ENGENDERHEALTH

Improving Access and Quality of Clinical Family Planning Services in the Public and Private Sectors in Ghana

End of Project Report for USAID-funded project
implemented by EngenderHealth
(October 1994- September 2004)

September 2004

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Suggested Citation: EngenderHealth (2004) Improving Access and Quality of Clinical Family Planning Services in the Public and Private Sectors in Ghana: End of Project Report (Accra, Ghana : EngenderHealth).

This publication was made possible, in part, through support provided by the U.S. Agency for International Development (USAID), under the terms of cooperative agreement 641-A-00-00-00080-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID.

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Executive Summary

From October 1994 to September 2004, EngenderHealth implemented a project in Ghana with the goal to assist the government of Ghana, Ministry of Health to improve accessibility and quality of clinical family planning services in the public and private sectors. This ten-year project was funded by the United States Agency for International Development (USAID) in the amount of just over $6 million.

The project was primarily focused on increasing access and quality to long-term and permanent methods (LTPM) of family planning, namely minilaparotomy under local anesthesia (ML/LA), no-scalpel vasectomy, and Norplant®. Key targets were met and in many cases exceeded, with 328 doctor/nurse teams trained in ML/LA and Norplant, 447 nurses trained in Norplant®, and 2,758 nurses trained in counseling. As a result, Ghanaian couples now have access to a fuller array of contraceptive methods, with 259 health facilities offering LTPM services and 27,274 women receiving female sterilization and 55,968 women receiving Norplant® over the course of the project.

What is most interesting and informative is looking at how this was achieved. Some of the keys to the success of the project include an innovative and effective system of working through sub-agreements directly with the country's ten Regions to enhance local ownership, having a strong focus on sustainability, taking a comprehensive approach, and being flexible and responsive to opportunities and changes in the environment.

Increasing access involved training providers, strengthening service sites through provision of equipment and assistance in renovation, and addressing demand with IEC activities such as use of satisfied clients and the well-received *Get a Permanent Smile* campaign to increase demand for vasectomy services. EngenderHealth took a systems development approach in training and "the key word was sustainability." First they trained trainers who were MOH staff, and then this group trained others, thereby building a sustainable program by instilling the capacity within the system rather than outside. One of the keys to expanding access to Norplant® was training nurses to provide this service. This was made possible by helping to create the necessary policy change in the family planning service delivery guidelines in 1996.

Improving quality included several elements: counseling training; COPE—Client Oriented Provider Efficient—a self-assessment quality improvement tool; whole-site training in infection prevention; and facilitative supervision. In addition to improving skills, these interventions also had an important impact on attitudes. For example, while supervision had typically been viewed negatively, after the training, supervisors worked in a more supportive and coaching manner, and as one supervisor explained, "people are now happy to see me."

Building on the lessons from this project, EngenderHealth and several partner organizations are implementing a new five-year Cooperative Agreement to improve the quality of health services in Ghana, beginning June 2004.

I. Introduction

Between 1993 and 2003, the modern contraceptive prevalence rate (CPR) in Ghana increased from 10.1 percent to 19 percent and the total fertility rate (TFR) decreased from 5.5 to 4.4. The country is on the way to meeting the goals set forth in the National Population Policy of 1994: to reduce the total fertility rate to 5.0 by 2000, to 4.0 by 2010, and to 3.0 by 2020; to increase modern contraceptive prevalence rate from 10 percent to 15 percent by 2000, to 28 percent by 2010, and to 50 percent by 2020; to achieve a minimum birth spacing of at least 2 years for all births by 2020 (cited in Jain *et al*, 2003).

Table 1: Statistics from Demographic and Health Surveys for Ghana

Year	**Population**	**TFR**	**CPR**	**Method Mix** (among currently married women)
1993	17 million	5.5	All 20.3% Modern 10.1%	Pill 3.2% Condoms 2.2% Injectables 1.2% IUD 0.7% Female Sterilization 0.9% Implants 0%
1998	18.3 million (1999 estimate)	4.6	All 22% Modern 13.3%	Pill 3.9% Condoms 2.7% Injectables 3.1% IUD 0.7% Female Sterilization 1.3% Implants 0.1%
2003	20.5 million*	4.4	All 25% Modern 19%	Pill 5.5% Condoms 3.1% Injectables 5.4% IUD 0.9% Female Sterilization 1.9% Implants 1.0%

* from the Population Reference Bureau's *2003 World Population Data Sheet.*

Ghana has a decentralized health system. In 1996, the Ghana Health Service and Teaching Hospitals Act established the Ghana Health Service (GHS) and the Teaching Hospitals Boards as the executing agencies responsible for delivering health care. The primary function of the Ministry of Health (MOH) is to formulate policy, determine health priorities, mobilize resources, establish a regulatory framework, and monitor performance. The country is divided into ten regions, and there are Regional Health Directorates that coordinate health activities and programs at the regional level. The Reproductive and Child Health Unit of the GHS is responsible for all family planning service delivery in the country. Services are also available from the private sector, such as the Planned Parenthood Association of Ghana (PPAG).

EngenderHealth began working in Ghana in 1986, introducing minilaparotomy under local anesthesia (ML/LA). They initially provided support to two teaching hospitals, and then the MOH expressed interest in scaling up this work. The official launching of the EngenderHealth Ghana country office was on February 16, 1994.

II. Overview of Project

In September 1994, EngenderHealth was awarded a Cooperative Agreement from the United States Agency for International Development (USAID) for work in Ghana. The goal was **to assist the government of Ghana, Ministry of Health to improve accessibility and quality of clinical family planning services in the public and private sectors.** The initial six-year cooperative agreement was awarded for $3,000,000 from October 1, 1994- September 2000. This was followed by three continuations or modifications, with the project eventually becoming a roughly six million-dollar project taking place over a ten-year period (Table 2).

Table 2: Overview of Cooperative Agreements and Continuations/Modifications

Dates	Amount
1. October 1, 1994 to September 30, 2000	$3,000,000
2. October 1, 2000 to September 30, 2001	$1,699,909
3. October 1, 2001 to September 30, 2003	$927,834
4. October 1, 2003 to September 30, 2004	$445,000
TOTAL	**$6,072,743**

The project was primarily focused on increasing access and quality to long-term and permanent methods of family planning, namely minilaparotomy under local anesthesia, no-scalpel vasectomy, and Norplant®. As stated in the 2000 Cooperative Agreement Continuation Program Description, the activities had a direct impact on the following sub-results:

- Increased access to reproductive health services through the establishment or institutionalization of family planning and reproductive health training system within the Ministry of Health

- Improved quality of reproductive health services through the development of quality systems and the training of both public and private family planning service providers in the use of quality tools and approaches

The key activities included: 1) strengthening the physical infrastructure of health facilities; 2) providing essential equipment and supplies; 3) training providers; 4) institutionalizing quality of care standards and quality improvement approaches, including infection prevention, facilitative supervision, COPE (Client Oriented Provider Efficient), and medical monitoring; 5) developing information, education, and communication (IEC) activities; and 6) introducing men's initiatives.

This end-of-project report was prepared through document review, including Cooperative Agreements and modifications, Annual Reports from EngenderHealth/Ghana to USAID for each year of the project, and evaluations. In addition, interviews were conducted in Ghana with staff from USAID, EngenderHealth, and the Ministry of Health to discuss

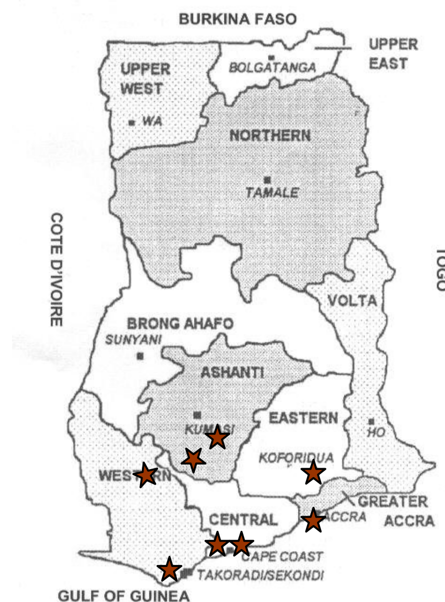
key achievements and lessons learned from the project. Information from the following three evaluations is used throughout the report:

- 1999. *Evaluation of AVSC-Supported Activities in Ghana*. Martha Jacob, David Mandel, Marcia Mayfield, and Manisha Mehta. A four-person team conducted field work between February 8 and 26, 1999. Data collection included reviewing documents, interviewing staff from EngenderHealth, USAID, and in-country counterparts, and visiting eight service delivery sites, as shown in Figure 1 (to be used for sentinel surveillance).

- 2003. *Review of EngenderHealth-Supported Activities in Ghana*. Aparna Jain, Godwin Tagoe, Caroline Tetteh, and Damien Wohlfahrt. Field work was conducted by a four-person team from July 7-25, 2003. Data collection included reviewing documents, interviewing staff from EngenderHealth, USAID, and in-country counterparts, and visiting the eight sentinel surveillance sites.

- 2004. *Measuring the Quality of Family Planning Services: Ghana*. This report summarizes data collected at a sample of eight service delivery sites at two points in time: time 1, December 2001-Feb 2002; and time 2, July 2003. A total of 153 indicators were measured through use of five data collection tools: 1) provider interview; 2) client exit interview; 3) observation of counseling services; 4) observation of clinical services; and 5) observation of clinical site/facility audit.

Figure 1: Map of Ghana with Location of Sentinel Surveillance Sites



III. Achievements

The Cooperative Agreements set out several targets in terms of the number of providers trained in minilaparotomy (ML), Norplant®, and vasectomy and in the number of clients receiving these services.[1] As shown in Table 3, the project achieved, and even surpassed, most of its targets, with the exception of clients receiving vasectomy services. As a result of this project, Ghanaian couples now have access to a fuller array of contraceptive methods in all ten regions of the country.

Table 3: Achievement of Key Targets, October 1994-September 2004

	Target	Actual
Doctor/nurse teams trained in ML/LA and Norplant*	370	328
Nurses trained in Norplant®	400	447
Nurses trained in counseling	2,200	2,758
Clients received female sterilization	25,000	27,344
Clients received Norplant®	45,000	55,968
,	300	217

* It should be noted that an additional 81 doctors were trained in Norplant only

But what is most interesting and informative is looking at how this was achieved. Some of the keys to the success of the project include an innovative and effective system of working through sub-agreements directly with the country's ten Regions, having a strong focus on sustainability, taking a comprehensive approach, and being flexible and responsive to opportunities and changes in the environment.

This project was implemented primarily through sub-agreements with the Regional Health Directorates. Workplans were developed collaboratively between EngenderHealth and the Regions, with the Regions selecting the sites and participants for training. In this way, the project was not seen as being imposed from the outside, but rather as a project that was owned and run by the MOH. As a representative from the MOH explained, "when you sign the agreement with them [the Regions], they are committed more." As EngenderHealth staff explained, "we give them the power. We play the role we're expected to play—we give technical assistance, help them—it is not like we come and say we have a program, here it is. So they feel that it is their program and so they take ownership." This way of working is important for creating trust: "sometimes they think you don't trust them, so they won't help make the program succeed. You need to show them you trust them." The MOH also spoke highly of this process, and how no other project used this mechanism, although they would like to see it replicated in other projects.

EngenderHealth developed a solid and financially stable sub-agreement management system. During the life of the project 52 sub-agreements were issued to local counterparts in the total amount of $2,246,052, representing over one-third (38 percent) of the total budget. With the sub-agreements, there was a more efficient flow of funds;

[1] The targets in Table 3 are from the final modification of the Cooperative Agreement

"the money is there, it's not like writing to headquarters for the money. They have easy access." Staff from USAID explained that "other groups had trouble because they didn't have a mechanism to give grants." The Regions also like the flexibility of the money, because if activities are not completed they can be reprogrammed for the next year. When a USAID staff person went with a financial analyst to look at what was happening, they found that the money was being used well and for what it was supposed to be used for. There is an ongoing challenge to give the MOH control but also ensure funds are spent efficiently. But, as EngenderHealth staff explain, "that is one of the major successes of this program—the ability to let go."

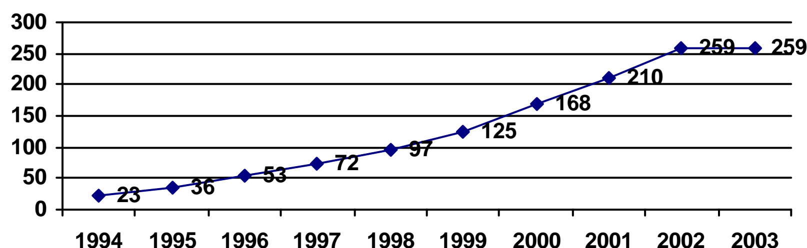
EngenderHealth also took a comprehensive approach in implementation. As stated in the continuation of the Cooperative Agreement, "While training plays an important role in preparing providers for services, it cannot stand alone. EngenderHealth's approach to improving services relies on a creative mix of training, technical assistance, and monitoring." In their approach in Ghana, improving quality and access means not just training providers, but setting up a sustainable system of training and supervision. It means not just working with one or two providers at a health facility, but working with the whole site. And it means not just looking at a family planning method in isolation, but looking at all the factors that affect whether that method will actually be available and accessible.

Activities and achievements fall under two main categories, Access and Quality, which are discussed in detail below. Examples are given of challenges faced along the way, and the effective ways that EngenderHealth and the MOH/GHS met these challenges. In addition, project management and documentation of the project are addressed.

Increased Access to Reproductive Health Services

Over the course of the project, the number of facilities providing long-term and permanent methods of family planning has increased from 23 to 259. As staff from USAID explained, "once EngenderHealth came in and expanded, the expansion was incredible."

Figure 2: Number of EngenderHealth-supported sites with LTPM services*



* It should be noted that some of these sites offer both ML and Norplant®, while some offer only Norplant®. For example, in 2002, 91 sites offered both, while168 offered Norplant® only

At times during the project, EngenderHealth focused their efforts on improving the quality at existing sites and consolidating the achievements rather than continually adding new sites, with the idea of creating full-service sites that receive the range of assistance in technical training, COPE, infection prevention, and counseling.

EngenderHealth also worked with the private sector. Work with the Planned Parenthood Association of Ghana (PPAG) included initiating long-term method capability at its three main service sites in Accra, Cape Coast, and Takoradi, and training nurse/midwives in Norplant® provision at all seven PPAG sites.[2] In addition, EngenderHealth worked with the Ghana Registered Midwives Association (GRMA) to provide support and training for private midwives in clinical family planning, counseling, infection prevention, and COPE.

Training: "Give them the power"

From 1994-2003, through this Agreement, 326 doctor/nurse teams were trained in minilaparotomy and Norplant®; 81 doctors were trained in Norplant® only, and 441 nurses were trained in Norplant® (Table 4). In addition, seven doctors were sent to India and Bangladesh for training in no-scalpel vasectomy. EngenderHealth has taken a systems development approach, and "the key word was sustainability." First they trained trainers who were MOH staff, and then this group trained others, thereby building a sustainable program by instilling the capacity within the system rather than outside. There are a number of encouraging signs for sustainability: activities around long-term and permanent methods (LTPM) are now included in MOH workplans; the Regions report on training in LTPM, infection prevention, and COPE; and, according to EngenderHealth staff, "when the MOH discusses this work, they say 'we did this' not 'EngenderHealth did this.'"

Table 4: Doctors and nurses trained in Minilaparotomy and Norplant®

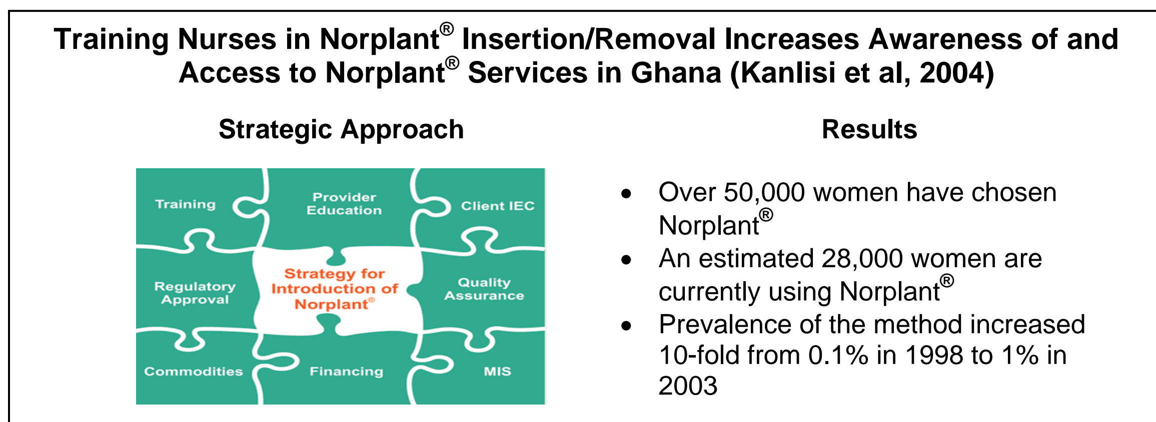
Objective	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total
Train doctor/nurse teams in ML and Norplant®	11	30	31	36	68	31	27	46	19	20	9	**328**
Train nurse/ midwives in Norplant®	-	-	-	-	3	64	83	142	68	68	19	**447**
Train doctors in Norplant®	-	-	-	40	-	13	3	21	4	-		**81**

The original plan in the Cooperative Agreement was to set up ten training centers, one in each region, so as to cut down on costs and travel time for training. However, EngenderHealth staff determined that not every place could be a good training center for a number of reasons. First of all, trainings were caseload dependent and in some regions there was not an adequate caseload. Also, in some cases, the staff were fine in the skills and in practice, but not necessarily appropriate as trainers. Finally, the interest of people

[2] EngenderHealth no longer provides support to PPAG due to the reinstated Mexico City policy.

affects whether or not it is possible to set up a training center. In spite of not having training centers in all ten regions, the existing centers have been able to train providers to cover sites in every region and most districts of the country (Jacob *et al*, 1999).

Initially, EngenderHealth trained only doctors in Norplant®. They had planned to also train nurses. However, the existing policy was not explicit about whether nurses could perform this surgical procedure, and although there was no policy forbidding nurses from inserting Norplant®, there was more of an 'unwritten law' against this practice. When women came for services, there was often a long line and no doctor available, and so the method was there but not really accessible. EngenderHealth staff documented these difficulties so that people became aware of the problem, and then they were able to use this evidence to advocate for changing the policy. And a perfect opportunity arose in 1996 when national family planning guidelines were developed. A number of organizations, including EngenderHealth, provided assistance in this process, and so a policy was created that clearly spelled out that nurses were allowed to provide Norplant®. This shows the importance of being attuned to the environment in which a program operates and being a credible voice to help to bring about necessary policy changes. Training nurses has been critical in increasing access to Norplant® and reducing waiting time for clients. This was mentioned in a 2003 report on trends in IUD use in Ghana: "'the success with the implant has been that there has been training of midwives and nurses apart from doctors in insertion and removal, and that has increased access and the demand is being met more in those places.'" (Gyapong *et al*., 2003)



There were a number of challenges faced in program implementation. The main issue was the problem of staff turnover. This is a widespread problem throughout Ghana; between 1996 and 2002, the number of doctors and nurses in Ghana decreased by 17% and 24%, respectively. (from the Quality Health Services Program description, 2004). In order to address this, EngenderHealth often conducted additional training so as to replace the skills lost when the trained provider left. In addition, low caseload also had an impact on training. As mentioned in EngenderHealth/Ghana's 1996 Annual Report, the lack of IEC materials on long term methods has adversely affected client load, and in turn, the low client load affected training and service delivery. This highlights the close link between supply and demand—unless there is adequate demand, caseloads can remain so low that training is very difficult. Because caseloads for vasectomy are so low in Ghana,

this challenge was addressed by sending providers to India and Bangladesh for training. However, sending providers from Africa to Asia for training is too expensive to do on a large scale.

The training did not just involve teaching new skills, but also changing attitudes. For example, EngenderHealth staff explained how service providers were resistant and reluctant to counsel women about sterilization; “they didn’t see the positives, that some women really want this, so we got satisfied clients to interact with providers during training to discuss why they did it, how it helped and we found that began to change providers’ attitudes.” After this success, EngenderHealth then tried to replicate the idea in the general public through using ‘satisfied clients’ and training them in public speaking and communication. This is discussed in more detail in the section on demand.

Service Site Strengthening: Benefits for and beyond family planning

In addition to training, EngenderHealth provided assistance for renovating health facilities and providing essential equipment and supplies. Renovations often included painting and partitioning to create greater privacy for counseling. These renovations helped providers initiate and provide high-quality services after receiving their training. In some cases, delays in completion of renovations in theaters and procedure rooms at facilities delayed the start of services after the training of doctor/nurse teams.

Initially, trained providers were given equipment after training to bring back to their facility. This was later changed so that trained providers return to their facility, and the facility then requested the equipment. This has kept it from being too closely tied to the individual provider. However, it can be a problem if the head of the facility is not supportive in following through on requesting the necessary equipment.

There were generally important side benefits to this work. Improvements at sites, whether in the physical structure or in new equipment, were not just beneficial for provision of long term and permanent methods but also for other services at the facility. For example, equipment provided to set up operation theaters for ML were subsequently able to provide emergency C-sections, and many of these sites were later upgraded to district hospitals.

Service Statistics

As a result of the training and strengthening of service sites described above, there have been significant increases in utilization of female sterilization and Norplant® services, as shown in Table 5 (It should be noted that Norplant® removals were not reported on until 1997). For example, while there were only 199 Norplant® acceptors at five sites in 1994, this increased to 13,010 acceptors in 2003. Given the increasing popularity of Norplant®, it is important to ensure that there is a regular supply at facilities. There have been problems over the years with reported stockouts of Norplant®. For example, the 1998 Annual Report states that one of the main constraints was that during the year there were stock outs of Norplant® in almost all the regions. There is an adequate supply of

Norplant® at the central level, but sometimes there are distribution problems due to people not ordering adequate supplies or distribution not occurring based on a site's need.

Table 5: Service Delivery statistics for EngenderHealth-supported sites

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004*	**Totals**
Norplant®												
Insertions	199	511	1,180	1,426	1,850	3,405	5,345	8,872	12,141	13,010	8,029	**55,968**
Removals				102	133	337	550	1,132	709	2,514	2,065	**7,542**
Female Sterilization	1,154	1,566	2,304	2,602	2,550	2,739	2,857	3,437	2,953	3,188	1,994	**27,344**
Vasectomy	4	6	2	11	9	20	11	21	21	26	63	**194**

* Reflects data only through September 30, 2004

The number of women receiving female sterilization has increased. EngenderHealth's work has focused on minilaparotomy (ML), but service statistics do not separate ML and C-section with bilateral tubal ligation, so it is not possible to track the increase in ML specifically. This makes it difficult to assess how much the use of ML has increased. Although this information would be useful, it is important to note that the goal was to increase use of sterilization generally, not only use of ML. While the number of acceptors of Norplant® has continually increased, the number of acceptors of female sterilization seems to have reached a plateau at roughly 3000 acceptors per year. EngenderHealth staff feel that this is because many women prefer a long-term method rather than a permanent one, as well as the fact that a Norplant® insertion is a faster and less costly procedure than a sterilization.

While the numbers of men choosing vasectomy has increased from 4 in 1994 to a high of 26 in 2003, with a total of 194 men receiving vasectomy over the past ten years, the demand for this service is still very low. EngenderHealth is addressing this through the *Get a Permanent Smile* IEC campaign, which includes several creative materials on vasectomy. These materials were developed by Lintas, an advertising agency, in 2003 and pre-tested, and then the media campaign was launched in the first quarter of 2004. In addition, a hotline has been set up, but this is ending in August 2004. It is interesting to

Get a Permanent Smile—A Pilot Project to Increase Awareness of and Access to No-Scalpel Vasectomy Services in Ghana (Kanlisi *et al*, 2004)

A Strategic Approach

Supply-side interventions:

- Brought providers to India and Bangladesh for training, including shifting attitudes
- Whole-site training at facilities
- Creating male friendly services

Demand-side interventions:

- Created a positive, upbeat image
- Used testimonials from satisfied clients
- Used several channels to deliver message

"Vasectomy is as much an IEC operation as a surgical operation."

A checklist for a successful program

√ Address both the demand and supply side of the equation

√ Emphasize effective promotion (IEC and advocacy)

√ Be attentive to the needs of men

√ Be attentive to developing providers' skills

√ Have strong leadership (champions)

note that in 2004 (through September), 63 men received vasectomy services—almost two and a half times the amount of the previous year. EngenderHealth and MOH/GHS expressed the desire to continue this program for a longer period of time given the initial positive response, and this is currently being done under the ACQUIRE project.

Demand as well as Supply: Sharing satisfaction

Due to the setting of their work in Ghana, EngenderHealth recognized the need to move beyond the supply side and also address demand. As described in EngenderHealth/ Ghana's 1996 Annual Report, EngenderHealth "has been operating against the background of unfavorable cultural beliefs and practices. There is the concern about misinformation on female sterilization and vasectomy. Generally, people want to have children irrespective of quality of life. Further, women attach their status and prestige to the number of children they have. Some health workers have a negative attitude towards the permanent methods. IEC activities should be intensified to change attitudes, behaviors, and practices of men and women in the reproductive age group."

EngenderHealth "played a critical role in instituting IEC efforts for P< methods services in the country, although this was not part of [their] mandate in its cooperative agreement with USAID" (Jacob *et al*, 1999). One of the main efforts was the satisfied clients program, where satisfied clients were identified and screened to be trained to be part of IEC activities to increase client load. They were given training in public speaking and communication. Originally, this was done for female sterilization, but was later expanded for users of other methods as well. Efforts were made to use existing structures rather than setting up new ones, and so the satisfied clients were sent out with the MOH outreach teams. However, there were some problems with their availability, in part because they worked as volunteers. They were given small incentives, such as t-shirts, eye visors, and badges to motivate them and identify them during their community work. It was viewed as problematic to pay them, because, as EngenderHealth staff explain, "if you pay them, it looks like you're paying them to say something."

The program has been generally viewed as a successful initiative. The 1998 Annual Report states that "satisfied clients activities in the region helped to raise client load and increase referrals." However, there was never any formal evaluation of the satisfied clients program.

The MOH still sees a need to work more in addressing rumors and misconceptions about family planning. They explain that many people in Ghana are still unsure about whether hormones will affect their body in negative ways, such as making them sterile or causing other illnesses. They also see a need for regular updates of health workers and top level personnel, because "when something wrong comes out of the mouth of a top person, we have had it."

Improved Quality of Reproductive Health Services

EngenderHealth took a comprehensive approach to improve the quality of reproductive health services. This included several elements, such as counseling training, infection prevention, monitoring and supervisory practices. It involved training at the site and central level as well as individual coaching and on-the-job training. Just as with the clinical side, training involved not only teaching new skills but also changing attitudes. This was particularly true for supervision, and training in facilitative supervision played a key role in bringing about this change.

EngenderHealth Quality Improvement Tools and Approaches in Ghana

Facilitative Supervision emphasizes mentoring, joint problem solving, 2-way communication between a supervisor and those being supervised, to meet the needs of those being supervised enabling them to meet the needs of clients.
COPE® (client-oriented, provider-efficient services) is a participatory self-assessment process for service sites, used and adapted worldwide that focuses on clients' rights and providers' needs to improve quality while promoting efficiency, ownership, and teamwork. COPE can be used to assess any type of health service
Whole Site Training is aimed at meeting the learning needs of teams at a service site. It links facilitative supervision, problem identification and solving, and training. It engages supervisors in identifying learning needs, and planning and implementing required learning activities and training for all essential team members through various means (OJT, courses, orientations, etc.).

There have been major improvements in quality of reproductive health care services. Findings from the measurement of 153 indicators of quality of care at the eight sentinel surveillance sites are shown in Table 6. These were measured at two points in time to see changes: time 1 was December 2001-February 2002; and time 2 was July 2003. Overall, the percent of favorable responses increased for almost half (49 percent) of the indicators from time 1 to time 2, while it remained the same for 37 percent, and decreased for only 14 percent of the indicators.

Table 6: Performance of indicators for elements of quality of care at sentinel surveillance sites

	Increased	Remained the same	Decreased	TOTAL
Access and Continuity	2	9	3	**14**
Information and Informed Choice	23	19	6	**48**
Safe Services	12	15	5	**32**
Privacy, Confidentiality, and Dignity	13	9	4	**26**
Staff Needs	25	4	4	**33**
TOTAL	**75**	**56**	**22**	**153**

The Ghana Service Provision Assessment Survey was undertaken in 2002 and gives a picture of the state of services nationally. It was suggested that EngenderHealth could try to use some of the data from this survey to look at the impact of their work over the course of the follow-on project. Some of the findings relevant to EngenderHealth's work to which EngenderHealth has likely contributed are given below.

√ Female sterilization is only offered in 9 percent and male sterilization in 2 percent of facilities. However, male or female sterilization is offered in over three-quarters (76

percent) of hospitals. The implant is offered in 17 percent of facilities, but was available in 12 percent on the day of the survey.

- √ Equipment for providing specific contraceptive methods was not universally available. Sixty-three percent of facilities providing IUDs had all the equipment for IUD insertion, and 60 percent of the facilities offering implants had all the equipment necessary for implant insertion.
- √ All infection control items (soap, water, clean gloves, disinfecting solution, and sharps box) were present in one out of five facilities. Items most often missing were water (missing from 59 percent of facilities) and disinfecting solution (missing from 60 percent).
- √ 15 percent of providers had received in-service training in Norplant—7 percent in the past 12 months, and 8 percent 13-59 months preceding the survey; 10 percent were trained in minilap—3 percent in past 12 months and 7 percent 13-59 months preceding the survey; 56 percent were trained in infection prevention—20 percent in past 12 months and 30 percent 13-59 months preceding the survey.
- √ Six in ten providers (59 percent) were personally supervised during the past six months.

Counseling training

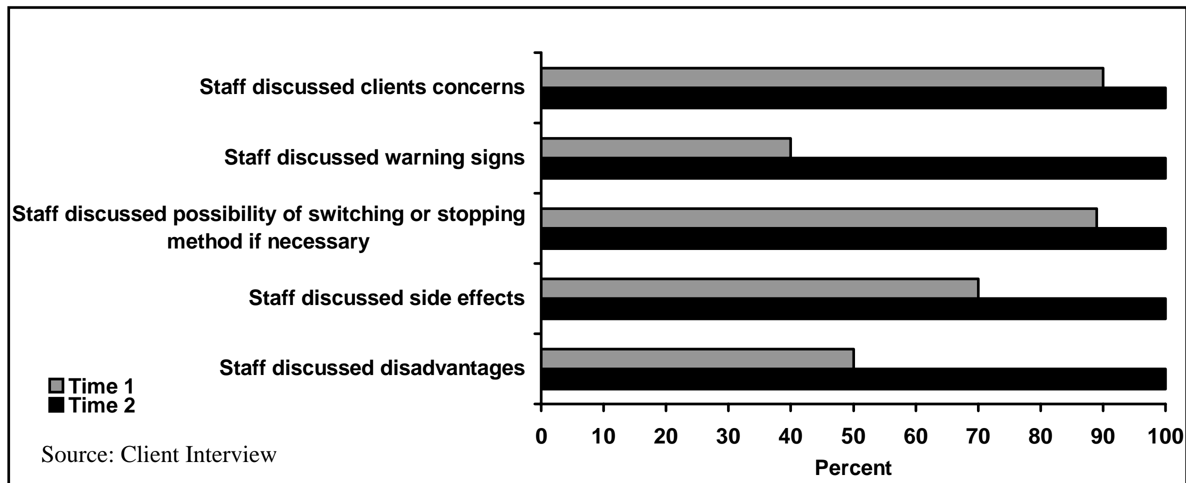
Over the course of the project, 2,758 nurses received training in counseling (Table 7). EngenderHealth began revisions of the counseling curriculum in 1999/2000 to expand upon sections related to STI/HIV/AIDS. Discussions during a training workshop in March 2000 at Koforidua also helped inform curriculum revision. According to medical monitoring visits, "there has been much improvement in the quality of services, especially in counseling." (EngenderHealth Annual Report, 2001).

Table 7: Nurses trained in counseling, by year

Objective	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	**Total**
Train nurses in counseling	38	197	89	244	342	169	191	459	269	662	98	**2,758**

Information from the sentinel site data shows some of the improvements in counseling over time. Both observations of counseling sessions and interviews with clients showed that providers gave more information to clients about disadvantages, side effects, and the possibility of switching or stopping a method (Figure 3).

Figure 3: Client perceptions of information received for selected FP methods



Source: Client Interview

COPE: "The tool is there, it is forever"

COPE—Client Oriented Provider Efficient—is a self-assessment quality improvement tool for health facilities. According to the MOH/GHS, this quality of care tool is known by most health workers and many continue to use it; "the tool is there, it is forever." According to the 2003 evaluation, most respondents mentioned improving infection prevention practices as an example of how COPE has improved the quality of services (Jain *et al.,* 2003). COPE is also an important way to get client perspectives; COPE tools include a client interview guide and a client-flow analysis.

In September 2003, a COPE review meeting was held for Regional COPE trainers to discuss activities carried out in all the regions after their training. Participants reported a number of achievements at many health facilities. However, they felt that as COPE was moved out to the sub-district level, it was important that the introduction be systematic and that District Health Management Teams (DHMTs) and their sub-districts be grouped together for the introduction. They also stressed the need for better sharing of results at the district and regional levels.

Facilitative Supervision: "People are now happy to see me."

This project has helped to bring about a dramatic change in people's views about supervision and in the way it is conducted. This change in attitude was important and was done in part through teaching people to put themselves in someone else's shoes. Previously, there was the feeling that "if the boss is coming, everyone runs, people don't understand why they are doing it. You need to think if you were the patient, would you like it, if you were the supervisor, how would you make it so staff didn't hide things from you." With facilitative supervision, there are efforts to make supervision more supportive and friendly, and more like coaching. As a nurse supervisor commented, "Facilitative supervision has helped me a lot. Supervisors are challenged to be up to date. People are

now happy to see me, and no longer try to hide away. We always have something to share. We sit down and discuss issues. I make suggestions on how staff can solve their problems." (Jain *et al*., 2003) Both MOH and EngenderHealth staff conduct supervision. EngenderHealth's strategy has been to build capacity for the MOH to do the follow-up.

Data from the sentinel surveillance sites show dramatic improvements in supervision. Interviews with providers showed improvement in all of the following activities:

- Supervisor helps to organize training for staff
- Supervisor provides written feedback to site after visit
- Supervisor helps to organize problem-solving exercise
- Supervisor examines records and provides feedback
- Supervisor observes different services
- Supervisor visited site at least once in last six months.

For example, at time 1, only 25 percent of providers said that supervisors examined records and gave feedback or observed different services. By time 2, this had increased to 75 percent of providers for both indicators.

Infection Prevention: "IP evolved out of our experience"

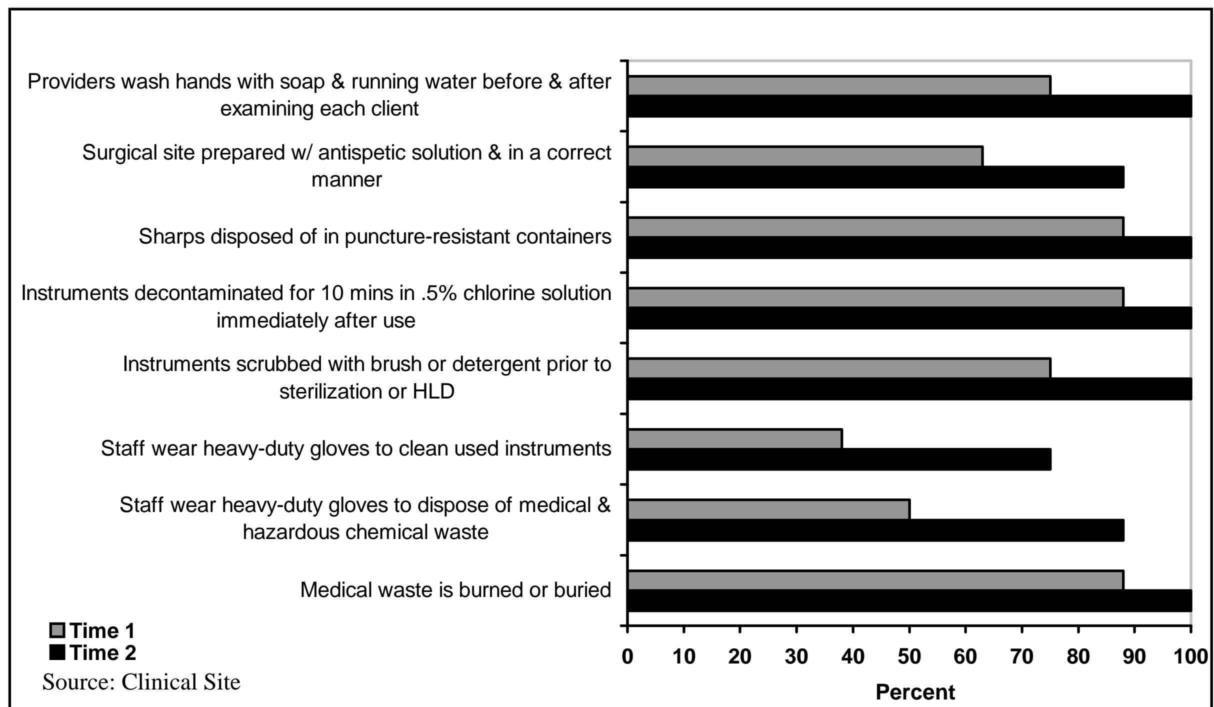
There were plans in the original Agreement to train in infection prevention (IP). During the course of implementing the project and monitoring sites, it became clear to EngenderHealth staff that there were many problems with IP practices, such as seeing needles just thrown about at facilities, rusting of equipment due to inappropriate concentration of chlorine, poor decontamination and disinfection of equipment for surgery, and increased incidence of wound infections. Improving this area was essential to improving quality of care. Therefore, from the beginning of 2001, IP training increased; "so IP evolved out of our experience." EngenderHealth has trained 26 master trainers from all ten regions in IP training and over 100 trainings have taken place at health facilities. Using a Whole-Site-Training Approach (WST), EngenderHealth conducted infection prevention training for the entire facility, including housekeeping staff who had previously never received any training. Work in this area shows EngenderHealth's awareness of needing to take a comprehensive approach and adapting the program to the needs identified in the course of implementation.

IP workshops at health facilities aim to upgrade the knowledge and skills of participants in infection prevention, and identify and develop special skills to ensure quality infection prevention practices at service sites. Participants speak highly of the importance and usefulness of this training. EngenderHealth's 2000 Annual Report to USAID points out that "In their end of workshop evaluation, most of the participants were impressed that most of the changes they want to implement do not need money but just a reinforcement of the standard precautions."

Follow up visits conducted to some sites where the training took place revealed that there has been remarkable improvement in IP practices (2001 Annual Report). Most of the facilities had improvised puncture-proof boxes for sharps disposal, clean single-use towels, and perforated soap dishes to ensure that the cake soap remains dry. In addition, the housekeeping staff were provided with utility gloves and boots. Other changes mentioned included hands being washed under running water and no more recapping of hypodermic needles (2002 Annual Report).

Figure 4 shows the improvement in infection prevention practices at the sentinel surveillance sites. For example, providers were much more likely to wear heavy-duty gloves to clean instruments and to dispose of medical and hazardous chemical waster.

Figure 4: Infection prevention practices



Source: Clinical Site

Other aspects of reproductive health: leveraging resources

EngenderHealth's work under this Cooperative Agreement went beyond family planning to broader reproductive health issues. For example, in 1996 the Ghana office was one of the first countries to get involved with the innovative Men as Partners (MAP) program. Launched in 1996, EngenderHealth's MAP program is rooted in the knowledge that genuine social change depends on male involvement with reproductive health issues. A critical component of the program is the belief that educating men about their own health as well as that of their partner can contribute to positive health outcomes for both. As EngenderHealth/Ghana staff explain, "the gender barrier is very high in our environment.

We are looking at men's role, and trying to address access by looking at gender inequity." In 1998, a national workshop on men as partners program was held as a follow up on the Mombasa International workshop on Men As Partners (MAP). Fifty participants attended and a country action plan was developed. In 1999, a two-day training on men's reproductive health services was conducted for staff of PPAG. A total of 27 participants, all staff of PPAG, attended the workshop. Topics discussed included EngenderHealth's male reproductive health model, management issues and a male specific COPE assessment and an on-site clinic tour. In addition, the EngenderHealth Country Director and PPAG Executive Director attended a MAP conference in London.

The EngenderHealth Ghana office was also given money for sexually transmitted infections (STIs) in 2002. Work in this area included strengthening syndromic management training and STI counseling. In addition, EngenderHealth conducted COPE for STIs and site orientation at facilities in three regions.

In several cases, EngenderHealth was able to attract resources from other donors because of their successful work in Ghana. For example, EngenderHealth worked with UNFPA in 2003 to develop guidelines on the prevention of mother-to-child transmission of HIV/AIDS. This draft manual was field tested in Koforidua Regional Hospital.

EngenderHealth also collaborated with Columbia University's Averting Maternal Death and Disability (AMDD) Program on two occasions in Ghana. As a result of the success of a fistula assessment in nine sub-Saharan African countries conducted by EngenderHealth and UNFPA in 2002, in 2003 the AMDD Program approached EngenderHealth to conduct a basic needs assessment of facilities offering fistula repair in Ghana and Rwanda. In Ghana, EngenderHealth visited six health facilities and met with representatives from the Ministry of Health and the Society of Ob/Gyn, Ghana to assess the quality and availability of fistula services.

In addition, as part of a larger effort to improve the quality of care in emergency obstetric care facilities, in summer 2002 the AMDD Program requested EngenderHealth to pilot some jointly developed quality improvement (QI) materials – the *Quality Improvement for Emergency Obstetric Care Leadership Manual* and accompanying *Toolbook* in Ghana and India. In Ghana, EngenderHealth partnered with the country's Prevention of Maternal Mortality Network (PMMT) to work in Winneba District Hospital in Awutu Efutu Senya District. As a result of this intervention, approximately 75 percent of the problems identified were solved by the staff themselves, while the remaining 25 percent involved issues requiring outside resources to resolve (e.g. staff shortages/lack of certain cadres of professional staff, lack of equipment).

Project Management

The EngenderHealth/Ghana office has an all Ghanaian staff. This has been helpful in terms of having people who understand very well how the MOH/GHS works. As they explain, "most of us worked in the districts before working here, so you know the people

and we work as colleagues. The relationships have been created. If you have worked in the system, you know how the system runs and you have to work within the system." Throughout the project, there has been a very close relationship with the MOH. As the MOH/GHS expressed this, "every activity was conceived together, the way things should work, where they should work. It was a joint thing."

It addition, there was very little staff turnover, both in terms of EngenderHealth staff and key personnel at MOH/GHS, during the course of the project. This has given important continuity and facilitated the smooth implementation of the project.

Table 8 shows the overall budget for the Cooperative Agreement, including the amount obligated and the amount spent over the ten-year project, as of June 30, 2004. The remaining balance of $122,438 will be spent by September 30, 2004, the official end date of the project.

Table 8: Ghana Cooperative Agreements Expenditures
(October 1, 1994 – September 30, 2004)

Description	Total obligation	Expenses	Balance
I. Direct Cost		***5,151,182***	
Sub-agreements		2,246,052	
Sub-contracts		4,555	
Salaries and benefits		1,114,729	
Contracts and professional fees		219,738	
Program travel, meeting and travel expenses		794,482	
Occupancy		268,638	
Equipment and supplies		350,228	
Program equipment		9,302	
Communication and printing		110,339	
Miscellaneous expenses		33,119	
II. Indirect Cost		***921,561***	
PROJECT TOTAL:	**$ 6,072,743**	**$ 6,072,743**	**$ 0**

Documentation and Information-Sharing

Results from the activities of the Cooperative Agreement have been documented, presented, and shared in a number of ways. Quarterly and Annual reports are given to USAID. In addition, EngenderHealth gave quarterly reports to the MOH, and the MOH used these to write their reports; "we can't write our reports without their reports."

EngenderHealth also organized a number of workshops during the course of this Cooperative Agreement, in addition to the MAP workshop mentioned above. In October 1995, a Quality Assurance Workshop was organized in collaboration with the Ministry of Health to examine the various dimensions of quality assurance and to identify factors that

mitigate against provision of quality services. There were fifty participants including policy makers and service providers at the workshop. In 2001, EngenderHealth Ghana hosted an international staff development workshop on ‘taking COPE to scale’ at Elmina for 14 international staff.

The following is a partial list of presentations and publications from the project:

- √ Kanlisi, N., A. Jain, J.M. Pile, F. Diabate Sambou. 2004. *Training Nurses in Norplant® Insertion/Removal Increases Awareness of and Access to Norplant® Services in Ghana*. Presented at IBP Africa Meeting, Entebbe, Uganda, June 2004. (winner of grand prize for posters in the conference’s family planning category)

- √ Kanlisi, N., P. Darko, G. Tagoe, I. Melngailis, J.M. Pile. 2004. *Get a Permanent Smile—A Pilot Project to Increase Awareness of and Access to No-Scalpel Vasectomy Services in Ghana*. Presented at IBP Africa Meeting, Entebbe, Uganda, June 2004. (overall winner in the conference’s family planning category)

- √ Ndong, I., I. Achwal, C. Cordero, R. Jacobstein, F. Ndede, J. Obwaka, J. Pile. 2004. *Africa: Long-term and Permanent Contraception to Rise Significantly by 2015*.

- √ Averting Maternal Death and Disability—presentation at Kuala Lumpur in 2004 using COPE for EOC.

- √ Presentation on COPE for HIV at International HIV/AIDS Conference in Bangkok, 2004.

- √ “Best practices, Decentralized training and supervision—lessons from Ghana.” Presented at conference in Lusaka, Zambia on Training in Africa. 2003

- √ “The effect of gender and power on SRH decision-making” presented at Amanitare conference in South Africa, 2003.

- √ Presentation in 2002 to Rotary Club in Ghana on vasectomy.

- √ Scaling up of minilap/Norplant services in Ghana through decentralized training—Washington DC at JHPIEGO meeting. 2001

- √ Presentation on COPE for child health to UNICEF in Ghana in 2001

- √ Kanlisi, Nick. “Crossing the digital divide: high tech training in low resources settings.” Presented at the Ghana computer literacy and distance education conference, GhaCLAD 2000.

- √ Presentation at MAP meeting in London, 1999

- √ Presentations on work of EngenderHealth in Ghana to MOH and at CAs meetings

- √ Case studies in EngenderHealth annual reports on Satisfied Clients and Norplant
- √ Expanding quality improvement in Ghana—EngenderHealth annual report to USAID, July 2000-June 2001.
- √ Ghana—Successful introduction and expansion—EngenderHealth annual report to USAID, July 2001-June 2002.

IV. Lessons Learned

1. The process of having sub-agreements directly with Regions enhances local ownership and sustainability and is an effective way to work in a decentralized system

2. Training nurses is key to increasing access to Norplant®, and so programs must include advocacy to change or create policies to make this possible

3. Taking a system-wide approach is effective for increasing access and improving quality. This means not looking at training in isolation from other factors, such as supervision and logistics. It also means not looking at methods in isolation from the systems in which they are provided.

4. In order to change practices at a facility, it is important to take a whole-site approach. For example, infection prevention training needs to include housekeeping staff, not just health care providers.

5. Training is not just about teaching skills but also about changing attitudes. It is necessary to address provider biases; they are also part of 'the community' when we talk about myths and misperceptions around family planning.

6. Facilitative supervision has improved the way supervision is conducted and perceived. However, according to EngenderHealth/Ghana staff, it would be useful to place more emphasis on the importance of giving adequate resources to supervision; "there has been reluctance of some trainers to move out—they claim they are very busy at the training hospitals. We could have done a better job of making the regions understand, and to make provisions for them to travel out."

7. It is important to have appropriate staff who understand the local context and how to work effectively within local systems.

8. Responsive flexibility, both from the agency and donor side, is important. A number of programs were added that were not part of the original agreement, including prevention of HIV/STI among pregnant women, facilitative supervision training, and the Satisfied Clients Program.

9. Supply and demand are closely linked, and both must be addressed, particularly for new or underutilized methods. Therefore, there must be funds available for IEC.

10. It is important to determine a feasible and meaningful way to monitor quality of care. One possibility is to choose a subset of indicators to measure more regularly and more widely. With the clinical training, it is possible to see impact in terms of the increases in numbers of clients receiving female sterilization, Norplant®, and vasectomy. However, it is more difficult to measure the impact of the counseling

training, for example. This is examined during medical monitoring visits, but this information was not systematically collected and analyzed. Data were collected at the eight sentinel surveillance sites, but this was not used for any kind of regular monitoring or feedback into the system. The follow-on project should explore more useful ways to monitor quality of care.

11. There should be more analysis of the implementation of COPE. Although COPE has been widely accepted, there is very little documentation of what has happened and what has been achieved.

12. Documenting the process and outcomes of projects is essential so that lessons are not only learned but are shared. Both EngenderHealth and USAID staff cite limited documentation on the part of the project. Part of the issue, according to EngenderHealth/Ghana staff, is that the program is based on principles of sustainability and local ownership, and so they are reticent to 'blow their own horn' about the project. EngenderHealth should explore ways to work with the MOH to produce collaborative documents that describe the project. In particular, it would be useful to write a case study about the effective way of working in a decentralized system through sub-agreements with the Regions, highlighting what made it work, what challenges were faced, and recommendations for others wanting to implement a similar process.

V. The Future: A Wider Scope

A new Cooperative Agreement was awarded to EngenderHealth and several partner organizations in 2004, beginning June 2004 and ending May 31, 2009 for $16 million. The Quality Health Partners Project (QHP) will provide evidence-based support to the Ghana Health Service (GHS) and a range of private institutions to improve the quality of health services in 28 of Ghana's most deprived districts, thereby contributing to improved health practices among Ghanaians, particularly in the areas of reproductive and child health (RCH).

This new project builds on the lessons and successes of the work over the past ten years, both in terms of the way of working and the tools that are used. For example, given the satisfaction and success of the sub-agreements with Regions, it is planned to use this process even more in the new project. Most importantly, the effective tools of quality improvement will be applied to a broader range of health issues, rather than focusing primarily on family planning. This responds to interest expressed by the MOH/GHS in applying EngenderHealth's approaches to other reproductive health areas, such as maternity care. As USAID staff explain, "there are lots of people already who can do training with no more assistance and we're going to take that model and apply it to broader health services."

In taking on this wider scope of activities, it is important to not forget about family planning. Staff from the MOH/GHS explain that "uptake has grown, but we are not there yet." As other reproductive health issues, such as HIV/AIDS, receive greater attention, there has been some concern that family planning is becoming neglected and that there is a need for "repositioning family planning" because "family planning is the bedrock of reproductive health."

Appendix 1: References

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2. EngenderHealth. 2004. *Measuring the Quality of Family Planning Services: Ghana.* Draft report.

3. Ghana Statistical Service (GSS), Health Research Unit, Ministry of Health, and ORC Macro. 2003. *Ghana Service Provision Assessment Survey 2002*. Calverton, Maryland: Ghana Statistical Service and ORC Macro.

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8. Jain, Aparna, Godwin Tagoe, Caroline Tetteh, and Damien Wohlfahrt. 2003. *Review of EngenderHealth-Supported Activities in Ghana*.

9. Kanlisi, N., A. Jain, J.M. Pile, F. Diabate Sambou. 2004. *Training Nurses in Norplant® Insertion/Removal Increases Awareness of and Access to Norplant® Services in Ghana*. Presented at IBP Africa Meeting, Entebbe, Uganda, June 2004.

10. Kanlisi, N., P. Darko, G. Tagoe, I. Melngailis, J.M. Pile. 2004. *Get a Permanent Smile—A Pilot Project to Increase Awareness of and Access to No-Scalpel Vasectomy Services in Ghana*. Presented at IBP Africa Meeting, Entebbe, Uganda, June 2004.

11. Population Reference Bureau. 2003. *2003 World Population Data Sheet*. www.prb.org.

Appendix 2: Indicators for Quality of Care

I. Access and Continuity

Family Planning Access and Continuity Indicators from the Provider Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
1. Family planning services are available at least five days a week	8/8	100%	8/8	100%
2. Tubal ligation services are available either at the site or by referral at least one day a week	7/8	88%	7/8	88%
3. Young adults are given access to methods and counseling without parental or spousal consent	8/8	100%	8/8	100%
4. The site does not require women to get their husband's consent in order to receive sterilization services	7/8	88%	6/8	75%
5. FP counseling and services are provided directly to men	6/8	75%	6/8	75%
6. Clients are told where to return for routine follow-up, including sources of care closer to home, if needed	8/8	100%	8/8	100%
7. Clients are told where to return in the event of questions or complications	8/8	100%	8/8	100%
8. At least one provider at the site provides vasectomy or NSV	0/8	0%	2/8	25%
9. At least one provider at the site provides female sterilization/tubal ligation	8/8	100%	6/8	75%
10. At least one provider at the site provides Norplant insertion and removal	8/8	100%	8/8	100%
11. At least one provider at the site provides IUD insertion and removal	8/8	100%	8/8	100%
12. At least one staff member provides contraceptive injections	8/8	100%	8/8	100%

Family Planning Access and Continuity Indicators from the Counseling Observation Module	Time 1		Time 2	
	Rate	%	Rate	%
13. Provider referred as needed, or scheduled a return visit	14/14	100%	18/19	95%

Family Planning Access and Continuity Indicator from the Client Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
14. Provider referred the client as needed or scheduled a return visits.	18/21	86%	18/20	90%

II. Information and Informed Choice

Information and Informed Choice Indicators from the Provider Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
1. Family planning talks have been held in the last month.	3/8	38%	7/7	100%
2. Service providers discuss the side effects of different contraceptive methods	7/8	88%	8/8	100%
3. Clients are told that they may discontinue or change a method at any time	5/8	63%	7/8	88%
4. Prospective sterilization clients are informed that temporary methods are available to them	7/8	88%	5/8	63%
5. Prospective clients for sterilization understand that the methods are permanent	8/8	100%	7/8	88%
6. Staff inform sterilization clients about the possibility of failure	3/8	38%	3/8	38%
7. Staff explain to clients how to reduce their risk for STIs/HIV/AIDS	5/8	63%	8/8	100%
8. Staff explain to clients whether or not their family planning method protects against STIs/HIV/AIDS	7/8	88%	8/8	100%
9. Staff ask whether client has had a history of STIs	4/8	50%	5/8	63%
10. At least 3 methods have been available within the past 6 months	8/8	100%	8/8	100%
11. At least 3 methods are available today	8/8	100%	8/8	100%

Information and Informed Choice Indicators Counseling Observation Module	Time 1		Time 2	
	Rate	%	Rate	%
12. Provider ASKED for background information and ASSESSED client's needs	14/15	93%	20/20	100%
13. Provider talked about contraceptive options	15/16	94%	19/20	95%
14. Provider used IEC materials (flip chart, samples of methods, brochures)	15/16	94%	18/20	90%
15. Provider discussed how to reduce STIs/HIV/AIDS	11/16	69%	15/20	75%
16. Provider discussed whether or not their family planning method protects against STIs/HIV/AIDS	12/16	75%	15/20	75%
17. Provider asked whether client has had a history of STIs	4/16	25%	5/19	26%
18. Provider discussed how to use a condom	4/16	25%	12/20	60%
19. For clients who chose a FP method, provider discussed *how to use* the method	14/14	100%	16/16	100%
20. For clients who chose a FP method, provider discussed *advantages* of the method	14/14	100%	16/16	100%
21. For clients who chose a FP method, provider discussed *disadvantages* of the method	12/14	86%	16/16	100%
22. For clients who chose a FP method, provider discussed *side effects* of the method	11/14	79%	15/16	94%

Information and Informed Choice Indicators **Counseling Observation** Module	Time 1		Time 2	
	Rate	**%**	**Rate**	**%**
23. For clients who chose a FP method, provider discussed *possibility of switching or stopping* the method	11/14	79%	13/15	87%
24. For clients who chose a FP method, provider discussed *warning signs related to* the method	10/13	77%	13/15	87%
25. For clients who chose a FP method, provider discussed *whether or not their method protects against HIV/AIDS or other STIs* the method	11/13	85%	11/11	100%
26. For clients who chose sterilization, provider discussed *permanency* of the method	3/3	100%	4/5	80%
27. For clients who chose sterilization, provider discussed *availability of temporary methods*	2/3	67%	5/5	100%
28. For clients who chose sterilization, provider discussed *possibility of failure*	2/3	67%	2/5	40%
29. For clients who chose sterilization, provider discussed that *method does not protect against HIV/AIDS and other STIs*	2/3	67%	4/5	80%
30. Provide helped client consider advantages vs. disadvantages of different methods	10/13	77%	10/13	77%
31. Provider assessed suitability of clients method choice	13/13	100%	15/15	100%
32. Family planning flipcharts or other booklets are available	16/16	100%	19/20	95%
33. Samples of at least 3 FP methods are available for demonstration	15/15	100%	20/20	100%

Information and Informed Choice Indicators from the **Client Interview** Module	Time 1		Time 2	
	Rate	**%**	**Rate**	**%**
34. Staff explained how to use selected contraceptive method	10/10	100%	7/7	100%
35. Staff discussed advantages of selected method	10/10	100%	7/7	100%
36. Staff discussed disadvantages of selected method	5/10	50%	7/7	100%
37. Staff discussed side effects of selected contraceptive methods	7/10	70%	6/6	100%
38. Staff discussed possibility of switching or stopping methods if necessary	8/9	89%	6/6	100%
39. Staff discussed warning signs of selected contraceptive method	4/10	40%	6/6	100%
40. Staff discussed client's concerns about the method	9/10	90%	6/6	100%
41. Staff discussed what to do if problems arise with method	10/10	100%	6/6	100%
42. Prospective sterilization clients were informed that temporary methods are available to them	2/2	100%	2/2	100%
43. Staff ensured that prospective clients for sterilization understand that TL and vasectomy are permanent	2/2	100%	2/2	100%
44. Staff informed sterilization clients that surgery carries certain risks	1/2	50%	1/2	50%
45. Staff informed sterilization clients about the possibility of failure	2/2	100%	2/2	100%

Information and Informed Choice Indicators from the Client Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
46. Staff informed sterilization clients that method does not protect against HIV/STIs	1/2	50%	1/2	50%

Information and Informed Choice Indicators from the Clinical Site module	Time 1		Time 2	
	Rate	%	Rate	%
47. The facility's informed consent form for female sterilization conform to EH standards	7/8	88%	7/8	88%
48. The facility's informed consent form for male sterilization conform to EH standards	2/8	25%	2/8	25%

III. Safe Service

Safe Service Indicators from the Clinical Site Module	Time 1		Time 2	
	Rate	%	Rate	%
1. Providers wash hands with soap and running water before and after examining each client	6/8	75%	8/8	100%
2. Gloves used whenever contact with blood or body fluids is anticipated	8/8	100%	8/8	100%
3. The surgical/procedure site prepared with an appropriate antiseptic solution and in a correct manner	5/8	63%	7/8	88%
4. Sharps disposed of in puncture-resistant containers	7/8	88%	8/8	100%
5. Instruments and other items decontaminated for 10 minutes in .5% chlorine solution immediately after use	7/8	88%	8/8	100%
6. Instruments and other items thoroughly scrubbed with a brush and detergent prior to sterilization or HLD	6/8	75%	8/8	100%
7. Appropriate parameters for steam sterilization, dry heat sterilization, or HLD followed	4/8	50%	3/8	38%
8. In the OT, contaminated furnishings and floor are cleaned between clients	5/8	63%	4/8	50%
9. Staff wear heavy -duty gloves to clean used instruments	3/8	38%	6/8	75%
10. Staff wear heavy-duty gloves to dispose of medical and hazardous chemical waste	4/8	50%	7/8	88%
11. Medical waste is buried or burned	7/8	88%	8/8	100%

Safe Services Indicators from the Clinical Observation Module	Time 1		Time 2	
	Rate	%	Rate	%
INT IUD				
12. Bimanual and speculum exams conducted before insertion	6/6	100%	1/1	100%
13. Aseptic, no-touch technique followed during insertion	4/6	67%	1/1	100%
14. Provider verifies critical information (LMP, pelvic exam findings)	6/6	100%	1/1	100%
Implant				
15. Aseptic technique is followed during insertion	11/15	73%	14/14	100%
16. Local anesthesia is given properly	15/15	100%	14/14	100%
17. Insertion technique is appropriate	12/12	100%	12/12	100%
18. Removal technique is appropriate	4/4	100%	9/9	100%
19. Provider verifies critical information (LMP, pelvic exam findings)	13/14	93%	12/13	92%
Injectable				
20. Aseptic technique is followed during injection	10/12	83%	8/10	80%
21. Safe injection technique is used (i.e. Aspiration prior to injection)	12/12	100%	9/10	90%
22. Provider verifies critical information (LMP, pelvic exam findings)	9/12	75%	10/10	100%
Minilap				
23. Local anesthesia with or without light sedation is used	5/5	100%	3/3	100%
24. The abdomen is entered safely (protecting the bowels & other organs)	5/5	100%	3/3	100%
25. The fallopian tubes are identified, retrieved, and occluded in a safe & traumatic manner	5/5	100%	3/3	100%
26. Each tube is followed to the fimbrial end to confirm that it is the fallopian tube	5/5	100%	3/3	100%
27. Aseptic technique is followed	5/5	100%	3/3	100%
28. Provider re-verifies critical information (LMP, pelvic exam findings)	5/5	100%	3/3	100%
29. The client is monitored just prior to starting the surgery, at least once during the procedure, and then every 30 minutes until the client has fully recovered from anesthesia	4/5	80%	3/3	100%
30. Following a surgical procedure, the provider reexamines the site for bleeding	5/5	100%	3/3	100%
31. Client is given postoperative instructions	5/5	100%	3/3	100%
32. Before patient is discharged, staff assess them to see if they can stand, eat, urinate, and repeat post-procedure instructions	5/5	100%	3/3	100%

IV. Privacy and Dignity

Privacy and Dignity Indicators from the Clinical Observation Module	Time 1		Time 2	
	Rate	**%**	**Rate**	**%**
INT IUD				
1. Provider treats client with respect	6/6	100%	1/1	100%
2. There is an area for clients to change privately before surgical procedure	4/6	67%	1/1	100%
3. The client is always kept covered and unexposed, except where and when exposure is needed	5/6	83%	1/1	100%
Implant				
4. Provider treats client with respect	13/14	93%	14/14	100%
5. If a client is awake during a surgical procedure, the surgical team engage the client in conversation to distract her from the procedure	8/15	53%	13/14	93%
Injectable				
6. Provider treats client with respect	12/12	100%	10/10	90%
Minilap				
7. Clients pain is alleviated	5/5	100%	3/3	100%
8. Provider treats client with respect	5/5	100%	3/3	100%
9. If a client is awake during a surgical procedure, the surgical team engage the client in conversation to distract her from the procedure	5/5	100%	3/3	100%
10. There is an area for clients to change privately before surgical procedure	4/5	80%	3/3	100%
11. The client is always kept covered and unexposed, except where and when exposure is needed	3/5	60%	3/3	100%

Privacy and Dignity Indicators from the Counseling Observation Module	Time 1		Time 2	
	Rate	**%**	**Rate**	**%**
12. Provider helped the client feel comfortable (through greeting the client, offering the client a seat, exhibiting concern and warmth, etc.)	16/16	100%	20/20	100%
13. Provider advised the client that their discussion is confidential	11/16	69%	15/19	79%
14. Provider listened attentively	16/16	100%	20/20	100%
15. Provider was respectful of the client and non-judgmental	16/16	100%	20/20	100%
16. The client was able to ask questions and clarify doubts	15/15	100%	18/18	100%

Privacy and Dignity Indicators from the <u>Counseling Observation</u> Module	**Time 1**		**Time 2**	
	Rate	**%**	**Rate**	**%**
17. Provider EXPLAINED what to expect during a procedure or exam	13/16	81%	14/18	78%
18. Counseling rooms/areas have visual privacy	16/16	100%	19/20	95%
19. Counseling rooms/areas have auditory privacy	11/16	69%	18/20	90%

Privacy and Dignity from the <u>Client Interview</u> Module	**Time 1**		**Time 2**	
	Rate	**%**	**Rate**	**%**
20. Client feels s/he had sufficient privacy	19/21	90%	19/20	95%
21. Provider helped the client feel comfortable	21/23	91%	19/20	95%
22. Provider advised the client that their discussion is confidential	9/23	39%	13/19	68%
23. Provider listened attentively	22/23	96%	19/20	95%
24. Provider was respectful of the client and non-judgmental	22/22	100%	20/20	100%
25. The client had the opportunity to ask questions and clarify doubts (There was two-way communication between the client and the provider)	17/21	81%	19/20	95%
26. Provider explained what to expect during a procedure or exam	14/20	70%	16/18	89%

V. Staff Needs

Staff Needs from the <u>Clinical Site</u> Module	**Time 1**		**Time 2**	
	Rate	**%**	**Rate**	**%**
1. For past six months, facility has had necessary equipment and expendable supplies to decontaminate	7/8	88%	8/8	100%
2. For past six months, facility has had necessary equipment and expendable supplies to clean instruments	6/8	75%	8/8	100%
3. For past six months, facility has had necessary equipment and expendable supplies for HLD or sterilization	7/8	88%	3/8	38%
4. For past six months, facility has had necessary equipment and expendable supplies to properly dispose of waste and sharps	5/8	63%	8/8	100%
5. For the past six months, facility has had sufficient supplies and equipment to keep the work environment clean	7/8	88%	8/8	100%
6. Hand washing facilities are near procedure and exam rooms	7/8	88%	8/8	100%
7. For the past six months, facility has had an adequate supply of clean water	7/8	88%	8/8	100%
8. For the past six months, facility has had reliable electricity	7/8	88%	8/8	100%
9. For past six months, facility had emergency equipment in working order	4/8	50%	6/8	75%
10. For past six months, facility had all emergency expendable supplies	4/8	50%	7/8	88%

Staff Needs from the Clinical Site Module	Time 1		Time 2	
	Rate	%	Rate	%
11. For past six months, facility had all emergency drugs	1/8	13%	2/8	25%
12. In the past 6 months, has the facility had all equipment and supplies needed to do a physical exam	7/8	88%	8/8	100%
13. In the past 6 months, has the facility had all commodities (methods)	6/8	75%	6/8	75%
14. In the past 6 months, has the facility had all instrument kits	7/8	88%	8/8	100%
15. In the past 6 months, has the facility had all FP expendable supplies	8/8	100%	7/8	88%
16. In the past 6 months, has the facility had all drugs needed to provide temporary FP (pills, IUD, Injectables, Norplant, barriers) methods	6/8	75%	8/8[3]	100%
17. For the past 6 months, has the facility had the specific instruments needed to perform female and/or male sterilization	7/8	88%	7/8	88%
18. For the past 6 months, has the facility had all expendable supplies and drugs needed for female and/or male sterilization	8/8	100%	6/8	75%
19. For the past 6 months, has the facility had the Operation Theater and supplies to perform female and/or male sterilization	8/8	100%	6/8	75%
20. Drugs and other supplies are kept in a manner that ensures good preservation	6/8	75%	7/8	88%

Staff Needs from the Provider Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
21. Guidelines/standards for family planning are available at this site	5/8	63%	7/8	88%
22. Guidelines/standards for infection prevention are available at this site	3/8	38%	7/8	88%
23. Statistics are posted in charts so all providers can review	1/8	13%	2/8	25%
24. Staff keep a record of complications	4/8	50%	6/8	75%
25. There is a venue for staff to discuss complications	3/8	38%	3/8	38%
26. A chief medical officer or top official follows-up with an investigation or training after a complication	4/8	50%	4/8	50%
27. Supervisor from outside visited at least once in last six months	3/8	38%	7/8	88%
28. Supervisor observes different services	2/8	25%	6/8	75%
29. Supervisor examines records & provides feedback	2/8	25%	6/8	75%
30. The supervisor helps to organize, or participate in, a problem-solving exercise (such as COPE) at the site	2/8	25%	4/8	50%

[3] Calculation excludes spermicides because all clinics reported that they have not received spermicides since the beginning of 2003.

Staff Needs from the Provider Interview Module	Time 1		Time 2	
	Rate	%	Rate	%
31. The supervisor helps to organize training for site level staff	1/8	13%	6/8	75%
32. Supervisor provides written feedback to a site after visit	1/8	13%	3/8	38%
33. Site keeps an inventory of supplies	7/8	88%	8/8	100%