



**Improved Quality of Reproductive and Child Health Services in
37 Districts in Ghana**

Endline Assessment Results

September 2009

**Quality Health Partners
Cooperative Agreement 641-A-00-04-00232**



Quality Health Partners is a bilateral assistance project funded by USAID/Ghana and led by EngenderHealth. JHPIEGO and Abt Associates are implementing partners on the project. Technical assistance is also provided by Initiatives, Inc. and Family Health International.



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Thanks also go to the QHP programme staff who helped to review the data collection tools, played dual roles as data collectors and supervisors during field work and reviewed the final report. We appreciate the project drivers who drove long hours on sometimes rough terrains with QHP and GHS staff during the data collection. The project's finance and administrative staff also worked overtime to provide logistical support to the effort. We are also appreciative of the effort of the Monitoring and Evaluation Unit of the EngenderHealth New York Office for reviewing the protocol and tools for the assessment.

This endline report compares results with baseline and midterm results undertaken at the beginning and midway of the QHP project. This present report draws a lot from the midterm report. Permit us to give special thanks to Kerry Bruce (former Monitoring and Evaluation Manager for QHP) who prepared the midterm report which provided the template for this endline assessment report and also to Dr. Cynthia Bannerman of GHS/ICD for her involvement in all three studies (Baseline, Midterm and Endline).

Abbreviations / Acronyms

ACT	Artemisinin –based Combination Therapy
BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
CHN	Community Health Nurse
COPE	Client-Oriented, Provider efficient (problem-solving methodology)
CYP	Couple Years of Protection
DHMT	District Health Management Team
FBA	Facility Baseline Assessment (QHP's Baseline Document)
FP	Family Planning
FS	Facilitative Supervision
GHS	Ghana Health Service
HRDD	Human Resource Development Division (of the Ghana Health Service)
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment (Malaria in pregnancy)
LSS	Life Saving Skills
LAPM	Long acting and Permanent Method (of Family Planning)
MA	Medical Assistant
NMCP	National Malaria Control Programme
QA	Quality Assurance
QAT	Quality Assurance Team
QHP	Quality Health Partners (Project)
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Executive Summary

The Quality Health Partners (QHP) project, managed by EngenderHealth, has been one of four bi-lateral assistance projects with the goal to support the Ministry of Health/Ghana Health Service to improve quality of Reproductive and Child Health in 37 most deprived districts in seven southern Regions of Ghana. QHP's work with the GHS involved the, development, dissemination and implementation of standards and guidelines, provision of equipment and supplies, and staff capacity building through training and facilitative supervision. Following five years of implementation, this endline was undertaken to measure the effect of QHP's work by comparing results with baseline and midterm assessments carried out in December 2004 and September 2007 respectively.

The results presented in this report represent data from a census of all QHP target facilities (about 200 mostly public health facilities), using a facility audit tool that examined the status of services in the facilities, observation tool that ascertained how sick children under five years are managed and RHMT/ DHMT tools that sought information from the Regional and District Health Management Teams on their supportive and supervision roles in their respective regions and districts.

Overall, significant gains were made in all RCH programme areas that QHP supported in the 37 target districts. Highlights of the major accomplishments are;

1. An increase in the percentage of facilities having quality assurance teams from 35.1% to 60% of facilities
2. Significant increases in provider assurance of patient confidentiality and privacy in all service units occurred between baseline and endline-from 21-61% in family planning and 58-92% in the delivery areas,
3. Improvement in patient right for information in respect of follow-on management of the sick child occurred between baseline and endline- from 33-70% of providers now tell caregivers what sickness their sick children have and from 40-93% of providers describe dosage of medicine given to treat patient.
4. Improvement in infection prevention measures in all service areas – from 31% at baseline to 46% at endline overall. In the individual service areas infection prevention measures increased in Child health (from 56-73%), family planning (from 31-70%), in Antenatal Care (from 33 – 96%) and in Delivery (from 51-80%)
5. Gradual increase in Couple Years of Protection achieved, with the greatest increase achieved in Year 5. CYP achieved increased by over 50% from 80,077 in October 2007-September 2008 to 128,565 in October 2008-September 2009.
6. Moderate gains in the sustainability of the Integrated Disease Surveillance and Response model for disease surveillance instituted in the first half year of QHP's work. 48% at baseline as against 14% of districts at endline experienced a disease outbreak. Also 81% against 21% of providers now complete their weekly reports while 49% against 55% have case based surveillance forms.

Human Resources

QHP's active collaboration with GHS in human resource capacity building culminated in the following (among a number of other Human resource documents): Finalization and dissemination of the In-Service Training Policy and the Human Resources Policies and Strategies for 2007-2011. Staff accountability efforts improved with 49% of staff who

now hold current job descriptions as against 29% at baseline. Again, facilities that had at least half of their staff appraised rose from 29% to 56%. QHP trained over 6,500 different cadres of staff within the service and assessment results also show that between 80 and 92% of providers in the different service areas had access of providers to in-service training.

Quality Assurance

Important strides were made with respect to quality assurance and facilitative supervision. The percentage of facilities having a quality assurance team increased consistently from 35.1%, to 52.1% to 60% at baseline, midterm and endline, respectively. However, about 30% of these teams did not have any action plan that helps guide the implementation of quality issues identified. The use of periodic and regular meetings for addressing gaps including quality assurance issues increased to 63% of facilities from a baseline of 45%. The use of COPE© (Client Oriented Provider Efficient services) exercise as a way of improving quality did not change much -36% but this is compensated for by the introduction and use of alternative QA methods. Facilities receiving regular external supervision remained nearly universal (94%) and significant improvement occurred in infection prevention measures in all service delivery areas- though more improvement is required in that area. This notwithstanding, provider knowledge of the correct procedures for processing instruments was improved in both the delivery and in the family planning units.

Child Health

Significant gains were also observed in the area of Child Health services between baseline and endline. Facilities with all essential equipment increased from 8% to 75%, and those with IMCI chart booklet increased from 30% to 84%. In the area of infection prevention, great improvement also occurred (56% to 94%). Also, 75% of facilities used standard referral note for referring clients to the next level of care. Increased proportions of providers are now assessing all of the danger signs in children (11.1% at baseline and 63% at endline). Physical examinations (checking temperature and weight) on sick children in key areas are increasingly being done while at the same time care givers rights to information are being provided more. While a 50% increase in the proportion of providers that correctly managed diarrhoea was observed at midterm, this declined slightly by endline, although between baseline and endline significant gains were nevertheless made (from 18% to 60%).

Family Planning

Improvement occurred in family planning uptake after a period of decline. Indeed, QHP sought to reverse the trend in CYP decline through the training of over 3,600 providers in family planning service provision (including 445 trained in LAPM). In addition, FP campaign activities to increase uptake of LAPM use were also implemented in all districts. These activities have yielded some results as CYP achieved increased from 80,077 in 2008 to 128,568 in 2009. The figures could have been higher but for the increased number of facilities that reported stock-outs in LAPM (i.e. IUD and Jadelle) in 2009. In addition, there were improvements in the provision of client privacy and quality

of information given to clients towards informed decision making. Improvement in infection prevention practices also occurred – although more efforts are needed in properly labelling decontamination solution.

Basic and Comprehensive Emergency Obstetric Care

For the reason that facility readiness for BEOC or CEOC impacts on quality of maternal and neonatal health care, the assessment sought to determine their availability in the target facilities. Very few health centres (13.4%) meet all the criteria for BEOC, however there have been remarkable strides towards improving the availability of key drugs in the delivery units and this is a significant increase over baseline. A little over half (51.4%) of hospitals meet all of the criteria for CEOC. The main constraints for hospitals are not having qualified staff to perform a manual removal of a placenta and/or a vacuum extraction. These areas are in need of more attention in future programming.

Ante-Natal Care

Successes were also chalked in the area of Ante-natal care services. Overall, visual and auditory privacy provided to clients improved (though a slight decline between endline and midline was noted). Improvements occurred in facilities having all infection prevention items (33% to 96%) as well as those with items for quality examination – functioning blood pressure apparatus and foetal stethoscope (88% to 96%). IPT use among pregnant women also increased (63% to 68% of first dose). About nine in ten providers benefitted from in-service training and external in-depth-supervision. There was however a decline in facilities that reported implementing focused-ANC at endline (from 84% at midterm to 72% at endline).

Delivery and Neonatal Care

Several areas of service provision in the delivery units showed consistent and significant improvements overtime. Over 80% (from a baseline of 51%) of facilities showed improvement in infection prevention practices, 90% of facilities had infrastructure and furnishings available and 81% (from 66% at baseline) of providers have correct knowledge of the active management of the third stage of labour. Level of preparedness for emergencies was equally high with about 86% of facilities having emergency packs for post partum haemorrhage. Moderate increases occurred in partograph use (from 69% at midterm to 73% at endline). This calls for increased attention during supervision which happened in 86% of facilities.

Overall, provider knowledge of neonatal care improved. The desired practice of suctioning the airways of newborn and bathed babies six hours after birth was almost universal among providers. Providers however, need to have at the ‘tips of the fingers’ all key routine care practices especially the use of the APGAR score and the provision of Vitamin K injection.

Integrated Disease Surveillance and Response

Significant gains achieved in the IDSR programme at midterm appeared to be waning as evidenced by the decline in performance in the availability of forms for surveillance data collection, monthly reporting of diseases, use of surveillance data and less than a 100%

investigation of outbreaks of diseases. This decline can be at least in part attributed to the discontinuance of QHP support for IDSR in years 4 and 5, other than through general supervision. Irrespective of the decline after the midterm, the support by QHP was worth the while since performance at endline remained in a large part better than that at baseline.

Conclusion

QHP has clearly contributed to numerous improvements in facility readiness and provider performance. Performances of most indicators measured at the beginning of the project were low as given by the baseline assessment results. With time and through the strong collaborative work by QHP and the GHS, steady improvements in quality of reproductive and child health services have occurred in all the 37 districts. Improvements noted at midterm in specific service areas like maternal and neonatal health care, child health care including malaria treatment, and family planning continued and even showed more improvement two years down the line. Support at ensuring equipment and logistics availability and effective use and skills development efforts have all played important roles in the gains made. Also significant in the contribution of improvements made is the intensified supervision and on-the job training adopted by QHP and GHS in the last two years of the project. Family planning service utilization appears to be on a rise after a period of stagnation and would therefore need attention satisfying demand created among the population, particularly in terms of ensuring the availability of family planning commodities. The only area which obviously saw a dip following an initial improvement as observed at midterm is in the performance of Integrated Disease Surveillance Response—although performances at endline were generally better than at baseline. The main reason for the decline (between midterm and endline) was the early discontinuation in support by QHP to IDSR activities probably at a time when the units responsible for IDSR were not adequately strengthened or lacked alternative sources of support.

With the conclusion of QHP it will be important for the Ghana Health Service to continue with monitoring and clinical supervision of the various RCH component services to ensure that the strides made are sustained. Fortunately QHP leaves having built the capacity of most staff in SRH within GHS in the target regions and districts. The GHS should therefore, with supportive and more clinically oriented supervision (IDS/OJT), be able sustain the achievements made.

Background

The Quality Health Partners (QHP) project was one of four bilateral projects contributing to USAID/Ghana's Strategic Objective Seven: Improved Health Status for Ghanaians. The other USAID/Ghana bilateral health projects are the Community-based Health Planning and Services-Technical Assistance Project (CHPS-TA), the Ghana Sustainable Change Project (GSCP) and the Strengthening HIV/AIDS Response Partnerships (SHARP) Project.

The QHP project began in June 2004 and was planned to end in May 2009 but had a no cost extension from USAID to September 2009. QHP focused on improving the quality of and equitable access to a package of Reproductive and Child Health (RCH) services in health facilities in 37 of the most deprived districts of the country's seven southern regions, as well as in other key health facilities in the country, including seven regional hospitals. The RCH service package included Safe Motherhood (antenatal and postnatal care, safe delivery and essential newborn care), Family Planning, Child Health/Integrated Management of Childhood Illness (IMCI), malaria prevention and treatment. An additional area of focus for QHP was in the area of Integrated Disease Surveillance and Response (IDSR). In high HIV prevalence areas, a package of services to improve the quality of anti-retroviral therapy, to reduce stigmatization related to HIV and AIDS in the facility and other key interventions was also provided.

Four programme goals were initially defined to guide QHP work:

1. Strengthened institutional capacity of the GHS to provide high quality health services using approved standards and guidelines
2. Improved systems for human resource capacity development
3. Improved supervision, monitoring, problem-identification/solving and communication skills
4. Raised standard of quality in private and public health facilities and development of a franchising approach

During the second half of the third year (2007), QHP transitioned to four modified goals that are listed below:

1. Strengthened policies and systems to ensure comprehensive delivery of quality services in the public and private sector
2. Improved quality of care and services at regional and district level and below
3. Strong and effective platform for monitoring and evaluation of the SO7 Elements and sub-elements through quality data collection and analysis
4. Improved quality of care for HIV patients in high prevalence areas

The modified goals reflected: a) an evolution of the QHP project, with most Human Resource policy and other national level work having been completed before or during the third year; b) a new role for QHP as the coordinating partner for SO7 (non-HIV) data collection and reporting; and c) an expanded portfolio of HIV and AIDS activities under the Get HIP! Initiative.

Target Districts and Population

QHP worked in approximately 200 facilities in 30 target districts (now 37 because 7 new districts were created but these new districts were more of sub divisions of some of QHP's target districts) in the seven southern regions of Ghana. These districts were selected by the MOH/GHS and USAID on the basis of being among the most deprived and remote districts in the country. The project was implemented in four districts in Ashanti Region, two districts in Brong Ahafo, all districts in Central Region (17), three districts in Eastern Region, one district in the Greater Accra Region, six districts in the Volta Region and four districts in Western Region. The project's emphasis was on public sector facilities at the health centre level and above.

Overall the project supported better quality health care for over 4 million people (Table 1), which was about one-fifth of the country's total population. However, many of QHP project initiatives reached beyond the 37 target districts as capacity building efforts at the regional level, had an impact throughout the region including non QHP target districts. In addition, some aspects of the QHP project (specifically the HIV component; and some PMI activities [three of the five sentinel sites] and the Other Public Health Threats [guinea worm eradication] component), were outside the 37 districts. These areas also benefitted from QHP's approach and methodology.

Central Region constituted a special focus for QHP because the project covered the entire region in support of the provision of better quality health care for over 1.9 million people.

At the national level QHP supported the following units of the Ghana Health Service: Institutional Capacity Division (ICD), the Human Resource Development Division (ICDD) the Reproductive and Child Health/family Planning Unit and the Integrated Diseases Surveillance Unit. ,

Table 1 QHP Target Districts and Population

District	Population 2009	District	Population 2009
Ahafo Ano South	180,549	Abura Asebu Kwanankese	108,623
Amasie West	146,899	Agona West Municipal	191,649
Bosomtwi	197,297	Agona East	
Atwima Kwanwoma		Ajumako Enyam Essiam	110,880
Ashanti Region Total	524,745	Asikuma Odoben Brakwa	107,782
Asutifi	105,510	Assin North	129,454
Sene	102,614	Assin South	107,410
Brong Ahafo Region Total	208,124	Efutu Municipal	204,932
Akatsi	110,732	Awutu -Senya	
Kadjebi	61,596	Cape Coast	142,398
		Gomoa East	234,857
Nkwanta	179,200	Gomoa West	
Nkwanta North		Komenda Edina Eguafo Abirem	135,563
North Tongu	154,456	Mfantsiman	184,294
South Tongu	76,775	Twifo Heman Lower Denkyira	133,049
Volta Region Total	582,759	Upper Denkyira East Municipal	130,749
		Upper Denkyira West	
Ahanta West	126,322	Central Region Total	1,921,640
Bibiani Anhwiaso Bekwai	146,674	Kwahu North	154,046
Juaboso	137,098	Akyemansa	
Bia	178,671	Birim North	139,918
Western Region Total	588,765	Eastern Region Total	293,964
		Dangbe West	142,633
		Greater Accra Region Total	142,633
	Total Population in 37 Target Districts	4,262,730	

QHP Implementation Strategies

QHP support evolved around four main strategies represented in the pathways to quality in Figure 1. One key strategy was helping to review, develop and implement standards and guidelines, both clinical and for human resource planning and management. The second, involved the organization of trainings for providers and managers in clinical as well as in “cross-cutting” topics like quality assurance, facilitative supervision and infection prevention. The third major area of QHP’s work was in providing support for supervision and the provision of technical assistance at the facility level while the fourth involved the provision of equipment and supplies.

Figure 1 – QHP’s Pathways to Quality Services



Methodology and Sampling for the Assessments

To establish the basis for measuring performance of the QHP project, an initial baseline assessment was undertaken at the beginning of the project in December 2004. In mid 2007, a midterm assessment was done to assess progress. This endline assessment was then undertaken between July and September 2009 to assess the overall effect of the project. In order to make for comparison, the tools developed for the baseline was adopted and used in collecting the midline and endline assessments data. In between the different assessments, three sets of monitoring activities were done, using aspects of the same instrument as checklist to ensure that service provision was done according to approved standards.

Results presented in this report were captured from the following instruments used during the facility baseline assessment, midterm and endline assessments.

1. Facility audit – review of management practices, provider knowledge, availability of equipment and supplies.
2. Provider observation – Observation of providers giving treatment to children presenting with fever or diarrhoea.
3. RHMT/DHMT interviews – Interviews with the Regional and District Health Management teams to review management practices and uses of data.

The three assessments involved a census of all QHP facilities. At the baseline in December 2004, 171 facilities¹ including all ten Regional hospitals in the country (n=10)

¹ Quality Health Partners (2005) Facility Baseline Assessment of Regional Hospitals and Facilities in 28 Target Districts in Seven Regions of Ghana (Accra, Ghana.; QHP). (NOTE: The number of Districts increased from 28 to 30 between the baseline and midterm and from 30 to 37 by endline due to subdivision of some districts in Central Region, Western Region, Eastern and Ashanti regions. The divisions are all within the geographical boundaries of QHP project and covering the same population size.

some high volume facilities (n=6) and referral facilities outside the target districts (n=3) were assessed. The midterm assessment however covered 193 facilities including 7 regional hospitals, 30 district and mission hospitals and 156 GHS health centres in the 30 districts after the seven southern regions and 30 target districts for QHP project focus had been better defined. In the endline, a total of 199 facilities covering 37 districts (due to sub-division of some districts) were surveyed. The 199 facilities included all the facilities covered at midterm as well as six others that were missed during the midterm due to inaccessibility.

To compare baseline results with those of the midterm and endline, the baseline dataset was edited to exclude all “non-focus” facilities bringing the total number in the dataset to 157 facilities (Table 2). Although different numbers of facilities were sampled in each of these datasets, the proportion of facilities sampled overall remains the same and there were no differences between the types of facilities sampled or the regions from which they were sampled.

Table 2 Number of Facilities in the Baseline (edited), Midterm and Endline Assessment by type and Region

	Baseline Dec 04	Midterm Sep 07	Endline Sep 09
Type of Facility			
Regional Hospitals	7	7	7
District/Mission/ Hospitals	28	30	37
Health Centres/Other	122	156	155
Region			
Ashanti	19	23	25
Brong Ahafo	8	12	11
Central	60	72	73
Eastern	11	10	11
Greater Accra	5	6	6
Volta	32	41	40
Western	22	29	33
Totals	157	193	199

In addition to completing a general facility audit in the target health centres and hospitals, an assessment of provider practice of treatment of children under five (focusing on malaria and diarrhoea) was conducted using the Provider Observation Tool. At baseline between 2 and 5 observations were conducted at each facility (some with the same provider, some with different providers). At midterm the main provider who treated children under five was targeted for observation (to reduce time and expenses in the field). At endline between one and two observations were made either of the same provider or with different providers in a facility. The total number of observations made was 421 for the baseline, 145 and 257 at midterm and endline respectively. Details about these observations can be found in the Child Health section of this report.

Interviews with the RHMT and DHMTs conducted during the midterm assessment covered 30 districts and 7 regions. In the endline 34 districts and 7 regions were interviewed.

The data in this report are presented in Tables and Figures. More detailed analyses (especially of the figures), showing variation by Region and type of facility are provided in the Appendix.

Limitations in the Data

There are a few limitations in these data. Regional figures as presented are not representative except for the Central Region where all districts were surveyed.

Many of the questions in this report focus on provider knowledge, rather than the gold standard of “practice.” Thus, some of the findings reflect provider knowledge of what they “should be doing,” which could vary from their actual practice.

RESULTS

Human Resources

This section highlights results on human resource issues with respect to staffing, availability of job descriptions, system of staff performance appraisal and in-service training.

Number and Type of Staff. A comparison of 145 matched facilities sampled at baseline and at endline shows considerable increases in the numbers of almost all categories of technical staff: doctors, nurses and public health nurses in target facilities. This increase reflects the concerted effort made by MOH to increase the number of pre-service training institutions, and of the MOH and GHS to deploy, compensate, motivate and retain staff. Efforts nevertheless are still required in training of more midwives to provide care to the increasing numbers of women within the reproductive age group in the population who would require delivery and related services.

Table 3 Total Number of Trained Staff in Districts and Facilities Surveyed

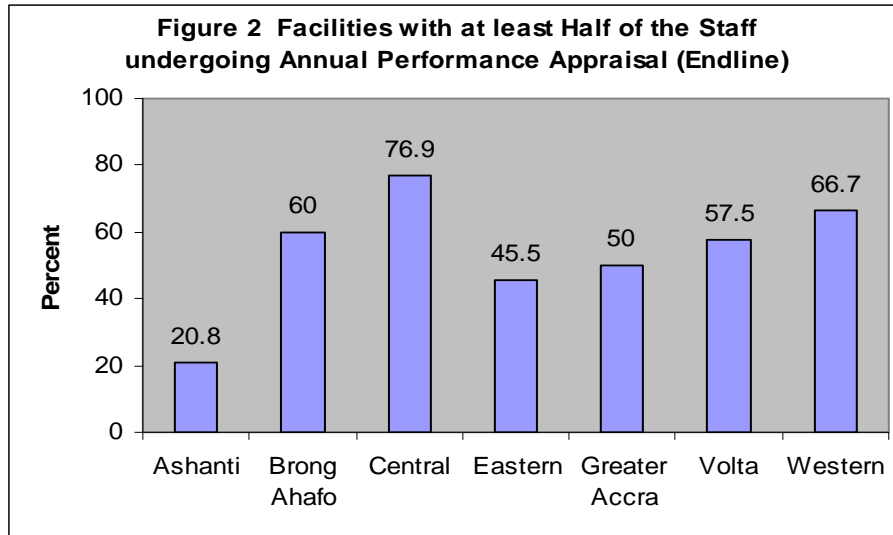
	Doctor		Medical Assistant		SRN		PHN		Midwife or Nurse Midwife		Community Health Nurse/ Enrolled Nurse	
	Base-line	End-line	Base-line	End-line	Base-line	End-line	Base-line	End-line	Base-line	End-line	Base-line	End-line
Regional Hospital	169	262	11	6	369	717	12	15	290	303	262	282
District/ Other Hospitals	56	81	27	40	190	457	12	13	282	250	208	274
Health Centres /Other	3	46	61	61	20	57	7	5	166	167	272	549
Totals	228	389	99	107	579	1231	31	33	738	720	742	1105

Job Descriptions. A key component of quality in evaluating provider performance is that each staff member in a health care facility should have a copy of their job description (that they hold). Through individual monitoring visits and training events, QHP encouraged managers to make job descriptions available to each staff. This indicator was measured at midterm but not at baseline. Between September 2007 and September 2009 there has been an increase (from 29% to 48%) in the percentage of facilities reporting that all staff had a copy of their job description – although the overall proportion remains less than 50%. Although the regional hospitals seem to be doing better than other facilities at ensuring that all staff had job descriptions, no improvement occurred in their performance between midterm and endline. Eastern, Western and Greater Accra regions recorded the highest proportions of facilities whose staff hold a written job description. Regions that performed less satisfactorily on this matter are Ashanti and Western regions (Table 4).

Table 4 Providers having Job Descriptions

% of facilities where all staff have a Current Job Description (that they hold)		
Type of Facility		
	Midterm	Endline
Regional Hospitals	57.1	57.1
District Hospitals	34.5	48.6
Health Centres	26.8	48.4
Region		
Ashanti	30.4	28.0
BAR	18.2	63.6
Central	43.1	50.7
Eastern	80.0	81.8
GAR	33.3	83.3
Volta	4.9	48.7
Western	11.5	37.5
Totals	29.1 (n=189)	48.7 (n=197)

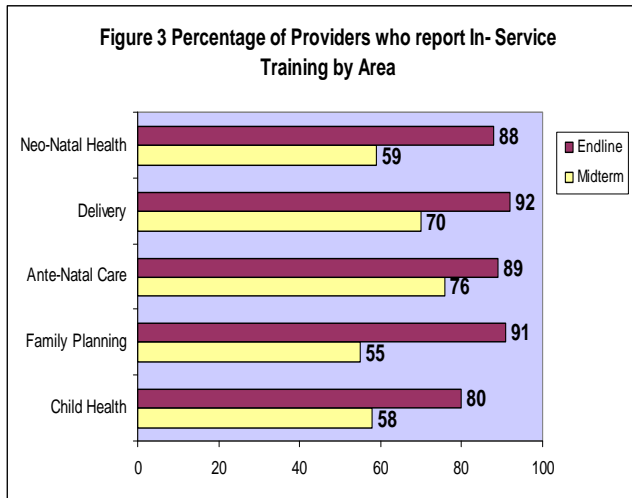
Performance Appraisal. To improve provider accountability and performance in the workplace, QHP actively worked with the Human Resource Development Division (HRDD) of the Ghana Health Service to revise and implement an improved performance evaluation system for all GHS employees. This involved the development, piloting and roll-out of revised provider performance appraisal tools as well as training personnel in their use. The tools were scaled-up to 19 districts (including all districts in the Central Region) after the pilot with the view to further roll out their use nationally. Regional and District Management Teams interviewed at midterm reported that 80.6 % of their offices budgeted for staff performance appraisal activities. As a result of these activities, provider performance is increasingly being formally assessed. At endline, 54.5% as against 28.6% of supervisors at midterm reported having at least half of their staff appraised. Regional results indicate the need for Ashanti, Eastern and Greater Accra to do more to ensure accountability by conducting staff appraisals. The high performance in the Central Region could be attributable to the early roll out of the new appraisal system in all of their districts (Figure 2).



In-Service Training. Another measure of quality is the availability of continuing medical education for health care providers. The Ghana Health Service has committed to providing in-service training to its employees at least once every three years as part of its In-Service Training Policy². QHP measured the percentage of providers by service delivery area who reported having in-service training during the past three year period (Figure 3). According to the midterm results, between 55 – 76% (depending on service area, e.g. child health, family planning, maternal and neo-natal health) of providers interviewed reported having attended in-service training within the past three years. Endline results show increases in the proportion of staff (between 80 – 92%) that benefitted from in-service trainings across all service areas within the period. The increases observed are attributable largely to the QHP/GHS In-Depth Supervision and On-the- Job Training (IDS/OJT) approach introduced in 2008 to ensure that most staff had access to quality updates to impart skills, improve confidence in service providers towards improved quality care to clients. On the specific service areas, providers in family planning and delivery had the highest proportions of staff benefitting from in-service training and child health service area, the least (Figure 3 and see details by facility level performance in Table A in the Appendix).

² Ghana Health Service (2005) In-Service Training Policy and Guidelines for Implementation (Accra, Ghana: Ministry of Health). Available on-line at www.ghanahqhp.org/index.php?id=354

Figure 3: In-Service training of providers in the last three years



The huge difference in proportion of facilities with family planning providers trained between midterm and endline (55% to 91%) may largely be attributable to the increased attention by USAID and GHS to reverse the downward trend in FP use and Couple Years of Protection (CYP) within the country. Indeed QHP received supplemental funding from USAID/Ghana to boost FP activities and to support a campaign aimed at increasing availability, demand and use of LAPM.

Human Resources – Key Findings

- There was an improvement (28% to 48%) in the proportion of facilities where all providers have a current job description-but there is still room for improvement.
- Facilities that had at least half of their staff appraised in the last year increased from 29% to 55%. More improvement is required for fuller coverage.
- About 4 in every 5 staff in all the service delivery areas benefitted from in-service training in their service area within the last three years.

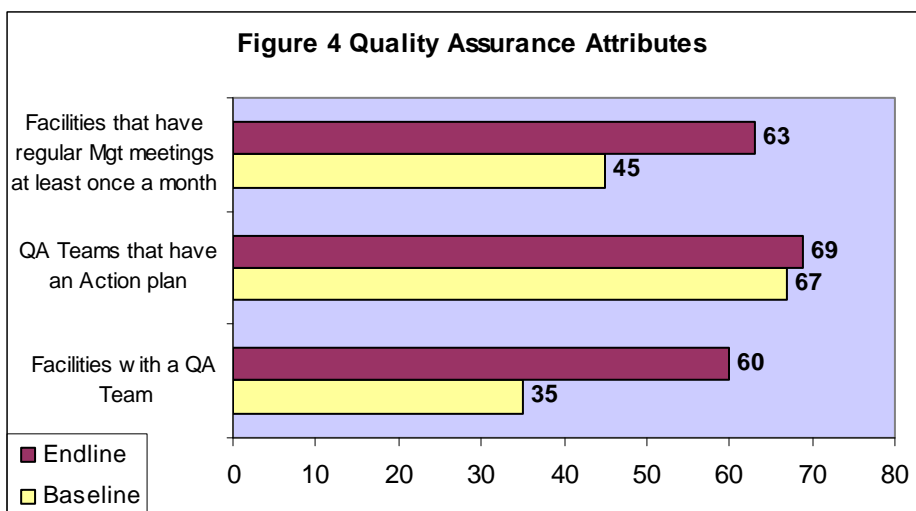
Quality Assurance

QHP assessed three main areas of Quality Assurance (QA): 1) the availability of QA teams within facilities; 2) the frequency and regularity of facility level management meetings; and 3) the use of Action plans.

Quality Assurance Teams. These teams were established to have an oversight of quality assurance in the provision of services within the facilities. At baseline, the total number of facilities that had a QA team was 54 and this increased to 99 facilities at midterm (not shown). By endline a total of 119 facilities had a functioning QA team. All three assessments showed that QA teams continued to have strong representation in hospitals. This is understandable against the backdrop that most QA teams were first established in the hospitals until late 2006 when trainings for the establishment of same in the sub-districts (health centre level) began. The increased proportion of facilities reporting a QA team at endline goes to prove that the concept is well institutionalized within the Ghana Health Service (see Figure 4 and details in Table B in the Appendix).

Regular Management Meetings. The percentage of facilities reporting that they have regular management meetings (at least once a month) also increased from 45% at baseline to 63% at endline (Figure 4). At the regional level, (except for Volta and Western Regions that reported fewer meetings) 60% or more of the facilities reported having had management meetings on monthly basis at endline. Consistent increases have also been observed at the health centre level when results of the three assessments are compared. Since meetings offer opportunities for concerns (including that of quality and work performance) to be discussed, one would want to believe that the frequency would have helped in getting issues that needed to be addressed to the attention of management for consideration. It may also be the case that despite the limited progress in the presence and use of formal QA action Plans, the management meetings may to some extent be accomplishing the same objective.

Action Plans. The Quality Assurance teams, once established were expected to draw action plans which would be periodically monitored and reviewed with the view to ensuring that identified quality assurance concerns at the facility level were addressed. The assessment showed a moderate increase in proportion of teams that had an action plan between the baseline and endline results (66.7% vs 69.1%) (Figure 4). While it was important that the number of teams had increased, their effectiveness could be further enhanced by the availability and use of action plans. With the action orientation of these teams not changing much, the desired impact of the QA teams is unlikely to be fully realised.

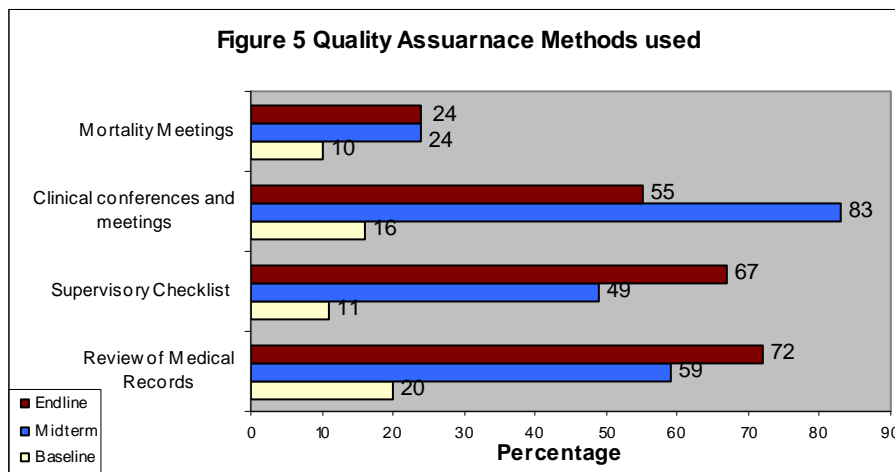


COPE. COPE, an acronym for Client Oriented Provider Efficient®, is an EngenderHealth concept which has been developed into a tool for helping facilities identify and improve quality assurance in service provision areas. COPE was targeted at hospitals during the first half of the project to empower facility level providers to recognize and make changes that are within their control. Since COPE was introduced after the start of the project no baseline information was collected on that indicator. By midterm more than one-third (70) of the target facilities had conducted COPE sessions, which was expected to lead to an institutionalized quality assurance process at these facilities. Not much appeared to have changed between midterm and endline with respect to COPE exercises in the facilities (Table 5). This may in part reflect reduced emphasis on COPE in years 4 and 5 in favour of the more clinically oriented IDS/OJT for MNH, IMCI and FP.

Table 5 Facilities that used COPE for Quality Assurance

	% of facilities ever done COPE exercise	
	Midterm	Endline
Type of Facility		
Regional Hospitals	100.0	100.0
District/ Mission/ Hospitals	83.3	56.8
Health Centres/Other	24.7	29.0
Region		
Ashanti	60.9	36.0
BAR	41.7	72.7
Central	26.8	31.5
Eastern	70.0	63.6
GAR	66.7	50.0
Volta	42.5	47.5
Western	13.8	12.1
Totals	36.6 (n=191)	36.7 (n=199)

QA Methods: The range of quality assurance methods used in facilities expanded progressively from baseline through midterm to endline even in facilities that did not have a QA team. Improvements are noted in the use of a variety of methods to ensure quality (see Figure 5 and Tables C in the Appendix for facility level details). Specifically there have been marked increases in the use of checklists to review services, surveys of medical records and clinical conferences and meetings. The use of clinical conferences or meetings decreased from 83% to 55% between midterm and endline but compared to baseline, there has been a significant overall upward trend in the use of this method. Mortality meetings overall continued to be the least used quality assurance method recording under 25% across all the assessment periods. Notably though are the increases in the use of mortality meetings in the regional and district hospitals where deaths are likely to occur. Mortality cases tend to be minimal at the health centres because they do not have inpatients and also refer severe illnesses to the hospitals. The overall improved performance in the use of these quality assurance methods may be attributed to the expanded availability of quality assurance training at all levels, including the health centre level. QHP training statistics for instance show that between May 2005 to September 2008, 525 service providers at all levels benefitted from quality assurance trainings. A key component of this training was practice with and implementation of analytical tools for improving quality at the facility level.



Supportive Management

Supervision: There was a consistent increase overall in the percentage of facilities reporting external supervision in the last six months between baseline, midterm and endline, from 75.8% to 94.3 and 94.4%. It is encouraging to note that the increase in the level of supervision from outside supervisors that occurred between baseline and midline was maintained, and as can be seen in Table 6 virtually all facilities benefited from external supervision.

Table 6 Supportive Management by Type of Facility and Region

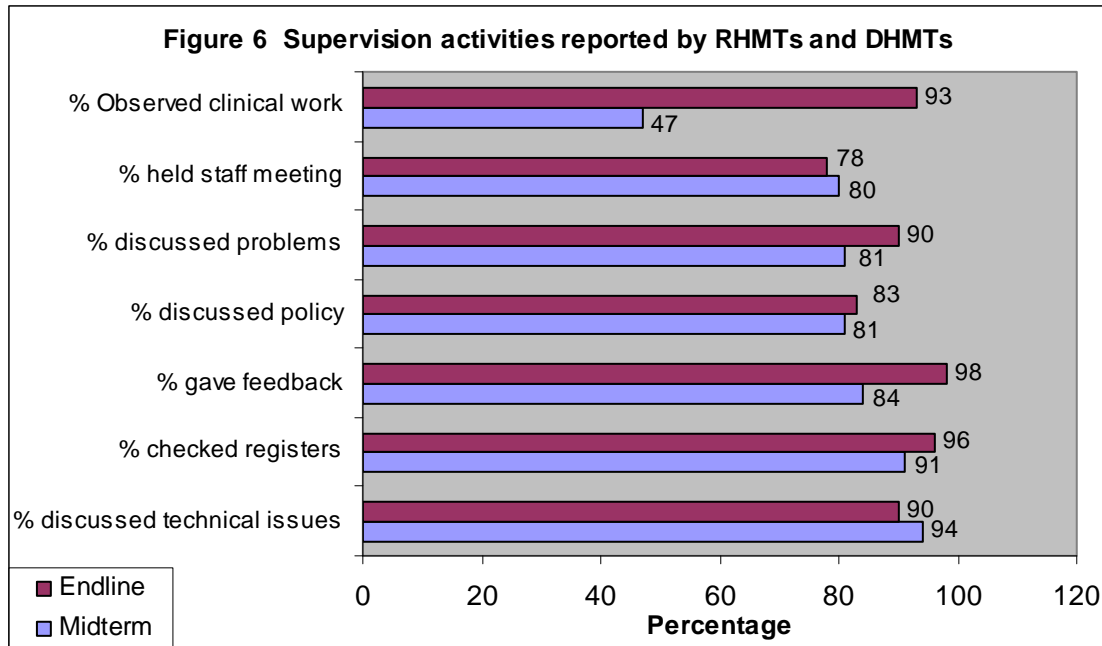
	% of facilities reporting external supervision visits in last 6 months		
	Base line	Mid term	Endline
Regional Hospitals	42.9	85.7	100.0
District/ Mission/ Hospitals	78.6	96.7	97.3
Health Centres/ Other	77.0	94.2	94.4
Ashanti	73.7	100.0	96.0
BAR	87.5	100.0	100.0
Central	83.3	97.2	97.2
Eastern	72.7	100.0	90.9
GAR	80.0	100.0	100.0
Volta	53.1	100.0	82.5
Western	86.4	69.0	100.0
Totals	75.8 (n=157)	94.3 (n=192)	94.4 (n=197)

The assessment further investigated the extent to which the different areas of reproductive and child health units benefitted from external supervision. Generally supervision received from external supervisors for all the service areas increased between midterm and endline. More than 85% of providers in all the service areas reported having been supervised by an external supervisor. Although significant increases were noted in all the service areas, across board, it is important to note that in IMCI the regional hospitals appeared to have been given little attention. This is understandable against the backdrop that IMCI is mainly for first level facilities and not regional hospitals. However, for the reason that some hospitals have medical assistants who treat sick children and some patients use the hospitals as their first reference point for treatment of their sick children, it would be important to increase efforts to get doctor and other providers participation in IMCI training-possibly through modified curriculum in view of the requirement for IMCI training.

Table 7 Supervision in the past 6 months by service delivery area

% of providers who report supervision by service area								
	Child Health (IMCI training followed up)	Family Planning	Ante-Natal Care	Delivery				
Type of Facility								
	Midterm	Endline	Midterm	Endline	Midterm	Endline	Midterm	Endline
Regional Hospitals	66.7	57.1	57.1	85.7	100.0	100.0	57.1	100.0
District Hospitals	76.2	87.1	72.7	93.3	92.9	86.5	86.7	88.9
Health Centres	70.8	86.4	61.3	96.1	63.3	92.3	46.2	84.1
Totals	71.7 (n=120)	87.0 (n=184)	62.6 (n=179)	95.2 (n=189)	69.5 (n=174)	91.4 (n=186)	53.9 (n=167)	85.7 (n=175)

Results of Regional and District Health Directorates interviewed during the midterm assessment, showed that 77.4% of Regions and Districts had written plans for supervisory visits (n=31). Endline results show a moderate increase with 80% of the Regions and Districts having available written plans for supervision. Almost all at midterm (93.8%, n=32) and at endline (97.5%, n=40) of Regions and Districts interviewed have supervisory checklists. At endline it is likely that the supervisory checklist used for these service delivery areas were the IDS/OJT tools. With respect to what they commonly do on monitoring visits (unprompted), the following responses presented in Figure 6 were given. Regional and District Health Directorate team members reported that they used a range of supervisory techniques such as; discussing technical issues, checking records, discussing policy issues and problems of the facility and holding staff meetings. The proportions of Regional and district health directorates that used these methods remained high at both midterm and endline with slight increases recorded at endline on almost all the methods used- an indication that overall supervisory activities increased over time.



This range of supervisory techniques mentioned at midterm by the Regional and District Directorates may be attributable to facilitative supervision trainings organized during the first half of QHP project. By midterm QHP had supported training of more than 370 providers and supervisors in facilitative supervision out of which 29 of 32 reporting districts and regions benefitted. On average, districts and Regions reported making 3.2 supervision trips per quarter (n=33). Although trainings in facilitative supervision were curtailed following the mid-point of the project because of the modified QHP mandate and related shift to the IDS/OJT approach, increases in the use of the techniques emerged at endline. Considering that 39 out of 40 surveyed districts and regions at endline indicated that they used the on-the-job-training and in-depth supervision tools developed by QHP in collaboration with the Ghana Health Service, one can sufficiently conclude that the use of those tools contributed to the increased employment of the various supervision techniques.

Indeed between October 2007 and July 2009, over 2,200 service providers benefited from in-depth-supervision and on-the-job training in the following service delivery areas (IMCI=545, MNH=602 and Family Planning=1083). Feedback from Supervisors that participated in IDS/OJT training acknowledged the gains they had in the areas of improved skills both in the technical areas as well as in the area of supervision. Service providers that also benefitted from on-the-job training were also full of praise for the trainings - because for some although they had received training in some skills the confidence to practice on their own was weak, but this changed following the IDS/OJT.

Referral Systems

Referral System Results. The proportion of facilities that had copies of the National Referral Guidelines developed in 2006 increased from 16.2% at midterm to 34% at endline. At midterm only a few districts in Central Region and Greater Accra Region had received these guidelines as part of a pilot project and it appears that a wider dissemination has not been completed though it was planned. This notwithstanding, the use of the standard referral forms for easy referrals to the next level of care improved.

The proportion of facilities that reported the use of the referral forms at midterm and endline respectively were, 71.3% and 70% of delivery units and 70.8% and 75.4% of child health providers (not shown in table). There is need for the about 30% of facilities that are not using the standard referral forms to be encouraged to do so, and this should be linked to fuller distribution of Referral Policies and Guidelines, and standardized referral forms.

Systems for Preventing Transmission of Infection

Infection prevention is an important measure of quality in health care provision particularly in facilities. The importance of the availability of systems to prevent the transmission of infection and ensure patient safety cannot be over-emphasized. Items required for infection prevention to be effectively done were checked. Items that should be available if infection is to be effectively prevented include soap, water, single use towels, sharps boxes and gloves in every consultation room in every service delivery unit of a facility. Additionally, in the delivery and family planning units where invasive procedures are performed – disinfectant for decontaminating instruments that ought to be available according to standards was checked.

QHP over the period invested significant resources in providing refresher training in infection prevention for about 1200 providers in target areas as part of quality service provision at the facility level. The support clearly paid off as evident from the endline results which show increases in the availability of infection prevention items in all the service provision areas (Table 8). At times while one area of service may be performing well on an important indicator such as infection prevention others may not be doing so well. In view of this the analysis also examined performance of infection prevention in totality across all the RCH service delivery areas. Results attained at the macro facility-wide level – where a facility must have all items in all service delivery units – show a 16% percent improvement between baseline and endline results. Though a significant improvement, it is still below 50%, which makes it important for the District and Regional Health Directorates to strongly support facilities to use any available resources, including Internally Generated Funds (IGF), to ensure that these items are in place at all times – as without them both the health provider and the client are placed at increased risk of contracting infections

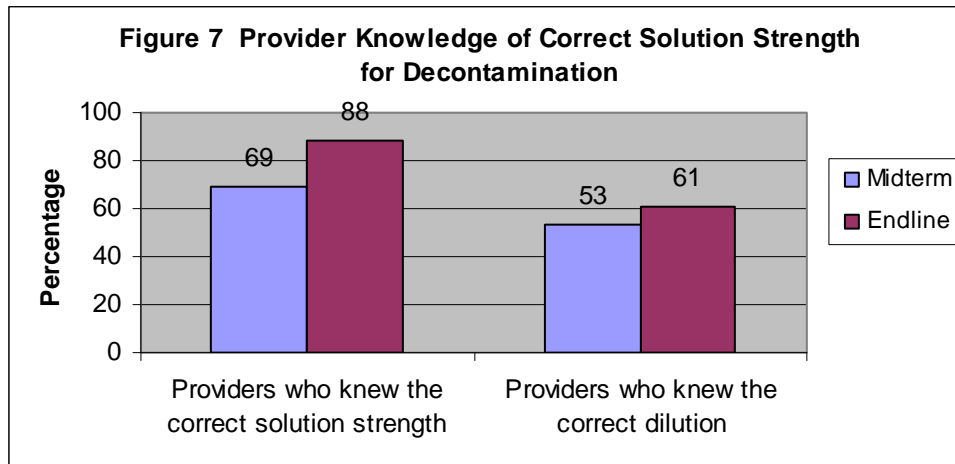
Table 8 Infection Prevention and Disposal Systems

% of facilities with all infection-prevention items ¹ in all service delivery areas			
	Baseline	Midterm	Endline
Type of Facility			
Regional Hospitals	33.3	40.0	71.4
District/Mission/ Hospitals	38.9	46.4	45.7
Health Centres/Other	28.1	36.4	44.9
Region			
Ashanti	10.0	27.3	37.5
Brong Ahafo	0.0	60.0	62.5
Central	32.5	38.8	50.7
Eastern	75.0	50.0	50.0
Greater Accra	25.0	20.0	60.0
Volta	45.5	38.5	38.2
Western	30.9	27.3	43.3
Totals	30.8 (n=81*)	36.9 (n=160*)	46.1(n=180*)

¹ Soap & water, sharps box, disinfectant, gloves and single use towels.

* If data were missing from any of the service areas they were excluded from the analysis.

Providers in the Family Planning and Delivery Units were further asked to indicate the correct solution strength for decontamination of instruments as well as the correct dilution ratio for the type of bleach they had in the room on the day of the assessments. Responses from both assessments show that overall the providers in the delivery units understood the dilution process better than the family planning providers and this is likely because the decontamination solution is used more often by providers in the delivery area than in the family planning area (see Figure 7 and Table D in Appendix for details).



Further questions about how to correctly process instruments after use were also asked. First the provider was asked the steps in processing instruments in an unprompted manner and if they did not mention a step – they were then prompted with that step. These questions were also asked at both the delivery and family planning areas. Overall - knowledge of correct processing of instruments was very high (Tables 9 and 10). Knowledge of instrument processing by providers in the regional hospitals for both the family planning and delivery areas was universal. However, since the consequences of improper infection prevention through inaccurate instrument processing could be life threatening, it is still important that other providers are also brought to speed in this area to ensure that the right things are done universally in all facilities.

Table 9 Provider knowledge of instrument processing: Family Planning Service Area

Type of facility	Soak instruments for 10 minutes		Wash with soap and scrub		High Level Disinfection (HLD)		Store in a clean dry place		All of the steps.	
	MT	EL	MT	EL	MT	EL	MT	EL	MT	EL
Regional Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
District/ Mission Hospitals	90.4	93.3	100.0	93.3	100.0	93.1	100.0	93.3	90.4	93.1
Health Centres/ Other	94.5	95.3	96.1	96.0	92.2	96.0	95.3	92.3	90.6	94.0
Totals	94.2 (n=156)	95.2 (n=187)	96.7 (n=156)	95.7 (n=187)	93.6 (n=156)	95.7 (n=186)	96.2 (n=157)	96.8 (n=187)	91.1 (n=157)	94.1 (n=186)

Table 10 Provider knowledge of instrument processing: Delivery Services Area

Type of Facility	Soak instruments for 10 minutes		Wash with soap and scrub		High Level Disinfection (HLD)		Store in a clean dry place		All of the steps.	
	MT	EL	MT	EL	MT	EL	MT	EL	MT	EL
Regional Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
District/ Mission Hospitals	93.1	97.2	100.0	97.2	100.0	97.2	86.2	94.4	79.3	91.7
Health Centres/ Other	96.9	97.7	96.2	97.0	90.8	96.2	93.1	92.4	84.7	87.9
Totals	96.4 (n=167)	97.7 (n=175)	97.0 (n=167)	97.1 (n=175)	92.8 (n=167)	96.6 (n=175)	92.2 (n=167)	93.1 (n=175)	84.4 (n=167)	89.1 (n=175)

Quality Assurance Key Findings

- Consistent increases in the number of quality assurance teams established in the facilities was noted- with increases in numbers recorded both at midterm and endline. Significant increase in the number of quality assurance methods reported at the health centre level during the midterm was equally maintained at endline.
- While the teams had been formed and functioning, quite a proportion of them do not have action plans which may have a potential of limiting the optimal benefit that the QA teams could bring to bear on their facilities.
- Increases in supervision levels by external supervisors to the facilities were noted both at midterm and endline. It is important to note that a more in-depth supervision was offered to providers at endline than at midterm since training of most supervisors in in-depth supervision occurred after the midterm assessment.
- Improvements in individual components of infection prevention systems were reported, but improvement is still needed in the use of decontamination solution in the FP unit.
- Provider knowledge of processing of instruments which was already high at midterm showed further improvement at endline.

Child Health Services

Capacity Building Activities for Quality Care for Sick Children

QHP complemented GHS efforts to improve treatment quality for sick children, particularly those under five years. The main focus of QHP's support was in the treatment of malaria and diarrhoea using the Integrated Management of Childhood Illness (IMCI) approach. Activities supported by QHP included training and supervision, equipment and material provision and, support in the development and review of policy and guidelines.

Trainings: Over the project period, QHP supported training of 834 health personnel in IMCI, covering all QHP supported districts. From the third year of the project, QHP changed its training strategy to focus more on on-the-job training rather than the off-site lecture type of training and this was to address observed inadequacies in provider skills while at the same time offering providers the opportunity to practice under supervision in their own settings (Table 11). In June 2008, GHS/RCH and QHP also began a collaborative process to develop an abridged training curriculum that reduced the original two weeks IMCI training to six days training and that also integrated neonatal care services (IMNCI instead of IMCI). The process was finalized in the first quarter of 2009 and the new curriculum was used in training 72 providers as master trainers who would support the GHS to roll out the training to other staff in future.

Table 11 IMCI/IMNCI trainings and IDS/OJT support given by QHP in target facilities

Clinical Training	IMCI/IMNCI	IDS/ OJT
May 2005 - Sep 2006	162	0
Oct 2006 - Sep 2007	75	0
Oct 2007 - Sep 2008	0	177
Oct 2008 - July 2009	72	368
Total	309	545

Equipment and Supplies. The availability of key equipment and supplies necessary in the provision of quality curative care for children was examined. This equipment includes infant and child weighing scale, minute timer and thermometer, jar for ORS, a cup and a spoon. Endline results show significant increases, overall, in the availability of the equipment in the facilities. Nearly ten times improvement in equipment availability in the facilities is noted when baseline and endline results are compared (7.6% to 75.4%). While these increases are observed at all facility levels the greatest improvements occurred at the regional hospital and the health centre level. Although QHP did not procure most of the IMCI equipment for these facilities, the baseline results provided a tool for both QHP and the GHS to advocate for the improvement in equipment supplies to the facilities (Table 12).

IMCI Chart Booklet. The IMCI chart booklet is a key job aid that helps providers to systematically carry out counselling and provide treatment to patients. QHP Liaison Officers and technical staff supported GHS to make the booklets widely available to providers in the consulting rooms across all QHP supported facilities. Indeed during

monitoring visits, checks were made to ascertain provider adherence to the key steps outlined in the booklet with the view to ensuring quality standardized care. Facilities that had the chart booklets more than doubled over time with four in five facilities having them in their consulting rooms (Table 12). In view of QHP's efforts at ensuring that all facilities had the booklets, an even higher percentage was expected, leading one to conclude that perhaps some providers on transfer had taken them as personal reference materials.

Table 12 Selected Essential Components to Support Quality Child Health Care

Type of Facility	% of facilities with all essential equipment ¹			% of facilities have IMCI Chart booklet (treatment algorithm)		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Regional Hospitals	28.6	28.6	71.4	57.1	80.0	71.4
District/Mission Hospitals	3.6	16.7	59.5	22.2	73.1	73.0
Health Centres/Other	7.4	28.2	79.4	29.5	82.3	86.5
Totals	7.6 (n=157)	26.4 (n=193)	75.4 (n=199)	29.5 (n=157)	80.9 (n=178)	83.4 (n=199)

¹ Functioning infant and child weighing scale, minute timer and thermometer and at baseline a jar/pitcher for ORS, cup and spoon.

Infection Prevention Items. Endline results show a 38% increase over baseline results in facilities with all infection prevention items. These increases occurred within all facility types with notable increases occurring at the health centre level when baseline and endline results are compared. The items assessed under infection prevention included the availability of soap, water, single use towels, sharps container and gloves (Table 13).

Referrals. As also noted in the Quality Assurance section, QHP worked with the GHS to develop a Referral Policy and Guidelines as well as standard referral form towards the establishment of a new referral system in the country. This new referral system was piloted in 2007 and introduced firstly to hospitals before it was rolled out to the lower levels of health care. The system sought to achieve standardization of referral especially at the health centre level, and to strengthen the referral links between levels of health facilities. QHP assessed the usage of these referral forms at midterm and endline and the results show an overall increase in use of the standard referral forms by health centres to refer patients to the next level of care (Table 13).

Table 13 Essential Equipment and other Materials for Quality Child Health Care

Type of Facility	% of facilities with all infection prevention items ²			% of facilities that use a standard referral form (no baseline)	
	Baseline	Midterm	Endline	Midterm	Endline
Regional Hospitals	57.1	40.0	85.7	100.0	85.7
District/Mission Hospitals	69.2	75.0	94.6	88.5	75.7
Health Centres/Other	56.2	78.3	93.5	66.9	74.8
Totals	56.2 (n=137)	76.8 (n=185)	93.5 (n=1990)	70.8 (n=178)	75.4 (n=199)

² This definition was soap, water, single use towels, sharps container, gloves in either the immunization room or where sick children were seen.

Other Child Health Practices. Routine growth monitoring prior to consultation increased consistently and considerably over time and across all facility levels. Universal or close to universal growth monitoring is reported at the regional hospitals and the health centre level. Again, nearly all facilities (more than 90%) have adopted the best practice of sponging and providing paracetamol to febrile children. Though the proportions of facilities providing this care declined slightly between midterm and endline, overall adherence levels are encouraging (Table 14). Facilities throughout the target area and especially health centres have improved the quality of their care.

Table 14 Factors Affecting the Quality of Child Health Care

Type of facility	% of facilities with routine system for growth monitoring before consultation			% of facilities with routine system for managing children with fever (sponging and paracetamol)		% of facilities with trained IMCI person providing services		% of facilities where IMCI resource person has followed-up training	
	Base line	Mid Term	End line	Mid term	End line	Mid term	End line	Mid term	End line
Regional Hospitals	71.4	80.0	100.0	80.0	100.0	57.1	87.5	66.7	57.1
District/Mission Hospitals	74.1	89.3	86.5	92.9	94.6	60.0	70.3	76.2	100.0
Health Centres/Other	75.4	89.2	95.5	97.4	89.7	59.6	83.8	70.8	95.0
Totals	75.0 (n=152)	89.2 (n=185)	93.0 (n=198)	96.2 (n=185)	90.9 (n=198)	59.5 (n=193)	81.3 (n=198)	71.7 (n=120)	94.0 (n=151)

Due to the practice within the health service whereby staff are sometimes shifted to areas for which they have no training, the study sought to assess whether the IMCI trained personnel were the ones providing treatment to sick children. The proportion of facilities that had an IMCI trained provider as the person who provides treatment for children increased from 60% at midterm to 81% at endline. In a similar vein, an overwhelming 94% of these providers at endline reported having benefited from follow-up support visit by a resource person, a standard practice of the IMCI human resource capacity building process. In spite of the considerable improvement at the district hospital and the health centre levels in respect of follow-ups, the regional hospitals appear to be getting less attention in terms of an IMCI resource person following up training.

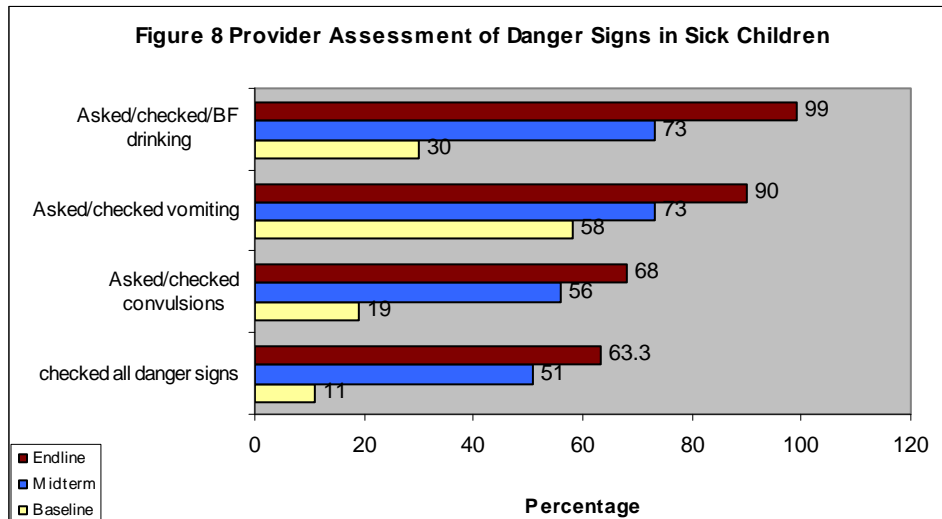
Adherence to Standards for Quality Service Provision – Child Health

Observation of Service Providers. At baseline all providers treating sick children were observed and a minimum of 2 and a maximum of 5 observations at each facility were sought. For the midterm, one observation per facility was planned, but due to length of time observations take and the need to have the appropriate caseload, there was no observation at some facilities. At endline, a minimum of one and a maximum of 2 observations were sought per facility. The differences in numbers are not a problem and the data would have been comparable because of the similar proportions of patients observed by facility type and by regions. However, these may not be exactly so because of the different proportion in types of providers (more doctors and fewer midwives at baseline). These notwithstanding the results provide a strong indication of the trends in managing child health (Table 15).

Table 15 Percentage of Sick Child Observations that were made by Type of Facility, Region and Provider Type

	Baseline (n / %)	Midterm (n/%)	Endline (n / %)
Type of Facility			
Regional Hospital	35 (8.3)	10(6.9)	10 (3.9)
District/Mission Hospital	109 (25.9)	31 (21.4)	56 (21.9)
Health Centre/ Other	277 (65.9)	104 (71.4)	190 (74.2)
Region			
Ashanti	44(10.4)	13 (9.0)	46 (18.0)
Brong Ahafo	35 (8.3)	5 (3.4)	17 (6.6)
Central	158 (37.5)	55 (37.9)	87 (34.0)
Eastern	21 (5.0)	9 (6.2)	8 (3.1)
Greater Accra	12 (2.8)	4 (2.8)	7 (2.7)
Volta	99 (23.5)	28 (19.3)	53 (20.7)
Western	52 (12.3)	31(21.3)	38 (14.8)
Type of Provider Observed			
Doctor	76 (18.1)	16 (11.0)	20 (7.8)
Medical Assistant	167 (39.7)	53 (36.6)	104 (40.6)
Nurse/CHN	88 (20.9)	37 (25.5)	66 (25.8)
Midwife	26 (6.2)	33 (22.8)	54 (21.1)
Other	12 (2.9)	3 (2.1)	12 (4.7)
Missing	52 (12.4)	3 (2.1)	0 (0.0)
Total Observations			
	n=421	n=145	N=256

Assessment of Danger Signs. Checking whether children who are presented sick can drink or breastfeed, whether they have had any convulsions and whether they have been vomiting everything are the key steps a provider takes in determining danger signs in children. Assessing danger signs informs the quality of the diagnosis made by the provider and ensures that a provider does not miss key signs that may signal a more acute problem. In all three assessments, QHP measured whether providers asked about these key danger signs. Overall, the results show consistent increase in performance between the assessments- from 11% to 51% to 63% at baseline, midterm and endline respectively. The area with the greatest improvement is in the provider asking about the child's ability to drink or breastfeed (Figure 8). Reasons why providers did not find out whether or not the sick child convulsed were not sought in this assessment.



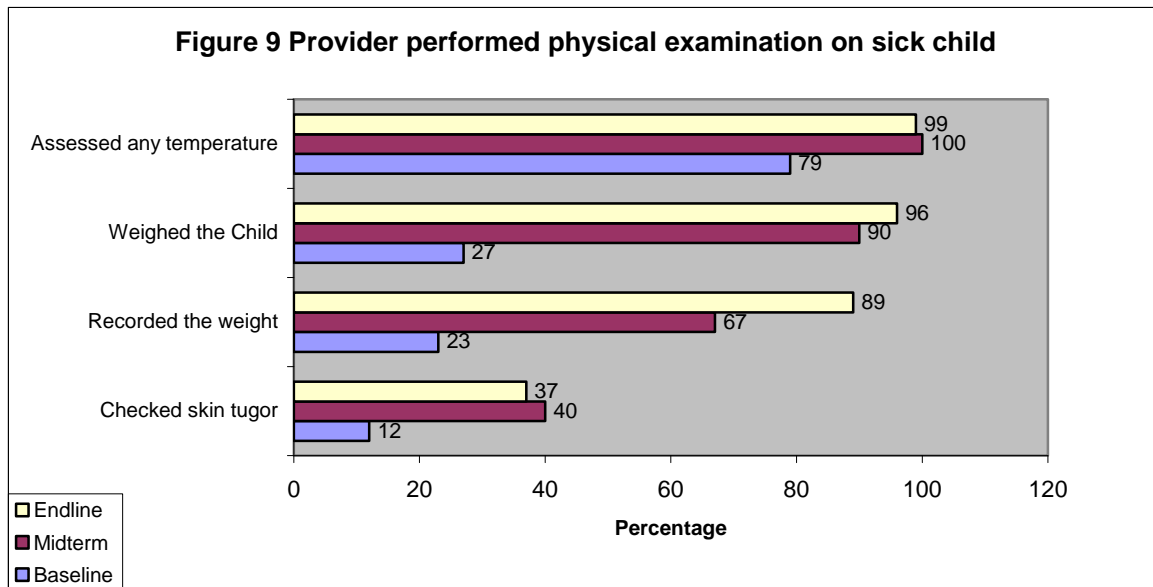
Further analysis with respect to the assessment of danger signs by provider type was done. Results indicate increases in all categories of providers (except for midwives) who assessed danger signs among children who reported with fever or diarrhoea (Table 16). The low performance of doctors may be understandable in light of the fact that most doctors use more clinical signs and investigations to assess severity of an illness. The midwives being the senior officers in charge often stand in when the Medical Assistants are not readily available to provide care for the sick child.

Table 16 Percentage of Providers who asked about all Danger Signs by Type of Provider

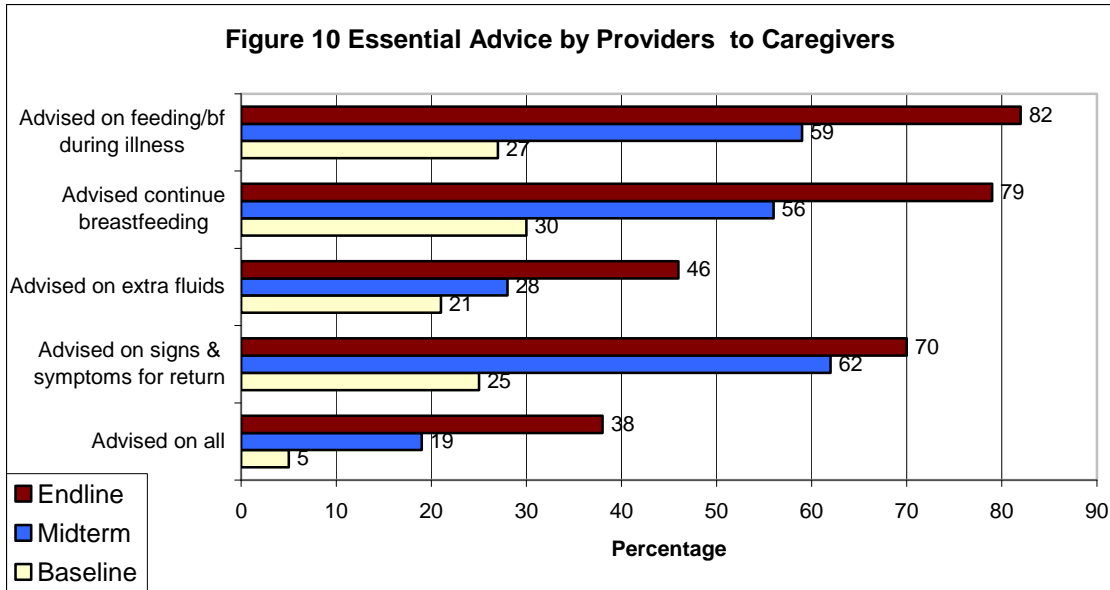
Provider Type	% of Providers that asked about all the danger signs		
	Baseline	Midterm	Endline
Doctor	4.2	13.3	50.0
Medical Assistant	11.7	53.8	74.0
Nurse	23.0	64.9	71.2
Midwife	0.0	50.0	46.3
Other	0.0	33.3	25.0
Totals	11.0 (n=368)	51.0 (n=142)	63.3 (n=256)

Physical Examinations: Providers' performance on how they carried out physical examinations was also assessed. Improvement in this area was also noted. The percentage of providers who assessed temperature was universal at both midterm and endline. Proportion of providers who ensured that children were weighed increased significantly from a baseline figure of 27% to 89% at endline –an encouraging development given that the weight of the child provides information on the nutritional status of the child and is also useful in calculating dosage of drugs. The area that would require increased attention is the assessment of children for dehydration, using the skin

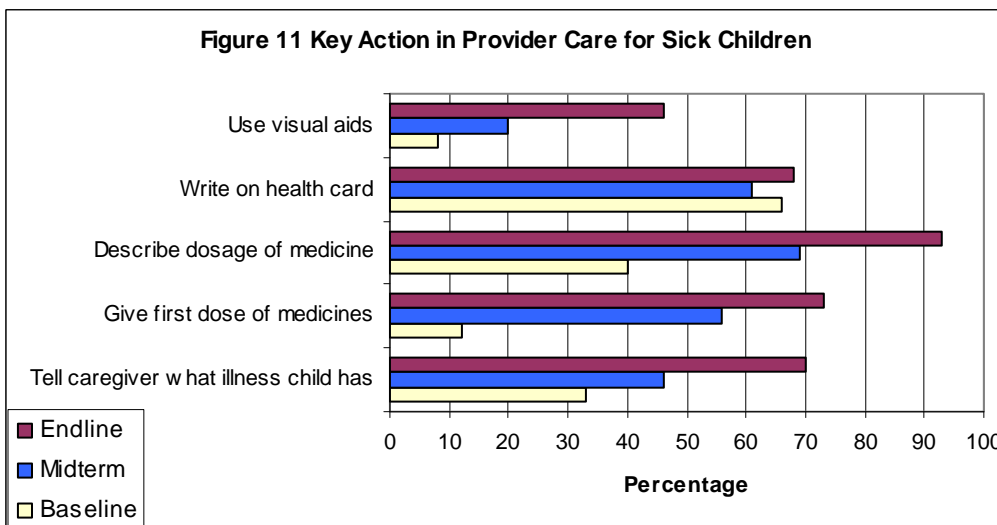
pinch as there was a slight drop in performance for this indicator between midterm and endline, despite an overall improvement (12% to 37%) from baseline to endline (Figure 9).



Advice to Caregiver. Caregivers need adequate information in order to appropriately continue with care at home. A provider should therefore advise the caregiver on key things to do in the further management of the child’s illness. Providers were examined in all three assessments on the type of advice given. There were significant increases in provider performance in almost all areas where advice needed to be given. Providing information on feeding and the need to continue feeding, and information on the signs and symptoms for return to the facility all improved significantly. Though the proportion of providers who advised on the need to continue to give fluids more than doubled from baseline to endline, it still remained less than 50% by endline (Figure 10).

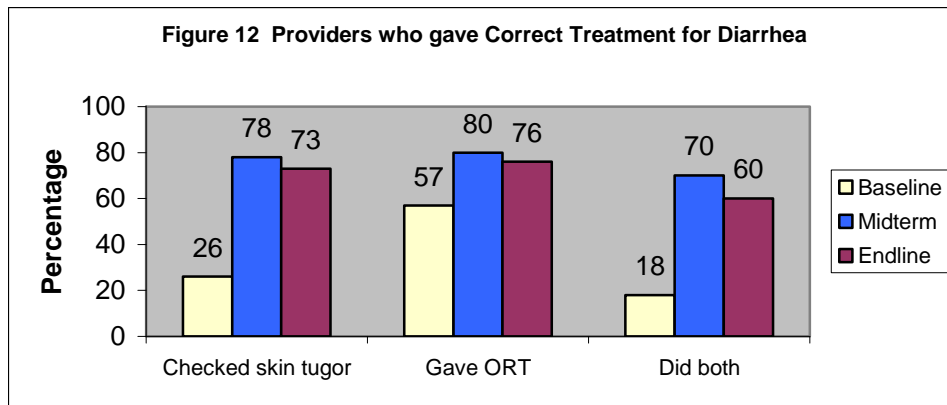


Other key provider Actions: One key action in child care is providers communication with caregivers about what illness the child has, improved considerably between baseline and endline (33% to 70%). Providers are also following standard practice by increasingly giving the first dose of medicine at the facility and explaining the dosage to caregivers. The use of visual aids increased steadily –from 8% at baseline to 46% at endline- still needing a lot more attention particularly as most of the caregivers tend not to be literate. With respect to the provider recording observations on the clients health card, very little changed (Figure 11).



Treatment of Diarrhoea: When children present with diarrhoea, two key actions needed to be taken by the providers are checking for dehydration (using the skin turgor test) and providing oral rehydration therapy to the sick child. Observations between midterm and endline results point to a slight decrease in the performance of these actions by providers. Nevertheless, when endline results are compared with those of baseline considerable improvement in performance has still been maintained. Overall, 60% of

providers at endline as compared to 18% at baseline took both required actions (Figure 12).



Child Health – Key Findings

- Improvements are noted in treatment and management of illnesses in children under five – providers (64%) are increasingly assessing all of the danger signs and providing all of the essential advice required-though efforts must be made to get on board the remaining 36%.
- In 80% of facilities IMCI trained providers are the ones providing treatment for sick children – an indication that sick children would likely receive quality care.
- Routine growth monitoring for sick children was almost universal.
- More physical assessments are now conducted during consultations including assessments for dehydration and fever.
- Clients rights are increasingly being correctly observed as providers are telling caregivers more about the consultation and allowing them to be part of the process.

Family Planning Services

Like the other service areas, QHP's support in family planning included the development of guidelines and protocols, provision of equipment and logistics supplies, and support for trainings and supervision. Of the 200 facilities that QHP supported, about 5% of them do not offer family planning services and this is because they are mission-based and affiliated to the Catholic Mission. In all, 182 out of 193 and 189 out of 199 facilities surveyed during the midterm and endline respectively offer family planning services. In view of this, the analyses for this section are based on facilities that offered the services during the period of the assessments. This section presents findings on the availability of equipment and logistics, human resource capacity, including knowledge of providers on specific tasks, as well as overall performance on selected outcome indicators.

Availability of Infrastructure and Resources for Family Planning

Family Planning Protocols/Handbook. The percentage of facilities reporting that they have a copy of the family planning protocols was about the same between baseline and midterm but shot up significantly by endline with a 30% increase, from 58% to 90% (Table 17). In collaboration with GHS, in 2007 QHP procured copies of the new Family Planning Protocols for distribution to the facilities. However, this was delayed and so at the time of the midterm assessment, the facilities did not have them. When they became available, QHP technical staff ensured that all facilities that offered family planning services had copies of the handbook for use in their consultation rooms. Additional copies were also given to providers during training sessions organized by QHP.

Infection Prevention in FP. As noted in the earlier part of the report, infection prevention is one of the key components for measuring quality of care in health service delivery. Family planning units in facilities assessed showed consistent improvement in their infection prevention practices over the three assessment periods. For instance, facilities that reported having all infection prevention items increased from 31% at baseline to 57% at midterm and to 70% at endline. The contribution to the overall increase is mainly from the health centres which saw about a 40% increase in the availability of infection prevention items between baseline and endline. With respect to the regional and district hospitals, though a general increase is noted between endline over baseline performance, there was a slight dip in performance when endline and midterm results are compared (Table 17). The main constraint to all facilities having infection prevention materials, as noted in the midterm report, is that many facilities that perform invasive procedures do not have decontamination solution or bleach that has the concentration clearly marked on the label. One explanation given is that facility bleach is usually purchased in bulk by stores/procurement officers who may not have adequate knowledge of requirements or may purchase whatever is readily available on the market. Where this is the case, facility management should enforce standards by ensuring that bleach with concentration clearly marked is procured.

Table 17 Resources in Family Planning Service Provision Areas

	% of facilities with protocols or guidelines for family planning ¹			% of facilities with all items for infection prevention ²			% of facilities with conditions for a quality pelvic examination ³		
Type of Facility									
	Baseline	Midterm	Endline	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Regional Hospitals	85.7	85.7	100.0	57.1	100.0	85.7	57.1	57.1	100.0
District / Mission Hospitals	70.8	77.3	76.7	46.4	73.9	70.0	35.7	39.1	56.7
Health Centres/Other	49.5	53.5	92.8	26.2	52.0	69.1	10.7	13.8	30.3
Regions									
Ashanti	41.2	47.4	86.4	31.6	40.0	72.7	5.3	0.0	13.6
Brong Ahafo	75.0	54.5	100.0	0.0	100.0	90.0	0.0	36.4	20.0
Central	55.4	64.7	88.5	31.7	61.4	72.2	23.3	20.0	47.2
Eastern	62.5	50.0	100.0	45.5	60.0	63.6	36.4	20.0	72.7
Greater Accra	100.0	83.3	100.0	40.0	66.7	83.3	20.0	33.3	66.7
Volta	60.0	53.1	97.2	40.6	43.2	61.1	12.5	10.8	22.2
Western	36.8	51.9	81.3	18.2	53.6	65.6	13.6	28.6	34.4
Totals	54.9 (n=142)	57.8 (n=173)	90.5 (n=189)	31.2 (n=157)	56.6 (n=182)	69.8 (n=189)	17.2 (n=157)	18.7 (n=182)	37.0 (n=189)

¹ Essentials of Contraceptive Technology book

² Water, soap, single-use towels, clean gloves, sharps container, decontamination solution for clinical equipment in facilities that perform invasive procedures.

³ Functioning spotlight, table and stool for gynaecological examination, visual and auditory privacy.

Pelvic Exam Equipment and Privacy. While conditions for a quality pelvic examination increased slightly over time, the results continue to be quite low -as less than 40% of facilities reported having all of the necessary conditions in place for a quality pelvic examination. There were differences in performance at the facility level. At the regional hospital level for instance, all the conditions for the pelvic examination were in place, while at the district hospital level more than 56% of facilities reported having the conditions in place. The low performance overall is actually due to the fewer proportions of health centres that have available the required conditions for pelvic examination. For this assessment the definition of quality pelvic examination included the availability of functioning spotlight, table and stool for gynaecological examination, and environment that fostered visual and auditory privacy.

Further analysis shows that while most health centres performed well on visual and auditory privacy (91%) and had tables for gynaecological examination (71%), only 37% of them had available functioning spotlights. The same pattern appeared when one examined the performance of the district hospitals although they performed better than the health facilities on all points. Generally, where facilities showed the most improvement was in the areas of client privacy (Table 18).

Table 18 Equipment for a Quality Pelvic Examination

	% of facilities with a functioning spotlight			% of facilities with a table for gyn exam			% of visual and auditory privacy		
Type of Facility									
	Base line	Mid term	End line	Base line	Mid term	End line	Base line	Mid term	End line
Regional Hospitals	71.4	71.4	100.0	85.7	57.1	100.0	57.1	100.0	100.0
District/ Mission Hospitals	42.9	42.9	60.0	60.7	87.0	86.7	51.9	90.9	96.7
Health Centres/ Other	14.8	18.7	36.8	53.3	53.1	71.1	59.0	82.0	90.8
Region									
Ashanti	15.8	10.0	27.3	15.8	10.0	45.5	42.1	95.0	100.0
BAR	0.0	36.4	20.0	62.5	72.7	90.0	25.0	100.0	100.0
Central	26.7	22.1	52.8	76.7	73.9	73.6	71.7	95.7	86.1
Eastern	36.4	20.0	72.7	45.5	60.0	90.9	40.0	100.0	100.0
GAR	20.0	50.0	83.3	80.0	80.0	100.0	80.0	66.7	83.3
Volta	21.9	11.1	27.8	34.4	41.7	66.7	53.1	51.4	91.7
Western	18.2	44.4	37.5	63.6	61.5	90.6	54.5	78.6	96.9
Totals	22.3 (n=157)	23.6 (n=178)	42.9 (n=189)	56.1 (n=157)	57.6 (n=177)	74.6 (n=189)	57.7 (n=157)	83.8 (n=179)	92.1 (n=189)

Procurement: Informed by findings from an equipment assessment conducted in September 2005 and monitoring data from September 2006, QHP procured some equipment to help improve Family Planning service provision at the facility level. Items procured include stethoscopes, sphygmomanometers, weighing scales, Minilap kits, IUD models and kits and, implant arm models and Norplant insertion kits. At the time of the midterm assessment most of the equipment had been delivered, except for the weighing scales. Medical weighing scales ordered by QHP arrived after the midterm assessment. It is important to note that most facilities prior to the midterm assessment had bathroom scales in the family planning units but standard requirement by GHS at the time meant that the bathroom scales were no longer appropriate for the facilities. Facilities were required to have in place functional medical scales and so for the two assessments (midterm and endline), facilities that did not have the medical scales were considered to be lacking. Although it was reported during the midterm that an estimated 84% of facilities will have the correct weighing scales after the arrival and distribution of weighing scales procured by QHP, the endline results do not support the initial projection. In all, a total of 58% of facilities at endline had the prescribed weighing scale in the family planning units. The proportions were almost the same for all facility types (Table 19).

Table 19 Equipment Procured by QHP Available in FP Service Delivery areas

	% of facilities with functioning sphyg.			% of facilities with functioning stethoscope			% of facilities with a functioning weighing scale		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Regional Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	85.7	71.4	57.1
District/Mission Hospitals	67.9	81.8	90.0	71.4	82.6	96.7	67.9	56.5	56.7
Health Centres/Other	64.8	78.3	86.7	68.9	79.6	84.9	66.4	21.3	57.9
Ashanti	57.9	90.0	86.4	57.9	90.0	86.4	73.7	35.0	45.5
Brong Ahafo	87.5	90.9	100.0	87.5	90.9	100.0	75.0	63.6	90.0
Central	66.7	87.0	91.7	71.7	88.6	91.7	80.0	11.4	47.2
Eastern	63.6	70.0	81.8	63.6	80.0	81.8	54.5	30.0	54.5
Greater Accra	80.0	83.3	100.0	80.0	83.3	100.0	80.0	66.7	66.7
Volta	68.8	54.1	86.1	75.0	54.1	88.9	81.3	47.2	72.2
Western	63.6	85.7	78.1	68.2	85.7	71.9	9.1	14.8	62.5
Totals	66.9 (n=157)	79.6 (n=181)	87.8 (n=189)	70.7 (n=157)	80.8 (n=182)	87.3 (n=189)	67.5 (n=157)	27.8 (n=180)	57.7 (n=189)

Equipment for LAPM: Both the midterm and endline assessments requested facilities to report on whether or not they had a service provider in IUD and implant insertion and removal and if they did a follow up question sought to know whether they had kits in place to perform the procedures. The endline results show that at least 90% of facilities with trained providers in the said method had the equipment to work with (Table 20). It is important to note that in the life of the project, QHP procured some IUD insertion kits for the facilities and these were distributed essentially after training sessions to ensure that trained providers were adequately equipped to offer the service. The high results noted at both the midterm and endline could largely be attributable to QHP direct support to the facilities.

Table 20 Equipment for Long and Acting Permanent Method of Family Planning

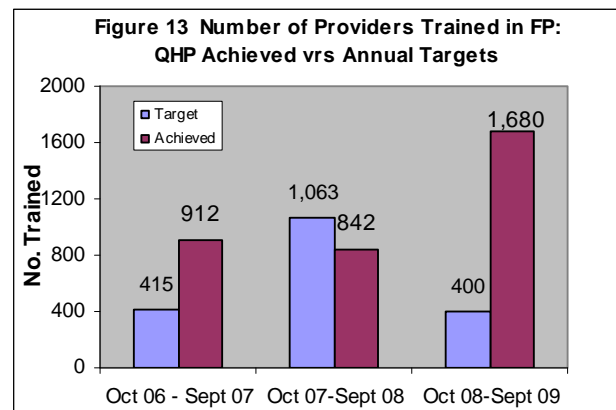
Region	% of facilities with trained provider and IUD kit		% of facilities with trained provider and Norplant kit	
	Midterm	Endline	Midterm	Endline
Type of Facility				
Regional Hospitals	66.7	100.0	83.3	100.0
District/Mission Hospitals	89.5	90.0	94.1	92.0
Health Centres/Other	78.7	91.6	83.3	88.0
Region				
Ashanti	100.0	85.7	80.0	72.2
Brong Ahafo	87.5	100.0	90.0	100.0
Central	82.5	90.5	89.7	86.0
Eastern	100.0	100.0	100.0	100.0
Greater Accra	100.0	100.0	100.0	100.0
Volta	55.6	90.5	50.0	87.5
Western	58.3	100.0	80.0	100.0
Totals	80.2 (n=86)	93.5 (n=108)	86.2 (n=65)	89.4 (n=132)

Trainings for Providers: QHP in collaboration with GHS identified and trained staff of the family planning units within the districts in a number of areas. Areas covered include skills building in the provision of long acting and permanent family planning methods such as minilap, and IUD and implant insertion and removal. QHP also received additional funding in the last year of its project to implement Post Partum Family Planning (PPFP) activities. In addition to posters, leaflets, directional sign posts and playlets developed and distributed to the facilities, QHP also trained a total of 662 providers in PPFP. Towards the latter half of QHP, on-the-job (OJT/IDS) training was intensified to improve provider skills in all areas of service provision as far as family planning was concerned and this saw as many as 1,083 providers benefitting from on site visits and more practical sessions within their own environment of work. The OJT was developed to address essential skill gaps that were noted during the initial assessments and other monitoring visits carried out jointly by QHP and GHS. In addition, a total of 539 providers was also trained in the Sexual and Reproductive Health Counselling curriculum, which had a focus on improved counselling skills for providers. A review of QHP's training targets and achievement shows that over 3,800 GHS staff have benefitted from trainings with the highest numbers occurring in the last year of the project (Table 21 and Figure 13).

Table 21 Type of Family Planning Trainings Organised

	ML/IUD Implant	PPFP	SRH/ FP	FP/ OJT	COPE (RH)
2006	25	0	108	0	730
2007	15	0	360	0	286
2008	143	0	59	259	186
2009	182	662	12	824	0
Totals	365	662	539	1083	1202
	3,851				

1. ML = minilap
 2. PPFP = Post Partum Family Planning
 3. SRH =Sexual and reproductive Health
 4. OJT=On the Job-Training
 5. COPE=Client Oriented and Provider Efficiency
- * Note that some service providers may have benefitted from more than one training



*Trainings between Oct 06-Oct 08 included some cross cutting topics such as Quality Assurance, Facilitative Supervision and Infection Prevention relating to FP

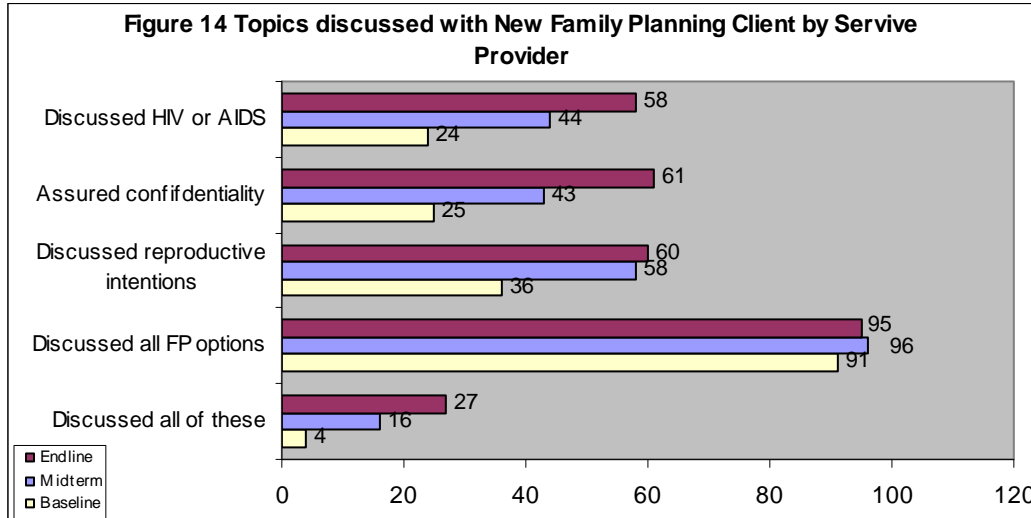
Supervision of FP Providers. Significant increase was noted in the proportions of facilities where providers received external supervision between midterm and endline. Similarly, the proportion of providers who reported receiving in-service training on FP topics almost doubled when midterm and endline results are compared. These considerable improvements are largely accounted for by the increases in QHP supported trainings including OJTs in family planning during the last two years of its operation (Table 22).

Table 22 Supervision of FP Services

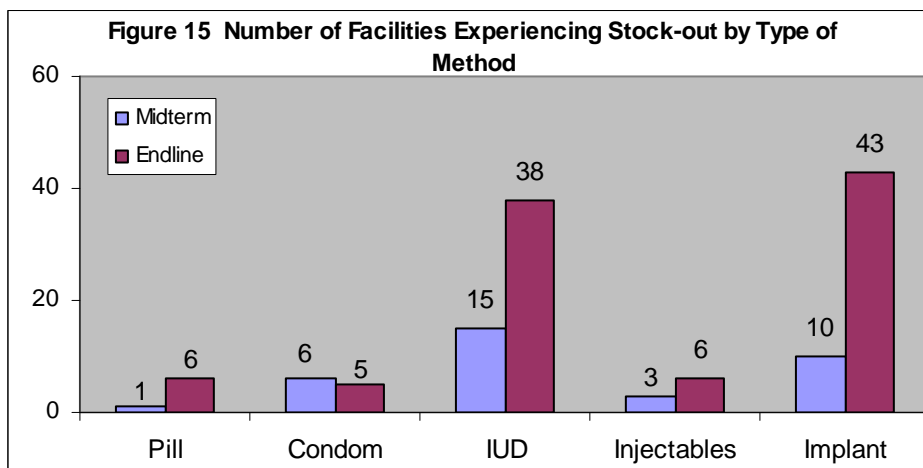
Region	% of facilities where a supervisor has observed FP services in past 6 months		% of providers who report receiving in-service training on FP topics (within the last 3 years)	
	Type of Facility			
	Midterm	Endline	Midterm	Endline
Regional Hospitals	57.1	85.7	50.0	100.0
District/ Mission/ Hospitals	72.7	93.3	59.1	90.0
Health Centres/ Other	61.3	96.0	55.0	90.6
Totals	62.6 (n=179)	95.2 (n=188)	55.4 (n=177)	90.9 (n=186)

Counselling Skills: To ascertain the effect of the training in SRH as well as the OJTs, family planning providers' knowledge of the essential components of family planning counselling was assessed. Providers were requested to enumerate the topics they covered during counselling with a new client. Endline results show increases in the proportion of providers who responded correctly (unprompted) on the key steps they followed in counselling. The greatest improvements were observed with discussing all methods and in discussing reproductive health intentions (which is essential in helping clients to make an informed choice). The importance of discussing reproductive health

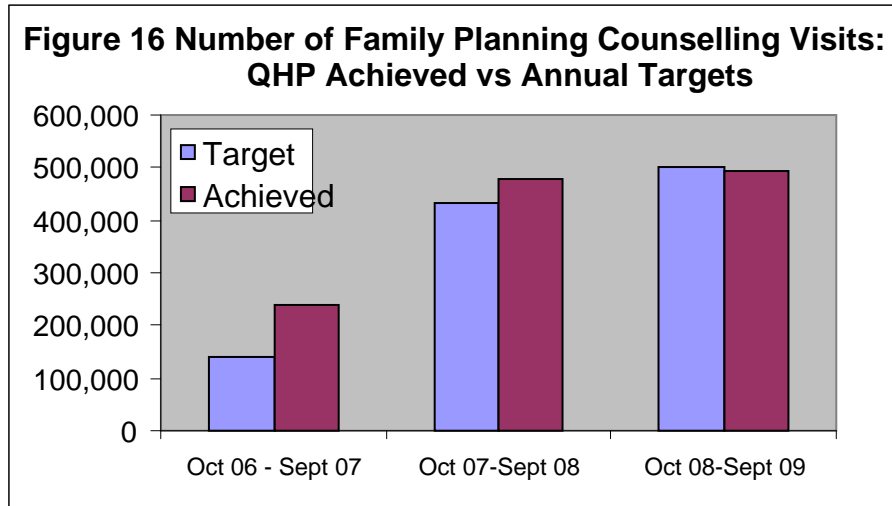
intentions relates to the high unmet need for family planning especially for people who desire a LAPM because they do not wish to have any more children. Though providers are discussing the individual essential topics, less than 30% of them overall are discussing all of the counselling topics at the same time with their clients.



Stock-outs of Family Planning Commodities: A total of 23 as against 61 facilities assessed during the midterm and endline respectively reported experiencing a complete stock-out of one type of family planning commodity in the past six months. This means that the facility was completely out of that type of commodity (all types of condoms or all types of pills or all types of injectables for instance) (Figure 15). With the exception of condoms where stock-outs were reported in fewer facilities, stock out for all other methods increased. Particularly worrying are the high numbers of facilities that reported stock out in IUD and implant especially because QHP had supported campaign activities for the promotion of LAPM in all the 7 regions of operation. While the decrease may have been caused by gaps in the logistics supply chain of the GHS, it is also possible that this may be due to increased demand for the methods, exceeding previously maintained stock levels. Further investigation into this may be required.



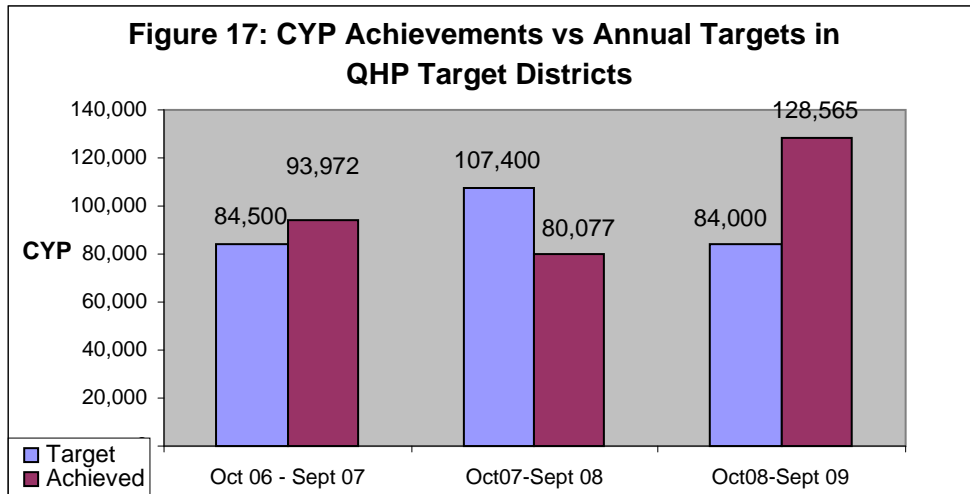
Family Planning Counselling Visits: QHP collects and reports on routine statistics from the 37 target districts on performance of family planning counselling visits. Given in Figure 16 are the annual targets and achievements from 2006 to 2009. The results clearly show increases across the years with targets being exceeded for the years 2006-2007 and 2007-2008 and about reaching the target for 2008-2009.



Acceptor Rates and Couple Years Protection: How QHP fared over the last three years in Couple Years Protection (CYP) is given in Figure 17. Performance in CYP over the life of the project has not been very consistent and a number of factors accounted for the low achievement in CYP during the early years of QHP. Some of the factors identified and enumerated in the QHP midterm report include the following:

- Loss of skilled LAPM trainers and providers, and low caseload combining to effectively eliminate LAPM from the mix of FP methods available at some facilities.
- Depletion of Norplant stocks and non-availability of Jadelle to replace it during late 2006 and the first half of 2007.
- Intermittent stock-outs of certain methods (IUDs, condoms, injectable).

To address some of these issues QHP and GHS initiated a family planning campaign in 2008 with the view to increase uptake of LAPM among clients. These efforts may have contributed to the increase in CYP particularly in the last year although the 2009 target informed by the previous year's achievement was a bit conservative.



Family Planning – Key Findings

- Infection prevention measures consistently improved over time in QHP supported facilities as well as in areas where intrusive procedures (such as IUD and Norplant insertions) are performed.
- Provider knowledge of essential counselling topics increased over all the various components needed for a new client to make a quality and an informed choice.
- Facilities have benefitted from QHP equipment procurement to improve the basic overall service provided.
- Facilities reporting complete stock-outs of a type of contraceptive method increased from 23 to 61 facilities between midterm and endline with many more facilities reporting stock outs in the longer term methods like IUD and Implant.
- After the low CYP achieved in earlier years, signs of improvement have begun to emerge particularly in the last year where there has been an over 50% increase in CYP (from 80,077 to 128,565). QHP LAPM campaign activities may have largely contributed to this observation.

Maternal and Neonatal Health

This section provides information on the components of maternal and neonatal health that QHP supported and they comprise: basic and comprehensive essential obstetric care services, antenatal, delivery and neonatal care practices.

Trainings in MNH: QHP supported training in life saving skills, partograph use and neonatal resuscitation (Table 23). Through on-the-job training (IDS/OJT), many more providers were helped to increase their skill level as well as their confidence in providing services within their own setting and context.

Table 23: Types of Trainings on Maternal and Neonatal Care

Clinical Training (MNH)	LSS	Focus ANC	Parto-graph	Focus ANC	MNH/OJT
May 2005 -Sep 2006	165	84	42	15	0
Oct 2006 - Sep 2007	50	0	0	29	0
Oct 2007 - Sep 2008	80	0	0	0	244
Oct 2008 - Sep 2009	34	0	0	0	358
Total	329	84	42	44	602

Basic and Comprehensive Essential Obstetric Care Services

The World Health Organization's definition of Basic and Comprehensive Essential Obstetric Care services is outlined in the following table.

Table 24 World Health Organization Definitions of BEOC and CEOC

Basic Essential Obstetric Care	Comprehensive Essential Obstetric Care
Administration of parenteral antibiotics, Administration of parenteral oxytocics, Administration of parenteral anti-convulsants for pre-eclampsia and eclampsia, Perform manual removal of retained placenta, Perform removal of retained products of conception, Perform assisted vaginal delivery.	All Basic Essential Obstetric Care PLUS+ Surgery, Anaesthesia and Blood Transfusion.

Source: Midterm Assessment Report, September 2007

QHP specifically worked with GHS and its facilities to ensure that emergency and routinely used medicines were available in the delivery unit of facilities and that best practices such as the use of oxytocics in the third stage of labour and use of magnesium sulfate to control eclampsia are followed, even at the health centre level. As part of QHP supported Life Saving Skills (LSS) training, midwives were also taken through the process of manual removal of the placenta. QHP however did not particularly focus on vacuum extraction as part of BEOC.

With the exception of antibiotics that were widely available in most delivery units of health centres at the time of the baseline, the others (oxytocics and anti-convulsants) were almost non-existent. Between the period of the baseline and midterm significant increases in the availability of oxytocics and anti-convulsants were reported. The gains made at midterm in the availability of oxytocics were maintained –with close to a 100% of facilities reporting availability. That of the anticonvulsants dropped but not to previously low levels reported at baseline. Facilities reporting on antibiotics did not change at endline (Table 25).

The percentage of facilities where a midwife can perform manual removal of the placenta also showed a considerable increase between baseline and endline (65% vs 80.3%) (Table 25). This encouraging performance could largely be attributable to the over 300 midwives supported by QHP in LSS training. Skill provision in the use of the vacuum extractor at the health centre level continued to be low over time. By endline, less than 30% of health centres had providers with skills in vacuum extraction. The overall performance in facilities that had all items for BEOC was also low-less than 15% over time. For performance of BEOC at the health centre and hospital levels, check details in Tables E and F in the Appendix.

Table 25: Availability of BEOC items in Health Centres

Indicator	Baseline	Midterm	Endline
% of facilities with drugs available			
Parenteral antibiotic	65.5	65.1	62.1
Parenteral oxytocics	7.3	98.4	97.0
Parenteral anti-convulsants	0.8	84.5	58.6
% of facilities that can perform or use			
Manual removal of retained placenta	65.1	69.8	80.3
Vacuum extractor	6.6	25.6	29.3
Number (N)	122	126	132

Comprehensive Emergency Obstetric Care (CEOOC) which comprises the components of BEOC in addition to blood transfusion and ability to perform a caesarean section operation – did not change appreciably in the target hospitals since the baseline assessment. Over half (57.4%) of hospitals meet the criteria for CEOOC including most Regional hospitals and a little less than half (46.3%) of District hospitals (Table 26).

Table 26 Availability of CEOC in Hospitals

Type of Facility	% of facilities that have all items for BEOC			% of facilities that can perform c-sections			% of facilities that can perform blood transfusion			% of facilities that have all items for CEOC		
	Base line	Mid term	End line	Base line	Mid term	End line	Base line	Mid term	End line	Base line	Mid term	End line
Regional Hospitals	71.4	85.7	66.7	100	100	100	100	100	100	71.4	86	67
District / Mission Hospitals	44.4	48.3	48.6	92.3	89.7	72.2	88.5	93	80.6	44.4	43	46
Totals Baseline(n=36) Midterm (n=43) Endline (n=43)	50	55.6	51.2	93.8	91.7	76.3	90.9	95	83.7	50.0	51.4	48.8

Endline results show a reduction in performance on all the indicators measuring CEOC. There was a decline for instance in the proportion of facilities that have all items for BEOC, that can perform caesarean sessions and give blood transfusion. One regional hospital at midterm and two at endline (Central and Ashanti regional hospitals) did not have parenteral antibiotics in their delivery units hence they did not meet the CEOC criteria. For District hospitals a combination of three factors influenced the low level of BEOC attainment, the non availability of magnesium sulphate, the non availability of a trained provider to perform a manual removal of a placenta, or to do a vacuum extraction and these contributed to the lower achievement of CEOC (Table G in the Appendix).

BEOC and CEOC – Key Findings

- Health centres that meet all the criteria for BEOC continue to be low-from 0% at baseline to 11% at endline.
- Two regional hospitals lacked antibiotics at the delivery units –hence did not meet the CEOC criteria.
- Only about half of all hospitals meet the criteria for CEOC. The main constraints for hospitals are the non availability of staff to perform a manual removal of a placenta and/or a vacuum extraction.

Ante-Natal Care

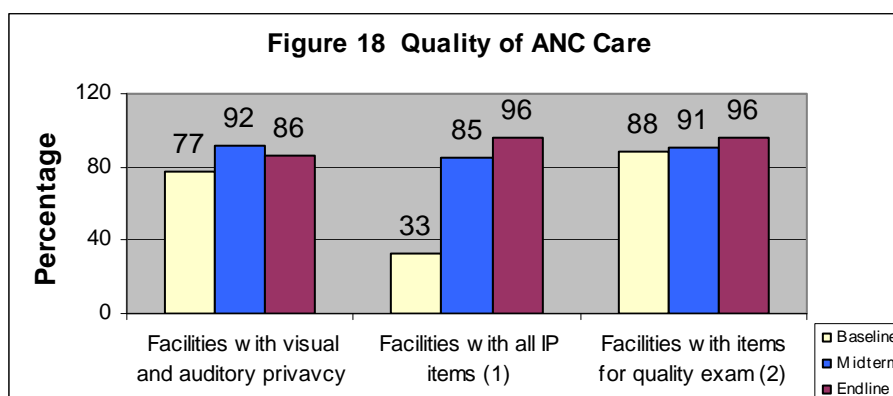
Capacity Building: Since the Ghana Health Service adopted the focused-ANC as a strategy in the provision of a comprehensive care to pregnant women, efforts have concentrated on how to roll out the strategy to facilities in the periphery. As part of its work to complement efforts of government in the area on MCH programme improvement, QHP supported training for more than 500 providers (includes those trained on-the-job) in focused ANC and also provided technical assistance and supervisory support. The midterm and endline assessments sought to ascertain whether focused ANC had become institutionalized and operational at the facility level. About 72% of facilities at endline as against 84.3% at midterm reported that they are implementing focused ANC. The drop may be due to a stricter definition of Focus-ANC applied at endline. The drop signifies the need for facility management to sustain the operationalisation of the practice in their facilities.

Tools developed by QHP in collaboration with the GHS to facilitate on-the-job training and in-depth supervision (IDS/OJT) were also used to improve the skills levels of providers at the ANC units of the facilities –particularly when monitoring visits by QHP technical staff in 2006 showed fewer providers at ANC receiving supervision from the District and Regional level. Providers in the ANC units had fairly good access to in-service training with more than three quarters (75.5%) of them at both midterm and endline meeting the GHS minimum criteria of receiving training once every three years (Table 27).

Table 27 In-service Training and Supportive Supervision in ANC Unit

Indicator	Midterm	Endline
% of ANC providers supervised in last six months	69.5 (n=174)	91.4 (n=186)
% of ANC providers who received in-service training in the last three years.	75.5(n=155)	88.6 (n=184)

Basic Measures of ANC Quality. QHP examined the quality of ANC service provided to clients focusing on three basic areas, namely; client access to privacy, the availability of all infection prevention measures and the availability of basic equipment in the consulting rooms. Results show significant improvements in all the areas over time with the greatest improvement occurring in the area of infection prevention where the availability of infection prevention items in facilities tripled between the period of the baseline and endline (33% vs 96%). (Figure 18 – details available in Table H in the Appendix).



¹ Infection-prevention items assessed were clean gloves, soap and water and a sharps container.

² Functioning blood pressure apparatus, foetal stethoscope.

Comprehensiveness of ANC Services: To assess the comprehensiveness of services at the ANC, providers were asked at midterm and endline (unprompted) to mention key topics discussed or services offered at the ANC clinic on routine basis. While this measure may understate the actual menu of the services provided, it gives an indication of services that are most often provided at ANC. The results at the endline mirror the pattern found at midterm. In addition to that, moderate increases are observed in all areas assessed at endline. While providers mentioned most of the key topics more than 60% of the time at both midterm and endline, family planning continued to lag behind – indicating that ANC providers give insufficient attention to family planning during ANC service provision (Table 28). See Table I in Appendix for details.

Table 28 Comprehensiveness of ANC Services

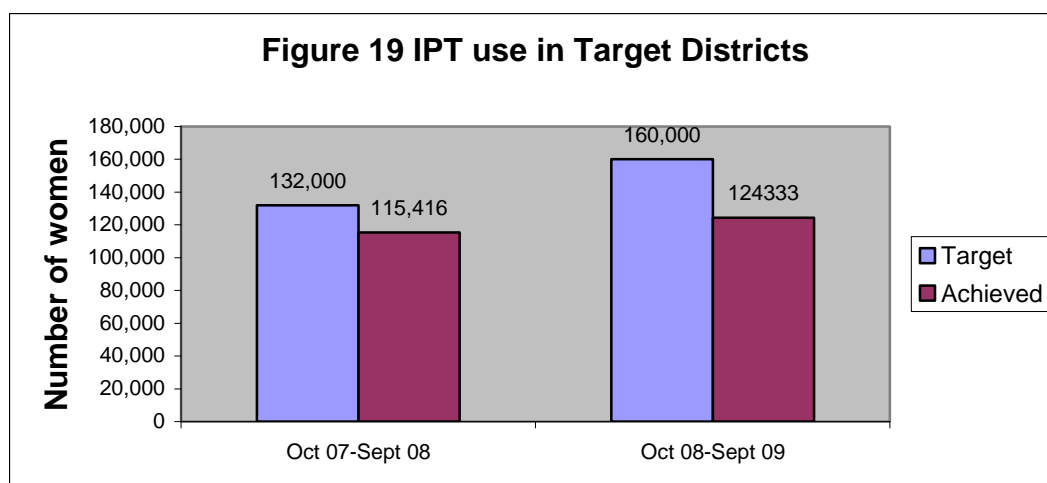
% of providers' who mentioned (unprompted) services offered at the ANC clinic	Midterm (N=175)	Endline (N=186)
TT vaccine	62.3	66.1
SP for IPT	84.5	88.7
Family Planning	42.5	44.3
Birth preparedness	77.1	74.2
Information on ITN or sale of ITN	64.4	66.3

ANC drugs. The availability of iron or folic acid and sulfadoxine/pyrimethamine (SP) in the ANC units was assessed and findings show that shortages of both drugs occurred in the target facilities three months prior to each of the assessments. Whereas continuous availability of SP improved over the period, that of iron or folic acid worsened. While it is good to note that SP stocks improved across all facility levels (particularly in the regional hospitals), the shortages of SP in more than a quarter of facilities surveyed in the Ashanti and the Brong Ahafo regions raise concerns (Table 29). Reasons for these shortages were however not investigated. While this measure considers short term availability of the drugs it does not reflect what occurred prior to the three month period as some facilities may have replenished run-out stock just before then.

Table 29 Shortages of key ANC drugs in the past three months

	% of facilities shortage iron or folic		% of facilities shortage of SP	
Type of Facility	Midterm	Endline	Midterm	Endline
Regional Hospitals	28.6	14.3	28.6	14.3
District/Mission Hospitals	6.9	11.1	20.7	19.4
Health Centres/Other	5.8	9.3	17.3	14.1
Region				
Ashanti	4.5	25.0	9.1	29.2
Brong Ahafo	9.1	25.0	9.1	25.0
Central	5.6	9.0	26.8	14.7
Eastern	10.0	9.1	20.0	9.1
Greater Accra	16.7	0.0	16.7	0.0
Volta	7.7	2.9	15.4	2.9
Western	6.9	6.1	10.3	21.2
Totals	6.9 (n=172)	9.8 (185)	18.3 (n=175)	15.1 (n=185)

IPT (Malaria in Pregnancy). The 2005 malaria drug policy, of the GHS requires the practice of intermittent preventive treatment (IPT) of malaria in pregnancy by the provision of three treatments with sulfadoxine-pyrimethamine (SP) starting after 16 weeks. QHP supported the development of the training manual on SP and trained providers on how to administer the SP. QHP has since 2007 collected monitoring data on the number of pregnant women who received IPT services, the data are presented in Figure 19. Although targets were not met, it is clear that the number of women who had a first dose of IPT increased. QHP targets on IPT for the current year were contingent on the expansion of activities to cover 10 additional districts to bring the number of districts from 30 (old districts before the subdivisions) to 40 districts but this could not be fully completed due to delays in revision of the malaria treatment policy.



QHP also assessed IPT use during the midterm and endline assessments and the endline results show that 68% of pregnant women received the first dose of IPT- an improvement over the 62.5% reported at midterm (Table 30). Treatment is often not completed and at endline only 46.9% and 29.8% received IPT2 and IPT3 respectively. Reasons given in the midterm report that women come for their first ANC visit late in the pregnancy and therefore unable to complete the full course before delivery continue to apply.

Table 30 Percentage of ANC Attendees who received IPT, January – March 2009

Month	ANC Registrants	ANC Attendance	IPT1	IPT2	IPT3
Jan 2009	15,952	49,283	10,201	6,629	4,188
Feb 2009	11,559	48,892	8,622	5,974	3,816
Mar 2009	11,550	51,839	7,700	5,741	3,664
Totals	39,061	150,014	26,523	18,344	11,668
Percentage Receiving IPT			67.9%	46.9%	29.8%

Ante-Natal Care – Key Findings

- Increased proportions of facilities are offering focused-ANC –but there is still need for attention in that area as a slight decline was observed between midterm and endline on proportions of facilities adhering to the standards.
- There has been significant improvement in infection prevention measures in the ANC units.
- Increased proportions of ANC providers continue to cover important counselling topics with clients – but there is need to capitalize on the opportunity also to discuss family planning.
- Few shortages in iron and SP occurred. However stock levels in Ashanti and Brong Ahafo regions on both drugs need improvement.
- In-service training and supervision for providers at the ANC units improved significantly with more than 4 in every 5 providers benefitting.
- The percentage of pregnant women who received at least one dose of IPT improved from 65% at midterm to 67.9% at endline although continuous attention is required to ensure that clients benefit from the two subsequent doses for maximized benefit.

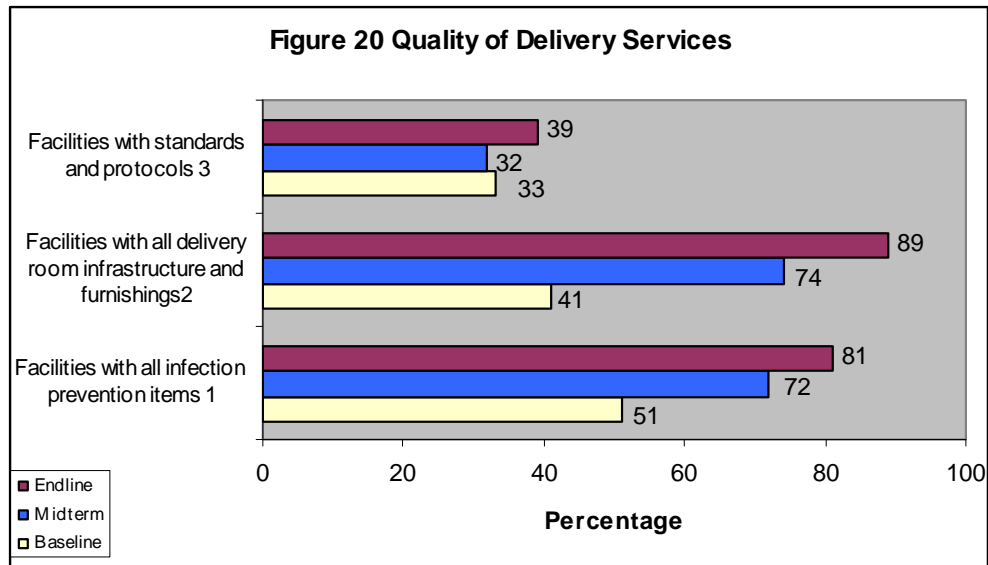
Delivery Care

Training and Supervision. Following the baseline assessment, QHP focused on supporting life saving skills (LSS) training for midwives in the target facilities and supplementing this training with cross-cutting quality improvement training in infection prevention, facilitative supervision and quality assurance. QHP also monitored the quality of delivery services, helped facilities develop action plans for addressing identified gaps and provided technical assistance to improve quality of services. Together with the GHS, QHP integrated and intensified on-the-job- training and in-depth supervision activities in the last two years of operation. These activities seem to have paid off considering the number of providers in the delivery units who reported having benefited from external supervision and in-service trainings. For instance 86% as against 54% reported external supervision and 92% as against 70% reported on-the job training at endline and midterm respectively (Table 31).

Table 31 Supportive Supervision in the Delivery Unit

	% of facilities supervised in last 6 months		% of providers trained in last three years)	
	Midterm	Endline	Midterm	Endline
Type of Facility				
Regional Hospitals	57.1	100.0	66.7	85.7
District/Mission Hospitals	86.7	88.9	72.4	88.9
Health Centres/Other	46.2	84.1	69.7	93.2
Totals	53.9 (n=167)	85.7 (n=175)	70.1 (n=157)	92.0 (n=176)

Quality of Delivery Services. Three key indicators were used here by QHP in measuring quality of delivery services and these are: availability of standards and protocols, availability of delivery room infrastructure and furniture and availability of infection prevention items. In all three areas significant improvements were made over the five year span of QHP. Facilities with the availability of all infection prevention items in delivery units increased from 51.0% at baseline to 81% at endline. Facilities with availability of infrastructure and furnishings more than doubled (from 41% at baseline to 89% at endline). However, little change occurred in respect of availability of protocols and standards (especially the national reproductive health protocol) across the three assessment periods (Figure 20). A recurrent problem has been observed with providers or supervisors treating these documents as their personnel property rather than belonging to the facility so that when providers or supervisors are transferred or retire, key documents may go with them. Details of regional and facility type results are given in Table J in the Appendix.



¹ Soap, water, single use towel, sharps container, gloves and decontamination solution.

² Visual and auditory privacy, BP cuff, delivery tray

³ Partographs and National Reproductive Health Protocol

Medications for Delivery. To avoid delays in deliveries as well as to increase quality care to women in labour, the standard practice prescribed by the GHS for delivery care is to have on hand at the delivery unit all necessary drugs. QHP technical staff over the period monitored the availability of these drugs in the delivery units and acted together with the districts and regions to address shortcomings identified. At midterm and endline QHP sought to assess the availability of these key drugs within the delivery unit. Overall, most facilities had the drugs available in the delivery unit, with an especially high percentage of facilities (98%) having an oxytocic drug – key in the management of the third stage of labour. Improvements in drug availability took place with respect to valium (82% to 87%), and magnesium sulphate injection (47% to 65%). This notwithstanding, emphasis still has to be put on further improving the availability and use of magnesium sulfate to manage eclampsia, especially at the health centre level, where there is capacity as midwives by the standard practice could identify eclampsia, give first aid and refer to a hospital. Other key drugs such as ergometrine injections, IV infusions also continue to be highly available. The only key drug that showed a drop is vitamin K and more needs also to be done to ensure its availability at all times (Table 32). See Table K in the Appendix for details.

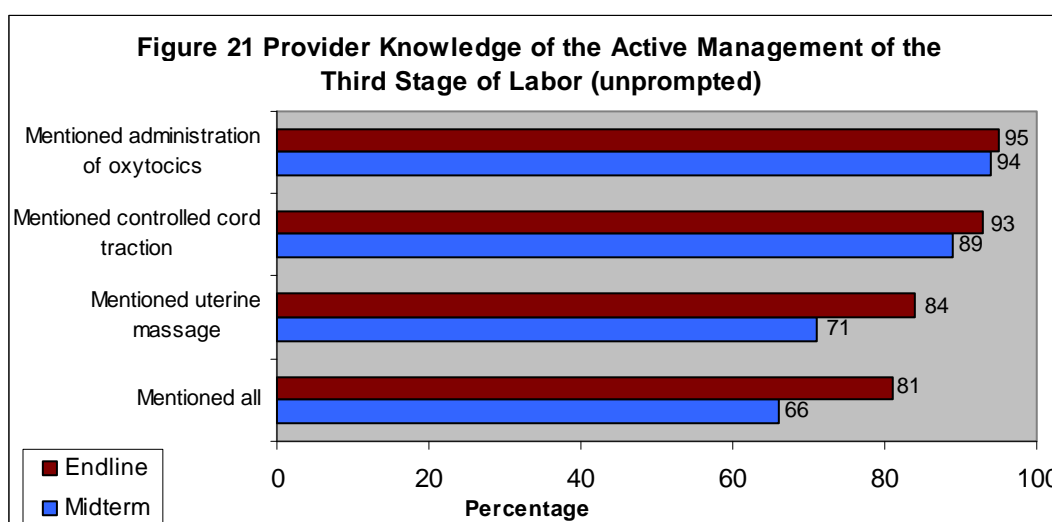
Emergency Packs. According to GHS standards, all delivery units should have handy pre-packaged emergency trays in delivery units to ensure the ready availability of required drugs, supplies and equipment a provider needs to manage an emergency. QHP technical staff in collaboration with their GHS counterparts monitored the availability of emergency packs in delivery areas in the facilities. Actions plans were developed to ensure that places which did not have them were assisted to have them in place. Considerable improvement is noted when endline results are viewed against that of the midterm. Improvements occurred in facilities that had an emergency pack for post-partum haemorrhage (56.4% vs 88.5%) and emergency packs for eclampsia (50.3% vs 73.4%). More than seven in ten hospitals (74.2% vs 71.4%) continued to

have an emergency pack for caesarean sections (Table 32) See Table L in the Appendix for details.

Table 32 Availability of Emergency Packs in the Delivery Units

Availability of	Midterm	Endline
Emergency Pack for Post-partum Haemorrhage	56.4 (n=163)	88.5 (n=176)
Emergency Pack for Eclampsia	50.3 (n=161)	73.4 (n=176)
Emergency Pack for Caesarean Sections (Hospitals Only)	74.2 (n=31)	71.4 (n=42)

Active Management of the Third Stage of Labour (AMTSL). The assessment sought providers knowledge on the key steps of the active management of the third stage of labour considering their importance to good delivery outcomes. At midterm, 65.5% of providers mentioned all three steps in the active management of the third stage, unprompted. By the endline the figure rose to 80.7% giving a 16% point increase in the proportion of providers who mentioned all three steps unprompted. Performing controlled cord traction and administering oxytocics featured most prominently on the minds of providers given the higher scores recorded (Figure 21, details available in Table M in the Appendix).



Partograph and Referral Forms. GHS encourages the consistent use of the partograph by providers to monitor pregnancies in order to determine in time any abnormality which might negatively impact on a good pregnancy outcome. This has also been emphasized in QHP supported ANC and LSS trainings.

Results reported at endline (72.7%) show a small improvement over that of the midterm (68.5%) - an indication that more midwives are prioritizing the use of the partographs in their delivery units. In respect of whether providers in the delivery unit are using the referral form to refer cases beyond them to the next level of care, no difference appears

to have occurred in the last two years or between the two periods of assessments (Table 33 and Table N in Appendix for details)

Table 33 Provider Use of Partographs and Referral Forms

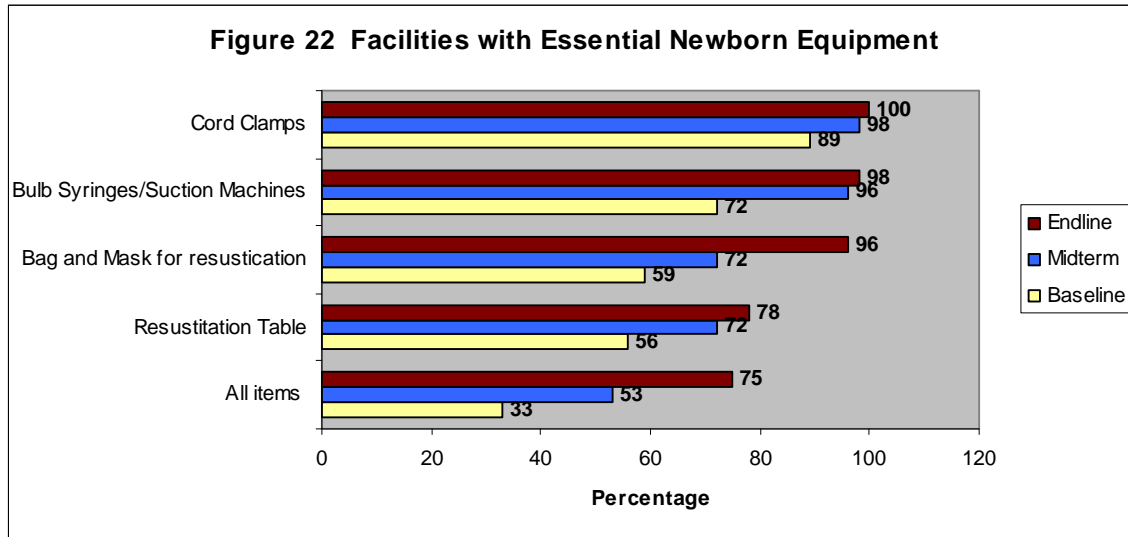
Indicator	Midterm	Endline
Provider consistently uses partographs (evidence seen)	68.5 (n=153)	72.7 (n=176)
Provider uses a standard referral note for next level of care	71.3 (n=160)	69.9 n=176)

Delivery Care – Key Findings

- Infection prevention practices have consistently improved since baseline.
- Considerable improvements have occurred in the proportion of facilities that have all delivery room infrastructure and furnishings (i.e. visual and auditory privacy, BP cuff and delivery tray).
- There is a considerable improvement in proportion of providers who have knowledge of the three key steps in the active management of the third stage of labour – A two times increase over the project lifespan.
- The availability of key drugs for managing labour – especially oxytocics continues to be high.
- Close to 90% of facilities have emergency packs in place- an indication of their high level of readiness to manage emergency situations.
- 73% of facilities are consistently using the partograph – however district hospitals and health centres need to increase adherence of its use.
- A high proportion of providers in the delivery unit benefited from supervision (86%) and in-service training (92%) which should impact positively on quality of care.
- Only 40% facilities have copies of the national reproductive health protocol for reference.

Availability of Quality Neonatal Care Practices

Basic Equipment for Newborn Care. The availability of basic equipment to care for newborns including a paediatric bag and mask for resuscitation, resuscitation tables, suction machines/bulbs and cord clamps have all increased significantly since baseline. The improvement is especially noticeable at the health centre level (see Figure 22 and details in Table O in Appendix).



Newborn Care Practices. The quality of newborn health care was assessed using two measures; namely providers who routinely suction airways of a newborn and providers who bath the newborn only after six hours (to maintain warmth). The significant increase observed at midterm in the percentage of providers at facilities who reported routine suction (from 50.7% at baseline to 99.4% at midterm) was maintained at endline. Steady improvement was also recorded in the already high percentage of providers who bath the newborn after six hours- from 84% to 92% to 94% at baseline, midterm and endline respectively (Table 34).

Table 34 Routine Newborn Care Practices by Facility Type and Region

Type of Facility	% of facilities that suction airways of newborn			% of facilities that provide immersion bath after 6 hours		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Regional Hospitals	57.1	100.0	100.0	85.7	100.0	100.0
District/Mission/Hospitals	44.4	100.0	100.0	85.2	86.2	91.7
Health Centres/Other	51.9	99.2	98.4	83.5	92.9	94.5
Regions						
Ashanti	68.4	95.4	100.0	100.0	95.0	95.7
Brong Ahafo	50.0	100.0	100.0	100.0	80.0	100.0
Central	31.0	100.0	97.0	66.7	98.5	100.0
Eastern	44.4	100.0	100.0	66.7	98.5	100.0
Greater Accra	40.0	100.0	100.0	100.0	83.3	100.0
Volta	95.7	100.0	100.0	95.7	100.0	89.3
Western	45.0	100.0	100.0	100.0	75.0	80.6
Total	50.7 (n=142)	99.4 (n=166)	98.8 (n=172)	83.9 (n=143)	92.0 (n=163)	94.2 (n=172)

Newborn Care in First Six Hours. Providers were asked to describe (unprompted) the key activities for care of the newborn in the first six hours. The most commonly mentioned care activities were maintaining warmth (95.4%), early breastfeeding (89.0%) and cord care (88.4%). Other areas of care, such as the use of APGAR score, eye care and resuscitation of babies were equally mentioned by over 75% of providers. Offering of vitamin K injections was the least mentioned (56.6%). Indeed with the exception of the vitamin K injection, responses on all other care practices show improvements (Table 35).

Table 35 Providers Knowledge of Routine Newborn Care Practices

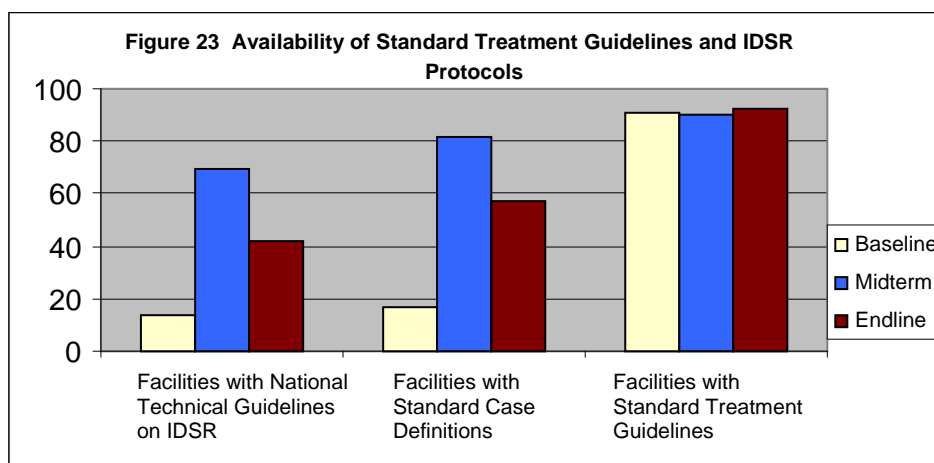
	% of providers mentioning other newborn care practices : UNPROMPTED Multiple response possible													
	APGAR score		Maintain warmth		Cord Care		Eye Care		Resuscit. of babies		Early BF		Vitamin K injection	
Type of Facility														
	Mid	End	Mid	End	Mid	End	Mid	End	Mid	End	Mid	End	Mid	End
Regional Hospitals	85.7	57.1	100	100	100	100	85.7	71.4	100	100	100	100	71.4	57.1
District/Mission/Hospitals	80.0	77.8	90.0	94.4	79.3	91.7	69.0	74.3	71.4	91.7	86.7	86.1	76.7	55.6
Health Centres/Other	70.0	76.9	90.1	95.4	84.5	86.8	64.6	76.0	65.6	72.9	88.5	89.2	62.3	56.9
Totals Midterm (n=168) Endline (n=173)	72.5	76.3	90.5	95.4	84.2	88.4	66.3	75.4	68.1	77.9	88.7	89.0	65.3	56.6

Integrated Disease Surveillance and Response (IDSR) Services

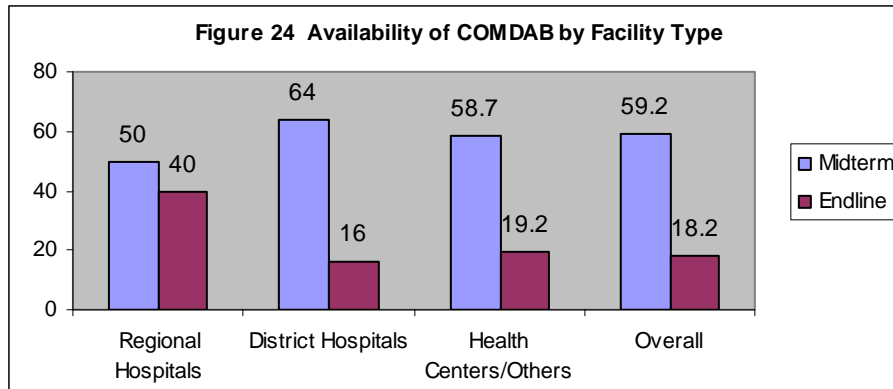
A good national disease surveillance system is useful for identifying cases of priority diseases and forestalling disease outbreaks. The effectiveness of the system is to a large extent dependent on the collection, analysis and use of surveillance data for decision making. As part of efforts to strengthen the national system, QHP in the first half of its work provided support in the review, printing and dissemination of IDSR standards, guidelines and reporting forms. Among these were the Communicable Disease Analysis Book (COMDAB), the National Technical Guidelines and the Community Based Surveillance registers.

IDSR Capacity Building. As part of capacity building efforts, QHP supported training of different cadres of GHS staff, particularly those involved in disease surveillance and control in all its seven regions of operation. Between 2005 and 2007, QHP trained a total of 1012 health staff in IDSR by improving their knowledge and skills in identification and surveillance of priority diseases and in related data processing, analysis and use.

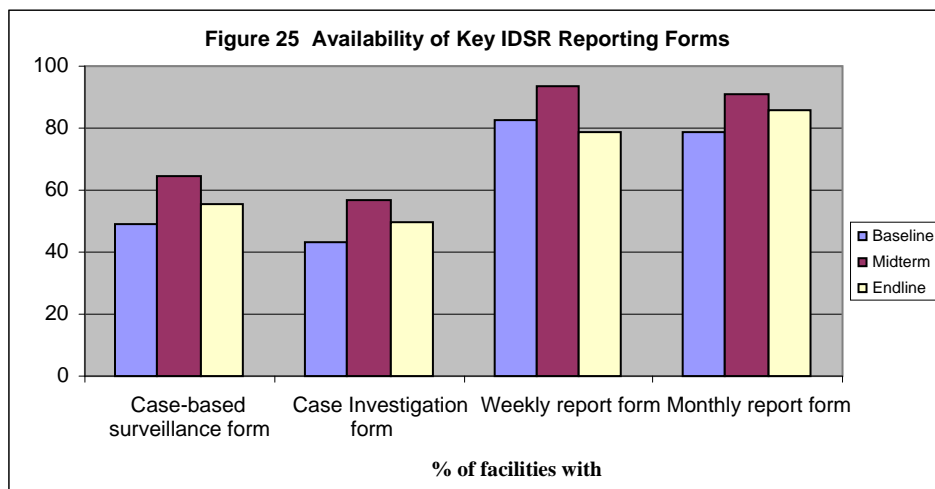
IDSR Standards, Guidelines and other Materials. In all three assessments QHP sought to ascertain the availability of guidelines in the facilities. Compared to midterm, findings from the endline assessment show decreases in the availability of the key standards and guidelines for IDSR, for instance in the availability of National Technical Guidelines (69.8% to 49.5%), Standard Case Definitions (82.0% to 51.3%), and Standard Treatment guidelines (89.9% to 92%) (Figure 23). It is encouraging to note however that some of the gains attained during the midterm period have been maintained- this is because in almost all cases, a higher proportion of facilities at endline than at baseline reported having the standards and guidelines. See Table P in Appendix for details.



Results show a decline in the use of the COMDAB (59.2% to 19.2%) which occurred across all facility levels with the greatest decline occurring at the district hospital level. The regional hospital reported the least decline in the availability of the COMDAB (Figure 24).



Report Forms. The availability of IDSR reporting forms in the facilities also decreased at endline. Decreases between midterm and endline are observed in the proportions of facilities with the case-based surveillance form (64.7% vs 55.7%), case investigation form (56.5% vs 49.7%), weekly reporting form (93.6% vs 78.9%) and monthly reporting form (90.7 vs 85.9%). An increase in performance is nevertheless observed when endline and baseline results are compared showing at least that some of the improvements achieved at midterm have been maintained (Figure 25). The decreases in performance at endline are likely due to the early discontinuation of QHP’s support for IDSR activities related to some shifts in project focus from 2008 forward.



Quality of Disease Surveillance Reporting. In all three assessments, monthly and weekly IDSR reports from each facility were reviewed to assess whether they were available and filled in correctly. While at midterm more monthly than weekly reports were completed, the reverse is seen at endline. The proportion of facilities with completed weekly reports increased from 60.6% to 80.1% between midterm and endline. Monthly reporting however, showed a decline from 77.4% at midterm to 60.1% at endline. At regional level it would be observed that while Volta region did well in completing the weekly forms (94.9%), it also recorded the poorest performance as far as the completion of the monthly forms was concerned (30.8%) (Table 36). About 76% of

the RHMT and DHMTs reported maintaining check sheets or records on timeliness of the weekly and monthly surveillance returns from the facility level.

Table 36 Completeness of Reports in Health Facilities

	% of facilities with Weekly Reports Completely* Filled Out in the Past Three Months			% of facilities with Monthly Reports Completely Filled Out in the Past Three Months		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Type of Facility						
Regional Hospitals	14.3	80.0	60.0	14.3	80.0	60.0
District/Mission Hospitals	32.1	75.0	83.9	35.7	78.3	64.5
Health Centres/Other	18.9	57.4	81.1	36.9	77.2	59.2
Region						
Ashanti	15.8	62.5	92.0	0.0	69.6	92.0
Brong Ahafo	37.5	83.3	81.8	50.0	75.0	81.8
Central	26.7	48.3	70.5	48.3	73.2	60.7
Eastern	27.3	66.7	72.7	45.5	100.0	90.9
Greater Accra	0.0	20.0	66.7	0.0	66.7	50.0
Volta	21.9	84.2	94.9	34.4	86.6	30.8
Western	4.5	43.5	80.6	31.8	77.3	53.3
Totals	21.0 (n=157)	60.6 (n=165)	81.0 (n=184)	35.7 (n=157)	77.4 (n=164)	60.1 (n=183)

*Completely means 80% or more of the reports were filled in correctly and were available for review.

Data for Decision Making. The assessment also sought to determine whether facilities had any analysis of their demographic and malaria data posted or displayed for review. Results show that the proportion of facilities that had demographic data displayed increased consistently from baseline through to endline - giving a total of 37.1% increase from between baseline and endline (24.6% to 61.7%). Similar to the guidelines and reporting formats, overall proportion of facilities with graphs on malaria trends decreased from a midterm figure of 30.9% to 21.7% at endline. Overall, very minimal improvement seem to have occurred in facilities in the display of malaria trends over time, an indication of sub-optimal use of disease surveillance data in decision making. The increased proportions of facilities with demographic data displayed may be viewed in light of the fairly invariable nature of that data which therefore do not require regular updates as with the case of malaria statistics (Table 37).

Table 37 Use of surveillance data in Health Facilities Type of Facility

	% of facilities where demographic data are displayed			% of facilities with a graph of malaria trends current to latest month		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Type of Facility						
Regional Hospitals	20.0	50.0	80.0	20.0	16.7	40.0
District/Mission Hospitals	16.0	26.1	45.2	24.0	36.0	19.4
Health Centres/Other	26.8	43.1	64.6	15.2	30.6	21.6
Region						
Ashanti	10.5	9.1	52.0	0.0	43.5	16.0
Brong Ahafo	57.1	83.3	72.7	71.4	75.0	36.4
Central	34.0	57.6	57.4	26.4	21.7	23.0
Eastern	0.0	87.5	90.9	16.7	87.5	45.5
Greater Accra	0.0	83.3	100.0	0.0	16.7	16.7
Volta	33.3	28.2	71.7	13.3	23.1	20.5
Western	4.5	7.4	45.2	0.0	18.5	12.9
Totals	24.6 (n=142)	41.0 (n=173)	61.7 (n=183)	16.9 (n=142)	30.9 (n=175)	21.7 (n=183)

At the RHMT/DHMT levels, seventeen districts reported disease outbreaks in the last 12 months at midterm and at the endline five districts reported. The decline in the proportions of districts reporting a disease outbreak in the last 12 months could partially be attributable to the QHP/GHS IDSR strengthening activities. At midterm all cases (100%) of these outbreaks were investigated and reports written; at endline 83.3% of the cases were investigated. While the high proportion of cases investigated gives an indication that surveillance data at the higher levels of the health system are effectively used, it is important that at all times diseases outbreaks be investigated (Table 38).

Table 38 Management of Disease Outbreaks at the Regional and District Level

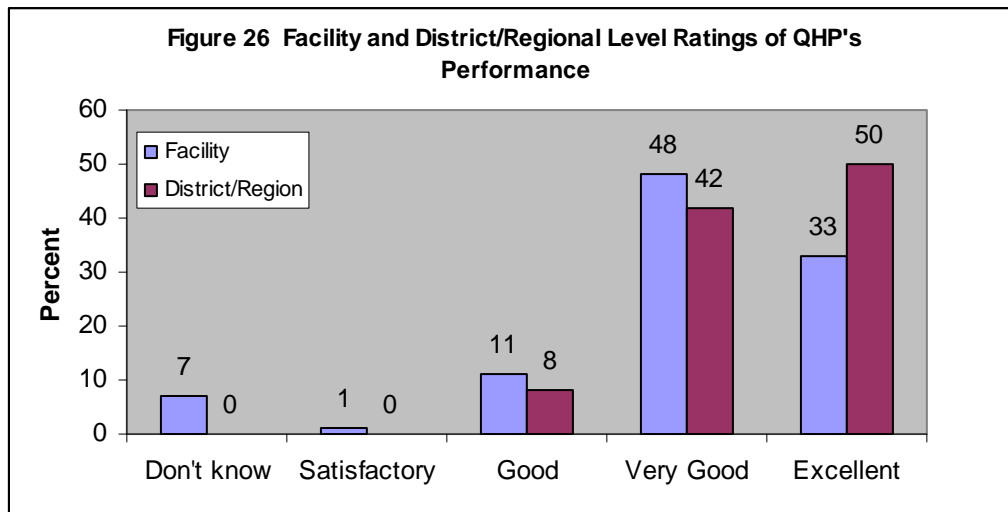
	% of Regions or Districts experiencing a disease outbreak in last 12 months		% of Regions or Districts that wrote a report on the outbreak	
	Baseline	Endline	Baseline	Endline
Totals	48.4 (n=36)	13.5 (n=37)	100.0 (n=14)	83.3 (n=5)

IDSR – Key Findings

- Increases were maintained in endline over baseline results on the availability of standards, guidelines and reporting forms related to IDSR across almost all levels of facility.
- Surveillance reporting declined as little change occurred between baseline and endline –an indication of sub optimal use of surveillance data for decision making particularly at the district level.
- Good adherence to the practice of completing weekly reports has been maintained.
- In almost all cases disease outbreaks that were reported in the Regions and Districts were investigated and reports were written.

Rating of QHP Performance

Heads of facilities and Regional/District Health Management Teams were asked to rate on a scale of 1 to 5 the overall performance of QHP in supporting health care services in their facilities and districts (Figure 26). Overall, 81% of facility heads and 83% of Regional/District Heads of Health Services rated QHP's performance as very good or excellent. Positive observations that these heads noted as reasons for their ratings are the staff capacity building activities in all service areas that QHP supported as well as documents and equipment that were provided in support of services. Most of the challenges they noted were beyond QHP's capacity to address and these included inadequate service providers and support staff for some facilities. A few noted that they had no provider trained in IMCI. QHP planned to train qualified providers in all facilities that provided care for sick children, but there were two main limitations. First, some trained staff were transferred to areas outside of QHP districts and secondly, the process for reviewing the new IMCI curriculum took quite a long time causing planned trainings to be delayed- but Trainers were later trained and GHS would do well to make use of these to downstream trainings to all such providers.



Recommendations

Human Resources

1. Close to 50% of all providers in facilities have a job description (that they hold) and this ought to be strengthened as it provides clear guidance to staff on their job expectations
2. The GHS should ensure an equitable system of accountability within the Service where promotions are based on staff performance appraisals that are carried out at least once in a year. In view of this the improved staff performance appraisal process should be further scaled up through orientations and provision of guidelines and forms, to effectively conduct performance appraisals among their supervisees. In the Central region where the system was introduced, supervisors are increasingly carrying out performance appraisals with staff, with positive feedback from both supervisors and staff.

Quality Assurance

3. District and Regional technical teams need to follow up with QA teams in health care facilities to ensure that they are fully functional and have action plans. To ensure that the action plan items are implemented during monitoring visits. Regions and Districts should also make efforts to measure the number of problems addressed by the QA team.
4. Facilities should be encouraged to hold periodic management meetings to identify and address quality assurance issues among other things. Currently 60% of facilities hold regular management meetings.
5. The In-Depth Supervision and On-the-Job Training (IDS/OJT) concept and tools for MNH, IMCI and FP should continue to be scaled up based on the very promising results thus far in the 37 target districts.

Referral Systems

6. More than 70% of providers are using a standard referral note to send a patient to the next level of care even though only 35% of facilities have the national referral guidelines. The ICD unit of the GHS should liaise with the regions and districts to ensure wider distribution and availability of the Referral Policy and Guidelines in the facilities, while all facilities are encouraged to use the standard referral forms.

Infection Prevention

7. Infection prevention practices overall saw a significant improvement in all areas of service provision. However, the GHS/RCH needs to pay more attention to infection prevention practices in the family planning units that perform invasive procedures on the correct use of and dilution ratio for decontamination solution.

Child Health Services

8. Regional and District technical teams need to ensure the sustainability of certain institutionalized best practices in child health care, including the following that were found to be almost universally implemented: growth monitoring before consultations; routine sponging and giving of paracetamol as a way of managing

children with fever and the practice of supervisors providing follow-up on all IMCI trained personnel.

9. GHS must maintain and improve upon the increased numbers of providers who are correctly assessing danger signs in children presenting with fever and diarrhoea. This is important to avoid missing opportunities in identifying latent symptoms that could be life threatening. Doctors and midwives providing treatment for sick children need particular attention since they less frequently assess all danger signs in sick children.
10. The culture of documentation needs strengthening as Provider's use of the child's health card continues to be low. Providers should be encouraged to record child weight as well as all key findings in the child health record book as this provides a good history for monitoring the child's growth and health.
11. Close to a quarter of facilities lack essential equipment such as functioning infant and child weighing scales, minute timer and thermometer and jars for ORS. District and Facility management should ensure the availability of such items in all facilities.
12. Job aids are infrequently used in providing information during child care. There is need for the availability of job aids in the facilities to facilitate easy understanding of information among caregivers. A malaria job aid that has been in process for some time should be completed, reproduced and widely distributed.
13. About 20% of providers treating sick children have no training in IMCI. The Regions and Districts should identify these providers for subsequent IMCI trainings.

Family Planning Services

14. The QHP/GHS family planning campaign initiative started in mid 2008 appears to be making gains as seen in the increase in CYP in 2009. The RCH Unit should collaborate closely with the regions and districts to promote post campaign activities in order to sustain interest generated in FP use. Durbars and radio programmes at the community level could be helpful. In general, a more local approach linking supply, demand and advocacy seems to hold promise for increasing achievement in CYP.
15. A total of 61 facilities reported stock out of family planning commodities in the last six months. Norplant and IUD were the most affected. The Districts and facility management need to monitor stock levels of facilities more closely to avoid stock-outs and to improve availability of a full range of methods that any facility is expected to offer.
16. Almost all facilities discuss family planning options with new clients and this practice should be maintained. However, in about 40% of facilities, providers neither assure clients of confidentiality nor discuss clients' reproductive intentions. Regional and District family planning supervisors need to highlight these areas during supervision visits.

Maternal and Neonatal Health

17. Shortages of SP in one out of four facilities in the Ashanti and Brong Ahafo regions in the past three months need to be investigated further and measures put in place to reduce these shortages.

18. Although close to 75% of pregnant women received first dose of IPT, uptake of the subsequent doses continue to be low. The GHS/NMCP needs to put in place a better system of tracking women to ensure that a larger percentage of expectant mothers receive all three doses as recommended and to strengthen ANC counselling to reinforce the importance of completing the three doses..
19. Although increased proportion of facilities ensure the availability of emergency packs in the delivery units, 40% of all facilities and hospitals lacked emergency packs for eclampsia and caesarean sections respectively. Regional and district supervisors need to pay more attention to ensure that facilities that do deliveries have the required packs in place.
20. Supervision of the delivery units needs to be improved, especially in Ashanti, Volta and Western Regions in BEOC. As noted under QA above, the Regional and District Technical teams should continue the use of the In-Depth Supervision and On-the-Job Training tools to reinforce skills of providers in the delivery units.
21. Close to 30% of facilities do not consistently use partographs and there is need for supervisors to monitor this more closely and hold providers (and themselves) more accountable for its use.
22. About one in every five facilities lack resuscitation tables. The District and Facility management should ensure the availability of these tables (to GHS specification) in the delivery units.

Disease Surveillance

23. There were fewer reports of disease outbreaks in the districts due to highly successful introduction of IDSR in the districts and regions. Active surveillance of diseases should be continually pursued by the Disease Surveillance Unit of the GHS to avoid outbreaks.
24. Gains made in IDSR appear to be gradually declining in some areas following QHP's withdrawal in support after the second year of implementation: 40% of facilities did not complete monthly reports, only 20% of facilities display graphs showing trends in malaria and less than a 100% of districts investigated reported disease outbreak in their districts. Regional surveillance units should be proactive in addressing these identified gaps.

APPENDICES

Table A In-Service training of providers in the last three years

% of providers who report in-service training by topic										
	Child Health		Family Planning		Ante-Natal Care		Delivery		Neo-Natal Health	
	Mid-term	End-line	Mid-term	End-line	Mid-term	End-line	Mid-term	End-line	Mid-term	End-line
Type of Facility										
Regional Hospitals	66.7	57.1	50.0	100.0	85.7	83.3	66.7	85.7	71.4	100.0
District Hospitals	67.9	75.7	59.1	90.0	84.6	83.8	72.4	88.9	63.0	86.1
Health Centres	56.4	81.6	55.0	90.6	73.0	90.1	69.7	93.1	56.9	88.0
Totals	58.3 n=180	79.6 n=196	55.4 n=177	90.9 n=186	75.5 n=155	88.6 n=184	70.1 n=157	92.0 n=174	58.7 n=150	88.1 n=168

Table B Quality Assurance Attributes

	% of facilities with a QA Team			% of Quality Assurance Teams that have an Action Plan			% of facilities have regular mgt meetings at least once per month		
	Base-line	Mid-term	End-line	Base-line	Mid-term	End-line	Base-line	Mid-term	End-line
Regional Hospitals	71.4	100.0	100.0	60.0	100.0	100.0	100.0	85.7	100.0
District/ Mission/ Hospitals	85.7	89.7	70.3	79.2	83.3	57.7	78.6	63.3	78.4
Health Centres/ Other	21.0	42.9	55.2	56.0	54.5	71.4	34.4	52.6	58.1
Ashanti	26.3	21.7	48.0	60.0	60.0	75.0	42.1	69.6	60.0
BAR	25.0	75.0	63.6	100.0	22.2	71.4	75.0	69.2	72.7
Central	52.6	69.4	72.2	66.7	68.0	78.8	48.3	68.1	76.7
Eastern	63.6	80.0	72.7	85.7	100.0	100.0	63.6	90.0	90.0
GAR	0.0	50.0	83.3	-	33.3	100.0	60.0	83.3	83.3
Volta	15.6	34.2	60.0	40.0	91.6	50.0	31.3	17.5	45.0
Western	22.7	37.9	30.3	60.0	40.0	30.0	36.4	41.4	42.0
Totals	35.1 (n=154)	52.1 (n=190)	59.6 (n=198)	66.7 (n=54)	64.9 (n=97)	69.1 (n=117)	45.2 (n=157)	55.4 (n=193)	63.3 (n=199)

Table C Methods of Quality Assurance Used by Type of Facility

% of facilities reporting use of these quality assurance methods															
	Supervisory Checklist Service Components			Supervisory Checklist Service Provision			Mortality Meeting			Survey of Medical Records or Registers			Clinical Conferences or meetings		
	Base line	Mid term	End-line	Base line	Mid term	End-line	Base line	Mid term	End-line	Base line	Mid term	End-line	Base line	Mid term	End-line
Regional Hospitals	14.3	85.7	100.0	14.3	85.7	71.4	42.9	85.7	100.0	42.9	100.0	85.7	71.4	85.7	100.0
District/ Mission Hospitals	39.3	76.6	81.1	32.1	76.6	56.8	39.3	86.6	70.3	25.0	93.3	73.0	39.3	96.5	70.3
Health Centres/ Other	4.1	42.1	61.9	4.9	29.5	42.6	0.8	9.3	9.7	18.0	50.3	71.0	7.4	79.7	49.0
Total	10.8 (n=157)	49.2 (n=189)	66.8 (n=199)	10.2 (n=157)	39.8 (n=189)	46.2 (n=199)	9.6 (n=157)	24.4 (n=188)	24.1 (n=199)	20.4 (n=157)	59.0 (n=188)	71.9 (n=199)	15.9 (n=157)	82.6 n=184)	54.8 (n=199)

Table D Provider knowledge of correct solution strength for decontamination – Family Planning

	Provider in FP unit knew the correct solution strength		Provider in the FP unit knew the correct dilution	
Type of Facility				
	Midterm	Endline	Midterm	Endline
Regional Hospitals	85.7	85.7	83.3	85.7
District/ Mission Hospitals	90.5	79.3	73.7	53.3
Health Centres/ Other	64.6	89.9	47.1	61.5
Region				
Ashanti	75.0	80.0	52.9	60.0
BAR	90.9	100.0	100.0	100.0
Central	60.0	93.0	40.6	73.6
Eastern	70.0	100.0	70.0	90.9
GAR	83.3	100.0	50.0	80.0
Volta	71.4	91.7	68.6	25.0
Western	68.0	68.8	31.8	50.0
Totals	68.6 (n=172)	88.0 (n=184)	52.7 (n=165)	61.1 (n=185)

Table E Availability of BEOC in Health Centres (Baseline and Endline)

Regions	% of facilities had drugs available ²						% of Facilities can perform / use				% of facilities have all items for BEOC (all items in all columns)	
	Parenteral antibiotics		Parenteral oxytocics		Parenteral anti-convulsants		Manual removal of retained placenta		Vacuum extractor ³			
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
Health centres	65.6	62.1	71.3	97.0	0.8	58.6	65.1	80.3	6.6	29.3	0.0	11.3
Ashanti	85.7	47.4	92.9	89.5	0.0	36.8	57.1	57.9	0.0	26.3	0.0	0.0
BAR	100.0	20.0	83.3	100.0	0.0	100.0	83.3	100.0	16.7	100.0	0.0	20.0
Central	55.3	73.2	55.3	100.0	0.0	91.2	61.4	94.6	8.5	33.3	0.0	21.0
Eastern	87.5	100.0	87.5	100.0	12.5	87.5	100.0	100.0	12.5	12.3	0.0	0.0
GAR ¹	50.0	80.0	100.0	100.0	0.0	40.0	50.0	80.0	0.0	20.0	0.0	20.0
Volta	57.7	26.3	61.5	94.7	0.0	10.5	50.0	36.8	3.8	5.3	0.0	0.0
Western	70.6	70.0	94.1	95.0	0.0	15.0	81.3	90.0	5.9	35.0	0.0	5.0
Totals	65.6 n=122	62.1 n=312	71.3 n=122	97.0 n=312	0.8 n=122	58.6 n=312	65.1 n=109	80.3 n=312	6.6 n=122	29.3 n=312	0.0 n=122	11.3 n=312

¹ A high number of zeros here is due to the low number of facilities sampled (n=5).

² At baseline the availability of antibiotics and anti-convulsants was assessed at the pharmacy level. At midterm the availability of all three drugs was assessed in the delivery unit on the day of the assessment.

³ At baseline whether a facility had a functioning piece of equipment was assessed. At midterm whether the facility had a provider who could perform a vacuum extraction was assessed. So these measures are not directly comparable.

Table F Availability of BEOC at Hospitals

	% of facilities had drugs available						% of Facilities can perform / use				% of facilities have all items for BEOC (all items in all columns)	
	Parent-eral antibiotics		Parenteral oxytocics		Parenteral anti-convulsants		Manual removal of retained placenta		Vacuum extractor			
	MT	EL	MT	EL	MT	EL	MT	EL	MT	EL	MT	EL
Type of Facility												
Regional Hospitals	85.7	66.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	85.7	66.7
District/ Mission Hosp	86.2	97.1	100.0	100.0	96.6	80.6	79.3	88.9	62.1	63.9	48.3	48.6
Region												
Ashanti	60.0	80.0	100.0	100.0	100.0	100.0	80.0	100.0	60.0	80.0	60.0	60.0
BAR	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Central	92.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0	61.5	75.0	53.8	72.7
Eastern	50.0	50.0	100.0	100.0	100.0	100.0	100.0	100.0	50.0	100.0	0.0	50.0
GAR	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Volta	87.5	88.9	100.0	100.0	87.5	100.0	50.0	77.8	62.5	77.8	37.5	55.6
Western	100.0	100.0	100.0	100.0	100.0	36.4	75.0	81.8	100.0	36.4	75.0	0.0
Totals	86.1 n=36	92.7 n=41	100.0 n=36	100.0 n=41	97.2 n=36	83.7 n=41	83.3 n=36	90.7 n=41	69.4 n=36	69.8 n=41	55.6 n=36	51.2 n=41

Table G Availability of CEOC in Hospitals

	% of facilities have all items for BEOC			% of facilities can perform c-sections			% of facilities can perform blood transfusion			% of facilities have all items for CEOC		
	Baseline	Midterm	Endline	Baseline	Midterm	Endline	Baseline	Midterm	Endline	Baseline	Midterm	Endline
Type of Facility												
Regional Hospitals	71.4	85.7	66.7	100.0	100.0	100.0	100.0	100.0	100.0	71.4	85.7	66.7
District / Mission Hospitals	44.4	48.3	48.6	92.3	89.7	72.2	88.5	93.3	80.6	44.4	43.3	45.7
Ashanti	80.0	60.0	60.0	100.0	100.0	100.0	100.0	100.0	100.0	80.0	60.0	60.0
BAR	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Central	46.2	53.8	72.7	83.3	76.9	83.3	84.6	84.6	91.7	46.2	46.2	63.6
Eastern	50.0	0.0	50.0	100.0	100.0	100.0	100.0	100.0	100.0	50.0	0.0	50.0
GAR	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Volta	50.0	37.5	55.6	100.0	100.0	88.9	100.0	100.0	100.0	50.0	33.3	55.6
Western	0.0	75.0	0.0	100.0	100.0	36.4	80.0	100.0	45.5	0.0	75.0	0.0
Totals	50.0 (n=36)	55.6 (n=36)	51.2 (n=43)	93.8 (n=32)	91.7 (n=36)	76.3 (n=43)	90.9 (n=33)	94.6 (n=37)	83.7 (n=43)	50.0 (n=34)	51.4 (n=37)	48.8 (n=43)

Table H Quality of ANC Care

Regions	% of facilities with visual and auditory privacy in ANC area			% of facilities with all items for infection prevention in ANC service areas ¹			% of facilities with all items for a quality physical ANC exam ²		
	Base-line	Mid-term	End-line	Base-line	Mid-term	End-line	Base-line	Midterm	End-line
Type of Facility									
Regional Hospitals	85.7	85.7	85.7	57.1	85.7	100.0	100.0	100.0	85.7
District/ Mission Hospitals	70.8	92.9	94.6	35.7	79.3	100.0	96.4	86.2	97.3
Health Centres/ Other	78.1	92.1	94.4	31.1	86.2	95.0	85.2	92.0	95.8
Regions									
Ashanti	53.8	100.0	95.8	36.8	86.4	100.0	89.5	100.0	95.8
Brong Ahafo	75.0	90.9	75.0	12.5	72.7	100.0	100.0	100.0	100.0
Central	87.2	94.3	92.8	40.0	88.7	95.7	91.7	91.5	95.7
Eastern	75.0	90.0	100.0	54.5	100.0	90.0	90.9	88.9	100.0
Greater Accra	40.0	83.3	100.0	20.0	83.3	100.0	100.0	66.7	83.3
Volta	83.3	80.8	97.1	31.3	80.8	97.1	68.8	84.6	94.3
Western	72.7	93.1	93.9	13.6	78.6	93.8	95.0	93.1	97.0
Totals	76.9 n=104	92.0 n=174	94.1 n=186	33.1 n=157	85.1 n=174	96.2 n=186	87.9 n=157	91.4 n=174	95.7 n=186

¹ Infection-prevention items assessed were clean gloves, soap and water, disinfecting solution and a sharps container.

² Functioning blood pressure apparatus, foetal stethoscope.

Table I Comprehensiveness of ANC Services

% of providers who mentioned these routine services are offered at the ANC clinic (unprompted)										
	TT vaccine		SP for IPT		FP		Birth preparedness		ITN info or sell ITN	
	MT	EL	MT	EL	MT	EL	MT	EL	MT	EL
Type of facility Region										
Regional Hospitals	57.1	57.1	71.4	100.0	57.1	71.4	85.7	85.7	71.4	85.7
District/Mission Hospitals	58.6	64.9	82.8	81.1	17.9	43.2	72.4	67.6	50.0	73.0
Health Centres/Other	63.3	66.9	85.6	90.1	46.8	43.3	77.7	75.4	66.9	66.2
Regions										
Ashanti	90.9	41.7	95.5	62.5	77.3	25.0	95.5	83.3	81.8	33.3
Brong Ahafo	54.5	71.4	72.7	85.7	27.3	28.6	63.6	85.7	63.6	71.4
Central	60.6	77.1	81.7	91.4	46.5	51.4	76.1	70.6	63.6	77.1
Eastern	80.0	72.7	100.0	100.0	66.7	54.5	90.0	72.7	90.0	45.5
Greater Accra	83.3	50.0	100.0	100.0	0.0	16.7	66.7	50.0	16.7	16.7
Volta	61.5	68.6	88.5	97.1	19.2	52.9	76.9	68.7	72.0	91.4
Western	37.9	57.6	75.9	88.7	34.5	39.4	69.0	84.8	48.3	66.7
Totals MT (n=175) EL (n=186)	62.3	66.1	84.6	88.7	42.5	44.3	77.1	74.2	64.4	68.3

Table J Quality of Delivery Services

Regions	% of facilities with all infection-prevention items ¹			% of facilities with all delivery room infrastructure and furnishings ²			% of facilities with standards and protocols		
	Base Line	Mid term	End line	Base line	Mid term	End line	Base line	Mid term	Endline
Type of Facility									
Regional Hospitals	71.4	71.4	100.0	71.4	100.0	100.0	71.4	42.9	71.4
District/ Mission Hospitals	78.6	69.0	88.9	53.6	72.4	94.4	55.6	31.0	30.6
Health Centres/ Other	43.4	73.1	78.0	36.1	72.5	86.4	24.5	31.5	39.1
Regions									
Ashanti	73.7	68.2	83.3	52.6	90.9	95.8	21.1	4.8	16.7
Brong Ahafo	0.0	100.0	87.5	50.0	70.0	100.0	12.5	88.9	75.0
Central	63.3	70.6	79.7	45.0	76.5	76.5	39.7	42.0	47.8
Eastern	63.6	66.7	100.0	27.3	100.0	100.0	33.3	44.4	70.0
Greater Accra	80.0	50.0	80.0	60.0	83.3	100.0	100.0	44.4	50.0
Volta	31.3	73.1	85.7	34.4	46.2	92.5	41.7	16.7	28.6
Western	31.8	76.0	71.6	27.3	69.2	96.6	4.8	30.8	22.6
Totals	51.0 (n=157)	72.3 (n=166)	81.1 (n=175)	40.8 (n=157)	73.7 (n=167)	88.6 (n=175)	32.6 (n=144)	31.9 (n=163)	38.6 (n=175)

¹ Soap, water, single use towel, sharps container, gloves and decontamination solution.

² Visual and auditory privacy, BP cuff, delivery tray

³ Partographs and National Reproductive Health Protocol

Table K Availability of key drugs in delivery service area on day of assessment Endline Only

	% of facilities that had a shortage of these drugs on the day of the midterm visit						
	Valium inj	Mag Sulf Inj	Vit K Inj	IV infusion	Ergomet Inj	Oxytocic Inj	Antibiotic Inj
Type of Facility							
Regional Hospitals	100.0	100.0	85.7	100.0	100.0	100.0	66.7
District/Mission Hospitals	91.7	80.6	86.2	100.0	97.2	100.0	97.1
Health Centres/Other	85.6	58.6	58.6	97.7	89.4	97.0	62.1
Region							
Ashanti	91.7	50.0	70.8	95.8	79.2	91.7	54.2
Brong Ahafo	50.0	100.0	100.0	100.0	100.0	100.0	50.0
Central	67.0	92.8	73.9	100.0	95.6	100.0	77.6
Eastern	100.0	90.0	80.0	100.0	90.0	100.0	90.0
Greater Accra	100.0	50.0	100.0	100.0	100.0	100.0	83.3
Volta	92.6	39.3	14.3	100.0	92.9	96.4	46.4
Western	83.9	22.6	80.6	93.5	87.1	96.8	80.0
Totals	87.4 (n=176)	64.8 (n=176)	67.6 (n=176)	98.3 (n=176)	91.4 (n=176)	97.7 (n=176)	69.4 (n=176)

Table L Availability of Emergency Packs in the Delivery Units (ENDLINE)

Type of Facility	Emergency Pack for Post-partum Haemorrhage	Emergency Pack for Eclampsia	Emergency Pack for Caesarean Sections (Hospitals Only)
Type of Facility			
Regional Hospital	100.0	100.0	100.0
District / Mission Hospitals	88.9	80.6	65.7
Health Centres/ Other	87.8	70.0	
Region			
Ashanti	87.0	69.6	100.0
Brong Ahafo	100.0	100.0	100.0
Central	100.0	92.6	75.0
Eastern	90.0	80.0	100.0
Greater Accra	83.3	83.3	100.0
Volta	66.7	63.0	66.7
Western	80.6	32.3	45.5
Totals	88.5 (n=176)	73.4 (n=176)	71.4 (n=42)

Table M Active Management of the Third Stage of Labour – Provider Knowledge

	What are the key steps in the active management of the third stage of labour? UNPROMPTED						% of providers that mentioned all	
	% mentioned Administration of oxytocics		% mentioned controlled cord traction		% mentioned uterine massage			
	Mid term	Endline	Mid term	Endline	Mid term	Endline	Mid term	Endline
Regional Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
District/Mission/Hospitals	100.0	94.4	93.3	88.9	70.0	88.9	70.0	80.6
Health Centres/Other	92.4	94.7	87.8	94.0	69.5	82.0	62.6	79.7
Ashanti	95.5	95.8	86.4	91.7	81.8	75.0	77.3	70.8
Brong Ahafo	100.0	87.5	100.0	100.0	80.0	87.5	80.0	87.5
Central	95.6	97.1	95.6	95.7	70.6	85.5	67.9	84.1
Eastern	100.0	100.0	100.0	100.0	100.0	90.0	100.0	90.0
Greater Accra	83.3	66.7	83.3	66.7	66.7	66.7	66.7	66.7
Volta	81.5	100.0	74.1	89.3	59.3	82.1	37.0	75.0
Western	100.0	90.3	84.6	93.5	61.5	90.3	61.5	83.9
Totals	94.0 (n=168)	94.9 (n=176)	89.3 (n=168)	93.2 (n=176)	70.8 (n=168)	84.1 (n=176)	65.5 (n=168)	80.7 (n=176)

Table N Provider Use of Partographs and Referral Forms

	Provider consistently uses partographs (evidence seen)		Provider uses a standard referral note for next level of care	
	Midterm	Endline	Midterm	Endline
Type of Facility				
Regional Hospitals	100.0	100.0	100.0	42.9
District/ Mission Hospitals	84.6	72.2	78.6	75.0
Health Centres/ Other	63.6	71.4	68.5	69.9
Region				
Ashanti	40.0	70.8	50.0	62.5
BAR	100.0	87.5	100.0	50.0
Central	70.8	82.6	83.1	78.3
Eastern	100.0	90.0	100.0	10.0
GAR	66.7	83.3	100.0	66.7
Volta	87.5	64.3	73.1	75.0
Western	42.9	48.4	26.1	77.4
Totals				
	68.5 (n=153)	72.7 (n=176)	71.3 (n=160)	69.9 (n=176)

Table O Availability of Essential Newborn Care Equipment

	Bag and Mask or tube for baby		Resuscitation Table		Suction Machine / Bulb Syringes		Cord Clamps		% of facilities have all items essential newborn items		
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	
Type of Facility											
Regional Hospitals	100.0	100.0	71.4	100.0	100.0	100.0	100.0	100.0	71.4	100.0	
District /Mission Hospitals	88.5	100.0	76.0	88.9	92.3	100.0	92.3	100.0	60.0	88.9	
Health centres	48.6	95.4	50.5	73.1	65.7	97.7	87.3	100.0	24.5	69.2	
Regions											
Ashanti	47.0	100.0	31.6	54.2	68.4	95.8	89.5	100.0	22.2	54.2	
BAR	57.1	100.0	12.5	100.0	37.5	100.0	75.0	100.0	12.5	100.0	
Central	63.8	93.9	69.6	87.9	82.5	100.0	93.1	100.0	43.6	81.8	
Eastern	62.5	90.0	75.0	50.0	62.5	90.0	87.5	100.0	33.3	50.0	
GAR	60.0	83.3	40.0	16.7	40.0	100.0	100.0	100.0	00.0	16.7	
Volta	54.2	100.0	50.0	89.3	54.2	100.0	83.3	100.0	30.4	89.3	
Western	57.1	100.0	63.2	77.4	95.0	96.8	85.7	100.0	35.0	74.2	
Totals											
	58.5	96.5	56.1	77.5	72.3	98.3	88.8	100.0	33.3	74.6	

Table P Availability of Standard Treatment Guidelines and IDSR Protocols

	% of facilities with National Technical Guidelines on IDSR			% of facilities with Standard Case Definitions			% of facilities with COMDAB ¹ (Midterm only)	
	Baseline	Midterm	Endline	Baseline	Midterm	Endline	Midterm	Endline
Type of Facility								
Regional Hospitals	75.0	100.0	80.0	75.0	100.0	80.0	40.0	50.0
District/Mission Hospitals	30.4	84.0	37.5	26.1	84.0	54.8	16.1	64.0
Health Centres/Other	7.5	60.0	51.0	12.8	80.9	57.0	19.2	58.7
Region								
Ashanti	5.3	95.7	72.0	0.0	100.0	52.0	36.0	87.0
Brong Ahafo	33.3	91.7	90.9	33.3	100.0	100.0	36.4	83.3
Central	11.5	74.2	54.0	26.4	80.0	56.5	13.3	91.9
Eastern	50.0	66.7	45.5	50.0	66.7	72.7	36.4	71.4
Greater Accra	0.0	83.3	66.7	0.0	83.3	83.3	50.0	50.0
Volta	7.1	35.0	38.5	3.4	76.9	43.6	7.9	7.7
Western	19.0	44.4	19.4	14.3	26.9	54.8	12.9	20.0
Totals	13.4 (n=134)	69.8 (n=176)	49.5 (n=184)	16.9 (n=136)	82.0 (n=172)	51.3 (n=184)	19.2 (n=184)	59.2 (n=174)

¹ Communicable Disease Analysis Book

GHS / QHP ENDLINE EVALUATION: FACILITY AUDIT TOOL

I am representing the Ghana Health Service and the Quality Health Partners to collect data to assess performance towards achieving our programme's goals. We are collecting information that will help us to understand the impact our programme has had on maternal, child, and reproductive health services. This information will be used to design programmes to improve these services.

During this data collection process we will be talking to the in-charge of the facility, providers in the ANC, Delivery, Family Planning and OPD. We will be looking at the standards of practice. We will meet with the in-charge at the end of our assessment to provide feedback on our findings. All information from this exercise will be used to assess the QHP programme as well as for programme improvement. You can refuse to answer any question or all the questions however your participation will provide insight into the performance of the project and help the GHS in responding to needs of your facility and the health care needs for Ghanaians in general. The whole process should not take more than 3 hours.

We are asking for your help to ensure that the information collected is accurate. If there are sections where someone else is the most appropriate person to provide information, we would appreciate you introducing us to that person.

Do you have any questions for me?

If you have any questions after this interview – you can contact Angela Bannerman – the Senior Manager for Monitoring and Evaluation (0244 277 395) or Richard Killian – Chief of Party of the Quality Health Partners Project (021 775 585)

Can we begin now?

SIGNATURE OF RESPONDENT

DATE

FACILITY IDENTIFICATION										
Name of Region: _____ Name of District: _____ Name of the facility _____ Telephone Number : _____ Name of Monitor(s) _____ _____ Date: _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">REGION CODE</td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> </tr> <tr> <td style="padding: 5px;">DISTRICT CODE</td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> </tr> <tr> <td style="padding: 5px;">FACILITY CODE</td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> <td style="padding: 5px; text-align: center;"><input style="width: 30px; height: 30px;" type="text"/></td> </tr> </table>	REGION CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>	DISTRICT CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>	FACILITY CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>
REGION CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>								
DISTRICT CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>								
FACILITY CODE	<input style="width: 30px; height: 30px;" type="text"/>	<input style="width: 30px; height: 30px;" type="text"/>								
Type of Facility: Regional Hospital = 1, District Hospital=2, Mission Hospital =3, Health Centre =4, Other =5	<input style="width: 30px; height: 30px;" type="text"/>									

This section to be answered by the In-Charge, Administrator, or the Most Senior Officer found at the facility at the time of visit.

100	I have some questions about the staff. We want to know the <u>highest technical qualification</u> and the number of staff who are routinely assigned for services. This may include staff who provide both inpatient and outpatient services but NOT staff who function purely administratively. COUNT STAFF IN ONLY ONE CATEGORY. DO NOT INCLUDE STAFF IN TRAINING.		
	QUALIFICATION	TOTAL NUMBER	
	A) Medical Doctors (INCLUDE DOCTORS WITH SPECIALTY TRAINING)	MEDICAL DOCTOR	<input type="text"/> <input type="text"/>
	B) Medical Assistants	MEDICAL ASST	<input type="text"/> <input type="text"/>
	C) Public Health Nurses	PH NURSE	<input type="text"/> <input type="text"/>
	D) Midwives	MIDWIFE	<input type="text"/> <input type="text"/>
	E) SRN/RGN	SRN	<input type="text"/> <input type="text"/> <input type="text"/>
	F) Disease Control Officers / Field Technicians	DCO	<input type="text"/> <input type="text"/>
	G) Community Health Nurses	CHN	<input type="text"/> <input type="text"/>
	H). Enrolled Nurses	EN	<input type="text"/> <input type="text"/>
	I) Pharmacists	PHARMACIST	<input type="text"/> <input type="text"/>
	J) Dispensing Technicians / Assistants	DISPENSING TECH	<input type="text"/> <input type="text"/>
	K) Lab Technicians/technologists/assistants	LAB. TECH.	<input type="text"/> <input type="text"/>
	L) Nutrition Technical Officers	NUT. TECH	<input type="text"/> <input type="text"/>
	M) Ward Assistants / Ward Maid / Health Aides	WARD ASST	<input type="text"/> <input type="text"/>
	N) Environmental Health Officers	ENVIRONMENT HEALTH OFFICER	<input type="text"/> <input type="text"/>
	O) Biostatistician / Medical Records Assistants	BIOSTATS	<input type="text"/> <input type="text"/>
P) Others: SPECIFY _____	OTHER	<input type="text"/> <input type="text"/>	

101	Do individual staff have a written Job Description for themselves that they can show? (ask to see copies)	YES, ALL.....1 YES, SOME.....2 NONE.....3 DON'T KNOW.....8
102	How many staff have been appraised in the last year?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
103	Was there any evidence?	YES.....1 NO.....2
104	Do you have copies of the National Referral Policy and Guidelines (February 2006)?	YES.....1 NO.....2 DON'T KNOW.....8
105	Does this facility have copies of the Standard Treatment Guidelines 2004 (Blue Book)?	YES.....1 NO.....2 DON'T KNOW.....8
106	Is there a copy of the Standard Treatment Guidelines (2004) in each consulting room?	YES.....1 NO.....2 DON'T KNOW.....8

This section to be answered by the In-Charge of the Pharmacy or the Most Senior Officer found at the pharmacy at the time of visit.

107	HAS THERE BEEN A STOCK-OUT OF ANY OF THE FOLLOWING IN THE LAST 6 MONTHS?	STOCK-OUT	NO STOCK-OUT
	a) SULFADOXINE-PYRIMETHAMINE	1	2
	b). ACTs	1	2

COMMENTS:

QUALITY ASSURANCE TOPICS

108	Does this facility have a Quality Assurance Team?	YES.....1 NO.....2 DON'T KNOW...8	→110 →110	
109	Does the team have a Quality Assurance Action Plan? IF YES, ASK TO SEE THE PLAN OR EVIDENCE OF RECENT ACTIVITY AND DISCUSS	YES, PLAN SEEN.....1 YES, NO PLAN SEEN.....2 NO.....3		
110	What are some of the quality assurance tools used or activities done at this facility? <u>DO NOT READ THE OPTIONS! AFTER THEY HAVE SAID ALL – PROMPT FOR OTHER METHODS.</u>			
	METHOD	METHOD USED :		
		Mentioned	Prompted	Not Used
	a) Supervisory checklist for health system components (e.g. service specific equipment, drugs, supplies and records)	1	2	3
	b) Supervisory checklist for health service provision (e.g. Observation Check list)	1	2	3
	c) Mortality meeting	1	2	3
	d) Periodic audit of medical records or service registers	1	2	3
	e) Client Satisfaction or Staff Satisfaction Survey?	1	2	3
	f) Feedback from Regional/District Health Management Team Visits	1	2	3
	g) Clinical Conferences/Meetings	1	2	3
	h) Other (SPECIFY)	1	2	3
111	Does this facility hold regular meetings to review management or administrative issues?	YES.....1 NO.....2 DON'T KNOW.....8	→113 →113	
112	How often are regular meetings held to discuss management / administrative issues? Other (specify) _____	WEEKLY/BI-WEEKLY.....1 MONTHLY.....2 QUARTERLY.....3 OTHER.....8		
113	When was the last time a supervisor from OUTSIDE this facility came for a <u>supervisory visit</u> ?	IN LAST 6 MONTHS.....1 MORE THAN 6 MONTHS AGO.....2 NEVER SUPERVISED FROM OUTSIDE FACILITY.....3		
114	Has this facility ever conducted a COPE exercise?	YES.....1 NEVER DID COPE.....2 DON'T KNOW.....9	→IDSR →IDSR	
115	When was the COPE exercise conducted?	YEAR _____		
116	What problems were solved after the last COPE exercise?			

IDSR TOPICS

This section to be answered by the person in charge for IDSR and disease reporting.

200	Does this facility have the following protocols or guidelines? IF YES, ASK TO SEE A COPY.	Observed /Reported	Not Available
	a) National Technical Guidelines on IDSR	1	2
	b) Standard Case Definitions (separate copy or they say it's in the Technical Guidelines)	1	2
	c) Communicable Disease Analysis Book (COMDAB)	1	2
201	Does this facility have the following forms?		
	a). Case based surveillance report form?	1	2
	b). Case Investigation form for AFP and NNT?	1	2
	c). Weekly notifiable disease reporting form?	1	2
	d). Line List for reporting case-based information form?	1	2
	e). Monthly communicable disease surveillance report form?	1	2
202	Forms and Record Keeping: Ask for and review IDSR forms for the <i>past 3 months</i>: Indicate Numbers:		
	a. How many Weekly Notifiable Disease Reporting forms have been completely filled out for the period?	<input type="text"/> <input type="text"/>	99= no forms
	b. How many Monthly Communicable Disease Surveillance report forms have been completely filled out for the period?	<input type="text"/> <input type="text"/>	99= no Forms
203	Data Analysis:	Yes	No
	Does the facility have monthly trend analysis graphs for malaria posted /displayed for review? (Must be current to the last quarter.)	1	2
204	Does the facility have displayed demographic data (population, age/sex distribution) of the catchment area?	1	2
205	Does the facility make use of the COMDAB to analyze disease? (filling the graphs and taking appropriate action)	1	2

COMMENTS:

FAMILY PLANNING

This section to be answered by the In-Charge of the FP Unit or the Most Senior Officer found at the unit at the time of visit.

300	Do you offer Family Planning Counselling or Services?	YES.....1	→ANC
		NO.....2	
301	ITEMS REQUIRED FOR FAMILY PLANNING SERVICES	a). Is item present?	
	SERVICE DELIVERY PROTOCOLS	Obs erve d	RA
		Not Available	
	a) The Essentials of Contraceptive Technology (Green Book) or Family planning-a Global handbook for Providers (Green Book)	1	2
	b). Visual and auditory privacy for examination	1	2
	c) Working Spotlight source	1	2
	d) Working Table and stool for gynaecological exam	1	2
	e). Working Blood pressure apparatus	1	2
	f). Working Stethoscope	1	2
	g). Working Weighing scale (not bathroom scale)	1	2
	h). Handwashing Facilities (water, soap, single use towel)/ hand sanitizer	1	2
	i) Clean gloves	1	2
	j) Sharps container	1	2
	k) Decontamination solution for clinical equipment (not mixed but have concentration written on it)	1	2
	l). Waste bin (with pedal operated lid, plastic lined)	1	2
	m). Sterile needles and syringes	1	2
302	What is the correct solution strength for decontamination? (Answer is 0.5%)	CORRECT.....1 NOT CORRECT.....2 NOT APPLICABLE.... 8	
303	For the type of bleach solution available in the procedures room today – how many parts of water do you need to add to one part bleach to make the correct strength solution for decontamination? (See table below – do not read)	CORRECT.....1 NOT CORRECT.....2 TAKE SOLUTION FROM PHARMACY.....3 NO SOLUTION AVAIL... 8	
304	What are the steps in processing instruments correctly? DO NOT READ THE ANSWERS – CIRCLE IF MENTIONED.	Mentioned	Prompted
	a). Place in decontamination solution for 10 minutes	1	2
	b). Remove from solution and scrub with soap and water.	1	2
			3

c). HLD / Sterilize the instruments	1	2	3
d). Store the equipment properly	1	2	3

Table for interviewers:

5% liquid bleach	3.5% liquid bleach	3% liquid bleach	2.5% liquid bleach	1.5% liquid bleach	8 degrees chlorox	12 degrees chlorox
1 part bleach to 9 parts water	1 part bleach to 6 parts water	1 part bleach to 5 parts water	1 part bleach to 4 parts water	1 part bleach to 2 parts water	1 part bleach to 3.8 parts water	1 part bleach to 6.2 parts water

		YES	NO												
305	Is there a provider trained in IUD Insertion?	1	2												
306	Do you have an IUD Kit?	1	2												
307	Is there a provider trained in Norplant or Jadelle insertion?	1	2												
308	Do you have a Norplant or Jadelle insertion kit?	1	2												
309	What are the key topics/issues that you cover during family planning counselling with a NEW ACCEPTOR?	FP COUNSELLING													
	DO NOT READ THE RESPONSES! CIRCLE IF MENTIONED. WHEN THEY ARE DONE – THEN PROMPT FOR ANSWERS	Men- tioned	Prompted	Provider does not discuss											
	a). Assure confidentiality	1	2	3											
	b). Discuss reproductive intentions with client (does she/he want another child?)	1	2	3											
	c). Discuss all FP options for client	1	2	3											
	d). Discuss STIs (or respond to their questions)	1	2	3											
e). Discuss HIV/AIDS (or respond to their questions)	1	2	3												
311	Has any supervisor observed you providing family planning services in the past 6 months ?	YES.....1 NO.....2→3 13 DON'T KNOW.....8→313													
312	Was the supervisor from this facility or from outside this facility?	THIS FACILITY.....1 OUTSIDE THIS FACILITY..2 BOTH.....3													
313	(Ask the person providing FP services) Have you received refresher or update training including on- the- job training on Family Planning in the last 3 years?	YES.....1 NO.....2 DON'T KNOW.....8													
SERVICE STATISTICS (COMMODITIES THE METHODS)															
314	New Acceptor	Continuing Users	Lo-Fem	Ovrette	Male Condom	Fem Cond	Cu T	Micro -G	Micro -n	Depo	Mlap /BTL	Vac	Nat FP	Norigynon	Implant
JAN 2009															
FEB 2009															
MAR 2009															
MARK STOCK-OUTS OF ANY METHOD IN LAST 6 MONTHS															

Comments

ANTE-NATAL CARE SERVICES

This section to be answered by the In-Charge of the ANC or the Most Senior Officer found at the facility at the time of visit.

ITEMS REQUIRED FOR ANTENATAL SERVICES		(a) Is item present		
400	FACILITY AND EQUIPMENT	Observed	RA	Not Available
	a). Visual and Auditory Privacy	1	2	3
	b). Working BP apparatus	1	2	3
	c). Working Foetal Stethoscope	1	2	3
	d). Sonicaid	1	2	3
	e) Hand-washing Facilities (water, soap, single use towel)/ hand sanitizer	1	2	3
	f). Sharps Box	1	2	3
	g) Waste Bin (pedal operated, plastic lined)	1	2	3
	h) Spotlight source (flash light accepted)	1	2	3
	i) Thermometer	1	2	3
	j) Tape measure	1	2	3
	k) adult weighing scale	1	2	3
	401	What key topics/services are routinely discussed or offered at the ANC clinic? DO NOT READ THE RESPONSES! CIRCLE IF MENTIONED. WHEN THEY ARE DONE – THEN PROMPT THEM	Mentioned	Prompted
	a) Tetanus Toxoid vaccine?	1	2	3
	b) Prescribe SP for Intermittent Preventive Treatment?	1	2	3
	c). Discuss family planning?	1	2	3
	d). Discuss birth preparedness and complication readiness?	1	2	3
	e). Provide mothers with information about ITNs or provide them with ITNs	1	2	3
		Yes	No	
402	Has the facility had a shortage in the <u>last three months</u> of either iron or folic acid?	1	2	
403	Has the facility had a shortage in the <u>last three months</u> of Sulfadoxine – Pyrimethamine (SP)?	1	2	
405	Is focused-ANC practiced at this facility?	1	2	
406	Has a supervisor observed you providing ANC services in the past 6 months at this facility?	YES.....1 NO.....2 DON'T KNOW...8		→408 →408
407	Was the supervisor from this facility or from outside this facility?	THIS FACILITY.....1 OUTSIDE THIS FACILITY.....2 BOTH.....3		
408	Have you (person providing services) received in-service training including on- the job- training in ANC in the last 3 years?	YES.....1 NO.....2 DON'T KNOW...8		

Please Collect Service Statistics on ANC Attendance and IPT use (Monthly midwife's return Form A)

409	Month	ANC Registrants	ANC Attendance	IPT1	IPT2	IPT3
A	January 2009					
B	February 2009					
C	March 2009					

COMMENTS:

DELIVERY CARE

This section to be answered by the In-Charge of the Maternity or the Most Senior Officer found at the unit at the time of visit.

No Delivery Services Offered (go to IMCI) 99

500	ITEMS REQUIRED FOR DELIVERY SERVICES EQUIPMENT	(a) Is item Present?		
		Observed	RA	Not Available
	a). National Reproductive Health Service Protocol (Yellow Book)	1	2	3
	b). Visual and Auditory privacy for women delivering	1	2	3
	c). Functioning BP Apparatus	1	2	3
	d). Delivery Tray (including scissors, 2 artery forceps, cord clamps, oxytocin, bulb syringe and needle)	1	2	3
	e). Emergency Tray / Pack for Post –Partum Hemorrhage (PPH)	1	2	3
	f). Emergency Tray / Pack for Eclampsia	1	2	3
	g). Emergency Tray / Pack for Caesarean Section	1	2	3
	h) Handwashing Facilities (water, soap, single-use towel)	1	2	3
	i) Disposable gloves / Sterile Gloves	1	2	3
	j) Sharps container	1	2	3
	k) Decontamination solution with written concentration	1	2	3
	l). Waste Bin (pedal operated, plastic lined.)	1	2	3
	m).Personal protective gear (apron, gown, goggles, mask, boots)	1	2	3
	n) Thermometer	1	2	3
	o) BP Apparatus	1	2	3
	p) Functioning light source	1	2	3
501	What is the correct bleach solution strength that should be used for decontamination? (Answer is 0.5%)	CORRECT.....1 NOT CORRECT.....2 NOT Applicable.....8		
502	For the type of bleach solution available in the procedures room today – how many parts of water do you need to add to one part bleach to make the correct strength solution for decontamination? (See table below – do not read)	CORRECT.....1 NOT CORRECT.....2 TAKE SOLUTION FROM PHARMACY.....3 NO SOLUTION AVAIL.....8		
503	What are the steps in processing instruments correctly after they have been used on a client? DO NOT READ THE ANSWERS – CIRCLE IF MENTIONED. WHEN PERSON IS DONE PROMPT FOR OTHER ANSWERS.	Men- tioned	Prompt- ed	Not Done
	a). Place in decontamination solution for 10 minutes	1	2	3
	b). Remove from solution and scrub with soap and water.	1	2	3
	c). HLD / Sterilize the instruments	1	2	3
	d). Store the equipment properly	1	2	3

5% liquid bleach	3.5% liquid bleach	3% liquid bleach	2.5% liquid bleach	1.5% liquid bleach	8 degrees chlorox	12 degrees chlorox
1 part bleach to 9 parts water	1 part bleach to 6 parts water	1 part bleach to 5 parts water	1 part bleach to 4 parts water	1 part bleach to 2 parts water	1 part bleach to 3.8 parts water	1 part bleach to 6.2 parts water

504	ARE THESE ITEMS AVAILABLE TODAY IN THE DELIVERY AREA?	Yes	No	
	a). Valium Injectable	1	2	
	b). Magnesium Sulphate	1	2	
	c). Vitamin K ₃ Injectable	1	2	
	d) IV infusion set or Intravenous fluids (dextrose saline, normal saline)	1	2	
	e) Injectable ergometrine (check storage)	1	2	
	f). Injectable oxytocin (syntocinon) (check storage)	1	2	
	g). Injectable antibiotic or infusion antibiotic	1	2	
505	Are partographs used CONSISTENTLY at this facility? (ask to see evidence)	1	2	
506	Can you or another midwife at this facility perform a manual removal of retained placenta after delivery?	1	2	
507	Can you or another midwife / physician at this facility use a vacuum extractor for assisted deliveries?	1	2	
508	Does this facility perform caesarean section operations?	1	2	
509	Does this facility give blood transfusions?	1	2	
510	Do you use a standard referral and feedback form to refer clients to the next level of care? (Ask to see evidence)	1	2	
511	Name the key steps in the active management of the third stage of labour? DO NOT READ THE RESPONSES! CIRCLE IF MENTIONED. WHEN PERSON IS DONE PROMPT FOR OTHER RESPONSES	MEN- TIONED	PROMP- TED	NOT DONE
	a) Administration of oxytocin	1	2	3
	b) Controlled cord traction	1	2	3
	c) Uterine massage	1	2	3
512	Has a supervisor observed you providing delivery services in the past 6 months at this facility?	YES.....1 NO.....2→514 DON'T KNOW.....8→514		
513	Was the supervisor from this facility or from outside this facility?	THIS FACILITY.....1 OUTSIDE THIS FACILITY..2 BOTH.....3		
514	Have you (person conducting deliveries) received in-service training including on- the-job training in delivery care in the last 3 years?	YES.....1 NO.....2 DON'T KNOW.....8		

Please Collect Service Statistics on Deliveries from Jan-Mar 09 (Monthly midwife's return Form A)

515	Deliveries	Jan 2009 (A) Total	Feb 2009 (B) Total	March 2009 (C) Total

COMMENTS

NEWBORN CARE SERVICES

ITEMS REQUIRED FOR NEWBORN CARE SERVICES		(a) Is item Present?		
516	SUPPLIES FOR BABY	Yes	No	
	a) Bag and mask or tube and mask (baby) for resuscitation, SKAMGOA	1	2	
	b) Resuscitation table for baby	1	2	
	c) Suction machine/ bulb syringes	1	2	
	d) Cord clamps / Cord Ligatures	1	2	
517	Can you describe key activities of care for the newborn in the first 6 hours? DO NOT READ RESPONSES – CIRCLE IF MENTIONED	Mentioned	Prompted	NOT DONE
	a). APGAR Score (conducted at 1 minute and 5 minutes)	1	2	3
	b). Suctioning the airways of the newborn	1	2	3
	c). Maintaining Warmth	1	2	3
	d). Washing (only after 6 hours – in order to maintain warmth)	1	2	3
	e). Cord Care	1	2	3
	f). Eye care	1	2	3
	g). Resuscitation of babies who do not breathe properly at birth	1	2	3
	h). Early initiation of breastfeeding (within 30 minutes of delivery), without pre-lacteal feeds	1	2	3
	i). Vitamin K ₃ Injection	1	2	3
	j). Immunization	1	2	3
	518	Does this facility do the following routinely	Yes	No
a) Suction airways of all new borns?				
b) Bath new born babies within 6 hours of birth?				
c) Provide OPV to the newborn prior to discharge?				
d) Provide BCG to the newborn prior to discharge?				
e) Provide Vitamin A to the mother prior to discharge?				
g) Conduct audits of maternal deaths or 'near miss deaths'?				
h) Conduct audits of newborn deaths or 'near miss deaths'?				
519		Have you (person caring for newborns) received in-service or on-the-job training in newborn care in the last 3 years?	YES.....1 NO.....2 DON'T KNOW.....8	

COMMENTS

IMCI

This section to be answered by the In-Charge of the OPD or the Most Senior Officer found at the OPD at the time of visit.

600	Has anyone in this facility been trained in IMCI? (Ask 7 days or 11 days training) IF YES HOW MANY PEOPLE HAVE BEEN TRAINED? <input type="text"/> <input type="text"/>	YES.....1 → HOW MANY NO.....2 → 602 DON'T KNOW...8 → 602
601	Is the person who was trained in IMCI managing sick children?	YES.....1 NO.....2 DON'T KNOW.....8
602	Supplies needed for treatment of sick children (located in consulting OR vitals OR treatment rooms)	Observed RA Not Available
	a) Handwashing Facilities (water, soap, single use towel)/ hand sanitizer	1 2 3
	b) Infant Weighing Scale (in room or central area)	1 2 3
	c) Child Weighing Scale (in room or central area) – Hanging Salter Scale	1 2 3
	d) Thermometer	1 2 3
	e) Timer/Watch with second hand	1 2 3
	f) Cup, Spoon, Water and ORS for providing ORT	1 2 3
	g). Sharps Box	1 2 3
	h). Disposable gloves	1 2 3
	i). IMCI Chart Booklet	1 2 3
603	Is there a ROUTINE system where sick children are weighed <u>prior</u> to the consultation for the illness?	YES.....1 NO.....2 DON'T KNOW.....8
604	Is there a ROUTINE system where children with fever are sponged and or given paracetamol <u>prior</u> to the consultation for the illness?	SPONGED ONLY.....1 SPONGED AND PARA...2 NO.....3 DON'T KNOW.....8
605	Has the Regional/District IMCI trainer or resource person been here to supervise/follow-up training in the six months?	YES.....1 NO.....2 DON'T KNOW.....8 N/A.....9
606	Have you (person caring for sick children) received in-service or on-the-job training in the management of sick children <u>in the last 3 years</u> ?	YES.....1 NO.....2 DON'T KNOW.....8
607	Is the new combination therapy Artesunate/Amodiaquine being used to treat sick children at this facility?	YES.....1 NO.....2 → If no, go to DON'T KNOW...8 next section
608	IF YES, What is the dosage for a child that weighs 20 kgs? (Answer Artesunate 4mg/kg (80mg) and Amodiaquine 10mg/kg (200 mg) for 3 days.	CORRECT.....1 NOT CORRECT.....2
609	Do you use a <u>standard</u> referral and feedback form to refer clients to the next level of care? (Ask to see evidence)	YES.....1 NO.....2 DON'T KNOW.....8

COMMENTS:

CONCLUSION / WRAP – UP WITH IN-CHARGE OF THE FACILITY

On a scale of 1 to 5 (where 5 represents the highest mark), how would you rate the overall performance of QHP project in supporting health care services in your facility/district? 5. Excellent 4. Very good 3. Good 2. Satisfactory 1. Poor
99. Don't Know_ (Indicate DK if respondent does not know about QHP)

What are some of the most important contributions QHP has made towards health care improvement in your region/district?

1) _____

2) _____

3) _____

Note here your overall observations

Summary findings and observations (positive)
1.
2.
3.
4.
5.
Summary findings and observations (challenges)
1.
2.
3.
4..
5.

**PROVIDER INFORMED CONSENT
(IMCI PROVIDER OBSERVATION)**

On behalf of the Institutional Care Division of the Ghana Health Service, I would like to invite you to participate in the Quality Health Partners (QHP) Endline Assessment. In December 2004, QHP with GHS conducted a Facility Baseline Assessment (FBA) to establish the basis for programming for its five year project. As the project comes to a close it is necessary to undertake an Endline evaluation to assess the effect of the project's support to the facilities over time.

We will like to observe child health care services at this facility today. Please understand that your participation is entirely voluntary. If you decline, this will in no way affect your ability to receive health care at this facility. Any information you provide will be kept strictly confidential; your name is not required and you will not be identified in any way.

If you need to contact us with any questions, please contact Angela Bannerman, the Sr. Manager for Monitoring and Evaluation at the Quality Health Partners project (021 778 558 or 0244 277 395), Richard Killian, QHP Project Director (012 778 558) or Dr. Cynthia Bannerman – ICD (021 684 209).

If you agree to participate in this research on behalf of your facility, please sign or thumb print below.

Signature or thumbprint

Date

**Care Taker Informed Consent Form
(IMCI PROVIDER OBSERVATION)**

On behalf of the Institutional Care Division of the Ghana Health Service, I would like to invite you to participate in the Quality Health Partners (QHP) Endline Assessment. In December 2004, QHP with GHS conducted a Facility Baseline Assessment (FBA) to establish the basis for programming for its five year project. As the project comes to a close it is necessary to undertake an Endline evaluation to assess the effect of the project's support to the facilities overtime.

We will like to observe child health care services at this facility today. Please understand that your participation is entirely voluntary. If you decline, this will in no way affect your ability to receive health care at this facility. Any information you provide will be kept strictly confidential; your name is not required and you will not be identified in any way.

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If you agree to participate in this research on behalf of your facility, please sign or thumb print below.

Signature or thumbprint

Date

FACILITY IDENTIFICATION	
Name of Region: _____	REGION CODE <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
Name of District: _____	DISTRICT CODE <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
Name of the facility _____	FACILITY CODE <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
Name of Monitor(s) _____	PROV TYPE <input style="width: 30px; height: 20px;" type="text"/>
Date: _____	FACILITY TYPE <input style="width: 30px; height: 20px;" type="text"/>
Type of Provider Observed: Doctor =1, MA = 2 Nurse =3, Midwife =4, Other = 5	OBSERVATION <input style="width: 30px; height: 20px;" type="text"/>
Type of Facility: Regional Hospital = 1, District Hospital=2, Mission Hospital =3, Health Centre =4, Other = 5	(For first observation of a provider write 1, for the second with the SAME provider write 2)

NO.	QUESTIONS	CODING CLASSIFICATION	
		YES	NO
103	Does the Provider ask about or does the Caregiver mention if the child has any of the following symptoms?		
	A) Diarrhea?	1	2
	B) Fever/ Hot body?	1	2
	C) Cough?	1	2
104	Does the Provider ask about or the caregiver mention any of the following (DANGER SIGNS):	YES	NO
	A) If the child is unable to drink/breastfeed or eat at all?	1	2
	B) If the child is lethargic or unconscious?	1	2
	C) If the child has had convulsions with this sickness?	1	2
	D) If the child vomits everything?	1	2
105	Does the Provider perform any of the following physical examinations?	YES	NO
	A) Take temperature using thermometer (or done at a central point)?	1	2
	B) Feel the child for fever or body hotness?	1	2
	C) Check skin turgor for dehydration (pinch abdominal skin)?	1	2
	D) Weigh the child? IF YES: (or done at a central point)	1	2 → 106
	E) Record weight on a child health record book/folder	1	2

106	Does the Provider ask about or perform other assessments of the child's health?	YES	NO	Not Applicable
	A) Offer the child something to drink or put the child to the mother's breast?	1	2	9
	B) Ask about normal feeding /breast feeding practices when the child is not ill?	1	2	9
	C) Ask about feeding/breast feeding practices for the child during this illness?	1	2	9
	D) If the child has fever, sponge them in order to reduce the fever? (or done at a central point)	1	2	9
	E) Give paracetamol to reduce the child's fever (or done at a central point)	1	2	9
	F) Look at the immunization card/ Discuss vaccination schedule and status with the mother?	1	2	9
	G) Look at the child health record book either before beginning the consultation or while collecting information from the caregiver or when examining the child?	1	2	9

107	QUESTIONS	CODING CLASSIFICATION		
	Does the Provider provide any of the following advice when counselling the caregiver?	YES	NO	Not Applicable
	A) Provide general information about feeding or breastfeeding the child?	1	2	
	B) Give extra fluids to the child during this sickness?	1	2	
	C) Continue feeding the child during this sickness and after?	1	2	
	D) Tell the care giver what illness(es) the child has?	1	2	
	E) Describe signs or symptoms in the child for which the caregiver should bring the child back to the facility?	1	2	
108	Were medications prescribed or provided during the consultation? IF YES: DID THE PROVIDER:	1	2 →109	
	A) Give the first dose of the drug?	1	2	9
	B). Explain how to administer the drugs at home?	1	2	9
	C). Prescribe Artesunate 4mg/kg and Amodiaquine 10 mg/kg (or comparable treatment)?	1	2	9
	D). Give ORS at the facility?	1	2	9
	E) Explain how to give ORS at home?	1	2	9
109	Did the Provider use any visual aids when providing health education or counselling the caregiver about the child?	1	2	

110	Did the Provider write on the child health record book?	YES.....1 NO.....2 NO CHILD HEALTH RECORD BOOK.....3 DON'T KNOW.....8
111	What was the provider's classification/diagnosis? CIRCLE ALL DIAGNOSIS NOTED	MALARIA.....1 DIARRHEA.....2 ARI.....3 OTHER.....4
112	Has the provider been trained in IMCI?	YES 1 NO 2 DON'T KNOW 8

COMMENTS:

**GHS/QHP ENDLINE EVALUATION
(RHMT & DHMT only)**

I am representing the Ghana Health Service and the Quality Health Partners to collect data to assess progress towards achieving our programme's goals. We are collecting information that will help us to understand the impact our programme has had on maternal, child, and reproductive health services. This information could also be used to design programmes to improve these services.

During this data collection process we will be talking to different members of the RHMT/DHMT including the Director, the Finance person, the Health Information Officer, those in charge of supervision and we will be collecting some service statistics. Answering of questions is voluntary. Your participation in this process will not affect your ability to participate in training or receive equipment from the Quality Health Partners project. The whole process should take less than 1 hour.

We are asking for your help to ensure that the information collected is accurate. If there are sections where someone else is the most appropriate person to provide information, we would appreciate your introducing us to that person.

Do you have any questions for me?

If you have any questions after this interview – you can contact or Angela Bannerman – the Senior Manager for Monitoring and Evaluation (0244 277 395) or Richard Killian – Chief of Party of the Quality Health Partners Project 021 778 558

Can we begin now ?

SIGNATURE OF RESPONDENT

DATE

FACILITY IDENTIFICATION	
Name of Region: _____	REGION CODE <input type="text"/> <input type="text"/>
Name of District: _____	DISTRICT CODE <input type="text"/> <input type="text"/>
Name of Respondent _____	
Telephone Number of facility/respondent _____	
Name of Interviewer _____	
Date: _____	

Implementation of planned activities – Talk to the RDHS/DDHS/Project Coordinator		
Person not available (go to next section)99		
100	Did you ever see copies of the QHP sub-agreement programme description and budget?	Yes.....1 No.....2

HR –Talk to the HR Manager		
Person not available (go to next section)99		
101	Does every staff in this region/district hold a copy of their job description?	Yes, 100%.....1 Yes >50%.....2 Yes <50%.....3 No.....4
102	How many managers or supervisors have been trained in performance appraisal?	<input type="text"/> <input type="text"/>
103	How many personnel appraisals have you conducted and/or received in the last year? (If any, ask to see appraisal reports)	<input type="text"/> <input type="text"/> <input type="text"/>
104	REGION ONLY: Have all newly recruited or posted staff in the last year been given a formal orientation/induction? (If YES ask for evidence)	Yes, 100%.....1 Yes >50%.....2 Yes <50%.....3 No.....4 No new staff...5

Indepth Supervision/On-the Job Training (IDS/OJT) or Facilitative supervision – Talk to the person responsible for technical supervision			
Person not available (go to next section)99			
105	Number of supervisors trained in facilitative supervision or IDS/OJT	<input type="text"/> <input type="text"/> <input type="text"/>	
106	Are written plans for supervisory visits available?	Yes.....1 No.....2	
107	Are supervisory checklists/ IDS OJT tools used?	Yes.....1 No.....2	
108	How long ago was the last supervisory visit or OJT/IDS done?	3 months or less.....1 4 – 6 months2 More than 6 months...3	
109	Can we see the latest report?	Yes Seen.....1 No, Not Seen.....2	
110	What was done at the last supervisory visit? (unprompted) –What did you do at the last visit?	Mentioned	Not Mentioned
CIRCLE ALL THAT THEY MENTION – DO NOT READ			
	a). Checked/Review Registers	1	2
	b). Discussed Problems (welfare of supervisees, access to facility)	1	2
	c). Discussed policy or administrative issues	1	2
	d). Discussed technical issues	1	2
	e). Held a staff meeting	1	2
	f). Observed Clinical Work	1	2

	g). Gave feedback on the Visit	1	2
	h). Other- specify _____	1	2
111	How many supervisory visits including IDS/OJT were conducted in the last quarter?	<input type="text"/>	<input type="text"/>
112	Do you send feedback to the facilities?	Yes.....1	No.....2
113	Do you have copies of the feedback reports? (verify)	Yes and seen1	Yes and not seen ...2 No, not seen.....3

Financial reporting – Talk to the Accountants		
Person not available (go to next section)99		
114	For RHMTs - Have financial reports been submitted to QHP for the last month? If not facilitate submission. Reason for non-submission:	Yes.....1 No.....2 NA.....8
115	For DHMTs, have receipts and financial records for sub-agreement activities (e.g FP campaign) been completed and submitted to the RHMT? Reason for non-submission:	Yes.....1 No.....2 NA.....8

Activity reporting – Talk to the Health Information Officer/Training Coordinator		
Person not available (go to next section)99		
116	Have all quarterly SO7 Reporting Forms been filled in and submitted? If not, facilitate transmission.	Yes.....1 No.....2

IDSR – Talk to IDSR Coordinator		
Person not available (go to next section)99		
117	Do you have a check sheet or record showing the timeliness of the weekly and monthly surveillance returns? (Ask to see)	Yes.....1 No.....2
118	Is there a monthly trend analysis of graphs for Malaria cases and deaths displayed on a billboard (updated to most recent quarter)?	Seen.....1 Not Seen.....2
119	Has there been any disease outbreak(s) in your district /region in the past 12 months? What disease(s)? _____	Yes.....1 No.....2
120	If Yes – was the outbreak(s) investigated and was a report written?	Yes.....1 No.....2

Service Statistics (FP USERS AND COMMODITIES) – DISTRICT ONLY

121	Jan 2009	Feb 2009	Mar 2009
New Acceptors			
Continuing Users			

STOCK OUTS OF ANY METHOD IN THE LAST SIX MONTHS. **Mark 'X'** under method that had a stock-out

122	Lo-Fem	Ovrette	Male Cond	Fem Cond	Copper T	Micro-G	Micro-n	Depo	Norigynon	Implan t

Jan – Mar 2009

		Hospitals	Health Centres	CHPS Comp	Other
123	How many facilities/Units reported on FP service statistics for this period?				
124	How many facilities/Units reported on ANC service statistics for this period?				
125	How many facilities reported on malaria cases for this period?				
126	How many facilities reported on diarrhea cases for this period?				

CONCLUSION / WRAP-UP WITH RDHS/DDHS/PROJECT COORDINATOR

On a scale of 1 to 5 (where 5 represents the highest mark), how would you rate the overall performance of QHP project in supporting health care services in your facility/district? 5. Excellent 4. Very good 3. Good 2) Satisfactory 1) Poor 99) Don't Know_ (Indicate DK if respondent does not know about QHP)

What are some of the most important contributions QHP has made towards health care improvement

1) _____

2) _____

3) _____

NOTE HERE YOUR OBSERVATIONS

Summary findings and observations (positive)
1.
2.
3.
4.
5.
Summary findings and observations (challenges)
1.
2.
3.
4..
5.

COMMENTS