PHC PERFORMANCE MANAGEMENT (PHC-PM) ACTIVITY

NORTH TONGU, GHANA

Improving Access to Quality Skilled Delivery through a Performance Management Approach

1. INTRODUCTION & CONTEXT

North Tongu District is located in the southeast part of Ghana's Volta Region and serves more than 100,000 people across mainland, island, and riverine communities. Seasonal flooding, long travel distances, and transportation constraints limit timely access to health services, particularly for pregnant women in remote areas.

Skilled delivery coverage[1] represents a critical component of safe maternal care and a key indicator of primary health care (PHC) system performance. Routine data reviews conducted by the District Health Management Team (DHMT) highlighted persistent gaps in skilled delivery coverage. Disaggregated analysis identified weaknesses in service readiness, provider competencies, pregnancy follow-up systems, and financial and behavioral barriers affecting women's access to facility-based care, particularly in hard-to-reach communities.

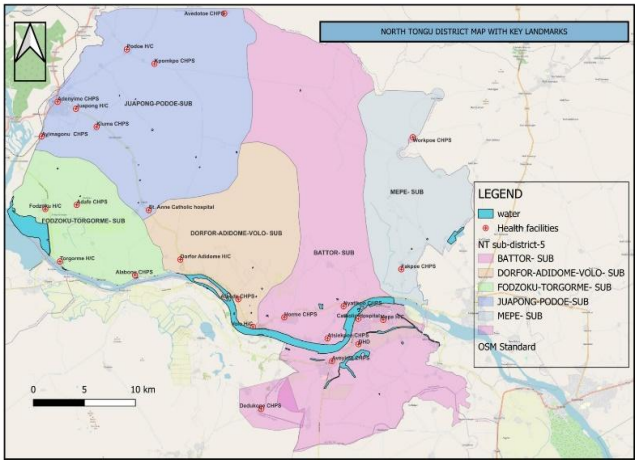

Figure 1: Map of North Tongu with accompanying health facilities.

[1] Skilled delivery is defined as childbirth attended by accredited professionals (midwives, doctors, or nurses) trained to manage normal deliveries, identify complications, and provide emergency referrals (WHO, 2025).

These challenges were further reflected in a regional assessment of emergency obstetric readiness across Volta Region health facilities (Figure 2), which showed variability in facility preparedness to deliver lfiesaving obstetric care.

As the body responsible for planning, supervision, data use, and stakeholder coordination across the PHC system, the DHMT plays a central role in addressing these challenges. Through support from the Primary Health Care Performance Management (PHC-PM) Activity, the DHMT strengthened its capacity for structured data review and adaptive management for improving skilled delivery.

Through structured improvement cycles under the PHC Leadership Development Program (PHC-LDP), the DHMT systematically analyzed performance data, identified root causes, and translated findings into prioritized, coordinated actions. The DHMT selected skilled delivery in cycles 3 and 4 as one of itsDHMT's Desired Measurable Results (DMRs) – i.e., specific, quantifiable, and time-bound targets that teams set to improve health service delivery.

This case study summarizes North Tongu's improvement journey across Cycle 3 (Feb–Jun 2025) and Cycle 4 (Jul–Dec 2025),[2] highlighting the strategies applied, results observed, and lessons learned that could inform similar PHC strengthening efforts in other settings.

2. ROOT CAUSES & BARRIERS IDENTIFIED

To improve skilled delivery performance, the DHMT conducted structured data review and validation sessions, focus group discussions (FGDs) with pregnant women and nursing mothers, facility assessments, and stakeholder engagements. These processes helped identify systemic and behavioral barriers related to service readiness, provider performance, and community-level access at PHC facilities.

Service readiness gaps included shortages of emergency medicines and delivery equipment, identified by data collection using tools such as KoboCollect. Infrastructure constraints – particularly in lower-level health facilities – reduced the reliability of care and weakened trust in facility-based delivery. During FGDs, women expressed uncertainty about whether health facilities had the necessary supplies and support to manage complications, which influenced their decisions about where to deliver. Patient reports of poor staff attitudes discouraged facility use by pregnant women and reduced confidence in the system's ability to manage complications.

Provider competency and performance issues further affected service quality. Collected data at facilities identified weak healthcar provider adherence to Basic Emergency Obstetric and Newborn Care (BEmONC) protocols and limited supportive supervision.

[2] Skilled delivery was not selected as a DMR for Cycles 1 & 2 – for a fuller picture of the project intervention, please see the "About the Project" box.

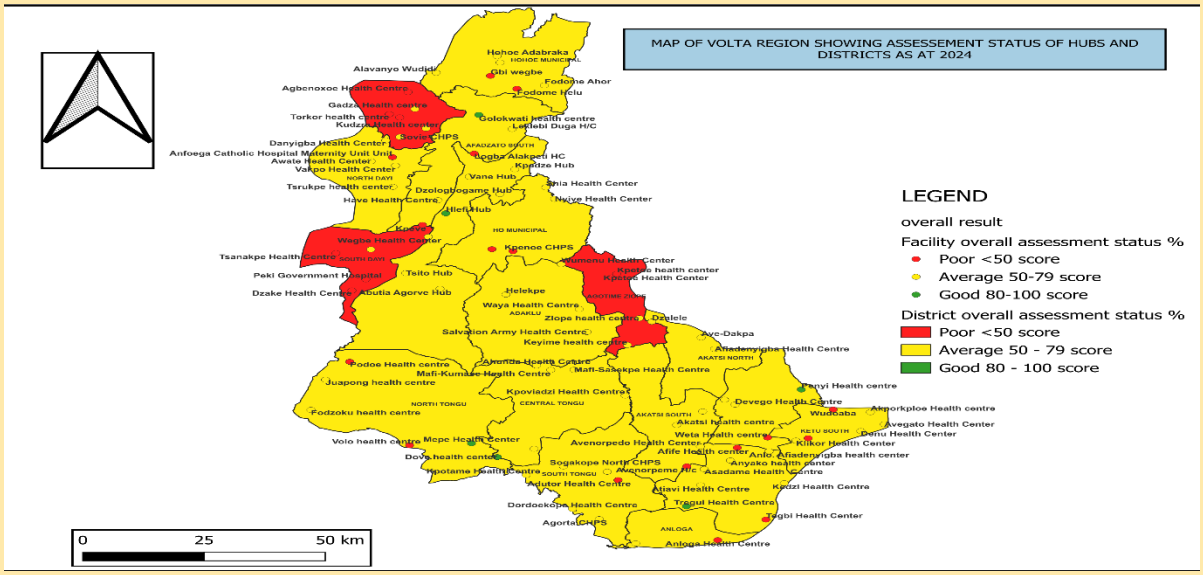

Figure 2: Performance of districts expressed on a map of the Volta Region.

An assessment was conducted in health centers across the Volta region to determine the region's readiness on BEmONC seven signal functions: management of postpartum hemorrhage, administration of parenteral antibiotics, administration of magnesium sulphate, remove retained products of conception, manual removal of placenta, resuscitation of the newborn, and assisted vaginal delivery.

Demand-side and financial barriers further constrained access. Gaps in pregnancy tracking and inconsistent follow-up — especially in island and riverine communities — contributed to delayed care-seeking. Informal user fees (i.e., unauthorized facility charges) – reported during FGDs and confirmed through stakeholder engagement – created additional financial disincentives for women already facing transportation and access challenges.

Together, these findings underscored the need to strengthen emergency readiness, reinforce provider competencies, institutionalize systematic pregnancy tracking, and improve client experience and affordability.

3. IMPROVEMENT STRATEGY & PRIORITIZED ACTIONS

The DHMT refined its improvement strategies over time based on routine performance review and implementation feedback.

During its initial performance improvement cycle (Cycle 3), the DHMT prioritized

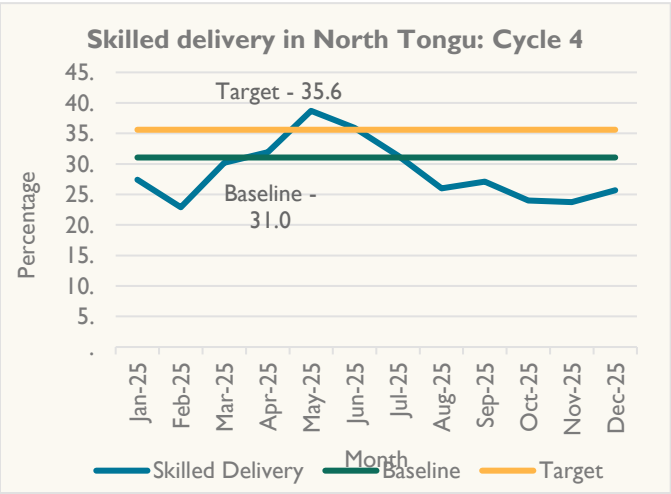

Figure 3: Percentage skilled delivery - Cycle 4

(Excluding Catholic Hospital, Battor to demonstrate progress specifically at lower facility levels).

strengthening emergency obstetric readiness and reinforcing adherence to BEmONC protocols. Initial actions focused on addressing readiness gaps through the procurement of essential supplies, supervised clinical drills, and increased facility monitoring.

As implementation progressed, the DHMT observed that district-wide performance gains observed in Cycle 3 were largely driven by Battor Catholic Hospital, a high-volume referral

facility. This masked limited progress at lower-level PHC facilities. To better align with the DMR's intent to strengthen primary care-level services, the DHMT extended the DMR into Cycle 4 and refined its measurement to focus exclusively on lower-level performance.

Cycle 4 emphasized improving provider-client interactions, strengthening pregnancy mapping and follow-up, expanding community health worker (CHW) involvement in early identification, and addressing financial barriers such as informal fees. The DHMT also introduced antenatal care (ANC) cohort registers (to record and track groups of pregnant women over time) and strengthened monitoring tools to support more systematic tracking of pregnant women so providers could better anticipate arrivals.

Catalytic grants – flexible funds designed to address priority bottlenecks – supported activities in both cycles. The DHMT used these funds to procure emergency medicines and essential delivery equipment, support customer-care coaching for midwives, and finance the distribution of ANC tracking tools and supervision activities.

Table 1. Evolution of DHMT Strategy Across PHC-LDP Cycles

Cycle	Focus	How Strategy Evolved
Cycle 3 (Feb-Jun 2025)	Strengthen emergency readiness & basic service quality	Improved emergency readiness, BEmONC adherence, and availability of essential delivery equipment and medicines.
Cycle 4 (Jul-Dec 2025)	Strengthen PHC-level skilled delivery & address behavioral and financial barriers	Shifted focus to lower-level facilities, enhanced staff attitudes and client experience, strengthened follow-up and CHW engagement.

4. IMPLEMENTATION: KEY ACTIVITIES ACROSS CYCLES

Together, the two performance improvement cycles reflect a shift from strengthening emergency obstetric capacity to ensuring that pregnant women can more readily access timely, respectful, and high-quality delivery care.

Cycle 3: Strengthening Emergency Readiness and Facility Service Quality (Feb-Jun 2025)

During Cycle 3, the DHMT focused on improving the availability of emergency medicines and essential delivery equipment – including delivery sets, Ambu-bags, suction machines, fetal dopplers, and ultrasound machines – and reinforced adherence to BEmONC protocols through Helping Babies Breathe drills, targeted clinical coaching, and increased supportive supervision. The DHMT intensified facility monitoring visits to identify service gaps and mentor staff. The team supplied standardized maternal health commodities, particularly in Community-based Health Planning and Services (CHPS) zones serving hard-to-reach areas to strengthen emergency response capacity. Through these actions, the DHMT improved frontline readiness and reinforced clinical standards across PHC facilities.

Figure 4: Training on use of new equipment procured through catalytic grants

Cycle 4: Improving Client Experience, Pregnancy Tracking, and Community Engagement (Jul-Dec 2025)

During Cycle 4, the DHMT shifted focus toward improving women's experience of care and strengthening early pregnancy identification and follow-up. Midwives participated in customer-care training and field-based coaching to reinforce respectful maternity care. The DHMT introduced ANC cohort registers and pregnancy-mapping tools to improve systematic tracking and follow-up of pregnant women, and strengthened coordination with CHWs to support early identification, referral, and community mobilization around the skilled delivery DMR.

The DHMT also enforced monitoring mechanisms to eliminate informal user fees that discouraged facility-based deliveries and continued reinforcing emergency preparedness practices to sustain gains achieved during Cycle 3. Emergency preparedness was reinforced throughout the cycle to sustain gains from Cycle 3.

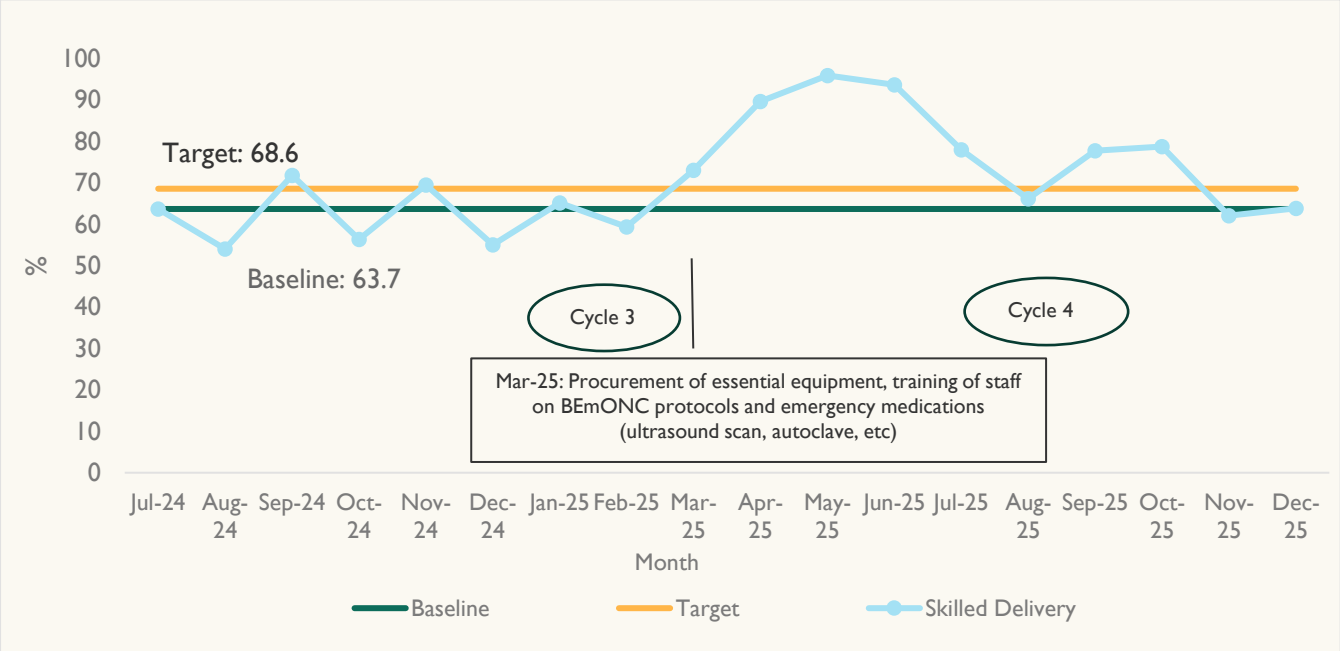

Figure 5: Skilled delivery in North Tongu

Trends in skilled delivery performance show steady improvement across Cycles 3 and 4, with gains following key quality-of-care interventions including procurement of essential equipment and staff training on BEmONC protocols.
(Data source: DHIMS2)

5. RESULTS & EVIDENCE OF CHANGE

Implementation of the improvement strategies coincided with measurable gains in skilled delivery performance and strengthened key system drivers of maternal health service utilization. Routine monitoring data generated by facilities illustrate both progress and areas that required strategic refinement across the PHC-LDP cycles.

Skilled Delivery Performance

At the start of implementation, skilled delivery performance showed variability across facilities, with persistent gaps at the PHC level. District-

wide improvements observed during Cycle 3 were driven largely by Battor Catholic Hospital.

During the final Cycle 3 PHC-LDP review session, the DHMT recognized this distortion and refined the DMR measurement to track skilled delivery only among PHC-level facilities. Following this adjustment, PHC-level performance showed meaningful improvement in Cycle 4. Performance gains during Cycle 4 coincided with strengthened pregnancy identification and follow-up systems, enhanced CHW engagement, improvements in client experience, and removal of informal financial barriers. Facility-based deliveries became more consistent across CHPS zones and health centers, reflecting strengthened PHC-level service delivery capacity. Although monthly fluctuations persisted, overall PHC-level trends improved relative to baseline.

6. LESSONS LEARNED, SUSTAINABILITY, & RECOMMENDATIONS

Implementation of Cycles 3 and 4 generated several practical insights into the drivers of skilled delivery coverage. Through routine monitoring, reflection sessions, and targeted supervision, the DHMT strengthened its understanding of the behavioral, operational, and system-level factors influencing women's access to safe delivery services.

Lessons Learned

The district's experience highlighted three cross-cutting lessons that shaped strategy refinement:

- **Refining measurement strengthens decision-making.** Early district-level performance was skewed by high burden facilities, masking PHC-level gaps. Adjusting the DMR improved targeting and accountability.
- **Emergency readiness is foundational but insufficient on its own.** Improved supplies and reinforced BEmONC adherence strengthened clinical capacity, but women's experience of care and financial accessibility continued to influence care-seeking decisions.
- **Intentional pregnancy tracking improves uptake.** ANC cohort registers and mapping tools supported more systematic identification and follow-up of pregnant women.

Together, these lessons reinforced the importance of pairing clinical readiness with people-centered service delivery and consistent follow-up.

Sustainability Conditions

To maintain improvements beyond the PHC-LDP cycles, the DHMT is embedding strengthened practices into routine PHC operations. Priority areas include:

- Institutionalizing respectful maternity care by integrating customer-care principles into supervision and coaching.
- Sustaining emergency readiness through reliable supply chains, equipment monitoring, and continued reinforcement of BEmONC skills.
- Maintaining systematic pregnancy tracking through consistent use of ANC cohort registers and intentional mapping, supported by active CHW engagement.

Embedding these systems into routine DHMT and facility workflows will help ensure gains remain durable and continue to expand across PHC facilities.

Recommendations for Future Scale-Up

Drawing on experience from both cycles, the DHMT identified practical actions to further strengthen skilled delivery and support potential replication:

- Allow sufficient time in improvement cycles for behavior change, community engagement, and system adjustments to take root.
- Continue supporting DHMT-led implementation and monitoring, including supervision, CHW coordination, and community mobilization.
- Address staffing gaps—particularly midwives and nurses—to ensure reliable 24-hour skilled delivery services at the PHC-level facilities.

These recommendations reflect North Tongu's growing capacity to lead iterative improvement efforts while offering actionable guidance for districts facing similar challenges.

Key System Shifts

Across the two cycles, several system shifts contributed to improved skilled delivery uptake and strengthened the foundations for ongoing performance improvement:

- **Improved emergency readiness and protocol adherence:** Facilities increased availability of essential delivery equipment and emergency medicines. Reinforced BEmONC adherence—supported by Helping Babies Breathe drills, targeted coaching, and supervision—strengthened provider confidence and emergency response.
- **Better client experience and respectful maternity care:** Customer-care coaching improved interactions between midwives and clients, reduced reports of poor staff attitude declined, and women expressed greater comfort seeking care, contributing to increased skilled delivery utilization at PHC facilities.
- **Stronger pregnancy tracking and consistent follow-up:** ANC cohort registers and intentional mapping tools improved early identification, tracking, and follow-up of pregnant women, enabling more timely care seeking.
- **Enhanced CHW engagement and community mobilization:** Structured coordination between CHWs and facility teams strengthened outreach, awareness, and early pregnancy identification—particularly in hard-to-reach areas.
- **Reduced financial barriers to skilled delivery:** Eliminating informal user fees improved equity in access and reduced financial disincentives for seeking skilled care.

Together, these system shifts contributed to a more reliable, people-centered delivery of maternal health services and supported North Tongu's progress toward strengthening PHC-level skilled delivery performance.

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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, Ubora Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.