities[284]	Develop format for reporting Share draft report at ICC/CS for inputs Finalise reporting format and circulate to partners	• Hold 1-day meeting of NPC and GHS to develop reporting format, 10 people • Include in agenda at relevant ICC/CS meeting, no additional cost	Finalised reporting format	2016	GHS,* NPC, MoH, ICC/CS, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		SMA2.6 Hold consultative meetings with relevant agencies to identify gaps, issues, and areas for improvement	Hold regular meetings with members of the relevant agencies to discuss issues	• Meet 8 agencies in offices twice a year to discuss key issues, gaps, etc., 6 people	Number of meetings held (target: 80)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs
SMA3. Improved coordination with the private sector to better leverage resources in FP service provision	SP 5	SMA3.1 Take the total market approach to all FP commodities and clarify the role of the public, nonprofit, and for-profit sectors through a thorough market segmentation analysis[285]	Segment the market to appropriately target clients with public, social marketing, and commercial resources	• Assign implementing partner staff to lead the update of the market segmentation process and conduct secondary data analysis of available data, 80 days • Assign government or implementing partner staff to develop a profile of the market segments through ,methods such as qualitative market assessments and willingness-to-pay studies, 60 days	Assessments conducted (target: 2)	2019	GHS,* NPC, MoH, development partners, NGOs, private sector
		SMA3.2 Align the contraceptive market analysis with the TMA strategy, with growth towards market segmentation—with the private sector taking on contraceptive brands[286]	Encourage development of contraceptive brands that the private sector can later take on	• Encourage development of contraceptive brands that the private sector can later take on, included in regular work and meetings, no additional cost	Number of private sector contraceptive brands introduced (target: 3)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		SMA3.3 Foster an enabling environment for the private sector in FP service provision and explore opportunities for PPPs[287]	Develop a TMA strategy based on the 2015 market analysis—including a private sector engagement plan to encourage strong partnerships between the public and private sectors to maximise and leverage resources to meet needs of different population groups at different levels. All partners to understand the current status, agree on the future "state" (method mix by wealth quintile, age, etc.), identify key target groups for potential growth, and be on board with the idea of "taking on" specific market segments, or "getting out of the way" for others to fill the role	• Assign 2 implementing partner staff to develop TMA strategy, 60 days • Hold 2 3-day workshops to finalise the strategy in 2016, 25 people • Hold a 3-day workshop to review the strategy in 2019, 25 people	FP TMA strategy developed in 2016 FP TMA strategy updated in 2019	2016 2019	GHS,* NPC, MoH, development partners, NGOs, private sector
			Disseminate the FP TMA strategy	• Hold a meeting to disseminate the TMA strategy in 2016, 50 people • Print the TMA strategy, 100 pages, 500 copies	FP TMA strategy printed and disseminated (target: 500)	2016	GHS,* NPC, MoH, development partners, NGOs, private sector, media
			Establish a routine market segmentation and analysis forum for stakeholders (public and private) to know and better understand the market conditions, distribution and policy, and regulatory environment in which they operate, and discuss options and issues related to PPPs[288]	• Hold a 1-day market segmentation and analysis forum for stakeholders annually, 50 people	Public-private forum held (target: 5)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			Hold regional meetings with private stakeholders to identify opportunities to expand access to family planning	• Hold 1 half-day workshop per region annually to sensitise private organisations on the importance of promoting and using FP services, 15 people	Regional public-private forums held (target: 10 annually)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, development partners, NGOs, private sector
			Develop and roll out segment-specific marketing campaigns; potential for PPP for branded marketing campaigns in conjunction with non-branded FP marketing	• Included in DC costs	Segmented marketing for family planning aligned with TMA strategy	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs, private sector
			Map distribution points for the various partners to see if the segmented markets are being served by the appropriate FP distribution points	• Assign 2 implementing partner staff to conduct biennial mapping of distribution points and analyse against the TMA strategy, 30 days • Present study findings at ICC/CS to take up recommendations, no additional cost	Number of TMA strategy distribution point mapping studies conducted (target: 2)	2017 2019	GHS,* NPC, MoH, development partners, NGOs, private sector
			Conduct study tours to countries where a comprehensive condom programming strategy has been implemented to learn lessons that can be applied in Ghana[289]	• Facilitate transport and daily allowance, international, 7 days, 10 people	Number of study tours conducted (target: 1)	2018	GHS,, NPC, MoH, development partners, NGOs, private sector

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SMA4. Improved coordination between national and regional levels, and within regions		SMA4.1 Coordinate with regions to ensure that national-level goals and plans reflect regional objectives, and vice versa	Ensure that Regional Health Directors are consulted in national planning processes, and orient them on how to effectively use and work with the Regional Resource teams	• Hold annual 2-day national planning meeting involving Regional Health Directors and other regional representatives, 50 people	Number of regional representatives attending annual planning meeting (target: 20 annually)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, development partners, NGOs
		SMA4.2 Define regional priority activities and programmes in alignment with national goals and annual plans	Develop annual regional FP plans that detail the regional health offices' and local partners' responsibilities	• Hold 10 2-day regional FP resource team retreats annually to develop regional FP plan, 20 participants per retreat	Number of regional annual plans developed (target: 50)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, development partners, NGOs
			Distribute the regional plan to officials at national, regional, and district levels, as well as NGOs, CSOs, and development partners	• Print regional plans annually, 10 50-page plans annually, 50 copies per plan	Regional plans printed and distributed (target: 2,500)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, development partners, NGOs
		SMA4.3 Improve coordination at the regional and district levels for FP programmes	Establish Technical Working Groups (TWGs) at the regional and district levels that include implementing partners as well as civil society and private sector representatives (first pilot in 3 regions, 25 districts) Provide resources for regional and district TWGs to carry out functions National ICC/CS to provide technical and logistical support and assist in the development of a basic indicator scorecard for family planning for the regional	• Assign 2 government or implementing partner staff to prepare TOR for regional and district TWGs, 5 days • GHS to send directive to each region and district to establish a regional or district TWG; directive to include guidelines, etc., no additional cost • Hold biannual regional TWG meetings in 3 regions in 2016–2018 and 10 regions in 2019–2020, 30 people	Regional and district TWGs established in each region and district (target: 226) Regional TWG meetings held (target: 10 regions with biannual meetings by 2020) District TWG meetings held (target: all districts with biannual meetings by 2020)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, districts, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
			and district levels to report on	• Hold biannual district TWG meetings in 25 districts in 2016–2018 and in 216 districts in 2019–2020, 20 people • Facilitate transport and daily allowance for 2 national staff to attend 1 regional TWG meeting annually • ICC/CS to review regional plan progress annually, no additional cost			
		SMA4.4 Regional focal people to coordinate services, NGO activities, and CIP implementation in each region	Appoint 2 regional focal persons to coordinate, support, and guide NGOs and partners' FP activities under the CIP framework (1 government and 1 implementing partner per region)	• Assign 1 government and 1 implementing partner staff to develop TOR, 3 days each • Appoint 2 regional focal people per region, 30 days annually each • Facilitate transport and daily allowance for 2 regional focal people per region, 20 days annually	Number of regional focal people appointed (target: 20 total, 2 per region)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		SMA4.5 District focal people to coordinate services, NGO activities, and CIP implementation in each district	Appoint 2 district focal persons to coordinate, support, and guide NGOs and partners' FP activities under the CIP framework (1 government and 1 NGO per district) District focal people to collaborate with regional focal people and send monthly reports	• Assign 1 government and 1 implementing partner staff to develop TOR, 3 days each • Appoint 216 district focal people, 20 days annually each • Facilitate transport and daily allowance for 2 district focal people, 216 districts, 10 days annually	Number of district focal people appointed (target: 216, 432 total, 2 per district) Percentage of district focal people submitting timely monthly update to region and GHS (target: 90%)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, districts, development partners, NGOs
SMA5. Improved knowledge to inform policy and programming		SMA5.1 Improve collaboration with research institutions and implementing partners to support learning from operational research to inform evidence-based decision making[290]	Document and share best practices Support annual Health Research Symposium	• Hold annual 2-day Health Research Symposium, 250 participants, 150 people-day attendance only, 100 people, support additional transport and daily allowance • Hold 10 organisational and planning meetings, 20 people	Number of Health Symposiums held (target: 5)	2016 2017 2018 2019 2020	GHS/HRDD,* GHS/ FHD, NPC, regions, districts, research institutions, academia, private sector, development partners, NGOs
			Support subcommittee members to translate research to inform policy making and programme decision making in government and implementing partner activities	• Select 10 Finance and Advocacy subcommittee members to meet as needed and report back to ICC/CS to serve as a working group for translating research to policy and programming • Hold 8 small meetings annually, 10 people	Working group formed for translating research to policy and programming Number of meetings of working group for translating research to policy and programming translation (target: 40)	2016 2017 2018 2019 2020	GHS,* ICC/CS, Finance and Advocacy subcommittee, development partners, NGOs
SMA6. FP/contraceptive use indicators are reported		SMA6.1 Provide tools for reporting and refresh HWs on DHIMS	Reporting tools printed and distributed Train HWs on current data	• Hold meeting to analyse and revise current reporting tools, 20 people • Assign 2 government staff to	Revised DHIMS/data collection tools, including disaggregation for	2016 2017	PPME,* GHS, MoH, regions, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
accurately from public and private facilities to improve quality of data entry			collection and reporting in DHIMS and other data collection tools	finalise after receiving guidance during meeting, 10 days each • Print reporting tools, 50 pages, 500 copies • Facilitate transport and daily allowance for distribution to all regions, 2 staff, 5 days per region • Hold 10 1-day regional training sessions, 25 people • Facilitate transport and daily allowance for Regional Resource Teams to conduct on-the-job training to scale down training in districts, 216 districts, 5 days per district	data from public and private facilities Number of HWs trained/received refresher training (target: 5,000)		partners, NGOs
		SMA6.2 Expand reporting of FP indicators in private and NGO sectors	Provide reporting tools to private and NGO providers Train/orient HWs in private sector on reporting of FP indicators Provide close mentoring and technical support	• Print reporting tools, 50 pages, 5,000 copies • Hold 1-day consultative meeting with key private market players, 30 people • Hold 1-day trainings annually for selected private sector organisations, 30 people	Reporting tool developed for and given to private sector Private sector HWs trained on use of reporting tool	2017 2018 2019 2020	PPME,* GHS, MoH, regions, development partners, NGOs, private sector
		SMA6.3 Conduct proper supportive supervision to improve timeliness of reporting	Establish deadlines for reporting and appropriate sanctions Prepare and distribute guide to reporting and sanctions	• Prepare and distribute M&E guide to reporting and sanctions, 20 pages, 500 copies • Provide clear consequences in writing of delayed submission of data, no additional cost	Number of copies of guide distributed (target: 500) Percentage of reports submitted timely (target: 90%)	2016 2017 2018 2019 2020	GHS,* MoH, regions, development partners
		SMA6.4 Review DHIMS tool	Review challenges with	• Assign government or	DHIMS Assessment	2016	PPME,* GHS,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		to address data quality and reduce incorrect data entry	data validation and DHIMS tool, and identify gaps related to FP indicators and data entry Implement corrective measures to improve DHIMS data quality and validation issues Develop validation tool as needed Hold meeting of key managers of DHIMS to fix error correction issues Train and equip managers with validation tools	implementing partner staff to guide and facilitate review process, emphasising FP indicators and data entry and validation issues, and develop validation tools, 40 days • Staff to participate in DHIMS review meetings, no additional cost • Hold 1-day orientation of managers on use of validation tool, 20 people • Cascade orientation on validation tool to districts through scheduled supportive supervision visits, no additional cost • Print and distribute validation tool, 10 pages, 5,000 copies	report and recommendations completed DHIMS error issues corrected Validation tool developed Number of copies of validation tool disseminated (target: 5,000)		MoH, regions, SD subcommittee, development partners, NGOs
		SMA6.5 Monitor and supervise data collection processes and analyse for quality and validity	Conduct workshops for district heads on proper monitoring and supervision of data collection and analysis	• Hold 10 half-day regional meetings for district heads/managers, 30 people per meeting	District heads trained on monitoring and supervision of data collection and analysis, and data collection and validation processes (target: 216)	2016	PPME,* GHS, MoH, regions, districts, development partners, NGOs
			Organise biannual meetings to review and validate data received from districts at regional level	• Hold annual meetings at regional level to validate data from districts, 50 participants per region	Number of regional meetings where data are validated (target: 10 annually)	2016 2017 2018 2019 2020	PPME,* GHS, MoH, regions, districts, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SMA7. Strengthened national LMIS for FP and other RH commodities at all levels to provide the required information for decision making in a timely manner		SMA7.1 Advocate for systems strengthening for the LMIS[291]	Conduct advocacy for systems strengthening for the LMIS	• Include advocacy for LMIS strengthening, training, supportive supervision, and additional resource for data entry and sharing in ongoing relevant advocacy activities, no additional cost	Number of meetings with specific advocacy for LMIS on the agenda (target: 2 annually)	2016 2017 2018 2019 2020	SSDM,* GHS, CMS, RMS, development partners, NGOs
			Print and distribute copies of SOP Manual for Management of Public Sector Health Commodities and accompanying LMIS tools to all facilities	• Print SOPs, 50 pages, 5,000 copies • Print LMIS tools, 50 pages, 5,000 copies	Number of SOP manuals and LMIS tools distributed (target: 10,000)	2016	SSDM,* GHS, CMS, RMS, development partners, NGOs
SMA8. FP/contraceptive use monitoring and supervision tools are reviewed for quality and effectiveness		SMA8.1 Review and update M&E tools, manuals, and guidelines	Assign government or implementing partner staff to evaluate and revise M&E tools, manuals, and guidelines as needed to enhance M&E of programme indicators (Standards & Tools for Monitoring Adolescent & Youth Friendly Health Services [AYFHS] 2016; RH Standards and Guidelines 2019; FP Protocol 2020) Organise workshops to finalise reviewed and edited monitoring and supervision tools being used	• Assign 2 government or implementing partner staff to evaluate and revise current M&E tools, manuals, and guidelines and make recommendations, 20 days • Hold 3 workshops per tool, 20 people	Number of M&E and supervision tools reviewed and revised (target: 3) Number of revised M&E and supervision tools circulated (target: 3)	2016 2019 2020	GHS,* NPC, MoH, development partners, NGOs
SMA9. M&E capacity improved to support GFPCIP implementation		SMA9.1 Train relevant personnel on the revised M&E tools	Train staff on new M&E tools relevant to family planning	• Organise national TOT on use of revised M&E tools, manuals, etc., 50 participants • Hold 3 subnational trainings for Regional Resource Teams,	Number of people trained on revised tools (target: 170)	2016 2017	NPC,* GHS, MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				40 participants per training • Regional Resource Teams to cascade training to district level, included in regular supportive supervision • Print and disseminate 3 M&E tools to regions, 50 pages, 500 copies per tool			
SMA10. Community monitoring tools provided and used to enhance accountability of services	SP 5	SMA10.1 Ensure FP scorecards are made available and used in public community activities by HWs and volunteers as well as those from NGOs and CBOs	Develop scorecard tools Produce scorecards for distribution Train and circulate use of community monitoring tools amongst public HWs, volunteers, NGOs, and CBOs involved in family planning	• Assign government or implementing partner staff to facilitate scorecard development process, 20 days • Hold 3-day workshops to develop scorecards, 20 people • Print scorecards, 2 pages, 20,000 copies • Include training for HWs, volunteers, NGO, and CBO staff who will use scorecards in regularly scheduled meetings and cascade them through supportive supervision	Scorecards developed, printed, and distributed HWs and community volunteers trained on scorecard use (target: 3,500) Scorecard analysis of programme statistics to assess if services are reaching all groups and promoting equity	2016 2017	GHS,* NPC, MoH, development partners, NGOs
SMA11. PPME department M&E capacity strengthened		SMA11.1 Equip PPME/GHS Division with adequately trained M&E staff	Request HR for staff support based on need	• Send letter to HR requesting for additional staffing, no additional cost • Allocate budget to support 1 additional M&E staff in PPME/GHS Division • Train staff on PPME/GHS activities via supportive supervision, no additional cost	Number of additional staff employed in PPME M&E department (target: 1)	2016 2017 2018 2019 2020	GHS,* MoH, development partners, NGOs
		SMA11.2 Strengthen M&E capacity in regions and	Build capacity for M&E in regions and districts	• Hold 10 regional refresher trainings for M&E officers in 2017 and 2019, 25	M&E officers trained	2017	GHS,* NPC, MoH, development

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
		districts		participants	(target: 226)	2019	partners, NGOs
		SMA11.3 Coordinate PPME/GHS department and FHD to improve collaboration	PPME to lead committee to work on data collaboration	• Compose committee of PPME and FHD staff to improve collaborations regarding data • Hold quarterly meetings, 10 participants	PPME and FHD collaboration deepened	2016 2017 2018 2019 2020	PPME and FHD at GHS*
SMA12. Improved NPC/MoH/GHS capacity to effectively lead, manage, and coordinate implementation of the GFPCIP		SMA12.1 Establish a committee comprising NPC, GHS, and MoH FP experts on staff, and facilitate monthly internal coordination meetings	Provide local and international trainings for members of the committee; e.g., trainings on FP programme management, coordination, etc. Allocate budget to facilitate regular coordination meetings of the committee	• Facilitate training budget, including transport and daily allowance, for selected staff to attend 1 international training and 6 national trainings, annually • Hold monthly staff coordination meetings, 15 participants	Number of NPC, GHS, and MoH staff with improved skills due to attending trainings (target: 35 staff) Number of staff coordination meetings held (target: 60)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs
		SMA12.2 Second senior staff of partner/consultants to NPC and GHS to support government staff and build on-the-job capacity through skill transfer	Partners to second senior staff or consultants to NPC and GHS to support CIP implementation and capacity of the agency staff	• Assign 2 government staff to develop TOR for 3 consultants, 9 days • Hire 3 senior technical people as consultants and second to NPC and GHS to support implementation of CIP and capacity building	Number of TOR prepared (target: 3) Number of consultants appointed on secondment (target: 3)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SMA13. District capacity to manage FP/ contraception programme strengthened and protocols adhered to through regular supportive supervision, leading to improved quality of rights-based FP services in the public and private sectors		SMA13.1 Ensure that FP programme management protocols have a guidance section for districts to ensure that healthcare facilities & trained providers are respectful of medical ethics & individual preferences, sensitive to gender & life-cycle requirements, & include the SOPs on privacy and confidentiality of services at all health facilities	Review protocols to ensure they are inclusive of all FP rights Print and circulate the protocols	• Hold meeting to review and edit protocols, 20 people • Assign 2 government or implementing partner staff to finalise edits and documents for production, 20 days each • Print protocols to circulate to regions and districts for distribution to all health facilities, 100 pages, 10,000 copies	Protocols reviewed and edited Number of protocols distributed (target: 10,000)	2017	GHS,* NPC, MoH, development partners, NGOs
		SMA13.2 Build capacity of district managers to coordinate, monitor, supervise, and manage programme by ensuring that all appropriate protocols are followed[292]	Train supervisors at district level to use all FP protocols, including Standards & Tools for Monitoring Adolescent & Youth Friendly Health Services (AYFHS) in Ghana	• Hold 10 training workshops in regions to build capacity of district managers of family planning, 25 people per workshop	Number of people trained (target: 216) Capacity of district managers built	2018	GHS,* NPC, MoH, development partners, NGOs
		SMA13.3 Implement supportive supervision using all FP protocols and logistics tools, including SOPs on privacy and confidentiality of services and the Standards & Tools for Monitoring Adolescent & Youth Friendly Health Services (AYFHS) in Ghana[293]	Supervisors regularly visit and ensure that protocols are followed for supportive and positive supervision—national supervision to regions semi-annually; regional supervision to districts quarterly; district supervision to facilities monthly; weekly supervision of CHPS	• Provide per diem, driver, and fuel for supportive supervision to reach 10 regions semi-annually • Provide per diem, driver, and fuel for supportive supervision to reach 216 districts quarterly (230 days due to size of metropolitan areas) • Provide per diem, driver, and fuel for supportive supervision to reach 4,250 facilities monthly • Provide per diem and fuel for	Proportion of FP providers supervised at least 6 times annually (target: 100%) Supportive supervision to assess provider practices to ensure that services are not subject to medically unnecessary barriers to access, including discrimination	2016 2017 2018 2019 2020	GHS,* NPC, MoH, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
				supportive supervision to reach 3,000 CHPS outreach zones monthly (CHPS outreach to be supervised weekly, family planning to support one-quarter of supervision visits)			
		SMA13.4 Ensure frequent site visits to maintain standards	Consultants and Regional Resource Teams carry out medical site visits to monitor FP activities	• Fund programme for site visits, 4,250 sites to be visited annually, by district (2 per day) • 1 regional person to accompany consultants	Number of site visits carried out annually (target: 4,250)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, districts, development partners, NGOs
		SMA13.5 Request regular updates from district heads responsible for family planning	Internal weekly meetings at district level led by FP coordinator Monthly reports sent to regions for onward transmission to higher levels Working group comprising PPME, GHS FP programme officer, and programme officer from NPC to provide additional review of data and report after regional comments	• Establish working group of PPME, GHS, and NPC to review data and report quarterly • Hold quarterly working group meetings, 10 people	Number of district reports reviewed and written feedback provided to regions (target: 40 annually)	2016 2017 2018 2019 2020	GHS,* NPC, MoH, regions, districts, development partners, NGOs
SMA14. Key FP regional and district planners and implementers are knowledgeable about the GFPCIP and have developed regional workplans		SMA14.1 Hold regional GFPCIP dissemination events	Disseminate the GFPCIP to key regional and district stakeholders through regional events	• Hold 10 regional GFPCIP dissemination events to be attended by key regional and district representatives, including political leaders, coordinators, and community representatives, 100 participants per regional event • Print copies of the GFPCIP,	Number of participants at regional GFPCIP dissemination events (target: 1,000)	2016	GHS,* NPC, MoH, regions, districts, development partners, NGOs, CSOs, religious institutions, media, traditional authorities, academia,

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
for family planning based on the national GFPCIP				200 pages, 1,000 copies • Print copies of the shorter advocacy- and implementer-focused version of the CIP, 50 pages, 5,000 copies			private sector
		SMA14.2 Develop 10 costed regional FP workplans for 2016–2020, aligned to the national GFPCIP	Develop regional roll-out plan with lead consultant Assign teams to provide technical support to regions, following 10-step regionalised CIP process Finalise and launch 10 regional FP workplans aligned with the GFPCIP	• Hire 1 consultant to lead process and train staff to provide technical support to regions, 120 days • Assign government or implementing partner staff to work in teams of 5 to provide technical support to regions, 5 people, 40 days each per region • Facilitate transport and daily allowance for 5 people, 20 days per region • Hold regional meetings, 10 per region, 20 people each • Print 10 regional FP workplans, 100 pages, 200 copies each	Number of regions with FP workplans aligned with the CIP (target: 10)	2016	GHS,* NPC, MoH, regions, development partners, NGOs

Strategic Results	SP	Activity	Sub-activities	Inputs	Output Indicators	Timeline	Lead and Collaborating Organisations
SMA15. GFPCIP is regularly assessed and evaluated to guide future FP strategy development and programming		SMA15.1 Develop performance review mechanisms and organise internal reviews annually to assess progress	Hold meeting of coordinators, team, MoH/GHS, and partners Conduct annual national review of FP programme performance Circulate recommendations and review action steps Establish a small working group to ensure that recommendations are implemented to make significant improvements based on M&E data	• Hold 1 internal government review/planning meeting annually, 20 participants • Hold annual review of national FP programme with headquarters managers, regional managers, regional directors, etc., 100 people; facilitate travel and per diem for 50 people • Establish a small working group to monitor implementation of recommendations made post review, to meet quarterly, and report to ICC/CS biannually, 20 people	Recommendations of review implemented	2016 2017 2018 2019 2020	NPC,* GHS, MoH, regions
		SMA15.2 Perform mid-term review and end-of-plan evaluation of the GFPCIP	Recruit consultant to lead mid-term review process to assess implementation and impact report; recommendations circulated to all stakeholders and partners	• Hire consultant, 60 days • Facilitate transport and daily allowance for 3 people to visit 4 regions to review implementation process, 3 days per region • Prepare report and recommendations and submit to ICC/CS, MoH, GHS and NPC	Consultant hired Mid-term review completed and recommendations submitted	2018	NPC,* GHS, MoH, regions, development partners, NGOs
			Recruit consultants to conduct end-of-plan evaluation and provide recommendations for future programming success post GFPCIP Circulate report to all stakeholders and partners	• Hire 2 consultants, 80 days • Facilitate transport and daily allowance for 4 people to visit 5 regions to review implementation process, 5 days per region • Prepare report and recommendations and submit to ICC/CS, MoH, GHS, and NPC	Consultants hired End-of-plan review completed and recommendations submitted	2020	NPC,* GHS, MoH, regions, development partners, NGOs

ANNEX B. TABLES OF STRATEGIC RESULT COSTING, IN USD

Area 1: Demand Creation

		2016	2017	2018	2019	2020	Total
1	DC1. Multipronged rights-based SBCC strategy developed based on evidence and situational assessment of current SBCC interventions to improve the sociocultural environment for reproductive health and family planning, including behavioural factors, social and gender norms	154,260	0	0	0	0	**154,260**
2	DC2. Improved use of tailored media and communication materials for FP education	290,373	305,485	339,174	410,547	514,905	**1,860,483**
3	DC3. Innovative media initiatives used to create demand for FP services	26,649	17,322	21,141	19,877	20,374	**105,362**
4	DC4. Ethical use of media and advertisement on family planning practiced	65,781	167,543	3,768	40,225	3,959	**281,275**
5	DC5. All CHPS CHNs, CHOs, and CHVs are trained on rights-based FP demand creation and supplied with materials to improve CHPS capacity for rights-based FP demand creation	108,049	39,975	0	0	0	**148,024**
6	DC6. Mhealth technology piloted for household-level use	0	170,822	147,865	142,516	129,521	**590,724**
7	DC7. Role of champions, FBOs, religious leaders, civil societies, and opinion makers strengthened to create an enabling environment for increased demand for FP services and products	175,912	90,543	175,703	95,127	175,997	**713,280**
8	DC8. FP/contraceptive education included and fully implemented as part of the life skills teaching curricula provided in junior and senior high schools, with improved capacity of relevant teachers to deliver FP/contraception education	502,432	409,803	355,939	364,837	373,958	**2,006,968**

		2016	2017	2018	2019	2020	Total
9	DC9. FP/contraception education through peer-to-peer approach scaled up	3,000	600,727	486,390	495,319	507,702	**2,093,139**
10	DC10. Male involvement in FP demand creation improved	0	3,115	3,193	3,273	3,354	**12,935**
11	DC11. Communities and groups with increased awareness of FP benefits through community mobilisation events	38,915	39,888	40,886	41,908	42,955	**204,553**
12	DC12. Educated community members and clients who know and are empowered to demand their rights to FP/contraception information and services, including availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation	6,656	41,000	5,828	0	6,123	**59,607**
	Total	**1,372,026**	**1,886,222**	**1,579,885**	**1,613,628**	**1,778,848**	**8,230,609**

Area 2: Service Delivery

		2016	2017	2018	2019	2020	Total
1	SD1. Community-based FP/contraception services expanded in all CHPS facilities to improve access to comprehensive FP services	323,297	33,024	33,850	34,696	35,563	**460,430**
2	SD2. Access to facility-based FP/contraception services improved	302,186	186,256	9,172	2,234	9,637	**509,485**
3	SD3. FP access through outreach services improved	37,039	76,875	157,594	323,067	331,144	**925,719**
4	SD4. Quality of FP/contraception services in CHPS compounds, clinics, health centres, and all facilities improved	13,313	0	0	0	0	**13,313**
5	SD5. Improved FP/contraception quality of care in clinics, health centres, and hospitals	298,786	243,264	76,934	78,858	80,829	**778,672**
6	SD6. FP/contraception services integrated with other outpatient and inpatient services	287,013	287,000	294,175	301,529	309,068	**1,478,785**
7	SD7. "Lost to follow-up" for FP services minimised	1,152,500	1,094,188	1,121,542	1,241,116	1,178,320	**5,787,666**
8	SD8. Implement task shifting/sharing for LARCs to lower cadre of HWs to build human resource capacity for FP service delivery	213,127	214,418	219,778	225,273	230,905	**1,103,501**
9	SD9. Continuous refresher training and capacity building provided to HWs	77,922	186,974	220,907	210,276	215,533	**911,611**
10	SD10. FP/contraception pre-service training for doctors, midwives, and nurses strengthened	627,768	0	0	90,531	31,887	**750,186**
11	SD11. Im proved skills of current HWs to improve availability and access to FP services	7,620	369,000	0	387,681	0	**764,301**
12	SD12. FP clinic staff motivated	32,708	25,839	26,485	27,147	27,825	**140,004**
13	SD13. Improved access and quality of FP services in the private sector	208,061	50,327	51,585	52,875	54,197	**417,045**

		2016	2017	2018	2019	2020	Total
14	SD14. Improved access to and utilisation of FP/contraception services by young people	2,966,525	830,938	1,253,896	1,206,714	1,656,557	**7,914,631**
15	SD15. Educated HWs who know about client rights to FP/contraception information and services, including availability, accessibility, quality, equity and non-discrimination, informed choice, transparency, accountability, and voice and participation	87,535	71,750	63,038	43,076	0	**265,398**
16	SD16. SDPs equipped with the necessary HWs and supplies to provide rights-based FP services	20,570,928	22,466,866	24,551,253	26,845,366	29,343,258	**123,777,671**
	Total	**27,206,329**	**26,136,719**	**28,080,209**	**31,070,438**	**33,504,723**	**145,998,418**

Area 3: Contraceptive Security

		2016	2017	2018	2019	2020	Total
1	CS1. Forecasting, quantification, and procurement plans developed	28,188	67,259	29,615	24,382	31,114	**180,557**
2	CS2. FP commodities procured per the quantification and procurement plan	2,773	2,843	2,914	2,987	3,061	**14,578**
3	CS3. ECs are procured per the quantification and procurement plan	210,298	237,631	243,572	249,662	255,903	**1,197,067**
4	CS4. Timely delivery of shipments ensured	0	0	0	0	0	**0**
5	CS5. Warehousing capacity and efficiency improved	17,384	0	27,579	0	0	**44,963**
6	CS6. Distribution of protocols set/revised to improve distribution channels and commodity supplies and systems	22,770	0	0	0	0	**22,770**
7	CS7. Distribution system improved	1,201,806	1,316,781	1,134,675	1,163,042	1,192,118	**6,008,421**
8	CS8. Government and development partner workplans aligned to the supply chain master plan	0	3,411	0	0	0	**3,411**
9	CS9. Improved supply and distribution of commodities through systemic and innovative changes	9,464	0	0	0	0	**9,464**
10	CS10. Improved commodity regulatory practices through addressing regulatory challenges currently resulting in delayed distribution of commodities and delays in commodity supply	4,148	4,252	4,358	4,467	4,579	**21,805**
11	CS11. Regulatory bodies actively engaged in regular monitoring and testing of FP/RH commodities in the public and private sectors, and resource constraints for post-market QA resolved	18,596	13,312	13,644	13,986	14,335	**73,873**
12	CS12. Theft prevented and appropriate action taken when theft occurs	0	24,088	0	0	0	**24,088**

		2016	2017	2018	2019	2020	Total
13	CS13. Commodity procurement improved through revision of procurement guidelines	0	7,756	0	0	0	**7,756**
14	CS14. Improved stock management for commodities at the facility level	11,714	0	0	0	0	**11,714**
15	CS15. Improved detection and disposal of damaged/expired FP commodities	4,664	27,470	0	0	0	**32,134**
	Total	**1,531,807**	**1,704,803**	**1,456,358**	**1,458,525**	**1,501,111**	**7,652,603**

Area 4: Policy and Enabling Environment

		2016	2017	2018	2019	2020	Total
1	PEE1. Family planning is seen as a critical element of the national development agenda and a critical component to achieving the demographic dividend in Ghana, along with simultaneous investments in education, healthcare, and governance	3,328	43,512	3,497	45,715	3,674	**99,726**
2	PEE2. Multisectoral coordination ensures that FP and population goals and objectives are appropriately integrated with other health and development initiatives (including finance, social welfare, education, women's affairs, etc.)	41,399	33,290	43,495	34,976	45,697	**198,857**
3	PEE3. Improved ability of key policymakers to ensure that FP rights are protected in policy and programme design	555	10,162	55,434	10,676	58,240	**135,066**
4	PPE4. A national coalition of advocates/champions drawn from Parliament, local, cultural, and religious leaders to support rights-based family planning is established and supported	441,661	452,702	464,020	475,620	487,511	**2,321,513**
5	PEE5. Policymakers are able to advocate for bills related to family planning	1,664	4,665	1,748	4,901	1,837	**14,815**
6	PEE6. Young people in schools receive improved FP/RH information and access to services due to clarified policies on these interventions for young people in schools	5,023	14,530	2,914	2,987	3,061	**28,516**
7	PEE7. Policy on access for young people to FP services in clinical and community settings is clarified; service providers are knowledgeable on official policies affecting access by young people	0	33,527	0	0	0	**33,527**
8	PEE8. FDA and GSA have harmonised roles as statutory bodies	8,320	11,371	0	0	0	**19,692**
9	PEE9. Improved collaborative relationship with the FDA to support timely and quality-driven contraceptive approval processes	2,219	1,137	0	0	0	**3,356**
10	PEE10. Taxation of contraceptives removed	15,644	3,255	0	0	0	**18,900**

		2016	2017	2018	2019	2020	Total
11	PEE11. Inclusion of family planning in NHIS is operationalised	1,309	0	0	0	0	**1,309**
12	PEE12. Improved access to policy information, with FP policies widely disseminated and available on MoH, GHS, and NPC websites	124,558	127,672	130,864	134,136	137,489	**654,720**
13	PEE13. HWs are informed of key policies and implications for their work	36,763	4,496	38,624	4,724	40,580	**125,188**
	Total	**682,445**	**740,321**	**740,596**	**713,735**	**778,088**	**3,655,184**

Area 5: Financing

		2016	2017	2018	2019	2020	Total
1	F1. Financing gaps for family planning are identified and available funding information is disseminated to ensure transparency and accountability for financing and results, and to avoid duplication of efforts	80,809	39,412	40,398	41,408	42,443	**244,470**
2	F2. An official budget line for FP commodities (separate from reproductive health) is created in the MoH and MoF budgets to improve financial sustainability by increasing national GoG funding for family planning	13,285	2,843	13,958	2,987	14,665	**47,738**
3	F3. An official budget line for FP programmes (separate from reproductive health) is created in the MoH budget	10,308	10,566	10,830	22,421	11,379	**65,505**
4	F4. Subnational budgets prioritise financing for family planning, leading to improved sustainability of programmes	23,688	28,861	29,582	30,322	31,080	**143,533**
5	F5. Level of FP support from development partners is increased through targeted advocacy	17,992	16,736	18,903	17,583	19,860	**91,074**
6	F6. Non-traditional donors (e.g., corporations and media) from the private sector are educated about the benefits of investing in family planning to improve sustainability	540	3,396	567	3,568	596	**8,668**
7	F7. Implement improved financing mechanisms for FP/RH services	0	50,874	0	18,543	19,006	**88,423**
8	F8. Direct cost barriers to FP access are removed, thus improving access to FP services for all, not just those covered by NHIS	0	0	12,962	0	0	**12,962**
9	F9. A strong evidence base exists for increasing the government's and development partners' investments in family planning in Ghana	79,812	81,807	83,852	128,923	132,146	**506,541**
	Total	**226,436**	**234,495**	**211,053**	**265,755**	**271,174**	**1,208,913**

Area 6: Stewardship, Management, and Accountability

		2016	2017	2018	2019	2020	Total
1	SMA1. Improved annual planning for family planning	23,094	23,671	24,263	24,870	25,491	**121,389**
2	SMA2. Improved national coordination, partnerships, and integration of family planning between government and all stakeholders, including government organisations, NGOs, and development partners	119,651	94,908	97,281	121,111	102,206	**535,158**
3	SMA3. Improved coordination with the private sector to better leverage resources in FP service provision	42,699	20,095	75,230	48,207	11,706	**197,936**
4	SMA4. Improved coordination between national and regional levels, and within regions	1,136,079	1,161,098	1,190,126	1,496,397	1,533,807	**6,517,507**
5	SMA5. Improved knowledge to inform policy and programming	104,899	107,522	110,210	112,965	115,789	**551,386**
6	SMA6. FP/contraceptive use indicators are reported accurately from public and private facilities to improve quality of data entry	115,288	205,836	45,630	46,771	47,940	**461,465**
7	SMA7. Strengthened national LMIS for FP and other RH commodities at all levels to provide the required information for decision making in a timely manner	30,000	0	0	0	0	**30,000**
8	SMA8. FP/contraceptive use monitoring and supervision tools are reviewed for quality and effectiveness	9,328	0	0	10,045	10,297	**29,670**
9	SMA9. M&E capacity improved to support GFPCIP implementation	36,968	70,286	0	0	0	**107,253**
10	SMA10. Community monitoring tools provided and used to enhance accountability of services	9,352	0	0	0	0	**9,352**
11	SMA11. PPME department M&E capacity strengthened	2,219	56,653	44,356	59,521	46,602	**209,350**
12	SMA12. Improved NPC/MoH/GHS capacity to effectively lead, manage, and coordinate implementation of the GFPCIP	200,666	202,879	207,951	213,150	218,479	**1,043,126**

		2016	2017	2018	2019	2020	Total
13	SMA13. District capacity to manage FP/contraception programme strengthened and protocols adhered to through regular supportive supervision, leading to improved quality of rights-based FP services in the public and private sectors	4,843,237	4,889,380	5,161,704	5,136,905	5,265,328	**25,296,554**
14	SMA14. Key FP regional and district planners and implementers are knowledgeable about the GFPCIP and have developed regional workplans for family planning based on the national GFPCIP	733,424	0	0	0	0	**733,424**
15	SMA15. GFPCIP is regularly assessed and evaluated to guide future FP strategy development and programming	40,788	41,808	62,542	43,924	99,209	**288,271**
	Total	**7,447,692**	**6,874,137**	**7,019,294**	**7,313,867**	**7,476,854**	**36,131,843**

REFERENCES

[i] Ghana Statistical Service, Ghana Health Service, and the DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[ii] Bloom, David E., David Canning and Jaypee Sevilla. 2003. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change.* Santa Monica, CA: RAND.

Population Reference Bureau. 2013. *Harnessing the Demographic Dividend*. Available at: http://www.prb.org/Multimedia/Video/2013/demographic-dividend-engage.aspx. Retrieved 5 May 2015.

[iii] Ghana National Population Council. 2013. *RAPID—The Change We Seek: Population and Development*. Accra: Republic of Ghana. Available at: http://www.healthpolicyproject.com/pubs/154_GHANARAPIDBookletFINAL.pdf. Retrieved 11 August 2015

[iv] Health Policy Project and Marie Stopes International. April 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. Washington, DC: Futures Group, Health Policy Project.

[v] *High-impact Practices in Family Planning.* 2014. Available at: https://www.fphighimpactpractices.org/. Retrieved 20 August 2014.

[vi] These targets were set at a national meeting with regional representatives held 22 May 2015 in Accra and will be used to inform the next Revised Population Policy of Ghana.

[vii] Ghana Statistical Service, Ghana Health Service, and The DHS Program. March 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[viii] National Development Planning Commission (NDPC). December 2014. *Ghana Shared Growth and Development Agenda (GSGDA) II, 2014 –2017*. Available at: http://www.ndpc.gov.gh/GPRS/MnE/Ghana%20Shared%20Growth%20and%20Development%20Agenda%202014-2017%20(GSGDA%20II)_December2014.pdf. Retrieved 5 May 2015.

[ix] UNFPA. 1995. *International Conference on Population and Development – ICPD – Programme of Action.* A/CONF.171/13/Rev.1. Report of the International Conference on Population and Development.

[x] Ghana Health Service. December 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition.

[xi] FP2020. 2014. *Family Planning 2020: Rights and Empowerment Principles for Family Planning.* Available at: http://www.familyplanning2020.org/resources/4697. Retrieved 9 January 2015.

1. Agency and Autonomy: Individuals have the ability to decide freely the number and spacing of their children. To exercise this ability, individuals must be able to choose a contraceptive method voluntarily, free of discrimination, coercion, or violence.
2. Availability: Healthcare facilities, trained providers, and contraceptive methods are available to ensure that individuals can exercise full choice from a full range of contraceptive methods (barrier, short-acting, long-acting reversible, permanent, and EC). Availability of services includes follow-up and removal services for implants and IUDs.
3. Accessibility: Healthcare facilities, trained providers, and contraceptive methods are accessible—without discrimination, and without physical, economic, sociocultural, or informational barriers.
4. Acceptability: Healthcare facilities, trained providers, and contraceptive methods are respectful of medical ethics and individual preferences, are sensitive to gender and life-cycle requirements, and respect confidentiality.
5. Quality: Individuals have access to contraceptive services and information of good quality, which are scientifically and medically appropriate. Quality of care is a multifaceted element that includes but is not limited to the following: a full choice of quality contraceptive methods; clear and medically accurate information, including the risks and benefits of a range of methods; presence of equipped and technically competent providers; and client-provider interactions that respect informed choice, privacy, and confidentiality, and client preferences and needs.
6. Empowerment: Individuals are empowered as principal actors and agents to make decisions about their reproductive lives, and can execute these decisions through access to contraceptive information, services, and supplies.
7. Equity and non-discrimination: Individuals have the ability to access quality and comprehensive contraceptive information and services free from discrimination, coercion, and violence. Quality, accessibility, and availability of contraceptive information and services should not vary by non-medically indicated characteristics, such as age, geographic location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital, or other status.
8. Informed choice: Individuals have the ability to access accurate, clear, and readily understood information about a variety of contraceptive methods and their use. To exercise full, free, and informed decision making, individuals can choose amongst a full range of safe, effective, and available contraceptive methods (barrier, short-acting, long-acting reversible, permanent, and EC).

9. Transparency and accountability: Individuals can readily access meaningful information on the design, provision, implementation, and evaluation of contraceptive services, programs, and policies, including government data. Individuals are entitled to seek remedies and redress at the individual and systems levels when duty bearers have not fulfilled their obligations regarding contraceptive information, services, and supplies.
10. Voice and participation: Individuals, particularly beneficiaries, have the ability to meaningfully participate in the design, provision, implementation, and evaluation of contraceptive services, programmes, and policies.

[xii] Health Policy Project. 2015. *Costed Implementation Plans for Family Planning: The Basics.* Available at: http://www.healthpolicyproject.com/pubs/812_CIPTheBasicsFINAL.pdf. Retrieved 6 April 2015.

[xiii] Singh, Susheela, Jacqueline E. Darroch, and Lori Ashford. 2013. *Adding It Up: The Need for and Cost of Maternal and Newborn Care—Estimates for 2012*. New York: Guttmacher Institute. Available at: http://www.guttmacher.org/pubs/AIU-MNH-2012-estimates.pdf. Retrieved 2 October 2014.

[xiv] *Performance Monitoring and Accountability 2020.* Available at: http://www.pma2020.org/about-fp2020

[xv] Kohler, Hans-Peter, and Jere R. Behrman. 2014. *Benefits and Costs of the Population and Demography Targets for the Post-2015 Development Agenda: Post-2015 Consensus*. Working Paper as of 3 October 2014. Available at: http://www.copenhagenconsensus.com/sites/default/files/population_assessment_-_kohler_behrman_0.pdf. Retrieved 6 April 2015.

[xvi] WHO. 2011. *WHO Guidelines: Preventing Early Pregnancy and Poor Reproductive Health Outcomes Amongst Adolescents in Developing Countries*. Available at: http://www.who.int/reproductivehealth/publications/adolescence/9789241502214/en/. Retrieved 19 November 2014

[xvii] FP2020. *Ghana Country Commitments.* Available at: http://www.familyplanning2020.org/reaching-the-goal/commitments/all-commitments/commitment/. Retrieved 11 March 2015.

[xviii] *FP2020 London Summit*. Available at: http://progress.familyplanning2020.org/commitment. Retrieved 2 October 2014.

[xix] *London Summit on Family Planning—July 11, 2012*. Available at: http://www.who.int/workforcealliance/media/events/2012/LondonSummitonFamilyPlanningOverview.pdf. Retrieved 2 October 2014.

[xx] Family Planning Summit Metrics Group. 2012. *Technical Note: Data Sources and Methodology for Calculating the 2012 Baseline, 2020 Objectives, Impacts and Costings*. Family Planning Summit, 2012.

[xxi] FP2020. 2014. *The 2012 London Summit on Family Planning*. Available at: http://www.familyplanning2020.org/about-us/the-2012-london-summit-on-family-planning. Retrieved on 2 October 2014.

[xxii] Sustainable Development Goals. 2015. *Open Working Group Proposal for Sustainable Development Goals.* Available at: https://sustainabledevelopment.un.org/sdgsproposal. Retrieved on 5 May 2015.

[xxiii] Sustainable Development Goals. 2015. *Final Draft of the Outcome Document for the UN Summit to Adopt the Post-2015 Development Agenda. 8 July 2015*. Available at: https://sustainabledevelopment.un.org/content/documents/7603Final%20draft%20outcome%20document%20UN%20Sept%20Summit%20w%20letter_08072015.pdf. Retrieved on 17 July 2015.

[xxiv] *FP2020 London Summit*. Available at: http://progress.familyplanning2020.org/commitment.

[xxv] For TFR and MCPR: Benin: 2011–12 DHS, Burkina Faso: 2010 DHS; Cote d'Ivoire: 2011–12 DHS; Ghana: 2014 DHS; Guinea: 2012 DHS; Liberia: 2013 DHS; Mali: 2012–13 DHS; Niger: 2012 DHS; Nigeria: 2013 DHS; Senegal: 2010–11 DHS; Sierra Leone: 2013 DHS. ICF International. 2015. *The DHS Program STATcompiler*. Available at: http://www.statcompiler.com. Retrieved 10 August 2015.

[xxvi] For TFR and MCPR: Benin: 2011–12 DHS, Burkina Faso: 2010 DHS; Cote d'Ivoire: 2011–12 DHS; Ghana: 2014 DHS; Guinea: 2012 DHS; Liberia: 2013 DHS; Mali: 2012–13 DHS; Niger: 2012 DHS; Nigeria: 2013 DHS; Senegal: 2010–11 DHS; Sierra Leone: 2013 DHS. ICF International. 2015. *The DHS Program STATcompiler.* Available at: http://www.statcompiler.com. Retrieved 10 August 2015.

[xxvii] *Millennium Development Goals Indicators*. 2014. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx. Retrieved 10 August 2015.

[xxviii] *Millennium Development Goals Indicators*. 2015. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx. Retrieved 10 August 2015.

[xxix] National Population Council. Health Policy Project (HPP). *RAPID: The Change We Seek*. Available at: https://www.healthpolicyproject.com/pubs/154_GHANARAPIDBookletFINAL.pdf. Retrieved 20 March 2015.

[xxx] *FP2020 London Summit*. Available at: http://progress.familyplanning2020.org/commitment.

[xxxi] For TFR and MCPR: Brazil: 1996 DHS; Egypt: 2014 DHS; Ghana: 2014 DHS; Thailand: 1987 DHS. ICF International. 2015. *The DHS Program STATcompiler.* Available at: http://www.statcompiler.com. Retrieved 10 August 2015.

[xxxii] For TFR and MCPR: Brazil: 1996 DHS; Egypt: 2014 DHS; Ghana: 2014 DHS; Thailand: 1987 DHS. ICF International. 2015. *The DHS Program STATcompiler.* Available at: http://www.statcompiler.com. Retrieved 10 August 2015.

[xxxiii] *Millennium Development Goals Indicators*. 2014. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx. Retrieved 10 August 2015.

[xxxiv] *Millennium Development Goals Indicators*. 2015. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx. Retrieved 10 August 2015.

[xxxv] National Population Council. Health Policy Project (HPP). *RAPID: The Change We Seek*. Available at: https://www.healthpolicyproject.com/pubs/154_GHANARAPIDBookletFINAL.pdf. Retrieved 20 March 2015.

[xxxvi] Government of Ghana. *National Development Planning Commission. 2013. Country Report: ICPD beyond 2014.*

[xxxvii] Ghana Statistical Service. 2013. *Population and Housing Census Report. Millennium Development Goals in Ghana.* July 2013. Available at: http://www.statsghana.gov.gh/docfiles/2010phc/MDG%20report%20(24-10-13).pdf. Retrieved 27 January 2015.

[xxxviii] Ministry of Health. 2007. *National Health Policy. Creating Wealth* Through *Health*. September 2007. Available at: http://www.moh-ghana.org/UploadFiles/Publications/NATIONAL%20HEALTH%20POLICY_22APR2012.pdf. Retrieved 27 January 2015.

[xxxix] 1988–2008: ICF Macro. 2010. *Trends in Demographic, Family Planning, and Health Indicators in Ghana, 1960–2008: Trend Analysis of Demographic and Health Surveys Data.* Calverton, Maryland, USA: ICF Macro. Available at: http: //dhsprogram.com/pubs/pdf/TR6/TR6.pdf. Retrieved 27 January 2015.

2013: Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. Detailed Indicator Report: Ghana 2013. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January.

[xl] Bloom, David E., David Canning and Jaypee Sevilla. 2003. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change.* Santa Monica, CA: RAND.

[xli] Bloom, David E., David Canning and Jaypee Sevilla. 2003. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change.* Santa Monica, CA: RAND.

Population Reference Bureau. 2013. *Harnessing the Demographic Dividend*. Available at: http://www.prb.org/Multimedia/Video/2013/demographic-dividend-engage.aspx. Retrieved 5 May 2015.

[xlii] DHS Programme. 2014. *Unmet Need.* Available at: http://dhsprogram.com/topics/Unmet-Need.cfm. Retrieved 4 November 2014.

[xliii] 2014: Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[xliv] 2014: Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International

[xlv] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[xlvi] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[xlvii] 1988–2008: Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. Ghana DHS 2008. Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

2011: Ghana Statistical Service, Ghana Health Service, UNICEF, UNFPA, Japan Official Development Assistance, USAID and ICF International. 2011. Ghana Multiple Indicator Cluster Survey (MICS). Available at: http://dhsprogram.com/pubs/pdf/FR262/FR262.pdf. Retrieved 23 March 2015.

2013: Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

2014: Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[xlviii] 1988–2008: Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008*. Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

2011: Ghana Statistical Service, Ghana Health Service, UNICEF, UNFPA, Japan Official Development Assistance, USAID and ICF International. 2011. *Ghana Multiple Indicator Cluster Survey (MICS).* Available at: http://dhsprogram.com/pubs/pdf/FR262/FR262.pdf. Retrieved 23 March 2015.

2013: Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at:

http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

2014: Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme ICF International.

[xlix] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[l] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[li] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lii] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[liii] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[liv] Ghana Health Service. 2014. The Health Sector in Ghana: Facts and Figures.

Snow, Rachel, Christopher, H. Herbst, David Haddad, Janet Kwansah, James Antwi, and Victor Francis Ekey. 2013. *Toward Interventions in Human Resources for Health in Ghana.* March 2013. Available at: http://elibrary.worldbank.org/doi/abs/10.1596/9780821396674_CH03. Retrieved 24 August 2015.

[lv] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lvi] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lvii] Ghana Statistical Service (GSS) and Macro International Inc. (MI). 1994. Ghana Demographic and Health Survey 1993. Calverton, Maryland: GSS and MI. Available at: http://dhsprogram.com/pubs/pdf/FR59/FR59.pdf. Retrieved, 3 April 2015.

[lviii] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[lix] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[lx] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lxi] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[lxii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[lxiii] Ghana Statistical Services, September 2008. *Ghana Living Standards Survey. Report of the Fifth Round.* Available at: http://www.statsghana.gov.gh/docfiles/glss5_report.pdf. Retrieved 20 March 2015.

[lxiv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[lxv] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[lxvi] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[lxvii] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lxviii] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[lxix] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*. Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[lxx] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[lxxi] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[lxxii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.*

Unpublished notes and analysis.

[lxxiii] EngenderHealth; The ACQUIRE Project. New York. Solo, J., et al. 2005. *Repositioning Family Planning—Ghana Case Study: 'Give them the Power.'*

[lxxiv] Ghana Health Service. 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

[lxxv] Ghana Health Service. 2014. The Health Sector in Ghana: Facts and Figures.

[lxxvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[lxxvii] USAID | DELIVER PROJECT, Task Order I. 2011. *Ghana: Market Segmentation Analysis.* Available at: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/GH_MarkSegm.pdf. Retrieved 11 March 2015.

[lxxviii] EngenderHealth. The ACQUIRE Project. New York. Solo, J., et al. 2005. *Repositioning Family Planning—Ghana Case Study: "Give them the Power."*

[lxxix] Performance Monitoring and Accountability 2020 (PMA2020) Project. Kwame Nkrumah. University of Science and Technology (KNUST). 2013. *Detailed Indicator Report: Ghana 2013*.Baltimore, MD: PMA2020. Available at: http://www.pma2020.org/sites/default/files/Detailed-Indicator-Report-GHPMA2013-20Aug2014.pdf. Retrieved 27 January 2015.

[lxxx] USAID | DELIVER PROJECT, Task Order I. 2011. *Ghana: Market Segmentation Analysis.* Available at: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/GH_MarkSegm.pdf. Retrieved 11 March 2015

[lxxxi] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana DHS 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[lxxxii] Ministry of Health. 2014. Holistic Assessment of the Health Sector Programme of Work 2013. Ghana. Final version July 2014. Available at: http://www.moh-ghana.org/UploadFiles/Publications/Holistic%20Assessment%20Report%20June%202014140811072318.pdf. Retrieved 27 January 2015.

[lxxxiii] Ghana Health Service. 2013. Annual Report: 2013 Annual Reproductive and Child Health Report. RCH, GHS. Available at: http://www.ghanahealthservice.org/downloads/GHS-Reproductive_and-Child-Health-Annual-Report-2013.pdf. Retrieved 11 March 2015.

Available at: https://www.google.com/fusiontables/DataSource?docid=1xxX5BkwVc8uSfRbY04WGMcQbZDPTSj8McMLsz7A#map:id=3&nid=4271.

[lxxxiv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[lxxxv] Global Health Workforce Alliance, World Health Organization (WHO). 2008. *Case Study: Ghana: Implementing National Human Resources for Health Plan.* Available at: http://www.who.int/workforcealliance/knowledge/resources/casestudy_ghana/en/. Retrieved 27 January 2015.

[lxxxvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[lxxxvii] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[lxxxviii] USAID | DELIVER PROJECT, Task Order I. 2011. *Ghana: Market Segmentation Analysis.* Available at: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/GH_MarkSegm.pdf. Retrieved 11 March 2015

[lxxxix] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[xc] Population Council. 2014. *Increasing Access to Family Planning in Ghana through Policy Change: Task-sharing to Enable Auxiliary Nurses to Provide Contraceptive Implant Services: Policy Brief.* Available at: http://www.popcouncil.org/uploads/pdfs/2014RH_GhanaTaskSharingPolicyBrief.pdf. Retrieved 20 January 2015.

[xci] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[xcii] Ntsua, Stephen, Placide Tapsoba, Gloria Quansah Asare, and Frank Nyonator. 2011. *Repositioning Community-Based Family Planning in Ghana: A Case Study of the Community-Based Health Planning and Services (CHPS).* Accra: Population Council.

[xciii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[xciv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015-2020.* Unpublished notes and analysis.

[xcv] Population Council. 2014. *Increasing Access to Family Planning in Ghana through Policy Change: Task-sharing to Enable Auxiliary Nurses to Provide Contraceptive Implant Services: Policy Brief.* Available at: http://www.popcouncil.org/uploads/pdfs/2014RH_GhanaTaskSharingPolicyBrief.pdf. Retrieved 20 January 2015.

[xcvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[xcvii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[xcviii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[xcix] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[c] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[ci] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[ciii]Ministry of Health. 2012. *Health Commodity Supply Chain Master Plan.* September 2012. Available at: http://iaphl.org/files/2014/05/GhanaSCM-2013.pdf. Retrieved 11 March 2015

[civ]Ministry of Health. 2011. *Meeting the Commodity Challenge: The Ghana National Reproductive Health Commodity Security Strategy 2011–2016.* The Ministry of Health. January 2011.

[cv]Ministry of Health. 2004. *Meeting the Commodity Challenge: The Ghana National Contraceptive Security Strategy 2004 – 2010.* The Ministry of Health Agencies and Partners. Available at: http://www.rhsupplies.org/fileadmin/user_upload/Country_pages/Ghana/Systems/strategy.pdf. Retrieved 27 January 2015.

[cvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cvii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cviii] Ministry of Health. January 2011. *Meeting the Commodity Challenge: The Ghana National Reproductive Health Commodity Security Strategy 2011–2016.* The Ministry of Health.

[cix] Ministry of Health. 2012. *Health Commodity Supply Chain Master Plan.* September 2012. Available at: http://iaphl.org/files/2014/05/GhanaSCM-2013.pdf. Retrieved 11 March 2015.

[cx] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxii] Ministry of Health. 2012. *Health Commodity Supply Chain Master Plan.* September 2012. Available at: http://iaphl.org/files/2014/05/GhanaSCM-2013.pdf. Retrieved 11 March 2015.

[cxiii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxiv] Ministry of Health. 2012. *Health Commodity Supply Chain Master Plan.* September 2012. Available at: http://iaphl.org/files/2014/05/GhanaSCM-2013.pdf. Retrieved 11 March 2015.

[cxv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxvi] The use of "condoms" throughout the document refers to both male and female condom use unless otherwise specified. In addition, both male and female condoms will be promoted in the GFPCIP as components of a full method mix available to clients.

[cxvii]Ministry of Health. *Ghana National Condom and Lubricant Programming Strategy.* 2014. Draft, 2 November 2014.

[cxviii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxix] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxx] National Population Council. *1994 Revised National Population Policy*. Available at: http://www.hsph.harvard.edu/population/policies/GHANA.htm. Retrieved 20 January 2015.

[cxxi] National Population Council. *1994 Revised National Population Policy*. Available at: http://www.hsph.harvard.edu/population/policies/GHANA.htm. Retrieved 20 January 2015.

[cxxii] National Population Council. *1994 Revised National Population Policy*. Available at: http://www.hsph.harvard.edu/population/policies/GHANA.htm. Retrieved 20 January 2015.

[cxxiii] *Ghana Health Sector Medium-term Development Plan 2014–2017*. 17 July 2014.

[cxxiv] Ministry of Health. 2007. *National Health Policy. Creating Wealth through Health*. September 2007. Available at: http://www.moh-ghana.org/UploadFiles/Publications/NATIONAL%20HEALTH%20POLICY_22APR2012.pdf. Retrieved 27 January 2015.

[cxxv] Ghana Health Service. 2007. *Reproductive Health Strategic Plan 2007–2011*. Available at: http://www.moh-ghana.org/UploadFiles/Publications/GHS_Reproductive_Health_Strategic_Plan_FINAL_22APR2012.pdf. Retrieved 20 January 2015.

[cxxvi] Ghana Health Service. 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

[cxxvii] Ghana AIDS Commission. 2013. *National HIV and AIDS, STI Policy*. Available at: http://www.healthpolicyproject.com/pubs/153_Policyfinal.pdf. Retrieved 20 January 2015.

[cxxviii] Ministry of Health.2015. *Ghana National Condom and Lubricant Programming Strategy.*. September 2015.

[cxxix] Ministry of Health. 2012. *Health Commodity Supply Chain Master Plan.* September 2012. Available at: http://iaphl.org/files/2014/05/GhanaSCM-2013.pdf. Retrieved 11 March 2015.

[cxxx] Ministry of Health. 2011. *Meeting the Commodity Challenge: The Ghana National Reproductive Health Commodity Security Strategy 2011–2016.* The Ministry of Health. January 2011.

[cxxxi] Ministry of Women and Children's Affairs. 2004. *National Gender and Children Policy*. Available at: http://www.hsph.harvard.edu/population/womenrights/ghana.gender.04.pdf. Retrieved 20 January 2015.

[cxxxii] Ministry of Health, Ghana Health Service, UNICEF, UNFPA, WHO. 2009. *Ghana Strategic Plan for the Health and Development of Adolescents and Young People, 2009-2015. Healthy Young People: Better Future*.

[cxxxiii] National Population Council. 2000. *Ghana Adolescent Reproductive Health Policy.* Available at: https://www.k4health.org/sites/default/files/Ghana%20Adolescent%20Reproductive%20Health%20Policy.pdf. Retrieved 20 January 2015.

[cxxxiv] National Population Council. *1994 Revised National Population Policy*. Available at: http://www.hsph.harvard.edu/population/policies/GHANA.htm. Retrieved 20 January 2015.

[cxxxv] Population Reference Bureau. 2014. *The Role of Health Insurance in Family Planning.* Available at: http://www.prb.org/pdf15/health-insurance-family-planning.pdf. Retrieved 27 January 2015.

[cxxxvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxxxvii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxxxviii] EngenderHealth; The ACQUIRE Project. New York. Solo, J., et al. 2005. *Repositioning family planning—Ghana case study: "Give them the power."*

[cxxxix] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxl] Ghana Health Service. 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

[cxli] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxlii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxliii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cxliv] WHO. *The Abuja Declaration: Ten Years On*. Available at: http://www.who.int/healthsystems/publications/Abuja10.pdf. Retrieved 28 April 2015.

[cxlv] Ministry of Finance. 2015. Appendix 5A: Summary of MDA Expenditure Allocation – 2015. Available at: http://www.mofep.gov.gh/sites/default/files/budget/Budget-Appendix-Tables-2015.pdf. Retrieved 28 April 2015.

[cxlvi] 2006 to 2011 data:

Ministry of Finance. 2006. The Budget Statement and Economic Policy of the Government of Ghana for the 2006 Financial Year. Appendix 6: 2006 Proposed Expenditure Allocations by Programmes to MDAs (millions of cedis).

Ministry of Finance. 2007. *The Budget Statement and Economic Policy of the Government of Ghana for the 2007 Financial Year. Appendix 5: 2007 MDA Expenditure Allocations (millions of cedis)*. Available at: http://www.mofep.gov.gh/sites/default/files/budget/budget2007.pdf. Retrieved 30 April 2015.

Ministry of Finance. 2008. *Structure of 2008 Budget. Appendix 6: Total MDA Expenditure Allocation for MDA's (2008) from Statutory and Discretionary Sources*. Available at: http://www.mofep.gov.gh/sites/default/files/budget/2008_Budget.pdf. Retrieved 30 April 2015.

Ministry of Finance. 2009. *The Budget Statement and Economic Policy of the Government of Ghana for the 2009 Financial Year. Appendix 4B: MDA Expenditure Allocations (2009) from Discretionary Sources*. Available at: http://www.mofep.gov.gh/sites/default/files/budget/2009_budget.pdf. Retrieved 30 April 2015.

Ministry of Finance. 2010. *The Budget Statement and Economic Policy of the Government of Ghana for the 2010 Financial Year. Appendix 8 A: MDA Expenditure Allocations (2010) from Discretionary Sources*. Available at: http://www.mofep.gov.gh/sites/default/files/budget/Budget_2010.pdf. Retrieved 30 April 2015.

Ministry of Finance. 2011. *Budget Statements. Budget Statement for the year 2011. 2011_Appendix_Tables.xls. Appendix 8B: MDA Expenditure Allocations (2011) From Recurrent and Capital Expenditure*. from http://www.mofep.gov.gh/?q=budget-statements&page=2. Retrieved 30 April 2015.

2012–2015 data:

Ministry of Finance. 2012. *The Budget Statement and E Available at: Economic Policy of the Government of Ghana for the 2012 Financial Year. Appendix 9E: MDA Expenditure Allocations* (2012).

Ministry of Finance. 2013. *The Budget Statement and Economic Policy of the Government of Ghana for the 2013 Financial Year. Appendix 4G: MDA Expenditure Allocations – Grand Total* (2013).

Ministry of Finance. 2014. *The Budget Statement and Economic Policy of the Government of Ghana for the 2014 Financial Year. Appendix 7C: Summary of MDA Expenditure – 2014*.

Ministry of Finance. 2015. *The Budget Statement and Economic Policy of the Government of Ghana for the 2015 Financial Year. Appendix 5A: Summary of MDA Expenditure – 2015*.

[cxlvii] Ghana Health Service. 2008. *The Ghana National Financial Sustainability Plan for Contraceptives 2008–2011*, Draft update.

[cxlviii] Health Policy Project. GAP. 2012. *Resource Requirements for Family Planning in Ghana - Brief*. 2014. Available at: http://www.healthpolicyinitiative.com/Publications/Groups/group_33/33_GhanaGAPbrief_HPP_508.pdf. Retrieved 10 September.

[cxlix] Asante, Yaa. 2010. *Family Planning in Ghana: Contraceptive Security is still a work in progress*. Available at: http://www.rhsupplies.org/fileadmin/user_upload/Kampala/presentations/Asante_Yaa_-_Ghana_Country_Showcase_2010-05-28.ppt. Retrieved 28 April 2015.

[cl] RHInterchange, UNFPA. 2014. *Ghana - Summary of Shipments*. Available at: http://www.myaccessrh.org/rhihome?p_p_id=rhiuserportlet_WAR_rhiportlet&p_p_lifecycle=1&p_p_state=normal&p_p_mode=view&p_p_col_id=column1&p_p_col_count=1&_rhiuserportlet_WAR_rhiportlet__spage=%2Fshipmentsummary.do. Retrieved 18 March 2015.

[cli] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cliii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[cliv] USAID/Deliver Project.2015. *Ghana Contraceptive Security Indicators Data Dashboard.*

[clv] Ministry of Health. Meeting the Commodity Challenge: The Ghana National Contraceptive Security Strategy 2004 –2010. Available at: http://www.rhsupplies.org/fileadmin/user_upload/Country_pages/Ghana/Systems/strategy.pdf. Retrieved 28 April 2015.

[clvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clvii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clviii] Ghana Health Service. 2008. *The Ghana National Financial Sustainability Plan for Contraceptives 2008–2011*, Draft update.

[clix] Ghana Health Service. 2013. *Annual Report: 2013 Annual Reproductive and Child Health Report.* RCH, GHS. Available at: http://www.ghanahealthservice.org/downloads/GHS-Reproductive_and-Child-Health-Annual-Report-2013.pdf. Retrieved 11 March 2015.

[clx] Ghana Health Service. 2008. *The Ghana National Financial Sustainability Plan for Contraceptives 2008–2011, Draft update*.

[clxi] Ministry of Health. *Ghana Health Sector, 2008 Programme of Work*. Table of Procurement Plan.

[clxii] Ministry of Health. *Ghana Health Sector, 2009 Programme of Work*. Table of Procurement Plan.

[clxiii] Ghana Health Service. 2008. *The Ghana National Financial Sustainability Plan for Contraceptives 2008–2011, Draft update*.

[clxiv] AccessRH. *Ghana – Summary of Shipments*. Available at: http://www.myaccessrh.org/rhi-home?p_p_id=rhiuserportlet_WAR_rhiportlet&p_p_lifecycle=1&p_p_state=normal&p_p_mode=view&p_p_col_id=column-1&p_p_col_count=1&_rhiuserportlet_WAR_rhiportlet__spage=%2Fshipmentsummary.do. Retrieved 28 April 2015.

[clxv] USAID/DELIVER Project. Draft 2015. Accra, Ghana. Draft Ghana 2015 Survey, Version 27-03-15.

[clxvi] USD calculated as converted from cedi.

[clxvii] USD calculated as converted from cedi.

[clxviii] In 2013 the excess expenditure was due to over-procurement of condoms far in excess of what was needed.

[clxix] In 2014 the excess expenditure was due to a large quantity of condoms being procured to prevent stockouts as a result of substandard condom procurement in the previous year (2013).

[clxx] Quantities provided for some commodities were in excess of supply plan requirements for 2014.

[clxxi] USAID/DELIVER Project. 2015. *Ghana Contraceptive Security Indicators Dashboard*. Available at: http://deliver.jsi.com/dhome/whatwedo/commsecurity/csmeasuring/csindicators/csindicatordashboards. Retrieved 23 March 2015.

[clxxii] Health Policy Project. GAP. 2012. *Resource Requirements for Family Planning in Ghana – Brief*. Available at: http://www.healthpolicyinitiative.com/Publications/Groups/group_33/33_GhanaGAPbrief_HPP_508.pdf. Retrieved 10 September 2014.

Based on activity-based costing rather than average estimates of programme costs, the GFPCIP calculates a lower figure for 2016–2020.

[clxxiii] Chaitkin, M, M. Schnure, D. Dickerson, and S. Alkenbrack. 2015. *How Ghana Can Save Lives and Money: The Benefits of Financing Family Planning through National Health Insurance.* Washington, DC: Futures Group, Health Policy Project.

[clxxiv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxvi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxvii] Ghana Health Service. 2013. *Annual Report: 2013 Annual Reproductive and Child Health Report.* RCH, GHS. Available at: http://www.ghanahealthservice.org/downloads/GHS-Reproductive_and-Child-Health-Annual-Report-2013.pdf. Retrieved 11 March 2015.

[clxxviii] Kwame Nkrumah University of Science and Technology, School of Graduate Studies. *Factors Influencing the Utilisation of Family Planning Services in Kwabre District, Ghana.* 2007. Available at: http://ir.knust.edu.gh/bitstream/123456789/1436/1/Fredrick%20Akyeah.pdf. Retrieved 27 January 2015.

[clxxix] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, and ICF Macro*. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[clxxx] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxxi] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxxii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxxiii] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[clxxxiv] Health Policy Project. 2015. *Stakeholder Consultations for Ghana Family Planning Costed Implementation Plan, 2015–2020.* Unpublished notes and analysis.

[185] The focus on modern contraceptives reflects the prioritisation of more effective methods so as to lead to fewer unintended pregnancies, and thus an achievement of individuals' and couples' reproductive intentions.

[186] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[187] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[clxxxviii] The funding for this strategic priority is reflected as lower than actual, as many activities designed to support the capacity of CHPS are integrated into other activities to support improved capacity of SD across all cadres of HWs and thus are categorised as Priority 3.

[clxxxix] Bongaarts, John, John C. Cleland, John Townsend, Jane T. Bertrand, and Monica Das Gupta. 2012. Family Planning Programmes for the 21st Century: Rationale and Design. Available at: http://www.popcouncil.org/uploads/pdfs/2012_FPfor21stCentury.pdf. Retrieved 29 October 2014.

[cxc] Bongaarts, John, John C. Cleland, John Townsend, Jane T. Bertrand, and Monica Das Gupta. 2012. *Family Planning Programmes for the 21st Century: Rationale and Design*. Available at: http://www.popcouncil.org/uploads/pdfs/2012_FPfor21stCentury.pdf. Retrieved 29 October 2014.

[cxci] *Choices in Family Planning: Informed and Voluntary Decision Making*. EngenderHealth, 2003.

[cxcii] Bongaarts, John, John C. Cleland, John Townsend, Jane T. Bertrand, and Monica Das Gupta. 2012. *Family Planning Programmes for the 21st Century: Rationale and Design*. Available at: http://www.popcouncil.org/uploads/pdfs/2012_FPfor21stCentury.pdf. Retrieved 29 October 2014.

[cxciii] *Choices in Family Planning: Informed and Voluntary Decision Making*, EngenderHealth 2003.

[cxciv] Ademola Adelekan, Philomena Omoregie, and Elizabeth Edoni, "Male Involvement in Family Planning: Challenges and Way Forward." *International Journal of Population Research*, vol. 2014, Article ID 416457, 9 pages, 2014. doi:10.1155/2014/416457.

[cxcv] Ademola Adelekan, Philomena Omoregie, and Elizabeth Edoni. 2014. "Male Involvement in Family Planning: Challenges and Way Forward." *International Journal of Population Research* vol. 2014, Article ID 416457, 9 pages, 2014. doi:10.1155/2014/416457.

[cxcvi] Ghana Health Service. 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

[cxcvii] Ghana Health Service. 2014. *National Reproductive Health and Service Policy and Standards*. Third Edition, December 2014.

[cxcviii] "Condoms" refers to both male and female condoms.

[cxcix] Commodities for disease control and general reproductive health are not included in the FP commodity costing. Male condoms and female condoms are included only in the GFPCIP in the quantities necessary for the FP method mix, calculated according to the CPR disaggregated method mix in the DHS; therefore, condom procurement and programming for disease control would be costed outside of the GFPCIP and fall under the general RH and/or HIV strategic plans.

[cc] The generic (blank) Excel template can be accessed from:

Health Policy Project. 2015. *Family Planning CIP Costing Tool and User Guide*. 20 March 2015. Available at: http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=806. Retrieved 10 August 2015.

[cci] Asante, Felix Ankomah. 2013. *Cost of Family Planning Services in Ghana: A Technical Report Prepared for the National Population Council with Support from HPP/USAID and the Department for International Development (DfID), U.K., September 2013*.

[ccii] Ministry of Health, Uganda. 2014. Uganda Family Planning Costed Implementation Plan, 2015–2020. Kampala: Ministry of Health, Uganda. Retrieved 10 August 2015 from: http://www.healthpolicyproject.com/ns/docs/CIP_Uganda.pdf.

[cciii] Ministry of Health, Uganda. 2014. Uganda Family Planning Costed Implementation Plan, 2015–2020. Kampala: Ministry of Health, Uganda. Retrieved 10 August 2015 from: http://www.healthpolicyproject.com/ns/docs/CIP_Uganda.pdf.

[204] Ghana Statistical Service, Ghana Health Service, and The DHS Program. 2015. *Ghana Demographic and Health Survey Key Indicators 2014.* March 2015. Accra, Ghana: Ghana Statistical Service; Ghana Health Service; The DHS Programme, ICF International.

[205] Ghana Statistical Service. 2012. *2010 Population and Housing Census. Final Results.* May 2012. Available at: http://www.statsghana.gov.gh/docfiles/2010phc/2010_POPULATION_AND_HOUSING_CENSUS_FINAL_RESULTS.pd. Retrieved 20 January 2015.

[206] Ghana Statistical Service, Ghana Health Service, and ICF Macro. 2009. *Ghana Demographic and Health Survey 2008.* Accra, Ghana: GSS, GHS, and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR221/FR221[13Aug2012].pdf. Retrieved 20 January 2015.

[207] The CPR goals for married and unmarried women for 2020 were discussed and set at a "Reality Check" meeting on 22 May 2015 with key national and regional stakeholders.

[208] ICF International, 2012. *MEASURE DHS STATcompiler.* Available at: http://www.statcompiler.com. Retrieved 10 August 2015.

[209] The general service statistics align with the projections in the GFPCIP for almost all commodities. However, there is a significant discrepancy between the number of implant acceptors in the 2014 service statistics and the DHS method mix proportion for implants. This discrepancy should be explored further to determine if the removal rates for implants in Ghana are higher than global averages or if there is some other cause for this significant difference. The inclusion of implant and IUD removal in SD statistics may also help to address this question.

[210] Based on 2014 DHS.

[211] Based on 2014 DHS.

[212] "The number of units needed for a year of coverage is an input to the model. This is slightly different from the CYP factor, because it does not include method effectiveness and wastage (user, not supply chain). Rather, it is the number of units that a woman would need to have a full year's worth of commodities (i.e., three units of four-month injections). Default global estimates are based on workings from the 2011 USAID CYP update."

Weinberger, Michelle, Francisco Pozo-Martin, Tania Boler, Kenzo Fry, and Kristen Hopkins. 2012. *Impact 2: An Innovative Tool for Estimating the Impact of Reproductive Health Programmes*. Methodology paper

London: Marie Stopes. Available at: http://mariestopes.org/sites/default/files/Impact%202_Methodology%20and%20Assumptions_(2012%2007%2017)%20FINAL.pdf. Retrieved 30 July 2015.

[213] This is the estimated number of services, by method, that would need to be provided to reach the FP goal. These have been calculated based on the total users needed to reach the goal, continued use of LAPMs from baseline use (from historic services or CPR) and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

[214] This is the estimated number of users per method. These figures include continued use of LAPMs from baseline use (from historic services or CPR) and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

[215] Health Policy Project and Marie Stopes International. 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. April 2015. Washington, DC: Futures Group, Health Policy Project.

[216] Health Policy Project and Marie Stopes International. 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. April 2015. Washington, DC: Futures Group, Health Policy Project.

[217] Health Policy Project and Marie Stopes International. 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. April 2015. Washington, DC: Futures Group, Health Policy Project.

[218] Health Policy Project and Marie Stopes International. 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. April 2015. Washington, DC: Futures Group, Health Policy Project.

[219] DALYs = Disability Adjusted Life Years. "DALYs are the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability." DALYs Definition. Available at: http://www.who.int/mental_health/management/depression/daly/en/. Retrieved 24 August 2015.

[220] Ministry of Health. 2010. *Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development*. Available at: http://www.usaid.gov/sites/default/files/documents/1860/National_Health_Policy_July_2010.pdf. Retrieved 30 October 2014.

[221] The lead and collaborating organisation column has been purposely left non-specific for implementing partners so that stakeholders can work collaboratively in preparation for the 2016 start to assign roles and responsibilities to various government bodies, development partners, and implementing partners.

[222] GSPHDAYP 1.1.1; GSPHDAYP 1.1.2.

[223] GNCLPS 1.5; GNCLPS 5.6; GNCLPS 4.2; GNCLPS 4.6; GNRHCSS 1.1.

[224] GSPHDAYP 1.1.4.

[225] GSPHDAYP 1.1.3.

[226] GNRHCSS 5.1; GSPHDAYP 3.3.2.

[227] GSPHDAYP 3.3.3.

[228] GNRHCSS 2.3; GSPHDAYP 4.2.3.

[229] GSPHDAYP 1.1.5; 1.3.4.

[230] GNCLPS 3.5; GNRHCSS 2.1; GSPHDAYP 3.3.4.

[231] GSPHDAYP 3.3.5; 4.2.1.

[232] GNRHCSS 2.2; GNRHCSS 2.3.

[233] GSPHDAYP 1.2.2.

[234] "Sexuality and HIV education programs that emphasise gender equality and power dynamics are 5X more likely to reduce STIs and or unintended pregnancy than programs that do not." Haberland, Nicole. 2015. "The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies." *International Perspectives on Sexual and Reproductive Health* 41(1): 31–42.

[235] Ministry of Education. 2015. *SHS National Parameters, 2013/2014 School Year Data*. Available at: http://www.moe.gov.gh/site/statistics. Retrieved 27 August 2015.

[236] GSPHDAYP 1.2.3.

[237] GSPHDAYP 1.2.4; GSPHDAYP 2.4.3; GNRHCSS 7.8.

[238] GSPHDAYP 1.3.1.

[239] GSPHDAYP 1.2.9.

[240] GSPHDAYP 1.2.8, 1.2.10.

[241] GSPHDAYP 1.3.3.

[242] GSPHDAYP 4.3.2.

[243] GSPHDAYP 4.1.1.

[244] GSPHDAYP 4.2.2.

[245] GNRHCSS 1.4.

[246] GSPHDAYP 2.2.2.

[247] GNRHCSS 5.2; GNRHCSS 5.3.

[248] GNRHCSS 5.4; GSPHDAYP 2.4.1; GNRHCSS 7.7.

[249] GSPHDAYP 2.4.2.

[250] GSPHDAYP 2.4.4.

[251] GNRHCSS 5.5.

[252] GSPHDAYP 2.1.7.

[253] World Health Organization. 2015. "WHO Model List of Essential Medicines." 19th List. April 2015, Amended June 2015.

Available at: http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_JUN2015.pdf?ua=. Retrieved 21 July 2015.

[254] GNCLPS 1.12; GNRHCSS 7.13; GNRHCSS 7.15.

[255] GNRHCSS 7.14.

[256] GNRHCSS 7.16, 7.17.

[257] GNRHCSS 6.5.

[258] GNRHCSS 7.19.

[259] GNRHCSS 7.18.

[260] GNCLPS 4.5; GNCLPS 2.3.

[261] GNCLPS 3.3; GNCLPS 1.10.

[262] GNCLPS 5.5; GNRHCSS 6.3; GNCLPS 4.4.

[263] GNRHCSS 7.20.

[264] GNRHCSS 1.3.

[265] GSPHDAYP 5.2.7.

[266] Gillespie, Duff and Beth Fredrick. November 2013. "Advance Family Planning Advocacy Portfolio." Available at: http://advancefamilyplanning.org/portfolio. Retrieved 9 August 2015.

[267] GSPHDAYP 1.2.1.

[268] GNCLPS 1.9; GNCLPS 3.1.

[269] GNCLPS 1.3.

[270] GNRHCSS 3.1.

[271] World Health Organization. 2015. "WHO Model List of Essential Medicines." 19th List. April 2015, Amended June 2015.
Available at: http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_JUN2015.pdf?ua=1. Retrieved 21 July 2015.

[272] GSPHDAYP 5.5.2.

[273] GNCLPS 3.4; GNCLPS 1.11; GNRHCSS 3.3.

[274] GNRHCSS 3.4.

[275] GNRHCSS 2.4.

[276] GNRHCSS 2.5.

[277] GNRHCSS 3.8.

[278] GNCLPS 2.2.

[279] GNRHCSS 3.7.

[280] GNCLPS 2.1.

[281] GNRHCSS 4.1, 4.2; GSPHDAYP 5.1.4; GNCLPS 1.1.

[282] GNRHCSS 4.3.

[283] GSPHDAYP 3.1, 3.2; 5.1.8.

[284] GNRHCSS 4.4.

[285] GNCLPS 1.7; GNCLPS 2.4; GNCLPS 5.1 and 5.2; GNRHCSS 5.9.

[286] GNRHCSS 6.2.

[287] GNCLPS 4.1; GNCLPS 2.5.

[288] GNCLPS 1.6.

[289] GNCLPS 1.8.

[290] GSPHDAYP 5.4.3; 5.5.3.

[291] GNRHCSS 7.2; GNRHCSS 7.9.

[292] GSPHDAYP 2.1.4.

[293] GNRHCSS 5.6; GSPHDAYP (not specified); GNRHCSS 7.11.

For more information, contact:

Ghana Health Service
Private Mail Bag, Ministries, Accra, Ghana.
Telephone: 233 302 684271, 233 302 684310
http://www.ghanahealthservice.org/