



PRIMARY HEALTH CARE PERFORMANCE MANAGEMENT ACTIVITY

AKWAPIM SOUTH, GHANA

Strengthening Access to Skilled Delivery through a Performance Management Approach

I. INTRODUCTION & CONTEXT

Akwapim South Municipal Health Directorate in Ghana’s Eastern Region serves a predominantly rural, agrarian population living in widely dispersed communities. Geographic isolation, high travel costs, poor road infrastructure, and long distances to health facilities limit access to maternal health services, particularly skilled delivery – care provided by trained health professionals who can safely manage labor and complications. Consequently, women often delay or miss antenatal visits, rely on traditional birth attendants (TBAs), and face heightened risks during obstetric emergencies. Improving access to skilled delivery by addressing these barriers was therefore a district priority.

AKWAPIM SOUTH DISTRICT HEALTH ADMINISTRATION MAP

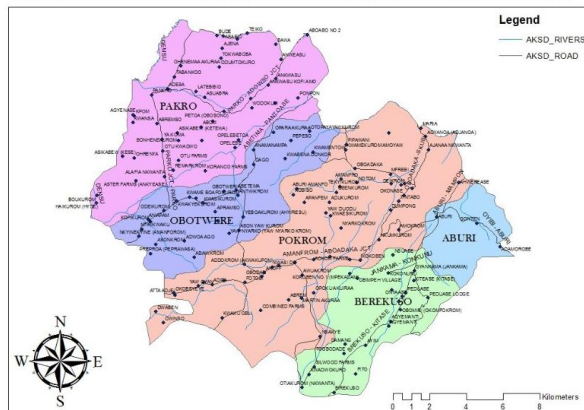


Figure 1: Map of Akwapim South

Although the district has multiple health facilities providing maternity services (Table 1), skilled delivery uptake has remained low. In March 2024, only 25.5% of births were attended by trained providers, compared with a district target of 41% and a national target of 65%. Through routine data review and root cause analysis, the DHMT identified several contributing barriers, including

gaps in night-time readiness, inconsistent outreach and pregnancy tracking, weak facility–community accountability, and limited provider preparedness for obstetric emergencies. Together, these barriers limited access to and confidence in facility-based maternity care.

The DHMT alone was unable to resolve the persistent performance gaps in skilled delivery within the district. Through the Primary Health Care Performance Management Activity (PHC-PM), the Akwapim South DHMT was supported to systematically analyze performance data, identify root causes, and translate findings into prioritized, coordinated actions across structured cycles under the PHC Leadership Development Program (PHC-LDP). The PHC-PM activity – implemented by Management Sciences for Health (MSH) and Uboru Quality Institute – allowed the DHMT to clearly identify root causes and implement targeted strategies to address longstanding challenges. The DHMT launched four improvement cycles through the

PHC-LDP between March 2023 and December 2025.

Table 1: Health system indicators – Akwapim South

Population Indices ¹	Number
Total Population	78,024
Public health centers	5
Community-based Health & Planning Services (CHPS) Posts	23
Christian Health Association of Ghana (CHAG) facilities ²	1
Private facilities	1
Expected Pregnancies	3,121
Physician Assistants	7
Nurses (Clinical and Preventive)	181
Midwives	45

The DHMT selected skilled delivery as one of its Desired Measurable Results (DMR) throughout the cycles. Performance rose to 35% in Cycle 1, fell to 25.49% in Cycle 2, and reached 35% again in Cycle 3, with Cycle 4 culminating in 34.2%.

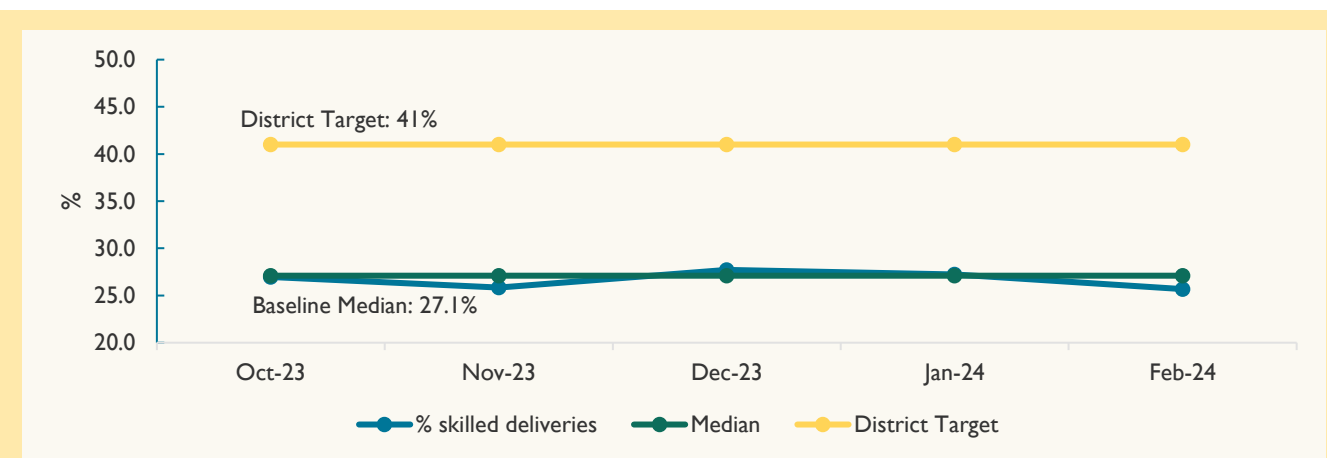


Figure 2: Skilled Delivery at PHC-PM Baseline

Prior to the intervention, percentages of births accompanied by a skilled attendant in Akwapim South was well below the national and district targets. NB: National target: 68.0%

¹ Sourced from District Health Information Management System (DHIMS2) in Ghana

² The Christian Health Association of Ghana (CHAG) is a key faith-based network providing essential healthcare services across Ghana, especially in underserved communities: <https://chag.org.gh/>

These shifts reflect the DHMT’s efforts to address readiness, competencies, and community trust and overall Community-based Health Planning Services (CHPS) improvements. This case study describes how improvements in infrastructure, provider capacity, community engagement, and digital tracking—combined with stronger data use and accountability—helped Akwapim South address persistent barriers to skilled delivery and strengthen overall PHC system performance.

2. ROOT CAUSES & BARRIERS IDENTIFIED

Baseline assessments conducted at the start of the PHC-PM intervention (January 2024) revealed interconnected systemic and behavioral barriers that kept Akwapim South’s skilled delivery performance well below district and national expectations. These barriers limited the availability, readiness, and perceived reliability of facility-based maternity care.

Limited Readiness for 24-Hour Delivery Service: Only 18% of facilities could provide round-the-clock delivery care. Essential conditions for safe night-time delivery were missing, including adequate security personnel, reliable lighting, appropriate delivery equipment, suitable midwife accommodation, and consistent CHPS functionality.³ These gaps made night-time delivery difficult or unsafe.

Workforce and Competency Constraints: Staffing patterns limited 24-hour coverage, and many midwives and Community Health Nurses (CHNs) required refresher training in BEmONC skills. Adherence to danger-sign and

referral protocols was inconsistent, and transport challenges restricted routine supervision and mentorship.

Weak Pregnancy Identification and Outreach Systems: The district lacked standardized pregnancy-tracking tools, resulting in inconsistent early pregnancy identification across subdistricts. Home visits and ANC outreach varied widely. Many women initiated ANC services late, reducing opportunities for birth preparedness counseling and timely referral.

Transport and Referral Barriers: Women in remote communities often faced long distances to facilities, unreliable transport options, and limited availability of emergency referrals at night. These constraints contributed to delays in reaching skilled care during labor.

Community-Level Barriers: Facility–community accountability structures were weak. CHMCs were underutilized, awareness of danger signs and available services was low, and reliance on TBAs persisted. These factors contributed to late presentation and preference for home delivery. Together, these barriers highlighted the breadth of challenges the DHMT sought to address through PHC-LDP improvement cycles.

3. IMPROVEMENT STRATEGY & PRIORITIZED ACTIONS

Using the PHC-LDP process, the DHMT translated baseline findings into a focused, multi-cycle improvement strategy aimed at addressing the core drivers of low skilled

³ A functional CHPS is one with the requirements as outlined in the CHPS operational policy/implementation plan:

<https://www.moh.gov.gh/wp-content/uploads/2016/02/CHPS-Operational-Policy-2005.pdf> /

<https://www.scribd.com/document/43437902/Guidelines-for-CHPS-Implementation> (e.g., staffing, infrastructure, community engagement, service delivery). Non-functional CHPS do not meet all these requirements.

delivery (Table 2). The strategy prioritized actions that could realistically be implemented and were expected to improve services, health worker preparedness, and community confidence. As the DHMT’s problem-solving capacity grew, the approach evolved from establishing basic conditions for delivery services to strengthening technical competencies and institutionalizing these practices within DHMT operations.

In the first cycle, the DHMT concentrated on establishing reliable conditions for skilled delivery, particularly during nighttime hours. This improved lighting, renovated midwife accommodations, deployed night security personnel, and engaged community leaders and actors to promote facility deliveries and address community concern, rebuilding confidence in facility deliveries. These actions established the basic conditions for increased utilization supported user friendly guidelines and orientation sessions that helped community members understand the referral processes and recognize danger signs in pregnancy and childbirth.

Once Cycle 1 improved readiness, the DHMT shifted to strengthening provider skills and early pregnancy identification. Standardized pregnancy-tracking tools improved coordination across CHPS zones and facilities, and midwives received refresher Basic Emergency Obstetric and Neonatal Care (BEmONC) training and mentorship to improve emergency response. TBAs were engaged to encourage early ANC attendance and timely referral while the DHMT closely monitored staff absenteeism. The DHMT also focused on addressing existing health system gaps by intensifying its financing efforts which

streamlined the availability of essential supplies required for maternal and newborn care.

In Cycles 3 and 4, the DHMT addressed persistent night-time and emergency barriers by strengthening community engagement and building more reliable support systems, including improved security measures and greater stakeholder involvement. The DHMT also intensified supportive supervision and used monthly data reviews to refine outreach strategies, while introducing motorized tricycles to reduce referral delays and improve transportation challenges. By Cycle 4, the DHMT shifted its focus on strengthening CHPS functionality by aligning service delivery with contextual needs of each CHPS zone. This included reclassification of CHPS zones from “Basic” to “Advanced”, enhancing community health officer (CHO) capacity and sub-municipal health management team supportive systems and improved leadership through standardized training modules. The cycle also prioritized equitable and high-quality PHC by strengthening community accountability structures and aligning logistical resources with the functional requirements of each CHPS zone.

Table 2. Evolution of DHMT Strategy Across PHC-LDP Cycles

Cycle	Focus	How Strategy Evolved
Cycle 1 (Mar-Jul 2024)	Infrastructure & community readiness	Established foundational conditions for skilled delivery
Cycle 2 (Aug 2024–Jan 2025)	Case-finding & provider skills	Strengthened pregnancy identification and midwife competencies
Cycle 3 (Feb–Jun 2025)	Security, BEmONC, digital tracking	Improved night coverage, emergency response, and data use
Cycle 4 (Jul–Dec 2025)	CHPS functionality & sustainability	Institutionalized systems and deepened community ownership

4. IMPLEMENTATION: KEY ACTIVITIES ACROSS CYCLES

Implementation occurred across four PHC-LDP cycles (Mar 2024–Dec 2025), each building on prior progress to strengthen readiness, provider capacity, and community engagement.

Cycle 1: Establishing Basic Readiness (Mar–Jul 2024)



Figure 3: Before and after facility renovations

The DHMT addressed foundational barriers to 24-hour skilled delivery by using catalytic grants to procure solar lamps, labor kits, delivery equipment, and essential supplies, thereby improving facility readiness for nighttime delivery.

The DHMT mobilized chiefs, TBAs and CHMCs to rebuild trust in facility delivery services. These actions established the minimum enabling environment for safe and reliable skilled delivery.

Cycle 2: Strengthening Pregnancy Identification and Provider Capacity (Aug 2024–Jan 2025)

With basic readiness improving, the focus shifted to identifying pregnant women early and strengthening provider competencies. CHNs conducted intensified household visits and ANC mobilization, supported by the roll-out of standardized pregnancy-tracking tools. This facilitated early identification, follow-up and improved attendance of at least 4 ANC sessions, an important step in the continuum towards skilled delivery. Midwives received refresher BEmONC training. This improved facility staff competencies on emergency care skills and adherence to danger-sign protocols. The DHMT strengthened community-facility referral linkages by engaging TBAs to encourage early facility attendance.

Cycle 3: Improving Night Coverage, Emergency Response, and Data Use (Feb–Jun 2025)



Figure 4: Motorized tricycle procured using catalytic grants.

Persistent gaps in night-time delivery and emergency readiness prompted further investments. DHMTs worked with CHMCs to recruit security personnel to expand 24-hour service availability for three facilities. Implementation of the tracking tool Know Your

Pregnant Women (KYPW) improved coordination between CHPS zones and facilities. The DHMT intensified supportive supervision and used monthly review meetings to identify service gaps and refine outreach efforts. Motorized tricycles helped reduce transport delays for referrals and home visits.

Cycle 4: Embedding CHPS Functionality and Sustainability (Jul–Dec 2025)

The final cycle focused on institutionalizing CHPS functionality and sustaining maternal health gains reclassified 24 CHPS zones by context-specific targeted capacity building through a standardized training curriculum. Community structures were revitalized through CHMC orientation, community entry activities, and well-supported volunteer engagement, which strengthened community involvement in CHPS and improved accountability. Monthly family meetings, stakeholder engagements and community scorecard sessions enhanced dialogue and performance monitoring. An equipment gap analysis was also conducted within CHPS facilities to inform procurement and allocation of logistics, alongside development of a preventive maintenance schedule to ensure sustained functionality and improve readiness. Supervision, performance review, safe motherhood outreach, and community-facility dialogues were gradually integrated into regular DHMT operations to sustain gains in skilled delivery.

5. RESULTS & EVIDENCE OF CHANGE

Implementation of the performance improvement strategy led to measurable gains in skilled delivery performance and key system drivers of maternal health service utilization in Akwapim South. Performance data generated by the DHMT and Uбора Quality Institute demonstrated both progress and persistent challenges across cycles.

Key System Shifts

Across the cycles, several system shifts contributed to improved skilled delivery uptake:

- **More facilities offered reliable 24-hour services**, supported by improved lighting, staff accommodation, enhanced nurse rest room and night security.
- **Provider readiness strengthened** through refresher BEmONC training with clinical attachment at the hospita, and continued mentorship programs at the facility level.
- **Pregnancy identification and follow-up improved** as standardized tracking tools and outreach were scaled up.
- **Referral capacity increased**, especially at night, with motorized tricycles and better coordination across CHPS zones.
- **Community trust grew**, reinforced by active engagement with chiefs, CHMCs, and TBAs and greater awareness of available 24-hour services.

These shifts helped stabilize skilled delivery performance and moved the district closer to achieving its 41% DMR target.

Skilled Delivery Performance

Figure 5 illustrates the month-by-month trend in skilled delivery coverage from October 2023 to December 2025. Performance coverage showed a fluctuation around a pre-implementation median of 27.1%, with noticeable shifts corresponding to the focus areas of each PHC-LDP cycle. Coverage increased during periods coinciding with strengthened readiness and provider support, rising to 35% during Cycle 1. Coverage fell during Cycle 2 as facilities navigated persistent night-time and referral challenges⁴ while new systems and processes were introduced. Performance improved again through Cycle 3 and early Cycle 4 as emergency readiness, data use, and CHPS functionality strengthened.

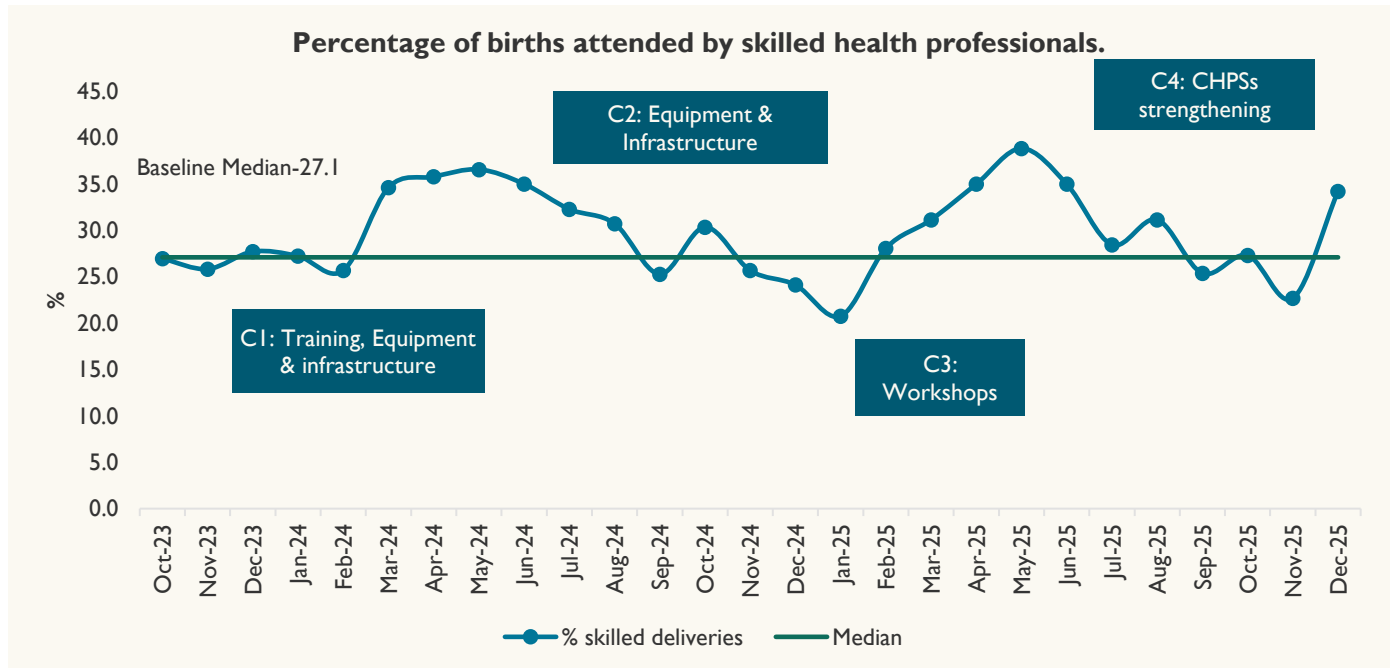


Figure 5: Skilled delivery in Akwapim South

During the four intervention cycles, skilled delivery coverage rose above the baseline median of 27.1%, with clear improvements following training, equipment upgrades, and infrastructure support (C1) and further equipment strengthening (C2). A brief dip around Dec 2024–Jan 2025 was followed by gains during cycle 3 workshops (C3). CHPS-focused activities in cycle 4 (C4) helped stabilize performance, and coverage increased again toward late 2025. Despite some seasonal fluctuations, the overall trend reflects steady progress and the importance of sustained PHC strengthening.

Night-time deliveries—a proxy indicator for both service readiness and community trust—also increased, rising from 55.1% to 66.7% over the period. This improvement suggests that investments in lighting, security, and midwife accommodation contributed to greater willingness and ability to seek care during labor at any hour.

6. LESSONS LEARNED, SUSTAINABILITY, & RECOMMENDATIONS

Across the PHC-LDP improvement cycles, the DHMT developed a deeper understanding of the system and community factors influencing skilled delivery. The experience underscored

⁴ DHMT improved facilities for nighttime delivery by renovating and providing washrooms for midwives to stay. Night schedules were also made and activities monitored on monthly basis.

the importance of collaboration, data use, and reliable readiness. Strengthening relationships between the DHMT, facilities, chiefs, CHMCs, and TBAs proved essential for building trust and improving coordination with community participation being a major bedrock for performance improvements.

- **Leadership commitment and teamwork across all levels** helped maintain momentum and improve performance.
- **Routine data use** supported early identification of gaps and timely adjustment of outreach, referral, and readiness strategies.
- **Facility readiness improvements** had the greatest impact when paired with motivated staff and active community leaders.

Sustainability Conditions

To sustain gains, the DHMT is institutionalizing PHC-LDP practices into routine operations, including regular data review, supportive supervision, and pregnancy tracking. The DHMT has begun allocating resources to maintain lighting, accommodation, and security. Revitalized CHMC platforms are helping to reinforce the availability and awareness of 24-hour services while closer partner coordination aims to ensure external support aligns with district priorities.

Recommendations for Future Scale-Up

The DHMT's experience offers several insights for similar settings:

- Motivated and well-supported staff drive improved performance
- Timely, high-quality data enables rapid problem-solving and course correction
- Engaging community leadership is essential for shifting care-seeking behavior toward facility delivery
- Reliable 24-hour readiness underpins sustained increases in skilled delivery uptake

Together, these lessons position Akwapim South to sustain maternal health improvements while offering a practical roadmap for other districts seeking to improve skilled delivery and strengthen PHC performance.



ABOUT THE PROJECT

PHC is the foundation of resilient and equitable health systems. Strong local leadership is essential to ensuring accessible, high-quality care that responds to community needs. In Ghana and Rwanda, national and district health authorities are strengthening health system performance through the PHC-PM Activity—an initiative led by government partners and implemented with local institutions, with support from the Gates Foundation and technical partners including MSH. At the heart of the model are four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement:

1. Leadership development
2. Operational data & integrated dashboards
3. Ongoing monitoring, evaluation, and learning (MEL)
4. Catalytic grant funding

Through adaptive performance management cycles, district health authorities continuously analyze, monitor, learn, and adapt—maturing over time into effective stewards of district health systems. The PHC-PM Activity is a collaboration between MSH, Ukora Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.