Family planning practice among Christian health service providers in Ghana: a case study

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Outline

- Introduction
- Profile of CHAG
- Challenges
- Results
- Discussion & Lessons Learnt
- Prospects & Potential for CHAG’s FP Programme
- Conclusion
There is evidence to show that family planning improves health, reduces poverty, and empowers women.

Impediments to FP service include limited access to service, lack of spousal consent and issues of faith and religion.

The interface between faith and professional practice/demands often presents a challenge.

So how does CHAG overcome this challenge to achieve national health outcome?
CHAG is a network of 300 health facilities and health training institutions, formed in 1967.

Facilities owned by 25 church denominations

Catholics 44%, Presbyterians 18%, Adventists 11%, Methodists (8), Anglicans, and the other minor groups 19%

CHAG provides services to the poor, neglected and deprived population

Christian Faith-based, reliable partner in health

Approximately 20,000 workers

An implementing partner and an agency of MOH

CHAG aligns its priorities to national health sector objectives
Background - Distribution of CHAG Facilities

10 regions

177 districts
CHAG contributes 29% of national in-patient services

Provides 20% of OPD care

As an implementing partner of the MOH, CHAG is mandated to implement key policies to achieve national health outcomes e.g. FP, MCH

Unity in diversity is a core value
Unity in Diversity: Enabler or Obstacle?
How does CHAG provide services required by the MOH (as an implementing partner) and at the same time protect the interest of its members some of whose doctrines abhor them from utilizing certain forms of family planning?

Specifically, the Catholic Group who form about 44% of the network (70% about 3 years ago) do not accept artificial FP.

How do you protect stakeholders’ interest –

- Doctrine (held strongly by Catholic Bishops)
- Professional development (for workers) and
- Need to provide FP service (MOH) and people in need
The Challenge

- Doctrinal inhibitions/barriers to demand
- Socio-cultural myths & misconceptions: e.g. use of FP promotes marital infidelity
- No data capture/reporting space for FP in the past
How CHAG overcomes the challenge

- CHAG tailors its services to become socio-culturally and religiously acceptable by both the denomination and the community.

- E.g. Artificial FP supplies – implants, condoms, oral contraceptives etc. given to denominations that accept these methods whereas Catholics are given cycle beads (used to plan or prevent pregnancy by tracking the start dates of a woman’s period based on the Standard Days Method (SDM))
Training in FP is specific to denominations based on doctrinal acceptance

Referring clients to the nearest government facility which provides such services

Leveraging CHAG’s diversity by enlisting Protestant Group

Addressing gender concerns: enlisting male support through sustained campaign

Promoting customized/tailor-made FP services by hybrid: Natural & Artificial
CHAG implements both artificial and natural family planning methods within our network despite doctrinal differences.

Thus CHAG satisfies requirements for the sector for which it is mandated as well as its stewardship mandate for its constituents.

In 2015, a total of 15,101 people accepted natural family planning, which formed 20.5% of total family planning acceptors representing about 46% more than that of 2014.

Of the acceptors of natural family planning for 2015, a total of 13,881 (91.9 percent) used LAM whilst 1,220 (8.1 percent) used SDM.

Proportion of adolescents (10-19 years) accepting FP increased from 13.7% to 17.0%.

Total FP acceptor increased from 67,312 to 73,648 (9.4% increase) over 3 years.
<table>
<thead>
<tr>
<th>Description</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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</thead>
<tbody>
<tr>
<td>Natural family planning</td>
<td>10,821</td>
<td>10,344</td>
<td>15,101</td>
</tr>
<tr>
<td>Male sterilization (vasectomy) acceptors</td>
<td>0</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Female sterilization acceptors</td>
<td>463</td>
<td>455</td>
<td>807</td>
</tr>
<tr>
<td>Condom (male) acceptors</td>
<td>3,748</td>
<td>4,591</td>
<td>8,192</td>
</tr>
<tr>
<td>Condom (female) acceptors</td>
<td>81</td>
<td>162</td>
<td>108</td>
</tr>
<tr>
<td>Oral contraceptives acceptors (the pill)</td>
<td>10,542</td>
<td>11,592</td>
<td>10,810</td>
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<tr>
<td>Implant acceptors</td>
<td>2,956</td>
<td>3,308</td>
<td>4,336</td>
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<td>Short term injectables (Depot Medroxyprogesterone acetate)</td>
<td>36,870</td>
<td>32,799</td>
<td>33,947</td>
</tr>
<tr>
<td>Intra-uterine Contraceptive device (IUCD)</td>
<td>119</td>
<td>134</td>
<td>202</td>
</tr>
<tr>
<td>All other artificial methods acceptors</td>
<td>64</td>
<td>93</td>
<td>131</td>
</tr>
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**Fig. 1: Trend of Family Planning by type: 2013 - 2015**
<table>
<thead>
<tr>
<th>Description</th>
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<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage postnatal registrants accepting family planning</td>
<td>16.7</td>
<td>14.6</td>
<td>14.8</td>
</tr>
<tr>
<td>Proportion of family planning acceptors who were adolescents (10-19)</td>
<td>13.7</td>
<td>15.0</td>
<td>17.0</td>
</tr>
<tr>
<td>Proportion of family planning acceptors who were adolescents (15-19)</td>
<td>12.3</td>
<td>14.2</td>
<td>16.0</td>
</tr>
<tr>
<td>Total Family Planning Continuing Acceptors</td>
<td>44,668</td>
<td>45,526</td>
<td>50,293</td>
</tr>
<tr>
<td>Total Family Planning New Acceptors</td>
<td>22,644</td>
<td>21,969</td>
<td>23,355</td>
</tr>
<tr>
<td>Total drop-outs</td>
<td>-</td>
<td>21,786</td>
<td>17,202</td>
</tr>
<tr>
<td>Total family planning acceptors</td>
<td>67,312</td>
<td>67,495</td>
<td>73,648</td>
</tr>
<tr>
<td>Total couple year protection</td>
<td>71,295.5</td>
<td>69,701.4</td>
<td>92,851.5</td>
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</tbody>
</table>
At the national level, only 2% women use LAM whereas within the CHAG network 18.9% do.  
Sustained outreach campaigns, durbars and radio education programs contributed to the achievement  
There’s association between CHAG’s intervention & increasing FP uptake  
Doctrinal inhibitions/barriers to FP utilization could be managed by referring Clients’ to willing & able Providers
Faith, socio-cultural and religious acceptability are important determinants for increased FP uptake.

FP uptake is a shared responsibility. Gov’t and FBOs could complement FP service delivery.

FBOs could protect clients’ needs, meet policy requirements for service provision whilst upholding doctrinal beliefs.
The Male component in FP

Adopted from: UNFPA Ghana
Prospects & Potentials for FP in CHAG

- FP is now on CHAG’s service delivery space
- The growing diversity: growth of Protestant & Pentecostal-Charismatic wing is a leveraging window for FP
- Innovative dialogue with Religious Leaders: Safe-motherhood vs Family Planning
- Emerging trust in “CHAG’s FP competency”
- Framework for Collaboration with credible Partners for FP
- Gatekeeping role and unexplored assets for FP uptake
The interests of Christian health facilities and those of the government may conflict at some point.

Being tactful and allowing work within the confines of faith and obligations helps in achieving desired outcomes.

Unity in diversity is an indispensable tool for CHAG’s FP programme.
THANK YOU

CHAG

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CHRISTIAN HEALTH ASSOCIATION OF GHANA