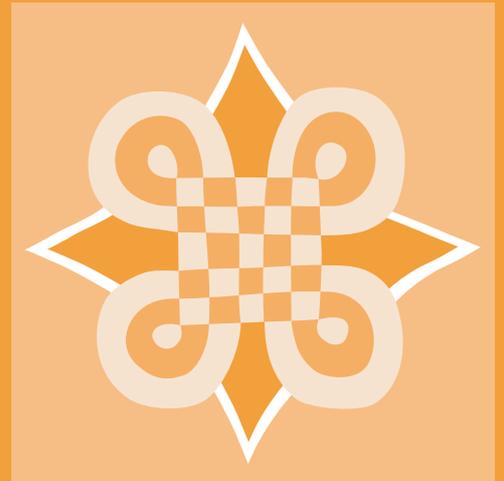
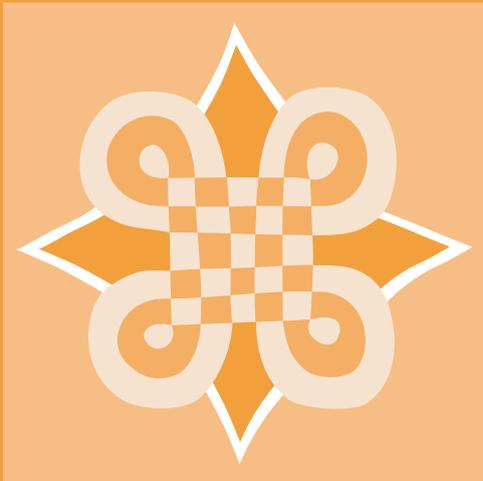
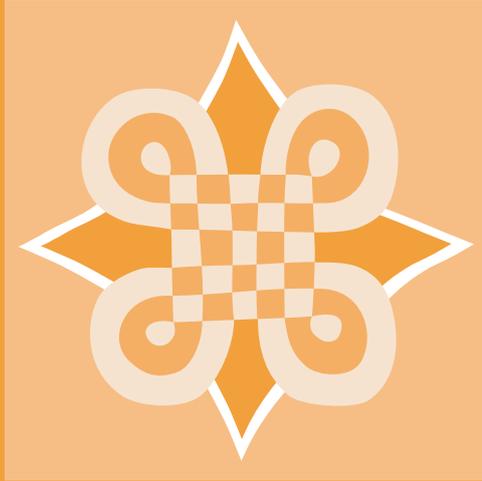


Ghana



Service Provision Assessment Survey 2002

Ghana

Service Provision Assessment Survey

2002

Ghana Statistical Service
Accra, Ghana

Health Research Unit
Ministry of Health
Accra, Ghana

ORC Macro
Calverton, Maryland, USA

August 2003

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Photographers: Susheela Engelbrecht (left) and Melissa May (centre and right)

This report summarizes the findings of the 2002 Ghana Service Provision Assessment (GSPA) Survey carried out by the Ghana Statistical Service together with the Ministry of Health and the Health Research Unit of the Ghana Health Service. ORC Macro provided financial and technical assistance for the survey through the USAID-funded MEASURE *DHS+* programme, which is designed to assist developing countries to collect data on fertility, family planning, and maternal and child health. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development

Additional information about the GSPA may be obtained from the Ghana Statistical Service (GSS), P.O. Box 1098, Accra, Ghana (telephone 233-21-671732; fax 233-21-671-731). Additional information about the MEASURE *DHS+* project may be obtained by contacting: MEASURE *DHS+*, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (telephone 301-572-0200; fax 301-572-0999; e-mail: reports@orcmacro.com; internet: www.measuredhs.com).

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Preface

The Ghana Statistical Service (GSS) together with the Ministry of Health, and the Health Research Unit (HRU) of the Ghana Health Service, is pleased to present the results of the Ghana Service Provision Assessment (GSPA) survey conducted in 2002.

This survey builds on the experience of the Situation Analysis Study (SAS), conducted in 1993 and 1996, which focused on the delivery of family planning and maternal/child health service. The 1993 study revealed some of the key issues that were likely to discourage people from using such services; the 1998 SAS, therefore, added a module on quality of health care in the facilities. The findings from the SAS helped to provide intervention measures for improving the quality of service, including the preparation and implementation of protocols and principles for the use of providers.

The GSPA represents a shift in focus to embrace other key important area in health delivery. The four priority areas that the survey covered are:

- Child health promotion and treatment of childhood illnesses
- Maternity care (antenatal, delivery, postpartum, and new born)
- Family planning services, and
- Services for the prevention and management of sexually transmitted infections (STIs) and HIV/AIDS.

The study allowed for a systematic nationwide examination of the strengths and weaknesses of health delivery systems, with particular attention to availability and functioning of health service. This is achieved by focusing on the facilities, staff and service provided in order to have an insight into the functioning of the system.

The results of the GSPA survey complement the results of the Ghana Demographic and Health Survey conducted in 1998. The findings will facilitate the evaluation of services in the four priority areas, which could ensure optimal utilization of facilities. This will also help improve efficiency and effectiveness in the entire health delivery system.

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**AG GOVERNMENT STATISTICIAN/
PROJECT DIRECTOR**

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We are very grateful to the Ministry of Health and the Ghana Health Service staff for their very useful contributions. In addition to MOH/GHS we are most grateful to the National Population Council (NPC), Planned Parenthood Association of Ghana (PPAG), and Ghana Registered Midwives Association (GMRA) for their support in both human and material (vehicles) resources. The contribution of the Government of Ghana, in the form of personnel, office infrastructure and vehicles for fieldwork is gratefully acknowledged.

Our appreciation also goes to all members of the National Steering Committee and the project personnel for their immense and diverse contribution towards the successful contribution of this study.

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**AG GOVERNMENT STATISTICIAN/
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Key Findings

The 2002 Ghana Service Provision Assessment (GSPA) survey was conducted in a representative sample of 428 health facilities throughout Ghana. The survey covered hospitals, polyclinics, health centres, health posts, clinics, and private maternity homes and included both government (public) and approved nongovernment (private) facilities. The GSPA used interviews with health service providers and clients as well as observations of provider-client consultations to obtain information on the capacity to provide and the existence of functioning systems to support quality services. The areas addressed were the overall facility infrastructure and specifically child health, family planning, maternal health services, and services for sexually transmitted infections (STIs) and HIV/AIDS. The objective was to assess the strengths and weaknesses of the infrastructure and systems to support these services, and to assess the adherence to standards in the delivery of curative care for children, family planning, antenatal care, and STI services.

Findings can supplement household-based health information from the 1990 Ghana Demographic and Health Survey (Ghana Statistical Service and Macro International, 1999), which provides information on the overall population's health status and use of services.

The GSPA survey was undertaken by the Ghana Statistical Service (GSS) supported by the Health Research Unit (HRU), the Ministry of Health (MoH), the Ghana Registered Midwives Association (GRMA), the Planned Parenthood Association of Ghana (PPAG), and the National Population Council (NPC), with technical assistance from ORC Macro, under the MEASURE DHS+ project. The study was funded by the United States Agency for International Development (USAID) and the Government of Ghana.

Facility Infrastructure and Infection Prevention

Thirty-eight percent of all facilities have a regular, 24-hour supply of electricity or a generator. Twenty-nine percent of facilities have no electricity at all. These were mainly clinics (47 percent) and health centres (34 percent).

Sixty-six percent of all facilities have an onsite water source, and 39 percent indicating that water is available year-round.

Soap was available in all assessed service delivery areas in 70 percent of facilities, and water in 68 percent of facilities. Gloves were available in all relevant service areas in 54 percent of facilities, while disinfecting solution was available in all relevant service areas in only 24 percent of facilities.

Sixty-seven percent of facilities had functioning equipment for either high-level disinfecting (HLD) or sterilizing, but only 51 percent of facilities had both the equipment and staff present who knew the correct processing time.

Service Availability

A full package of maternal, child, and reproductive health services, offered at a minimum frequency (curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services—temporary methods of family planning, antenatal care, immunization, and growth monitoring—provided at least 1 day per week), is available in 28 percent of all facilities.

Sixty-nine percent of facilities offer immunization services at the facility (either by facility staff or external staff) and 57 percent of facilities provide immunization services both at the facility and through an outreach program.

Eighty-eight percent of all facilities had at least one qualified provider (medical doctor, medical assistant, public health nurse, professional midwife or professional nurse); however, 26 percent of the clinics did not have a qualified provider.

Seventy-two percent of hospitals, but only 13 percent of all facilities had all items necessary to provide quality 24-hour emergency services. These were overnight or inpatient beds, at least two qualified staff, 24-hour onsite or on-call staffing, access to 24-hour emergency communication, a client latrine, and an onsite water source at least some time during the year. All elements plus a year-round onsite water supply and a 24-hour regular supply of electricity (or a generator) were available at 32 percent of hospitals and 5 percent of all facilities.

Facility Management

Twenty-three percent of all facilities had a management committee that holds documented meetings at least every 6 months. Hospitals were most likely to have such a committee.

Documented quality assurance activities were observed in 14 percent of all facilities.

Seventy percent of facilities received an external supervisory visit during the 6 months preceding the survey. At 56 percent of facilities, at least half of the interviewed providers were supervised in the previous 6 months.

Forty-nine percent of health care workers had received in-service training in the past 12 months and an additional 26 percent had received in-service training 13–59 months preceding the survey.

Twenty-eight percent of all facilities had all the supportive management practices, which include the following: facility received an external supervision in the past 6 months, at least 50 percent of all interviewed health care workers received in-service training in the past 12 months and were supervised during the past 6 months.

Eighty-six percent of facilities reported routinely charging for curative care for adults and 51 percent reported charging for children.

Management of Vaccines, Contraceptives, and Medicines Supplies

Thirty-seven percent of facilities storing vaccines had all items present for a cold chain monitoring system (thermometer in refrigerator, an up-to-date temperature chart, and refrigerator temperature between 0° to 8°C). Health centres were most likely to have all the items present.

Only 6 percent of facilities with observed stored vaccines had all the items present for monitoring stocks of vaccines (no expired items present; items stored by expiration date; and up-to-date inventory available). The weakest element in monitoring stocks was an up-to-date inventory; only 12 percent of facilities had this in place. However, only 9 percent of facilities had expired vaccines.

Expired medicines or contraceptives were rarely found; they were in only 3 and 2 percent of facilities, respectively.

Service-Specific Findings

Use of individual client cards is universal.

Most service delivery areas provide visual and auditory privacy for clients.

Service delivery protocols or guidelines were available in 57 to 74 percent of the service delivery areas, depending on the service, except for HIV/AIDS services. Protocols or guidelines for HIV/AIDS services were available in only 2 percent of the service delivery areas of the facilities offering this service.

Visual aids for health education were available in approximately half of the facilities offering antenatal care, STI, and HIV/AIDS services and for 92 percent of facilities offering family planning services, but they were only available for 27 percent of facilities offering child health services.

Child Health Services

The three essential child health services (curative care, growth monitoring, and routine vaccination at the facility) are available in 63 percent of all facilities. Services are best integrated in hospitals and health centres.

Curative care is provided 5 or more days per week in almost all the facilities offering this service (98 percent). Immunization and growth monitoring is offered mostly 1 or 2 days per week (54 percent and 61 percent, respectively).

Seventy-one percent of facilities offering child vaccination services and storing vaccines had all basic child vaccines available (BCG, polio, HepB/Hib (or DTP) and measles). Forty-three percent of facilities had all basic child vaccines and yellow fever vaccine available.

Forty-one percent of facilities offering child vaccination services did not have an adequate supply of syringes and needles.

Less than half (43 percent) of facilities offering child vaccination services documented either DPT dropout or measles coverage.

Capacity to provide prereferral care for seriously ill children is very limited because of the lack of prereferral medication. Only 2 percent of clinics and 6 percent of health facilities had the prereferral medicines available.

Preventive practices, such as assessing nutritional status, feeding practices, and immunization status are not done routinely.

Comparison between observed assessment, prescribed treatment, and final diagnosis, determined by the provider, demonstrates that the use of antibiotics seems very high and that the use of antimalarials and solution prepared from oral rehydration salt (ORS) is insufficient.

Family Planning Services

Many facilities (89 percent of all facilities) offer at least one modern, temporary method of contraception, and approximately half of all facilities offer counselling on the rhythm method. Male or female sterilization is offered in 76 percent of hospitals.

Progesterone-only injectables, combined oral contraceptives, and male condoms are the methods most frequently offered. The methods were available in approximately 80 percent of facilities offering these methods.

Visual aids were available in almost all of the facilities offering family planning services.

All conditions for quality pelvic examinations (visual privacy, examination bed, examination light, and speculum) were available in only 15 percent of facilities offering family planning services. The examination light was most frequently missing (in 78 percent of facilities). All items for infection prevention (soap, water, clean gloves, disinfecting solution, and sharps box) were available in 19 percent of facilities, with disinfecting solution and water most frequently missing.

Forty percent of the family planning providers offered STI treatment.

Equipment for providing specific contraceptive methods was not universally available. Sixty-three percent of facilities providing intrauterine devices (IUDs) had all the equipment for IUD insertion, and 60 percent of the facilities offering implants had all the equipment necessary for implant insertion.

A complete client history was obtained from 44 percent of first-visit clients.

Client knowledge could be improved; depending on the method, between 51 and 79 percent of clients asked after counselling knew the answer to a specific question about their method.

Maternal Health Services

Antenatal care is offered in 88 percent of facilities and is available 5 days per week in 78 percent of those facilities. Postnatal care is available in 70 percent of all facilities and postabortion care in 21 percent.

Tetanus toxoid (TT) immunization services were available on the same day as antenatal care services in 78 percent of facilities, most commonly in hospitals.

Half of all facilities offering antenatal care had all essential supplies for basic antenatal care (iron and folic acid tablets, tetanus toxoid, blood pressure apparatus, and faetoscope). Tetanus toxoid was missing in 31 percent of facilities and iron and folic acid tablets in 11 and 21 percent, respectively.

The lack of medicines for managing common complications during pregnancy was obvious in all facilities, including hospitals. Treatment for gonorrhoea and vaginal candidiasis was most commonly missing.

Anaemia testing (68 percent), urine protein testing (70 percent), and prescribing malaria prophylaxis (71 percent) were commonly reported as routine components of antenatal care. However, syphilis testing (4 percent) and voluntary counselling and testing (VCT) for HIV/AIDS (8 percent) were not. Hospitals were most likely to routinely include all the tests in antenatal care services.

Assessment of first-visit antenatal care clients does not uniformly include all the items defined as important. Complications during prior pregnancies were assessed in 59 percent of the observed first-visit clients with a prior pregnancy.

Advice on risk symptoms is not a routine component of antenatal care counselling (observed with 27 percent of first-visit clients, 25 percent of follow up clients, and reported by 35 percent of all clients).

Delivery services are available in 83 percent of all facilities but caesarean sections in only 11 percent. Ninety-two percent of hospitals provide this service. Emergency transportation support for maternity emergencies is available in 41 percent of all facilities.

Infection prevention items were available in only one out of three delivery service areas. Disinfecting solution and a sharps box were the items most often missing.

Sixty-five percent of all facilities reported being capable of manually removing a retained placenta. Fifteen percent of facilities offer blood services, with hospitals the most likely to do so.

STIs and HIV/AIDS

STI services are offered in 67 percent of all facilities and HIV/AIDS services in approximately one out of four facilities. Most facilities provide STI services at least 5 days per week.

Laboratory tests for the different STIs were not widely available. Hospitals and private religious facilities were most likely to conduct the tests.

Medicines for treatment of STIs were available in 32 percent of facilities. Hospitals were most likely to have at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis.

Physical examination of STI clients is not done routinely. Sixty-four percent of male clients were examined and only 47 percent of female clients were. Of the female clients examined, 69 percent had a pelvic examination.

Of the facilities offering HIV/AIDS services, only 41 percent are capable of testing for HIV/AIDS. Twenty-nine percent of those facilities indicated that they never use the test.

Of facilities that have TB services as a routine component of HIV/AIDS services, 84 percent had the ability to conduct a sputum test.

TB drugs are not widely available.

Abbreviations

AFB	Acid-fast bacillus
AIDS	Acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention
ANC	Antenatal care
ARH	Adolescent reproductive health
ARI	Acute respiratory infection
ART	Anti-retroviral treatment
BEOC	Basic essential obstetric care
BCG	Bacille de Calmette et Guérin
CDC	Centers for Disease Control and Prevention
CEOC	Comprehensive essential obstetric care
CHPS	Community-based health planning and services
CPI	Client provider instruction
D&C	Dilatation and curettage
DDHS	District director of health services
DHA	District health administration
DHMT	District health management team
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DPT	Diphtheria, pertussis, and tetanus
DPT/HepB/Hib	Diphtheria, pertussis, and tetanus/Hepatitis B/Haemophilis Influenza Type B
ELISA	Enzyme-Linked Immunosorbent Assay
EmOC	Emergency obstetric care
EPI	Expanded Program on Immunization
FEFO	First expired first out
FHI	Family Health International
FP	Family planning
GDHS	Ghana Demographic and Health Survey
GDP	Gross domestic product
GM	Growth monitoring
GMRA	Ghana Registered Midwives Association
GSPA	Ghana Service Provision Assessment
GSS	Ghana Statistical Service
HAART	Highly active Antiretroviral Therapy
HASS	Health administration and support services
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HRDD	Human resource development division
HRU	Health research unit
HW	Health care worker
IEC	Information, Education, Communication
INH	Isonicotinic acid hydrazide (isoniazid)
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IUD	Intrauterine device
MCH	Maternal and child health
MMWR	Morbidity and Mortality Weekly Report

MNH	Maternal and Neonatal Health Project
MoH	Ministry of Health
MTHS	Medium-Term Health strategy
MVA	Manual Vacuum Aspiration
N	Number
NACP	National AIDS Control Program
NGO	Nongovernmental organization
NPC	National Population Council
OI	Opportunistic Infection
OPD	Outpatient department
OPV	Oral polio vaccine
ORC	Opinion Research Corporation
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
OVC	Orphans and vulnerable children
PAC	Postabortion Care
PHC	Public Health Care
PLHA	People living with HIV/AIDS
PMH	Private Maternity Home
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PPAG	Planned Parenthood Association of Ghana
PPME	Policy, Programme, Monitoring, and Evaluation
QA	Quality assurance
RDF	Revolving Drug Fund
RDHS	Regional Director of Health Services
RHA	Regional Health Administration
RPR	Rapid plasma reagin
RTI	Reproductive tract infection
SAS	Situation Analysis Study
SC	Curative care for sick children
SDL	Self-Direct Learning
SPA	Service Provision Assessment
SSDM	Supplies, stores and drug management
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TFP	Temporary family planning
TST	Time-steam-temperature-sensitive (tape)
TT	Tetanus toxoid
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
U.S.	United states
USAID	United States Agency for International Development
U5MR	Under-5 Mortality Rate
VCT	Voluntary counseling and testing
VDRL	Venereal disease research laboratory
WHO	World Health Organization

1.1 Overview

The 2002 Ghana Service Provision Assessment (GSPA) is a survey designed to obtain information about the general performance of facilities that offer maternal, child, and reproductive health services, as well as services for sexually transmitted infections (STIs) including HIV/AIDS. From a representative sample of public and nongovernment facilities, information was collected to provide a picture of the strengths and weaknesses of the service delivery environment for each assessed service. The information on health services and health service providers from the GSPA survey will enable policymakers and program administrators to develop effective strategies for improving health service utilization and coverage and prioritizing resources in ways that will lead to improved health outcomes.

The GSPA survey provides representative regional and national information on both government and nongovernment facilities. The findings complement the household-based health information from the 1998 Ghana Demographic and Health Survey (Ghana Statistical Service and Macro International, 1999). This survey provided information on the health of the population and the utilization of health services.

1.2 Institutional Framework and Objectives of the GSPA Survey

The GSPA survey was undertaken by the Ghana Statistical Service (GSS), supported by the Health Research Unit (HRU), the Ministry of Health (MoH), the Ghana Registered Midwives Association (GRMA), the Planned Parenthood Association of Ghana (PPAG), and the National Population Council (NPC), with technical assistance from ORC Macro under the MEASURE *DHS+* project. The study was funded by the United States Agency for International Development (USAID) and the Government of Ghana.

The primary objectives of the GSPA survey were the following:

- To describe the preparedness of government and nongovernment health facilities in Ghana to provide quality child and reproductive health services
- To describe the preparedness of government and nongovernment health facilities in Ghana to provide quality services for sexually transmitted infections (STIs) including HIV/AIDS
- To identify gaps in the support services, resources, or the processes used in providing client services that may affect the ability of facilities to provide quality services
- To describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed
- To provide comparisons on findings between regions in Ghana and, at a national level, between different types of facilities as well as those operated by different authorities (i.e., government or nongovernment)
- To describe the extent to which clients understand what they must do to follow up on the service received so that the best health outcome is achieved.

1.3 GSPA Survey Content and Methods for Data Collection

The GSPA survey focused on basic health services that have been developed to improve the health status of the population, particularly that of women and children. Four high-priority health services, all interrelated in various degrees, were assessed: 1) child health, 2) family planning, 3) maternal health, and 4) sexually transmitted infections (STIs) including HIV/AIDS.

For each selected service, the presence and functioning of components considered essential for the provision and maintenance of quality health services were assessed. The components are those commonly promoted in programmes supported by organizations such as USAID, the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and other donors. The GSPA survey also assessed the presence of more sophisticated components, such as high-level diagnostic and treatment modalities and support systems for health services, which are most often introduced after basic services have been put in place.

The child health component was designed to assess the availability of preventive (immunization and growth monitoring) and curative health services, with a focus on the process followed in providing services to the sick child. Guidelines for Integrated Management of Childhood Illness (IMCI) set the standard against which service provision is measured.

The family planning component assessed available family planning services, with a focus on the process followed in counselling and providing contraceptive methods to the family planning client.

The maternal health component assessed all available maternal health services, including inpatient delivery and caesarean section, with a focus on the process used in counselling and screening during antenatal care visits.

The sexually transmitted infections component assessed the availability of services for diagnosing and treating STIs, with a focus on the process used in assessing and counselling the STI client. For HIV/AIDS, the availability of services related to counselling, testing, management, and prevention was assessed.

Four types of survey instruments were used for data collection:

- **Facility Resources Questionnaire** on resources, infrastructure and support services. The Facility Resources Questionnaire was designed to obtain information on the facilities' preparedness to provide each of the priority services. The questionnaire was used to collect information on the availability of specific items (including their location and functional status), components of support systems (such as logistics, maintenance, and management), and facility infrastructure, including the environment in which the services are delivered. The resources assessed were those necessary to provide a level of service that meets generally accepted standards. The support services are those that are commonly acknowledged as essential management tools for maintaining health services.
- **Provider interview.** Providers of health services were interviewed for information on their qualifications (training, experience, continued in-service training), the supervision they had received, and their perceptions of the service delivery environment.
- **Observation protocols tailored to the service being provided.** Observations of consultations for sick children, antenatal care, family planning, and STIs were conducted to assess the extent to which service providers adhered to standards based on generally accepted

practices for good quality service delivery. The process used in conducting specific procedures and examinations and the content of information exchanged between the provider and the client (history, symptoms, and counselling) were components of the observation.

- **Exit interview with the client who was observed receiving a service.** The exit interview assessed the client's understanding of the consultation or examination as well as his or her recollection of instructions received on treatment and preventive behaviour. The ability to recall key messages increases the likelihood that a client will be able to successfully follow treatment protocols and implement preventive behaviours that optimize health outcomes. Information was also collected on the client's perception of the service delivery environment.

The survey instruments were developed to provide information relating to the following basic questions:

1) To what extent are the surveyed facilities prepared to provide high-priority services? (Availability of Resources)

For each of the high-priority services, the Facility Resources Questionnaire and the provider interview gathered information on whether the facility has the capacity to provide the service at an acceptable standard of quality.

Capacity was measured by the presence of essential equipment and supplies in a location reasonable for providing a service. The items assessed for quality of services included training and supervision of staff; availability of service delivery protocols and materials for client education; availability and utilization of health information records; the service delivery environment; and facility systems for maintaining equipment, supplies, infection control, and quality assurance.

2) To what extent does the service delivery process follow generally accepted standards? (Care Process)

The GSPA survey assessed whether the procedures followed in service delivery meet standards for acceptable content and quality. The assessment was made by observing consultations between clients and providers. The main services observed were consultations for sick children, for STIs, for family planning, and for antenatal care. The observation focused on the information shared between the client and the provider and the process the provider followed when assessing the client, conducting procedures, and providing treatments.

The exit interview collected information on the client's perspective regarding information shared and received. The results of the exit interview provide data on the quality of client-provider interaction.

3) To what extent do support systems for maintaining or improving services exist, and how well are they functioning? (Support Services)

The Facility Resources Questionnaire collected information on whether there are specific support services for a health system and, if so, evidence that they are functioning. The systems that were assessed are management committees; quality assurance programmes; logistics for medicines, equipment maintenance, and infection control; and various monitoring systems (such as following service coverage rates and outcomes from referrals).

The GSPA survey collected data on the basic infrastructure of each facility that may contribute to better standards of service and increase client utilization. Information collected to assess this component

included the presence of electricity and water and the availability of amenities and services (e.g., types of services, days services are offered, and staffing levels).

4) What are the issues that the clients and service providers consider relevant to their satisfaction with the environment in which services are delivered?

The exit interview and provider interview were used to collect information on issues related to client and provider satisfaction.

1.4 Sample

A representative sample of facilities; a sample of health service providers at each facility; and a sample of sick child, family planning, antenatal, and STI clients were selected.

1.4.1 Sample of Facilities

The sample was selected to provide national and regional representation of the health facilities offering maternal, child, and reproductive health services. These included various types of hospitals, health centres, and other health units managed by the government (public) or by nongovernment organizations (private). Private pharmacies, doctor's offices, and private clinics were not included in the sample because no credible frame was available to ensure representativeness of the sample.

Among public-sector facilities, the sample covered hospitals, health centres, and clinics. Teaching/regional/district hospitals and polyclinics were selected for representing hospital services, health centres for representing health centres, and health posts and clinics for representing clinics. The private religious facilities represent all nongovernment facilities operated under a religious authority. The sample of the private religious facilities also covered hospitals, health centres, and clinics. Facilities operated by GRMA and PPAG were sampled separately. In the analysis by facility type, health centres and clinics were separated out. PPAG clinics were combined with clinics and health posts (both MoH and private religious). Private maternity homes (PMHs) were analyzed separately. In the analysis by operating authority, the division was made between public, private religious (including all nongovernment facilities operating under religious authority), and other private (including GRMA and PPAG) facilities.

The total sample size was determined based on funding, logistic considerations, and the minimum sample size for regions required, allowing the levels of analysis desired. The number of facilities selected for the survey was 428, out of a national frame of 1,444 facilities that offer services in the four priority health areas. Before the selection, the facilities in the frame were grouped by region and category (combination of facility type and operating authority), as described above. Within regions, the service delivery points were arranged by district before a random start was chosen to systematically select the required sample, with proportional representation to the number of facilities in each region. The result of the sampling procedure, therefore, is a sample that is self-weighted within a combination of region and type of facility.

To ensure that the sample included an appropriate number of facilities to permit analysis according to facility type and region, the survey oversampled facilities in some regions. Because the sample distribution for the selected health facilities was not directly proportional to the distribution of the facilities in the area, some types of facilities and/or facilities in some regions were overrepresented in the final national sample. To avoid the bias this would introduce at the national level, the data were weighted during the analysis. Table 1.1 provides information on the weighted percent distribution of facilities included in the sample as well as the weighted and unweighted number of facilities, and Table 1.2 provides this information for the facilities offering each assessed service. The number of cases reported in all subsequent tables in the report will be the weighted number of facilities. In examining the results by

region and/or facility type, however, it should be remembered that the estimates for the categories in which facilities were overrepresented in the sample have greater precision due to that oversampling than is implied by the weighted number.

<u>Table 1.1 Sample distribution of facilities by type of facility and region</u>			
Weighted percentage of facilities, weighted and unweighted number of facilities, by type of facility, operating authority, and region, Ghana SPA 2002			
Background characteristics	Weighted percentage of total sample	Weighted number of facilities	Unweighted number of facilities in sample
Type of facility			
Hospital	10	43	63
Health centre	39	166	140
Clinic	29	125	132
PMH	22	95	93
Operating authority			
Public	67	288	254
Private religious	9	39	67
Other private	23	100	107
Region			
Western	9	39	35
Central	7	30	30
Greater Accra	7	28	34
Volta	17	74	66
Eastern	12	50	56
Ashanti	16	71	69
Brong Ahafo	13	54	52
Northern	10	41	45
Upper East	5	20	21
Upper West	5	22	20
Total	100	428	428

Table A-1.1 provides additional details on the distribution of the sample, by type of facility and geographic location. Table A-1.2 provides additional detail on the weighted and unweighted numbers of facilities in the sample, by type of facility before grouping for analysis.

<u>Table 1.2 Percentage of facilities providing specific services</u>			
Weighted percentage of facilities offering the specific service, weighted and unweighted number of facilities offering the specific service, by service provided, Ghana SPA 2002			
Services provided at the facility	Weighted percentage of total sample	Weighted number of facilities providing service	Unweighted number of facilities in sample
Immunization	63	268	269
Consultation for sick children	94	404	405
Family planning	90	386	383
Antenatal care	88	375	373
Delivery care	83	357	359
Sexually transmitted infection care	67	286	301
HIV/AIDS care	26	111	136
Total	100	428	428

1.4.2 Sample of Health Service Providers

The sample of health service providers was selected from providers who were present in the facility on the day of the survey and who provided services in the four areas assessed by the GSPA survey. In facilities with fewer than eight health providers, all of the providers present on the day of the visit to the unit were interviewed. In the facilities where there were more than eight providers, all providers whose work was observed were interviewed, and a random sample of the providers not selected for observation were interviewed to obtain a minimum of eight provider interviews. The selection was carried out to ensure that, if available, at least one provider from each service was interviewed, even if no observations were conducted for that service. A provider was defined as a health care worker who actually provided client services of some type (counselling, health education, or consultation services). A nurse who only completed registers and who never provided any type of professional client services was not considered a provider. A maximum of three providers, for any given service, were interviewed. In total, 28 percent of eligible doctors, 65 percent of medical assistants, 31 percent of eligible nurses, and 19 percent of other or auxiliary staff were interviewed.

The results of the GSPA survey are based on the responses of the staff who were present on the day of the survey. The results of the interviews may be biased to the extent that these staff may not be representative of the staff who normally provide the services of interest in the facility. It is likely, however, that for most facilities, the interviewed staff are representative of the broader group since interviews were conducted during the facility's regular operating hours. So that the relevant providers were interviewed in each facility, providers were interviewed without consideration of their representativeness of the qualification and numbers of staff who were assigned to the facility; therefore, the provider data were weighted during analysis to account for the differentials caused by oversampling or undersampling a particular qualification of a provider in a facility type and region. The provider weight also takes into account the oversampling of the facilities described above.

Table 1.3 provides information on the weighted proportion of the providers as a percentage of the whole, within the type of facility, region, and qualification of provider, and the weighted and unweighted number of interviewed providers.

The number of cases reported in all subsequent tables in the report dealing with providers will be the weighted number of providers. In examining the provider data, it should be noted that estimates for the categories in which facilities and/or providers were overrepresented in the sample have greater precision due to that oversampling than is implied by the weighted number.

Table 1.3 Sample numbers for interviewed providers			
Weighted percentage of interviewed providers, weighted and unweighted number of interviewed providers, by type of facility, operating authority, region, and qualification of provider, Ghana SPA 2002			
Background characteristics	Weighted percentage of interviewed providers	Weighted number of interviewed providers	Unweighted number of interviewed providers
Type of facility			
Hospital	46	663	444
Health centre	27	396	478
Clinic	20	292	340
PMH	7	98	186
Operating authority			
Public	77	1,112	957
Private religious	16	234	282
Other private	7	102	209
Region			
Western	10	141	134
Central	7	106	120
Greater Accra	16	231	140
Volta	14	201	232
Eastern	16	228	184
Ashanti	15	218	222
Brong Ahafo	10	139	160
Northern	7	107	132
Upper East	2	32	58
Upper West	3	47	66
Qualification of provider			
Physician	6	87	101
Medical assistant	4	58	122
Public health nurse	3	36	61
Professional midwife	29	416	538
Professional nurse	7	99	45
Auxiliary nurse	25	359	339
Midwife assistant	4	51	86
Other technical/pharmaceutical	1	18	5
Ward assistant	13	187	75
Other	10	138	76
Total	100	1,448	1,448

1.4.3 Sample for Observations

The sample of observations was opportunistic—clients were selected for observation as they arrived—because there was no way to know how many eligible clients would come to the facility on the day of the survey. Where numerous clients were eligible for observation, the rule was to observe a maximum of five clients for each provider of the service, with a maximum number of 15 observations in any given facility for each service. In practice, fewer clients than were eligible were observed; this occurred because logistic arrangements sometimes resulted in missed observations. Any family planning or antenatal care client who was also assessed for symptoms of STI was observed both for elements related to STI services and elements related to either family planning or antenatal care, whichever was relevant. An attempt was made to interview the caretaker for all observed sick children and to interview all family planning, antenatal care, and STI clients before they left the facility.

When there were several eligible clients waiting for service, an effort was made to ensure that children with a sickness other than injury or skin or eye infection were selected for observation and that there was a mixture of new and follow up antenatal care and family planning clients observed. The ratio observers aimed for was “2 new for every 1 follow up case.” The flow of cases and the logistics of organizing observations, however, did not always allow this objective to be met. At the end of the day, data collectors collected data on the total number of eligible clients who attended the facility that day.

The observations were weighted using facility weights to adjust for overrepresentation of facilities (and subsequent observations) in the sample. Results of the GSPA survey are, again, potentially biased because the clients who were present on the day of the survey may not be representative of the clients who normally receive the services of interest in the facility.

Table 1.4 provides information on the weighted proportion of the observations for each service (as a percentage of the whole), the weighted number of observations utilized during analysis, and the actual number of observations.

Table A-1.3 provides information on the size of catchment populations, and Table A-1.4 presents the median numbers of staff assigned to facilities by type of facility, operating authority, and region.

Table 1.4 Sample of observed and interviewed clients			
Background characteristics	Weighted percentage of observed clients	Weighted number of observed clients	Unweighted number of observed clients
CURATIVE CARE FOR SICK CHILDREN			
Type of facility			
Hospital	29	412	562
Health centre	42	597	464
Clinic	20	287	284
PMH	10	138	124
Operating authority			
Public	74	1,065	969
Private religious	16	227	328
Other private	10	142	137
Total	100	1,434	1,434
FAMILY PLANNING			
Type of facility			
Hospital	23	139	204
Health centre	38	229	175
Clinic	31	187	184
PMH	9	55	48
Operating authority			
Public	77	471	436
Private religious	10	59	60
Other private	13	80	115
Total	100	611	611
ANTENATAL CARE			
Type of facility			
Hospital	26	476	667
Health centre	40	746	601
Clinic	20	376	348
PMH	13	248	230
Operating authority			
Public	76	1,395	1,325
Private religious	11	198	274
Other private	14	253	247
Total	100	1,846	1,846
STIs			
Type of facility			
Hospital	56	38	43
Health centre	20	13	9
Clinic	21	14	14
PMH	4	2	2
Operating authority			
Public	64	43	38
Private religious	31	21	26
Other private	5	3	4
Total	100	68	68

1.5 Study Implementation

1.5.1 Data Collection Instruments

Data were collected using the four types of survey instruments described earlier. These instruments were based on generic questionnaires developed in the MEASURE *DHS+* project and were adapted after consulting with technical specialists from the MoH, USAID, and NGOs knowledgeable about the health services and service programme priorities covered by the GSPA survey.

Operational definitions were developed for the health system components that were measured. They were revised for the GSPA survey after discussions in Ghana and after the pretest. A training manual was developed and distributed to all data collectors to support standardized data collection.

1.5.2 Training and Supervision of Data Collectors

Technical advisors from the MoH and the Health Research Unit (HRU) assisted the GSS to train 54 data collectors, 48 of whom were selected. Twelve data collectors were selected to pretest the survey instruments. Three teams pretested the instruments in Greater Accra and in the eastern and central regions of the country.

All of the data collectors were nurses. Training included practical experience in completing all questionnaires in different types of health facilities, as well as role-play for the observation and exit interviews.

In total, 15 teams of three persons each participated in the data collection. Each team was composed of a team leader and two interviewers/observers. For quality control, data collection teams were supervised throughout the field activities, and for some sections of the questionnaires reinterviews were done.

1.5.3 Methods for Data Collection

Each team received a list of facilities to be visited. Data collection took one day in most facilities, with two days being allotted to hospitals, if required. In addition, if one of the observed services was not being offered on the day of the survey, the team returned on a day when the service was offered. If the service was offered, the clients for that day were observed. If the service was offered but no clients came (as occurred occasionally with consultations for sick children and with STI clients), the team did not revisit the facility.

The team leader was expected to ensure that the informant for each component of the facility survey was the most knowledgeable person for the particular health service or system component being addressed. Where relevant, the data collector indicated whether a specific item being assessed was observed, reported available but not observed, not available, or whether it was uncertain if the item was available. Equipment, supplies, and resources for specific services were required to be in the relevant service delivery area or in an immediately adjacent room to be accepted as available. Informed consent was taken from the facility director and all respondents for the Facility Resources Questionnaire, from observed and interviewed providers, and from clients for observations and exit interviews.

1.5.4 Data Analysis

Assessing the availability of items. Unless specifically indicated, the GSPA survey considered observed items to be available.

Observations. In looking at the observation data, it should be noted that many facilities provide routine services for clients separately from the actual consultation (e.g., taking blood pressures and temperatures). There is often a period between these events and the point when the primary provider assesses the client. Although GSPA survey observers were instructed to follow a client through the entire system, this was not always possible logistically. Thus, when services were being provided outside the observed consultation on the day of the survey, the observed client was assumed to have received these services. Where this type of (functional) system applies, multiple providers participate in the services received by each client. The provider who ultimately diagnosed the client and completed the prescription was defined as the primary provider.

Observation data were collected based on whether a practice occurred or a piece of information was shared (process). No attempt was made to verify whether the practice was correct or whether the information shared was correct or complete.

Development of aggregate variables. Aggregating the data into subsets makes it possible to analyze many pieces of information and to see how they relate to the overall capacity to provide quality services. It also enables the monitoring of changes in capacity to provide services and changes in adherence to standards, since there may be improvements in some items but not in others. There are not yet generally accepted aggregates of the health information collected in the GSPA survey. Initial decisions regarding the composition of a particular aggregate can be difficult, with inclusion or exclusion of items equally valid, depending on the objective of the user. The aggregate variables in this report are an initial phase in the process of developing health information aggregates. They will be refined as users provide feedback on the aggregate variables found useful (or not useful) to policymakers and programme implementers.

1.5.5 Data Management, Report Writing, and Dissemination

Data management and analysis were carried out according to the following steps:

Management of questionnaires. Completed and verified questionnaires were collected by supervisors and sent to the GSS office for editing. All “other” responses were reviewed and recoded into categories relevant for data analysis.

Data entry. Data entry was conducted by the GSS staff. CSPro software developed by ORC Macro and the U.S. Census Bureau was used for data entry. Double entry of all questionnaires was carried out to identify possible entry errors. This operation took place from June through September 2002.

Data analysis. The design of the tabulation plan and the preparation of the programmes for the production of statistical tables were carried out from October through December 2002. Data analysis and clarification of questionable results were carried out from January through March 2003. During the process of data analysis, revisions were made to the analysis plan, based on feedback from MoH and the GSPA survey technical advisors, to ensure that the analysis was appropriate for the Ghanaian health system.

Development of final report. The final report was written with input from the ORC Macro technical staff, HRU, MoH officials responsible for the programmes included in the survey, and GSS staff.

After the draft report was finalized, a workshop was held with technical personnel in the health sector to present findings and make any corrections, changes, or additional explanations that were required before final publication. This took place during October 2003.

The health care system in Ghana is confronted with the formidable task of improving and guaranteeing the health and well-being of the Ghanaian people. The health system has the responsibility of combating illnesses associated with poverty and lack of education; at the same time, it has to deal with a growing population, inadequate funding and resources, and an increasing burden on the health care system due to the HIV/AIDS epidemic.

This chapter provides a brief overview of the health care system in Ghana as it relates to infrastructure and outpatient services. The chapter provides a context in which to view the findings of the Ghana Service Provision Assessment (GSPA) survey.

Information is presented with respect to the following:

- Relevant history, including health sector reforms and reforms in drug policy
- General organization of the health care system
- Health facilities
- Health manpower
- Public health programmes
- Health insurance.

2.1 History

2.1.1 Overview of the Health Situation

The health of Ghanaians has been improving since Ghana's independence in 1960. Infant mortality rate (IMR) among Ghanaian children has fallen from 133 deaths per 1,000 live births in 1957 to 57 deaths per 1,000 live births in 1988, and the under-five mortality rate (U5MR) has decreased from 154 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 1988 (Ghana Statistical Service and Macro International, 1999). Although improvement has been seen, the Ministry of Health (MoH) is of the view that rates of change have been slow, with current rates still far from desirable. The national level rates obscure the substantial differences that exist between groups and sectors of the country, and this is of great concern to the MoH. For example, IMRs vary from less than 57 deaths per 1,000 live births in the southern part of the country to over 100 deaths per 1,000 live births in the northern part.

Table 2.1 shows the major endemic health problems of various age groups in Ghana according to the Ministry of Health. The primary causes of preventable deaths in children under five years are malaria, malnutrition, diarrhoea, and acute respiratory infections (ARI).

With the current gross domestic product (GDP) estimated as US\$390 per capita, Ghana faces economic challenges, which are reflected in Ghana's poor state of health. These economic conditions make the choices of how to use Ghana's scarce resources to positively affect health care all the more important.

2.1.2 Health Sector Reforms

The health sector has seen many changes during the past decades. Initially, the MoH assumed the role of the sole provider of services with collaboration from the missions and the paragonment institutions such as the military, the police, and the mines. Its services were oriented more toward curative care than preventive care and involved programmes that were to a large extent donor driven.

Age group	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)	Disease (percent)
<1 year	Malaria (55.8)	Acute respiratory infections (11.2)	Diarrhoeal diseases (8.3)	Skin diseases and ulcers (4.4)	Anaemia (3.6 percent)	Pneumonia (2.1)
1-4 years	Malaria (57.3)	Acute respiratory infections (9.5)	Diarrhoeal diseases (6.4)	Skin diseases and ulcers (4.7)	Anaemia (3.4 percent)	Intestinal worms (1.8)
5-14 years	Malaria (49.7)	Acute respiratory infections (7.8)	Skin diseases and ulcers (3.4)	Diarrhoeal diseases (5.4)	Home and occupational accidents (3.3)	Intestinal Worms (2.7)
15-44 years	Malaria (38.5)	Pregnancy and related complications (6.3)	Other acute respiratory infections (6.0)	Skin disease and ulcers (4.1)	Home and occupational accidents (3.3)	Gynaecological conditions (3.1)
45-59 years	Malaria (35.8)	Hypertension (9.1)	Other acute respiratory infections (6.4)	Rheumatism and joint pains (4.5)	Skin disease and ulcers (3.9)	Acute eye infections (3.1)
≥60 years	Malaria (35.3)	Hypertension (12.3)	Other acute respiratory infections (7.0)	Rheumatism and joint pains (4.9)	Skin disease and ulcers (3.6)	Acute eye infections (3.3)

In 1996, Ghana developed Vision 2020, a long-term vision for growth and development that would move it from a low-income to a middle-income country by 2020. The Vision 2020 document defines the nation's areas for priority attention in the medium to long term as follows:

- Maximizing the healthy and productive lives of Ghanaians
- Fair distribution of the benefits of development
- Attainment of a national economic growth rate of 8 percent
- Reduction of the population growth rate from 3 percent to 2.75 percent
- The promotion of science and improved technology as tools for growth and development.

The MoH had developed and published its Medium-Term Health Strategy (MTHS) document and a five-year programme of work that is to guide health development in Ghana from 1997 to 2001. The objectives of the programme of work were to achieve the following:

- Increased geographical and financial access to basic services
- Better quality of care in all facilities and during outreaches
- Improved efficiency in the health sector
- Closer collaboration and partnership between the health sector and communities, other sectors, and private providers both allopathic and traditional
- Increased overall resources in the health sector, equitably and efficiently distributed.

Its mission statement, which summarizes the overall direction of the health sector, is as follows:

As one of the critical sectors in the growth and development of the Ghanaian economy, the mission of the health Ministries, Departments and Agencies is to improve the health status of all people living in Ghana through the development and promotion of proactive policies for good health and longevity; the provision of universal access to basic health

service, and provision of quality health services which are affordable and accessible. These services will be delivered in a humane, efficient, and effective manner by well trained friendly, highly motivated, and client oriented personnel.

In 1997, the common perception was that government, religious missions, and other donor-financed nongovernment organizations (NGOs) dominated health service provision. The government had, for some years, identified primary and preventive care and the major instrument for reducing morbidity and lengthening life. Although there had been substantial progress in developing a district-based package of primary services during the 1990s, this was still being delivered unevenly and was substantially dependent on vertical programmes. Moreover, there were important differences in the approach to health service priorities being adopted by religious missions, providers, and other private providers.

Until recently, the MoH developed its own policies, implemented and regulated them, evaluated its own performance, and developed the human resources needed to run the health service. This was deemed inefficient, and as part of the overall institutional reforms, there was a decision to decentralize roles and responsibilities to different agencies.

The passage of Act 525 in 1996 established the Ghana Health Service (GHS) as the implementing body for public sector health services. This marked a clear statement of intent for the public sector service delivery component, separating the service delivery, policy, and regulatory components of the MoH. The act also paved the way for the strengthening of the regulatory bodies, especially the Food and Drugs Board, the Nurses and Midwives' Council, the Medical and Dental Council, the Traditional Medicine Board, the Funeral Homes Board, and the Private and Maternity Homes Board.

Under Act 525, the MoH has been streamlined to be the backbone for the provision of general government policy direction, resource mobilization, monitoring and evaluation, and providing administrative support for the Minister.

The Ghana Health Service was officially launched in February 2003. Although the GHS is under the administrative supervision of the MoH, GHS staff are no longer civil servants; this allows more flexible management options. In establishing the GHS, the MoH recognizes the pluralistic nature of the provision of health service in the country. The Ministry's policies aim at improving public sector services and at strengthening the Private Medical and Dental Practitioners' significant contribution to service delivery. The health sector expanded to include the government health services; private, traditional, and nongovernment providers; civil society; and community groups.

2.1.3 Reforms in Drug Policy

The revolving drug fund (RDF) was started in 1992, using capital that had accumulated in facilities through the retention of fees during the previous year. These funds were used in two ways. A portion was withdrawn from facilities and used to form the seed capital of the regional medical stores, and the remainder was left at the health facility as the seed capital for the revolving drug fund. Guidance on the operational aspect of the fund was provided in the Cash and Carry manual written in 1989 and used for the initial training of staff. Other manuals relating to the operation of the RDF, such as procurement procedures, were developed.

The status of the various manuals or their application or applicability is not clear. Guidance on charges that can be made against the drug fund is also not clear. The pricing of drugs varies between facilities, with little standardization concerning the pricing policy. This variation is important as it means that the system fails to meet the government's strategy of equity and affordability in respect to health care

provision. In addition, the expected cash flow from drug sales falls short of the government’s target as a result of credit sales that are becoming the norm (Ministry of Health and Ghana Health Service, 2000).

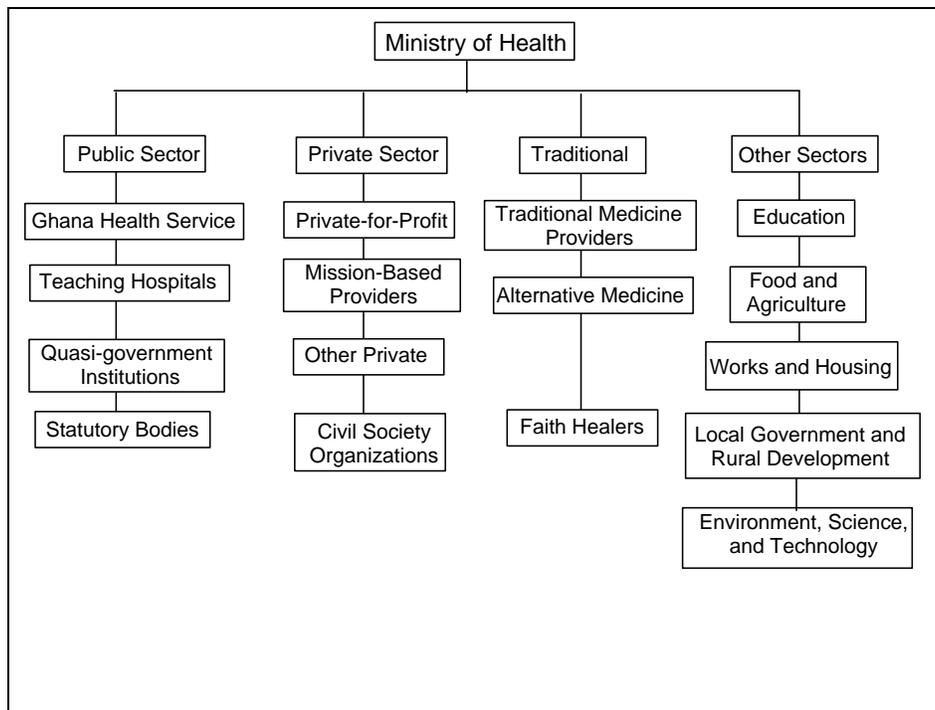
2.2 Overview of the Health System

2.2.1 Public Sector

Organization of the Ministry of Health

Figure 2.1 provides an outline of the various sectors and organizations for which the MoH has some responsibility.

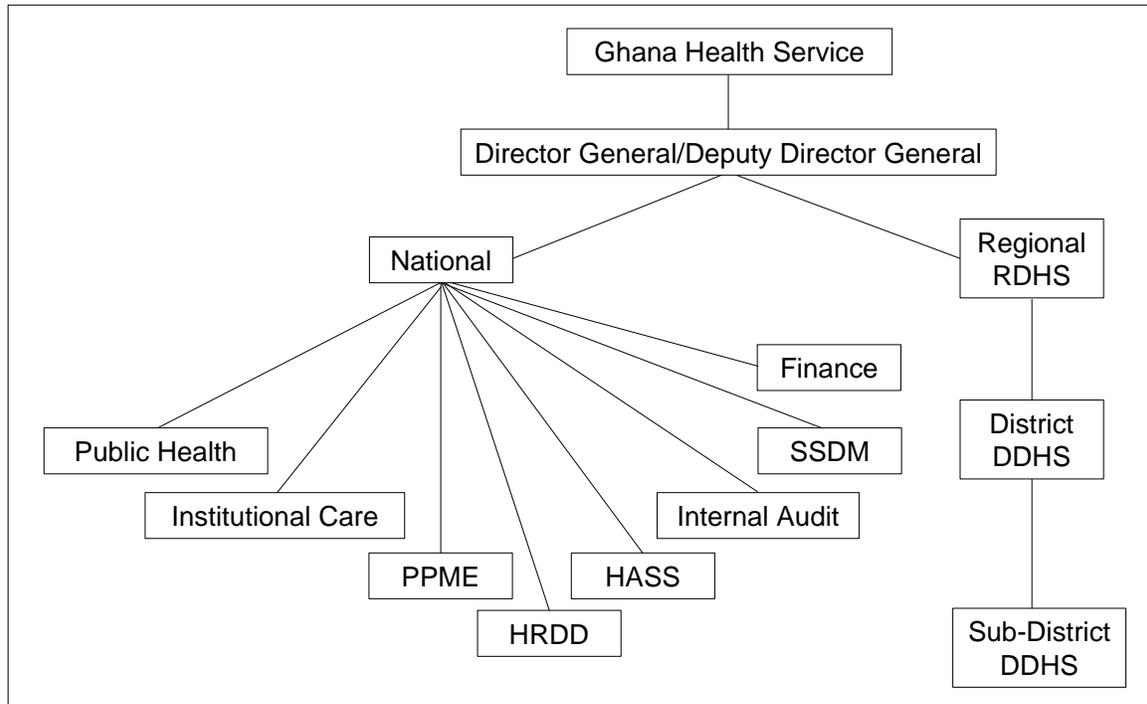
Figure 2.1 Relationship of the Ministry of Health to the various sectors and organizations in Ghana



Ghana Health Service

The GHS, the public sector service provider, has eight directorates, as shown in Figure 2.2:

Figure 2.2 Directorates of the Ghana Health Service



The public health directorate is responsible for the Reproductive and Child Health Programme, the Malaria Control Programme, the National AIDS/STI Control Programme, the Occupational Health Programme, the Parasitic Diseases Control Programme, and others, with Maternal, Child Health, and Family Planning services included under the Reproductive and Child Health Unit.

Regional and District Administration

As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of health structure from the national to the subdistrict. This has affected the supervision system, whereby one technical person down the line may supervise several technical areas of service delivery.

Structure of Delivery of Services

At the regional level, curative services are delivered at the regional hospitals and public health services are delivered by the District Health Management Team (DHMT), as well as the public health division of the regional hospital. The Regional Health Administration (RHA) provides supervision and management support to the districts and subdistricts within each region.

At the district level, curative services are provided by district hospitals, many of which are mission based. Public health services are delivered by the DHMT and the public health unit of the district hospitals. The District Health Administration (DHA) provides supervision and management support to the subdistricts.

At the subdistrict level, both preventive and curative services are provided by the health centres, as well as outreach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the Community-based Health Planning and Services (CHPS). The role played by the traditional birth attendants (TBAs) and the traditional healers is also receiving national recognition.

2.2.2 Nongovernment and Private Sectors

Although there are several health-oriented NGOs operating throughout the country, the population covered by the health services of these NGOs cannot be determined. The GHS supports the health services of NGOs and the private sector in several ways. In December 2002, the GHS initiated the process of awarding contracts to NGOs to undertake specific health services based on their comparative advantage. Government funds from the decentralized budget process were used to pay for the contracted NGO's service. The GHS also provides support to Mission health facilities by seconding staff and providing some essential equipment.

Currently, the private sector contributes 35 percent of health services in the country. Government support is targeted to raise this to 65 percent in the next 10 years. The private sector, however, provides basic curative health services and very few preventive services.

Modalities for supervision and monitoring of services of NGOs and the private sector are under development.

The NGOs and the private sector are to work with communities in collaboration with the DHMT and provide a quarterly progress report. Reports to the Policy Planning, Monitoring and Evaluation unit of GHS are presented biannually. Staff are trained by GHS but are not funded by the government. Their activities are guided by the GHS standards and protocols.

2.3 Health Facilities

A distribution of health facilities by type of facility and region is shown in Table A-2.1.

2.3.1 Health Centres

The health centre has traditionally been the first point of contact between the formal health delivery system and the client. It is headed by a medical assistant and is staffed with programme heads in the areas of midwifery, laboratory services, public health, environment, and nutrition. Each health centre serves a population of approximately 20,000. They provide basic curative and preventive services for adults and children, as well as reproductive health services. They provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services, and refer severe and complicated conditions to appropriate levels. The polyclinic is the urban version of the rural health centre. Polyclinics are usually larger, offer a more comprehensive array of services, are manned by physicians, and can offer complicated surgical services. They are mainly in metropolitan areas.

2.3.2 District Hospitals

District hospitals are the facilities for clinical care at the district level. District hospitals serve an average population of 100,000 to 200,000 people in a clearly defined geographical area. The number of beds in a district hospital is usually between 50 and 60. It is the first referral hospital and forms an integral part of the district health system.

A district hospital should provide the following:

- Curative care, preventive care, and promotion of health of the people in the district
- Quality clinical care by a more skilled and competent staff than those of the health centres and polyclinics
- Treatment techniques, such as surgery, not available at health centres
- Laboratory and other diagnostic techniques appropriate to the medical, surgical, and outpatient activities of the district hospital
- Inpatient care until the patient can go home or back to the health centre
- Training and technical supervision to health centres, as well as a resource centre for health centres at each district hospital
- Twenty-four-hour hospital services
- The following clinical services:
 - Obstetrics and gynaecology
 - Child health
 - Medicine
 - Surgery, including anaesthesia
- Accident and emergency services
- Nonclinical support services
- Referral services
- Contribution to the district-wide information generation, collection, planning, implementation, and evaluation of health service programmes.

2.3.3 Regional Hospitals

Regional hospitals form a secondary level of health care for their locations. They provide services to a geographically well defined area of a population of about 1.2 million. Regional hospitals are an integral part of the regional health system, functioning to support it. They provide specialized care, involving skills and competence not available at district hospitals, which makes them the next level of referral from district hospitals. Their personnel should include medical professionals, such as general surgeons, general medical physicians, pediatricians, general and specialized nurses, and midwives.

Regional hospitals should have 150 to 200 beds.

Regional hospitals should provide general clinical services in the following disciplines:

- Medicine
- General surgery and anaesthesia
- Paediatrics
- Obstetrics and gynaecology
- Dental services
- Psychiatry
- Accident and emergency services
- Ear, nose, and throat
- Ophthalmology
- Dermatology.

They should also provide the following services:

- Laboratory and diagnostic techniques for referrals from the lower levels of the health care system
- Teaching and training for health care personnel such as nurses and medical students
- Supervision and monitoring of district hospital activities
- Technical support to district hospitals, such as special outreach services.

2.3.4 Teaching Hospitals

Teaching hospitals are centres of excellence and complex health care. Governance of teaching hospitals is unusual because it involves many players, such as the MoH, the Ministry of Education, and university and political influences in the community; teaching hospitals have a high social and political profile. The care at these facilities requires more complex technology and highly skilled personnel. They have a high concentration of resources and are relatively expensive to run. They also support the training of health workers both preservice and in-service.

Teaching hospitals have the following functions:

- Health care
 - They provide complex curative tertiary care. They also provide preventive care and participate in public health programmes for the local community and the total primary health care system. Referrals from districts as well as the regions are ultimately received and managed at the teaching hospitals. The teaching hospitals have a special role in providing information on various health problems and diseases. They provide extramural treatment alternatives to hospitalization, such as day surgery, home care, home hospitalization, and outreach services.
- Quality of care
 - Teaching hospitals should provide a leading role in setting high-quality clinical standards and treatment protocols. The best quality of care in the country should be found at teaching hospitals.
- Access to care
 - Patients might only have access to teaching hospitals through a well-developed referral system.
- Research
 - With the concentration of resources and personnel, teaching hospitals contribute in providing solutions to local and national health problems through research.
- Teaching and training
 - Teaching functions are one of the primary functions of the teaching hospital. They provide both basic and post-graduate training for health professionals.

2.3.5 Private Maternity Homes

Private maternity homes fall under the governance of the Ghana Registered Midwives Association. They represent 17 percent of the health facilities providing reproductive health services in Ghana and have facilities in every region, with the highest number in the Ashanti region, followed by Greater Accra, and the least in the Upper East and West regions. Working in close collaboration with the Reproductive and Child Health Unit of the GHS, they offer reproductive and family planning services. In addition, some child welfare activities are carried out on their premises by health staff of public health facilities.

2.4 Health Manpower

Table 2.2 presents the number of health providers in comparison to population. Statistics for laboratory staff is not available.

Region	Population 2000	Number of doctors	Number of nurses	Population-to-doctor ratio	Population-to-nurse ratio
Western	1,924,577	122	1,361	15,775	1,414
Central	1,593,823	104	1,427	15,325	1,117
Greater Accra	2,905,726	1,016	5,694	2,860	510
Volta	1,635,421	103	1,895	15,878	863
Eastern	2,106,696	132	2,429	15,960	867
Ashanti	3,612,950	509	2,250	7,098	1,606
Brong Ahafo	1,815,408	113	1,493	16,066	1,216
Northern	1,820,806	42	1,104	43,352	1,649
Upper East	920,089	43	874	2,137	1,053
Upper West	576,583	27	524	21,355	1,100
Total	18,912,079	2,211	19,051	8,554	993

For the year 2000, the doctor-to-population ratio is 20,357 in the private sector and 14,752 in the public sector. The nurse-to-population ratio is 3,675 in the private sector and 1,295 in the public sector. As many as 915 nurses requested verification of their professional certificates in 2001, which indicates the number of nurses intending to leave the country in search of better opportunities (Nurses and Midwife's Council Register, 2002). Ghanaians constituted 9 percent of 5,334 sub-Saharan medical graduates in the United States (Hagopian et al., 2003).

2.5 Public Health Programmes

The MoH is focusing on a number of health priorities in Ghana, and specific health programmes have been developed to address these health priorities. The programmes are discussed below.

2.5.1 Reproductive and Child Health

The GHS has sanctioned the existence and free unfettered operation of the Reproductive and Child Health Unit. This unit has active branches at all levels throughout the country. For the past 13 years, the unit has provided an annual report based on data from regional, district, subdistrict, and other partners.

The components of the reproductive health programme are as follows:

- Safe motherhood, including antenatal, safe delivery, and postnatal care, especially breast-feeding, infant health, and women's health
- Family planning
- Prevention and treatment of unsafe abortions and postabortion care
- Prevention and treatment of reproductive tract infections, including sexually transmitted diseases and HIV/AIDS
- Prevention and treatment of infertility
- Management of cancer, including prevention and management of cervical cancers
- Responding to concerns about menopause
- Discouragement of harmful traditional practices that affect the reproductive health of men and women, such as female genital mutilation
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, preconception care, and sexual health.

Family planning services are designed to assist couples and individuals in their reproductive ages to space or limit the number of births, prevent unwanted pregnancies, manage infertility, and improve reproductive health. Services provided at delivery points include the provision of short-term methods (condoms, spermicides, oral contraceptives, and natural family planning methods), reversible long-term methods (IUDs, injectables, and implants), and permanent long-term methods (minilap tubal ligation, and vasectomy). Other activities include training of tutors, in-service training of staff, and counselling.

Currently, the reproductive health care system, which was designed for adults, is being modified to meet the needs of adolescents as well.

The child health programme constitutes all child health activities aimed at promoting and maintaining the optimal growth and development of children age 0-18 years. For programmatic purposes, it has been subdivided into three groups:

- Children under 5 years (0-4 years)
- School-age children (5-15 years)
- Adolescents (10-18 years).

The components of the child health programme include the following:

- Neonatal health care
 - Antenatal care services
 - Postnatal care services
- Child welfare services
 - Promotion of exclusive breastfeeding for the first six months and timely introduction of complementary feeding
 - Immunization
 - Growth promotion and nutrition rehabilitation
 - Curative care for minor ailments and injuries

- School health services
 - Screening and examination of school children and food vendors
 - Immunization
 - Health education on current public health issues
 - Management of minor ailments and injuries
 - Maintenance of a hygienic school environment
 - Referrals

- Adolescent health
 - Identification and management of common health problems affecting adolescents
 - Provision of services focused on adolescents, including counselling; information, education, and communication (IEC); and reproductive health issues in general
 - Referrals.

2.5.2 Expanded Programme on Immunization

In Ghana, the Expanded Programme on Immunization (EPI) was introduced in 1978 as a strategy to improve child health. Since 1985, the programme has been operational in all 10 regions and 110 districts. The programme's focus was on childhood immunizations against tuberculosis (TB), diphtheria, neonatal tetanus, pertussis, acute poliomyelitis, measles, and yellow fever. Immunizations against *Haemophilus influenzae* type b (Hib) and hepatitis B (HepB) vaccine were introduced in 2002. Despite several attempts to improve the programme, the national immunization coverage has remained low (MoH, 1992). In response to these low percentages, Ghana has implemented strategies and set a minimum target of 75 percent for DPT3/OPV3 coverage to be attained by the year 2001 as part of the health sector reform documented in the MTHS (MoH, 1995). The EPI goals articulated in this strategy include the following:

- Eradication of poliomyelitis by the year 2000
- Elimination of measles by the year 2004
- Control of hepatitis by the year 2004
- Control of yellow fever by the year 2004.

As part of attempts to improve the EPI services in the country, the policy environment was strengthened. In 1991, daily immunization services (DIS) were introduced for all delivery points, including hospitals (Policies and Priorities for the Health Sector 1994-1995, MoH). The DIS policy stated that health workers should use every contact with a child under five years of age to inquire about their immunization status and should proceed to vaccinate them or refer them as needed. There is evidence, however, that this policy is not being adhered to.

Another strategy encouraged by EPI includes static, outreach, and satellite clinics. Static clinics are facility based and operate daily from 8 a.m. to 3 p.m. All logistics and other items needed for immunization are expected to be available at these sites. Referrals from other types of clinics are received and attended to. Outreach clinics have staff who move from their station (static) to render the same kind of services they would have carried out at the static clinic in the communities. Specialized care is usually not provided. Logistics and vaccines are carried by the team. Outreach services are held either weekly, fortnightly, or monthly, depending on staff strength and distance of operation. Satellite clinics are performed close to the static clinics. Their purpose is to decongest static clinics. The main difference between outreach and satellite clinics is the distance from the static clinics. In a recent review, EPI was

criticized for its overdependence on outreach immunization activities, and the review suggested that more static sites be created.

The safety of injections policy was also introduced. It states that to ensure the safety of injections, the needles and syringes for routine immunizations should be disposable and autodestructive. Health staff are to use one sterile needle and syringe for each injection and should not reuse disposable syringes and needles. These needles are to be placed in a puncture-proof container after use and disposed of by burning (destructive incineration) or burying at least 0.5 m below the surface.

2.6 Health Insurance

2.6.1 Health Insurance

For several years, the percentage for recurrent allocation to the health sector had been stagnant around 6 percent. In 2003, the percentage increased to 12 percent, and it is hoped that this will continue until the Abuja declaration target of 15 percent is reached by the year 2006. The allocation of resources has now been built into a “deprivation index,” such that about 50 percent of recurrent expenditures goes to the district level, where most people live. Releases from the Poverty Reduction Fund have been targeted toward the deprived areas.

So that health care is affordable, the health insurance scheme is being vigorously pursued. The bill and legislative instruments (LIs) were presented to Parliament in 2003 for cabinet approval. Parliament has also approved the bill, which is awaiting the President’s assent for it to be passed into law. Currently, several small-scale pilot projects are ongoing within various districts in the country.

2.6.2 Other Health Funding Activities

An exemption policy to address the needs of the most financially vulnerable (paupers) was first designed to cover the services for contagious illnesses, such as TB and leprosy (LI 1313 Hospital Fees Regulations, 1985). The exemptions list has since been revised and expanded. A presidential fiat authorized exemptions for other vulnerable groups that were grossly underutilizing services (pregnant women, children under five years of age, and the aged). The present system has mixed objectives. Some elements promote the use of services that might otherwise be underused and to improve efficiency, while other elements are intended to minimize the cost of health care for the poor (Health Research Unit summary report on exemptions study, Ministry of Health, 2000).

There have been problems with the design and implementation of the exemption scheme. Although exemption guidelines have been distributed widely, provider knowledge about how exemptions should be applied varies and is low. As a result, exemptions are applied variably at the different health levels within and between regions. Services for all other diseases are to be paid for out of pocket, unless the system declares the person a pauper.

Although it is feasible to offer outpatient health services under a variety of conditions, there are certain infrastructure and health system components that are believed to encourage and support a consistent level of quality, and appropriate use of health services.

The first part of this chapter provides information on the presence of infrastructure and resources for supporting quality and appropriate use of services. These include availability of the following:

- A range of preventive and curative maternal, child, and reproductive health services at the same facility
- Qualified staff
- Facility infrastructure supportive of client utilization and quality services
- Facility infrastructure supportive of quality 24-hour emergency services.

The chapter also considers management components for supporting quality and appropriate use. These include

- Systems for addressing management issues
- Staff development activities through supervision and in-service training
- Community input to the facility
- Funding mechanisms to decrease financial barriers to use.

The chapter concludes by considering two additional critical systems for supporting quality of services in facilities:

- Logistics systems to support quality and availability of medicines, vaccines, and contraceptive methods
- Infection control systems and practices.

3.1 Basic Infrastructure and Resources Supportive of Use of Services

3.1.1 Availability of a Range of Services and Qualified Staff

The availability of a range of maternal, child, and reproductive health services and the frequency with which the services are offered are key elements influencing client use. Clients are more likely to seek services at a facility if they are certain that when they arrive the needed service will be available; indeed, they may be more likely to use a facility that provides a full range of services meeting most of their (and their family's) health needs. Among the qualified staff, the Ghana Service Provision Assessment (GSPA) survey assessed facilities for the presence of at least one provider who could provide curative care and be a resource for less-qualified service providers. This was defined as essential for providing the range of services assessed with a reasonable assurance of quality. In Ghana, a medical doctor, medical assistant, public health nurse, professional midwife, or a professional nurse is the level of provider capable of meeting this definition.

The following were defined by the GSPA survey as the range of services, minimum availability, and minimum qualification of staffing desirable at a facility, for encouraging use of facility services:

- A range of services offered a minimum number of days per week¹
 - Outpatient consultation services for sick children at least 5 days per week
 - Services for sexually transmitted infections (STIs) at least 1 day per week
 - Preventive services—child immunization, Expanded Programme on Immunization (EPI), routine growth monitoring, and antenatal care—at least 1 day per week
 - Temporary methods of family planning, at least 1 day per week
- Availability of facility-based normal-delivery services
- At least one qualified staff (medical doctor, medical assistant, public health nurse, professional midwife, or a professional nurse) assigned to the facility.

Table 3.1 provides aggregated information on availability of services and qualified staff. Figure 3.1 provides details on availability of each service assessed. Table A-3.1 and Table A-3.2 provide detailed information on the different services and staff availability, by type of facility, operating authority, and region.

Most of the hospitals (70 percent) and more than half of the health centres (57 percent) offered the full range of services (sick child, STI, EPI, growth monitoring, antenatal care, and temporary family planning) as compared to 27 percent of clinics (Table 3.1). Services least provided were EPI (66 percent), STI (67 percent), and growth monitoring (71 percent) (Table A-3.1). Although some facilities visited indicated that they did not offer STI services, this probably meant that no specific STI clinics or persons trained specifically for STI management were available but that clients reporting symptoms did get some treatment for their condition. For example, among facilities where it was reported that STI services were not offered, 13 percent indicated that STI services were, in fact, provided by family planning providers, and 12 percent indicated that the STI services were provided by antenatal care providers (data not shown).

The full range of services should be available in public hospitals and urban or rural health centres. The availability and sophistication of staff increases from the health post to the health centre to the hospital, and from the district hospital to the regional hospital. Within the private health sector, however, some specialized clinics exist. Private maternity homes (PMHs) may offer maternal health services as well as services for the sick child, but private clinics typically offer care for the sick without labour or delivery services.

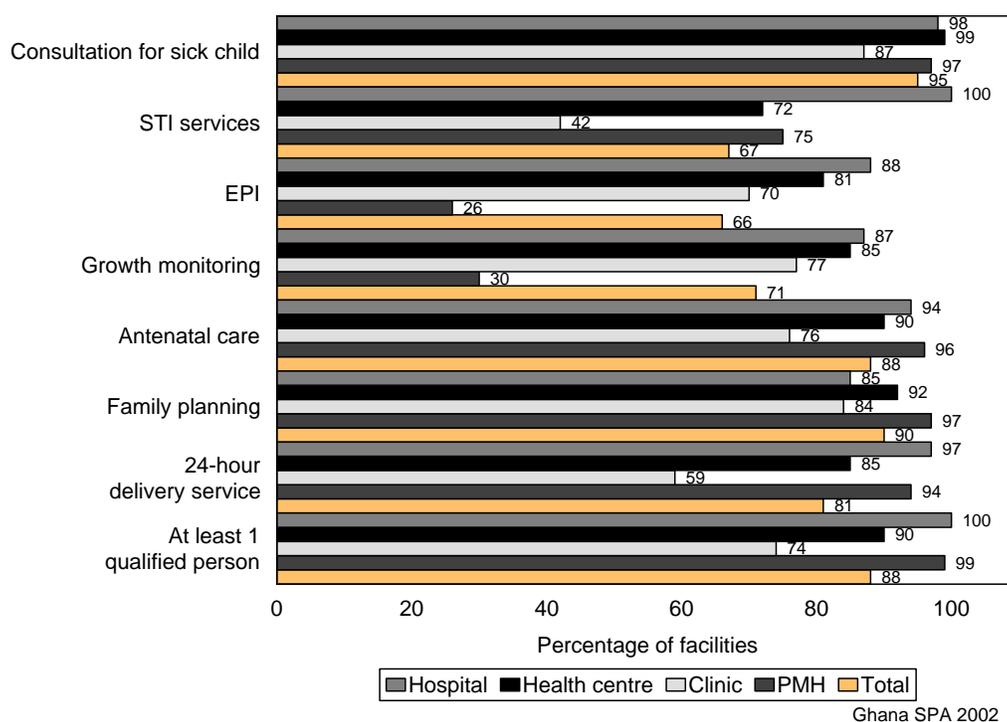
¹ In Ghana, almost all facilities (95 percent) reported that STI treatment was available through adult curative outpatient services at least 5 days per week.

Table 3.1 Availability of services and qualified staff to meet basic client needs					
Percentage of facilities that provide basic maternal, child, and reproductive health services at appropriate frequencies, offer delivery care, and have available staff with appropriate qualifications to serve basic client needs, by type of facility, operating authority, and region, Ghana SPA 2002					
Background characteristics	Percentage of facilities with:				Weighted number of facilities
	All basic services ¹	All services, minimum frequency ²	All services, minimum frequency, and 24-hour delivery services	All services, minimum frequency, qualified staff, ³ and 24-hour delivery services	
Type of facility					
Hospital	70	54	52	52	43
Health centre	57	44	42	41	166
Clinic	27	14	11	11	125
PMH	15	6	6	6	95
Operating authority					
Public	49	36	33	33	288
Private religious	39	22	22	22	39
Other private	15	7	7	7	100
Region					
Western	38	28	28	28	39
Central	63	59	59	59	30
Greater Accra	52	37	29	29	28
Volta	16	6	6	6	74
Eastern	42	31	29	29	50
Ashanti	32	14	14	14	71
Brong Ahafo	34	15	15	15	54
Northern	59	43	38	35	41
Upper East	30	28	28	28	20
Upper West	86	86	77	77	22
Total	40	28	26	26	428
¹ Some level of each of the following services: curative care for children, any services for STIs, temporary methods of family planning, antenatal care, immunization, and child growth monitoring					
² Curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least 1 day per week					
³ The definition for qualified staff in Ghana: medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse					

The type of services provided did not vary much between the different types of operating authority for the services evaluated, except that EPI and growth monitoring were notably low in the other private facilities (26 and 30 percent, respectively) (Table A-3.1). EPI and growth monitoring are conducted almost solely by the public health sector within their facilities and the private religious facilities. The availability of temporary family planning at hospitals is relatively low (85 percent), probably because several hospitals are managed by religious missions where services for temporary family planning are not provided as often.

Although 40 percent of all facilities provide all basic services, only 28 percent provides the services at a minimum frequency—sick child services 5 days per week and STI, temporary family planning, antenatal care, EPI, and growth monitoring services at least 1 day a week (Table 3.1). Almost all of the facilities offering the basic services at a minimum frequency also offered 24-hour delivery services (26 percent of all facilities).

Figure 3.1 Availability of basic services among all facilities (N=428)



All facilities offering basic services at a minimum frequency and 24-hour delivery services had qualified staff for providing curative care² assigned to the facility (Table 3.1).

Key Findings
A full package of maternal, child, and reproductive health services, offered at a minimum frequency, is available in 28 percent of all health facilities. Hospitals were most likely to offer all basic health services with minimum frequency (54 percent) and, as expected, private maternity homes were least likely (6 percent).
The full package of services at a minimum frequency with 24-hour delivery services were available in 26 percent of all facilities.
All facilities offering the basic health services and 24-hour delivery services had qualified staff for providing curative care assigned to the facility.

² Staff defined as qualified to provide curative care in Ghana were medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse.

3.1.2 Facility Infrastructure Supportive of Client Use and Quality Services

Although it is true that quality health services can be provided in the most minimal service delivery setting, there are basic client comfort amenities and infrastructure components that contribute to client and staff satisfaction, as well as to the quality and level of services possible. These items may contribute to client willingness to use a facility, as well as staff willingness to work at the facility, and may facilitate the capacity of staff to follow standards for quality services.

The key amenities and infrastructure components assessed included the availability of the following:

- A waiting area that protects clients from sun and rain, a functioning client latrine, and a basic level of cleanliness³ (basic client comfort amenities)
- Electricity available 24 hours a day, with minimal or no disruption during the period client services are normally provided, or a functioning generator with fuel (regular electric supply)
- An onsite (either inside or within 500 meters of the facility) water source, available year-round (regular water supply).

Table 3.2 provides information on client amenities, water supply, electric supply, presence of a generator, and aggregates of these. Table A-3.3 provides details on each item assessed, by type of facility and operating authority.

Quality of care is key to health sector reform in Ghana. Table A-3.3 shows that 63 percent of facilities had all client comfort needs available. In terms of client comfort amenities, the private religious (84 percent) and other private facilities (79 percent) were more likely than public facilities (54 percent) to have client latrines, protected waiting areas, and a clean facility. Only 65 percent of public facilities had client latrines available, compared with 90 percent of the private religious facilities and 91 percent of the other private facilities.

A regular supply of electricity contributes to the capacity of a facility to use equipment that contributes to quality of care and provides a reliable source of lighting when patient care is provided at night. While quality care is possible without electricity, ensuring adequate lighting for patient care and sterilizing or disinfecting equipment for reuse are difficult without electricity. As shown in Table 3.2, 38 percent of facilities had a regular electric supply or a backup generator. Twenty-nine percent of the facilities had no electricity or generator at all, mainly clinics (47 percent) and health centres (34 percent), but none of the hospitals. Ten percent of the facilities were observed to have a generator with fuel (Table A-3.3). An additional 5 percent reported that they had a functioning generator, and 14 percent reported that they had the fuel for the generator, but this was not observed (data not shown).

As expected, availability of water was greater than electricity in each region. Availability of water was greatest in the regions including the former and current capitals of Ghana—Central and Greater Accra and Upper West (Table 3.2). Thirty-nine percent of facilities had a regular water supply; hospitals (62 percent) and PMHs (69 percent) mainly used piped water as their most common water source. Health centres and clinics used protected wells or boreholes (55 and 52 percent, respectively). Two percent of health centres and 5 percent of clinics indicated that they had no water source (data not shown). Overall, 16 percent had a regular supply of both electricity and water. Thirteen percent of all facilities had all of the client comfort items in addition to a regular water and electricity supply, including 41 percent of hospitals, 15 percent of PMHs, 8 percent of clinics, and 7 percent of health centres (Table A-3.3).

³ The standard for “clean” was that there be no obvious waste or dirt on the floor or furnishings.

Percentage of facilities with:						
Background characteristics	All basic client amenities ¹	Onsite water source ²	Regular water supply ³	Regular supply of electricity/ backup generator ⁴	Regular supply of electric and water	Weighted number of facilities
Type of facility						
Hospital	86	96	61	77	46	43
Health centre	53	67	33	35	11	166
Clinic	56	55	35	24	12	125
PMH	79	69	44	42	18	95
Operating authority						
Public	54	64	35	32	12	288
Private religious	84	81	57	64	40	39
Other private	79	69	43	44	18	100
Region						
Western	60	51	33	28	13	39
Central	75	100	50	25	10	30
Greater Accra	81	90	77	50	36	28
Volta	44	66	31	40	13	74
Eastern	61	58	11	52	9	50
Ashanti	85	75	47	41	25	71
Brong Ahafo	72	56	45	32	18	54
Northern	45	50	31	47	18	41
Upper East	26	36	26	31	6	20
Upper West	67	95	64	5	5	22
Total	63	66	39	38	16	428
¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness						
² Water supplied in facility by tap or available within 500 meters of facility, may not be available year-round						
³ Year-round water supplied in facility by tap or available within 500 meters of facility						
⁴ Regular electric supply (24 hours a day) or a backup generator with fuel						

3.1.3 Infrastructure and Resources to Support Quality 24-Hour Emergency Services

It is not expected that all levels of health facilities will provide 24-hour emergency services, but given that 24-hour care is essential for the management of serious illness and potentially decreasing mortality, it is important to know about the availability of emergency services. For the purposes of the GSPA survey, “24-hour emergency services” refers to provision of emergency onsite treatment and also the capacity to monitor a seriously ill client overnight until, if necessary, referral of the client to an inpatient setting is possible.

The components assessed were the following:

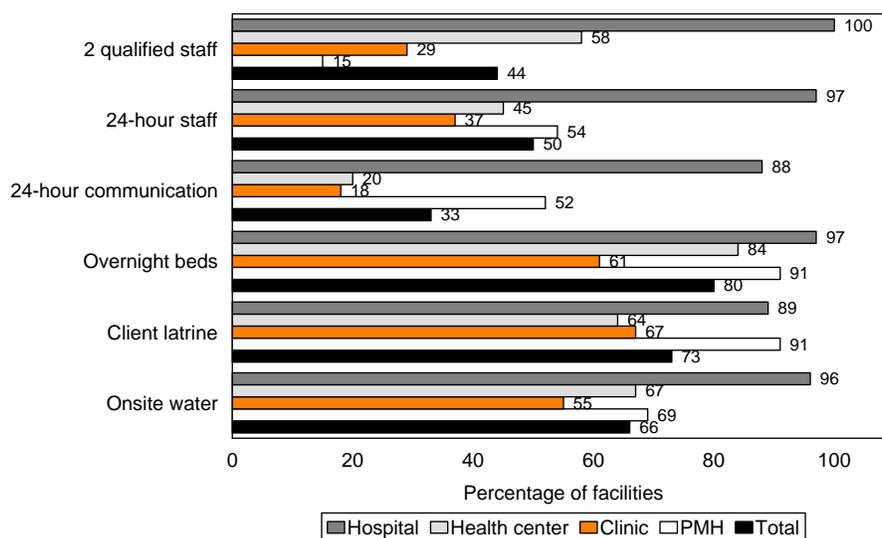
- A minimum of two qualified staff (either medical doctors, medical assistants, public health nurses, professional midwives, or professional nurses) assigned to the facility⁴
- Twenty-four-hour duty staff (either onsite or on-call)

⁴ At least two qualified staff are necessary for any assurance that they could be available 24 hours. The staff may be assigned to stay onsite or may be on-call (with documentation of their official responsibility to be available and within close proximity in case an emergency need arises).

- Twenty-four-hour access to emergency communication (onsite or within 5 minutes distance)
- Inpatient or overnight beds for caring for clients, at a minimum, until they are stable enough to transfer to a higher-level facility if needed
- Functioning client latrines
- An onsite source of water, within a minimum of 500 meters of the facility (seasonal shortages were defined as acceptable, though a nonseasonal onsite source of water was defined as preferable)
- A regular supply of electricity (24-hour electricity with minimum interruption or generator with fuel available) was not considered essential, but preferable.

Figure 3.2 presents information on the availability of individual items for 24-hour services, and Table A-3.3 provides detailed information on the same items by type of facility and operating authority. Table 3.3 provides aggregate information for all items defined as supporting 24-hour emergency services.

Figure 3.2 Availability of components to support 24-hour services (N=428)



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Forty-four percent of all facilities had two or more qualified staff assigned to the facility. As expected, hospitals were most likely (100 percent) and clinics and PMHs least likely to have two or more qualified staff assigned to the facility (29 and 15 percent, respectively) (Table A-3.3). Overnight beds were present in most facilities (80 percent), indicating that most facilities do provide overnight emergency care; however, only 61 percent of clinics had overnight beds. The availability of duty staff for 24-hour emergency services was also assessed in all facilities. Half of the facilities had staff onsite 24 hours a day, with hospitals most likely (97 percent). The private religious facilities (82 percent) were more likely to have duty staff onsite than were public (45 percent) or other private (52 percent) facilities. An additional 6 percent of the facilities had staff on-call 24 hours a day, with a duty schedule present at the facility. One-third of the facilities had access to emergency communication. This was more available in the other private facilities (53 percent) than in the public (25 percent) or private religious (48 percent) facilities. Hospitals (88 percent) were more likely to have emergency communications than were health centres (20 percent) and clinics (18 percent). Most of the hospitals were district hospitals where referral to regional hospitals would be essential.

Table 3.3 Availability of basic components to support quality 24-hour emergency services			
Percentage of facilities with basic components to support quality 24-hour emergency services and basic components to support quality 24-hour emergency services plus regular water and electricity, by type of facility, operating authority, and region, Ghana SPA 2002			
Background characteristics	Percentage of facilities with:		Weighted number of facilities
	Basic components of 24-hour emergency services ¹	Basic components and regular water and electricity ²	
Type of facility			
Hospital	72	32	43
Health centre	5	1	166
Clinic	7	4	125
PMH	7	3	95
Operating authority			
Public	11	3	288
Private religious	39	29	39
Other private	6	3	100
Region			
Western	13	0	39
Central	20	9	30
Greater Accra	24	15	28
Volta	9	1	74
Eastern	12	4	50
Ashanti	16	10	71
Brong Ahafo	7	6	54
Northern	10	5	41
Upper East	6	3	20
Upper West	13	5	22
Total	13	5	428
¹ At least two qualified staff assigned to facility, staff are onsite or on-call 24 hours a day, overnight beds, patient latrine, 24-hour emergency communication, onsite water source available at least sometime during year			
² Basic components, year-round onsite water source, and 24-hour regular source of electricity or backup generator with fuel			

Seventy-two percent of the hospitals but almost no health centres (5 percent), clinics (7 percent), and PMHs (7 percent) had all of the defined infrastructure components (two qualified duty staff assigned to the facility and onsite or on-call 24 hours a day, overnight beds, client latrines, 24-hour emergency communication, and an onsite water source) to support quality 24-hour emergency services (Table 3.3). Even lower percentages (5 percent of all facilities, 32 percent of hospitals) had all components to support quality 24-hour emergency services, plus a regular water and electric supply.

Key Findings
Infrastructure support (client comfort amenities, electricity, and water) is regularly available at 13 percent of facilities, including 41 percent of hospitals.
Only 38 percent of all facilities have a regular, 24-hour supply of electricity or a generator.
Sixty-six percent of all facilities have an onsite water source, with 39 percent indicating the water is available year-round. Public facilities had the least access to an onsite water supply (64 percent), and 35 percent indicated that the source was available year-round.
Hospitals are most likely to have 24-hour emergency service infrastructure support available, with 72 percent of hospitals having all assessed components.

3.2 Management Systems to Support and Maintain Quality and Appropriate Use of Health Services

Basic management and administrative systems are required to ensure that health services can be consistently provided as planned with an acceptable level of quality.

3.2.1 Management, Quality Assurance, and Referral Systems

The components assessed for supporting consistent provision of services at an acceptable level of quality were as follows:

- Functioning management committees
- Routine quality assurance activities
- Referral systems.

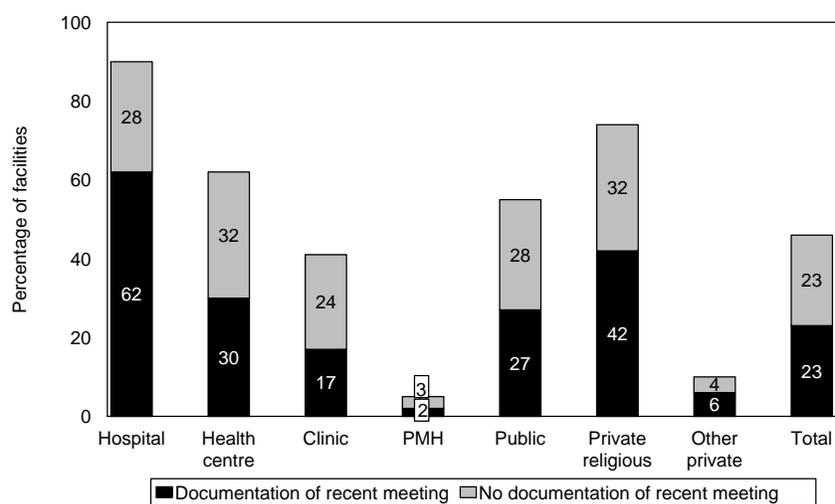
Table 3.4 summarizes data indicating the percentage of facilities where these basic management support mechanisms are in place. Figures 3.3 through 3.6 provide more information on reported management and quality assurance activities with and without documentation related to this activity. Table A-3.4 provides greater detail on specific quality assurance activities, by type of facility and operating authority.

Table 3.4. Management, quality assurance, and referral systems				
Percentage of facilities that have documentation of a functioning management committee, documentation of quality assurance activities, and a printed referral form, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities with:			Weighted number of facilities
	Management committee meetings at least every 6 months and observed documentation of a recent meeting	Quality assurance activities documentation observed	Referral form observed	
Type of facility				
Hospital	62	51	50	43
Health centre	30	14	19	166
Clinic	17	12	25	125
PMH	2	0	73	95
Operating authority				
Public	27	17	24	288
Private religious	42	20	32	39
Other private	6	2	72	100
Region				
Western	11	2	15	39
Central	41	58	25	30
Greater Accra	24	7	83	28
Volta	12	10	25	74
Eastern	33	24	40	50
Ashanti	17	16	42	71
Brong Ahafo	31	12	54	54
Northern	17	2	26	41
Upper East	14	8	14	20
Upper West	58	3	26	22
Total	23	14	36	428

The GSPA survey defined a functioning management committee as one that addresses facility-level management issues, meets at least every six months, and has some official record of proceedings.

It is impressive that just five years since the introduction of quality assurance programmes, 62 percent of hospitals have instituted management committee meetings that are properly documented (Table 3.4 and Figure 3.3). The levels in health centres (30 percent) and clinics (17 percent) were not as high but are still encouraging. Such programmes, however, barely exist in PMHs (2 percent). When asked about the frequency of routine management meetings, 42 percent indicated that they met monthly, and 55 percent indicated that they met at least once every six months (data not shown). When documentation of meetings was requested, however, only 23 percent of all facilities met at least every six months and had any minutes or other documentation of meetings available for observation (Figure 3.3 and Table 3.4). A record of meetings is considered to be an indicator of a functioning committee where follow-up on issues that are discussed can be monitored. An additional 23 percent of facilities said that they met at least every six months and maintained records but could not show any records on the day of the survey.

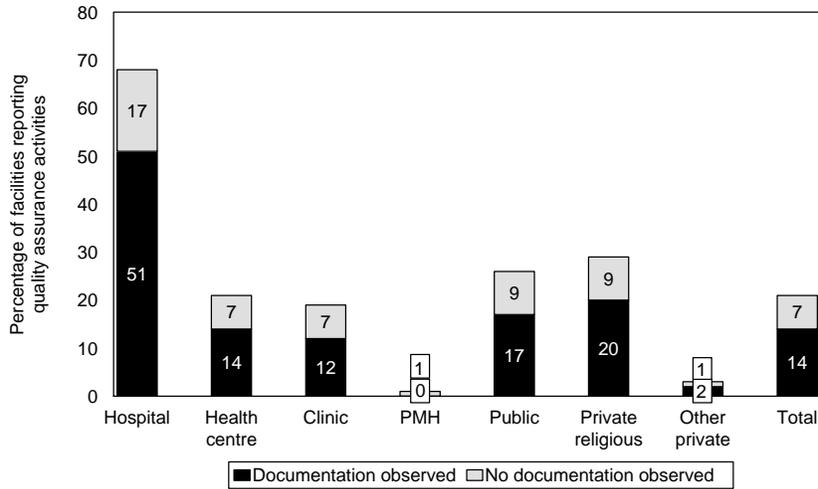
Figure 3.3 Facilities reporting health committees that meet at least every 6 months (N=428)



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Quality assurance activities refer to monitoring quality of care, identifying problems, and instituting changes that resolve the problems. Quality assurance activities may be a part of basic supervisory systems, but they go beyond supervision. There are a variety of valid approaches for implementing quality assurance activities. At a minimum, quality assurance requires that there be standards against which services and systems are compared to identify quality issues. The GSPA survey documents the approaches being used, who is responsible for seeing that the quality assurance activities are carried out, and whether the identified problems are addressed. While 21 percent of facilities indicated that they carried out quality assurance activities, documentation of quality assurance activities was observed in only 14 percent of facilities (Figure 3.4 and Table 3.4). Quality assurance activity documentation was slightly more common in private religious facilities (20 percent) than in public facilities (17 percent), whereas only 2 percent of other private facilities had documentation.

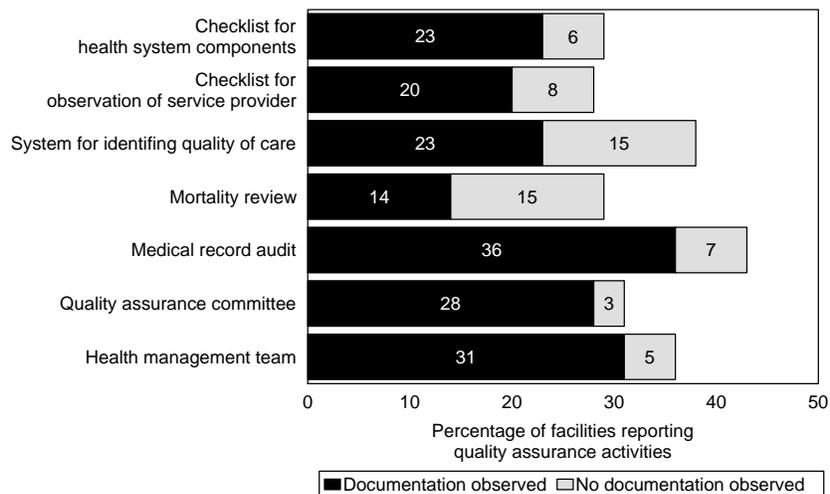
Figure 3.4 Facilities reporting quality assurance activities (N=428)



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Among the facilities reporting that they conducted quality assurance activities, 23 percent (and an additional 6 percent without documentation) (Figure 3.5 and Table A-3.4) had a supervisory checklist for health system components, and 20 percent (additional 8 percent without documentation) used a checklist for the observation of service provision. Twenty-three percent of facilities (additional 15 percent without documentation) had a system for identifying quality of care, with hospitals performing best (40 percent). Other aspects of the quality assurance programme carried out by all facilities included mortality reviews

Figure 3.5 Documentation of quality assurance activities among facilities reporting these activities (N=89)

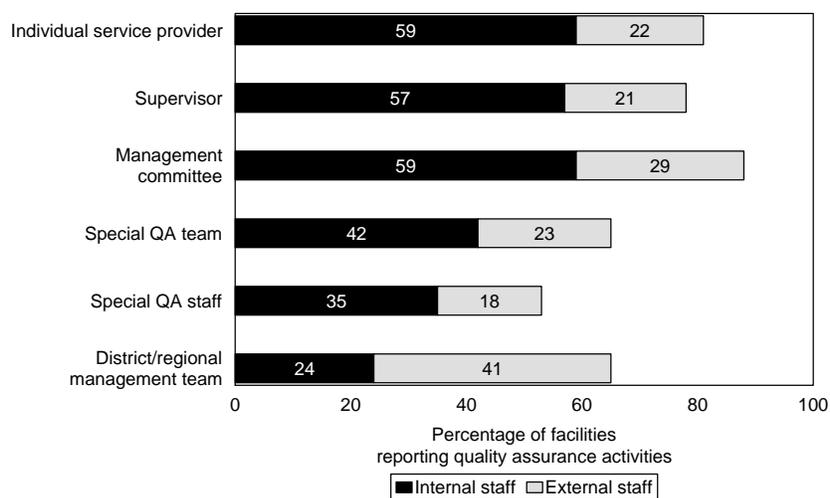


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(14 percent with documentation and an additional 15 percent without documentation), auditing of medical records or registers (36 percent with documentation and 7 percent without documentation), the existence of a quality assurance committee (28 percent and an additional 3 percent without documentation), and health management teams (31 percent with documentation and an additional 5 percent without documentation). Out of 95 PMHs visited, only one reported having quality assurance activities, and none of the activities assessed were performed by this facility (Table A.3.4).

Figure 3.6 shows that for many facilities the quality assurance activities are carried out by an individual service provider (81 percent) either internal to the facility (59 percent) or external (22 percent), by a supervisor (78 percent; 57 percent internal to the facility and 21 percent external), or by a management committee (88 percent; 59 percent internal and 29 percent external). Special quality assurance teams and staff existed internally for 42 and 35 percent of facilities, respectively, and externally for 23 and 18 percent, respectively. In 65 percent of facilities, personnel from the district health management teams were responsible for reviewing findings and taking action on quality assurance recommendations.

Figure 3.6 Person responsible for implementing quality assurance (QA) activities among facilities reporting these activities (N=89)



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The ability of a facility to ensure that clients needing services from a higher-level facility receive these services is an important aspect of quality of care and contributes to client confidence in a facility. If clients know that lower-level facilities can provide access to higher level facilities, if necessary, they may be less likely to bypass lower level facilities for their health needs. Clients who are referred to other facilities without any formal documentation risk being refused services or having services delayed if the referral facility must assess them as totally new clients. The GSPA survey collected information on whether, as a minimum, a facility uses an official printed referral form that provides client information needed for documenting the reason for the referral and any treatment already provided. As noted in Table 3.4, in 36 percent of facilities, referral forms were observed, and in an additional 6 percent, the facilities were unable to demonstrate the form at the time of the survey, although they reported having one (data not shown).

3.2.2 Supportive Management for Providers

The GSPA survey collects information to assess the extent to which facilities have supervisory and staff development activities important for supporting quality care. Supportive supervision activities that were assessed include the following:

- Supervision by external staff
- Personal supervision of service delivery providers
- Formal in-service training related to the services of health service providers.

Information on these topics is summarized in Table 3.5. Table A-3.5⁵ provides information on supervision and in-service training from the perspective of the health service provider, and Table A-3.6 provides details on facility-level supervision, delineating the proportion of facilities where none, 50 percent, and all of the interviewed staff reported elements of supportive management.

Supervision from persons external to a facility provides an opportunity to ensure that systemwide standards and protocols are followed at the facility level and to promote an “organizational culture” wherein it is expected that these standards and protocols will be implemented. It also provides an opportunity for exposing staff to a wider scope of ideas and relevant experiences. For the GSPA survey, at least one visit by an external supervisor during the six months preceding the survey was defined as routine external supervision. Seventy percent of the facilities reported that they had received an external supervisory visit during the six months before the study (Table 3.5). Hospitals (88 percent) and health centres (80 percent) were most likely to receive supervision. When facilities that were externally supervised were asked about the activities of the supervisors, 83 percent of the facilities indicated that registers had been checked and 91 percent of the facilities had discussed identified problems. Policies and technical matters were discussed in 52 and 79 percent of facilities, respectively. Observation of service provision—an important means of supporting quality of care—was carried out in 58 percent of facilities (data not shown).

In addition to general supervision of facility activities, the work of individual staff must be assessed so that their strengths and weaknesses can be identified and appropriate support provided. If at least half of the interviewed health service providers in a facility had been personally supervised at least once during the previous six months, the facility was defined as providing routine staff supervision. In addition to 70 percent of facilities having received external supervision during the past six months, at least half of the interviewed health service providers had been personally supervised during the past six months in 56 percent of facilities (Table 3.5). Facility-level practices related to supervision of individual health service providers varied by type of facility and by geographic region. None of the interviewed health service providers reported being personally supervised in 18 percent of facilities (the highest proportion being other private facilities, with 32 percent) (Table A-3.6). On the other hand, in 27 percent of facilities, all of the interviewed health service providers reported having been personally supervised. Facility-level supervision was relatively weak for facilities in the Central and Ashanti regions. This may be due to a different mix of facilities, with urban areas having a higher proportion of hospitals and, subsequently, a larger number of staff requiring supervision. Among all interviewed health service providers, 51 percent had been personally supervised during the six months before the survey, with private religious facility staff (39 percent) least likely to be supervised (Table A-3.5).

⁵ Additional information on specific in-service topics and staff supervision related to different services is presented in a subsequent chapter.

Table 3.5 Supportive management practices at the facility level

Percentage of facilities that had an external supervisory visit during the 6 months preceding the survey, percentage where at least half of the interviewed providers were personally supervised during the past 6 months, percentage where at least half of the interviewed health service providers received in-service training related to relevant services during the 12 months preceding the survey, percentage where at least half of the interviewed providers were supervised in the past 6 months and received related in-service training during the past 12 months, and percentage of facilities that had external supervision to the facility during the past 6 months and at least half of the interviewed providers were both supervised during the past 6 months and received in-service training during the past 12 months, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities where at least half of the interviewed health care workers:				Percentage of facilities with all supportive management practices ¹	Weighted number of facilities with at least one eligible HW ²	Weighted number of facilities
	Percentage of facilities with external supervisory visit	Were personally supervised in the past 6 months	Received in-service training in the past 12 months	Were personally supervised in the past 6 months and received in-service training in the past 12 months			
Type of facility							
Hospital	88	37	51	14	11	43	43
Health centre	80	65	61	38	37	163	166
Clinic	64	61	55	33	25	124	125
PMH	52	43	49	26	24	95	95
Operating authority							
Public	75	61	59	34	30	286	288
Private religious	74	47	43	23	20	39	39
Other private	53	44	50	27	24	100	100
Region							
Western	74	46	62	35	32	39	39
Central	55	18	49	14	14	30	30
Greater Accra	65	73	49	25	23	28	28
Volta	74	58	42	25	23	71	74
Eastern	71	58	71	41	38	50	50
Ashanti	65	38	42	14	11	71	71
Brong Ahafo	74	70	61	38	33	54	54
Northern	69	67	51	40	32	41	41
Upper East	58	70	81	52	43	20	20
Upper West	92	83	88	60	60	22	22
Total	70	56	56	31	28	425	428

¹ Facility received external supervision in the past 6 months; at least 50% of all interviewed health care workers reported being both individually supervised in the past 6 months and receiving in-service training relevant to the services they provide in the past 12 months.

² Health care worker (HW) providing child health care, family planning, antenatal care, newborn care, postnatal care, STI services or HIV/AIDS services

To maintain levels of knowledge and technical competence achieved during basic training, health service providers must be provided continuous exposure to current and new information. This not only refreshes knowledge but also serves to update practices as new policies and protocols are introduced. This is most often achieved through in-service training. It is recognized that health service providers may receive new information and individual instruction related to their work during routine supervisory visits. The GSPA survey, however, assessed specifically whether the health service provider had received any formal in-service training on topics related to the services offered in the 12-month period before the GSPA survey.

If at least half of the interviewed health service providers at a facility had received any in-service training relevant to their service during the 12 months before the survey, the facility was defined as having routine staff development activities. At least half of the interviewed providers had received in-service training related to their service in more than half (56 percent) of the facilities (Table 3.5). Twenty-six percent of facilities reported that all of their staff had received in-service training in the 12 months before the survey, and 16 percent of facilities reported that no health worker had received in-service training. None of these were from the hospitals; however, almost one-fourth of clinic and PMH staff received no in-service training during the past 12 months (Table A-3.6).

The GSPA survey defined routine supportive staff management practices as being present if at least 50 percent of the interviewed health service providers had both been personally supervised during the past 6 months and had received related in-service training during the past 12-months. Table 3.5 demonstrates that out of 425 facilities with at least one eligible health care worker, only 31 percent had at least 50 percent of their interviewed health care workers receiving supportive management. Levels were highest in public facilities (34 percent) and lowest in private religious facilities (23 percent).

3.2.3 Management Practices Supporting Community Involvement

It is generally accepted that encouraging community input into the functioning of a facility increases the accountability of the facility to the community it serves, and its understanding of the needs of the community, with the expected result being increased appropriate use of the facility and subsequent improved health within the population. Two of the most common mechanisms promoted under health sector development programmes include

- Community representation at facility meetings
- Mechanisms to elicit client feedback regarding the facility and services.

Table 3.6 provides summary information on facility activities to encourage community feedback.

In 1984, the Interim Management Committees (IMCs) were initiated. These were associations formed between the local communities served by a facility and facility management. They were, however, perceived to be interfering with the management of facilities and thus faded out. It is not surprising, therefore, that only 23 percent of facilities report community participation in some management meetings as routine. Table 3.6 shows that one-fifth to one-third of the different types of facilities experience some community participation. This could be true for community clinics, especially where they have been set up with community participation. In public facilities, however, community participation is more likely to be related to public health activities relevant to the communities, as opposed to discussions of facility management issues.

Table 3.6 demonstrates that 8 percent of facilities had some client feedback system in place and that 28 percent of facilities had some mechanism for obtaining community input. Of facilities that reported having a system for eliciting client feedback, client interviews were the most used (in 51 percent of facilities), as compared with client survey forms (12 percent) and suggestion boxes (13 percent) (data not shown). Out of all facilities that instituted client feedback systems, one in four made changes based on the feedback, a third (33 percent) improved client amenities, half changed service conditions, and 9 percent made financial changes (data not shown).

Table 3.6 Management practices supporting community feedback and access to facility				
Percentage of facilities that have routine community participation in management meetings, percentage having a system of acquiring client opinion and feedback, and percentage with either mechanism for obtaining community input, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities with:			Weighted number of facilities
	Community participation in some management meetings	Client feedback with system for review ¹	Mechanism for obtaining community input ²	
Type of facility				
Hospital	20	32	44	43
Health centre	32	10	36	166
Clinic	30	3	31	125
PMH	1	0	1	95
Operating authority				
Public	28	9	32	288
Private religious	37	19	53	39
Other private	4	2	5	100
Region				
Western	19	2	21	39
Central	15	16	30	30
Greater Accra	6	4	10	28
Volta	12	3	14	74
Eastern	30	8	30	50
Ashanti	9	15	22	71
Brong Ahafo	47	7	49	54
Northern	31	3	31	41
Upper East	8	3	8	20
Upper West	74	26	76	22
Total	23	8	28	428
¹ Some mechanism for eliciting client feedback and documentation of a review of client feedback				
² Either community representation at management meetings or system for eliciting client feedback is in place				

3.2.4 Funding Mechanisms That Decrease Financial Barriers to Use of Health Services

User fees may affect use positively (augmenting funds to improve services) or negatively (detering poor clients from using services). A means of improving appropriate use of services is to decrease out-of-pocket costs for clients. User fees with exemption schemes for vulnerable persons often help to augment inadequate budgets and, when used to supplement salaries, may decrease under-the-table payments that may be expected when health service providers are not paid adequately. Even well-functioning user-fee systems, however, frequently result in budget gaps if there is no system for reimbursing the facility for the cost of exempted clients or the costs that are not fully covered by clients who pay the full out-of-pocket fee. Methods for reimbursing facilities for client services, which also minimize out-of-pocket costs, include insurance plans, credit plans (delayed payment for services received today), and charity or equity funds that reimburse the costs of particular subsets of clients to increase their access to care.

The GSPA survey obtained information on various aspects of funding of health services at the facility level including the following:

- Practices related to user fees
- Other reimbursement mechanisms.

Table 3.7 summarizes the information on the proportion of GSPA survey facilities that have implemented common funding mechanisms.

Eighty-six percent of all facilities had a routine charge for curative care for adults, and 51 percent had a routine charge for curative care for children. Level of routine charges for adults did not differ much between different types of facilities or operating authorities. Levels of charges were lower for children, probably because an exemption policy that excludes charges for acute illness in children under five exists for the public sector. Far fewer facilities in the public sector had charges for children (37 percent), compared with other private facilities (85 percent). Only 9 percent of facilities reported participating in a discount or exemption scheme for some clients as part of a formal plan that included community/client financial support. Three percent of facilities allowed a credit or instalment payment system, and this was mostly in the other private facilities and primarily in two regions: Greater Accra and Eastern.

Background characteristics	Percentage with routine charges for curative care for:		Weighted number of facilities offering sick child services	Percentage with discount or exemption system for some clients	Percentage allowing reimbursement in lieu of direct charges ²	Percentage allowing credit or instalment payments	Weighted number of facilities
	Adults ¹	Children					
Type of facility							
Hospital	98	44	42	7	45	5	43
Health centre	97	34	164	8	8	2	166
Clinic	68	49	108	8	9	1	125
PMH	87	87	92	10	9	7	95
Operating authority							
Public	86	37	272	9	13	2	288
Private religious	89	63	38	4	18	2	39
Other private	87	85	96	10	9	7	100
Region							
Western	93	36	39	12	15	0	39
Central	72	20	30	0	6	0	30
Greater Accra	92	72	27	6	17	18	28
Volta	80	81	63	1	6	0	74
Eastern	88	49	49	0	11	10	50
Ashanti	91	68	67	7	28	3	71
Brong Ahafo	87	62	52	37	10	0	54
Northern	88	29	37	5	7	3	41
Upper East	70	3	20	9	12	0	20
Upper West	100	10	22	0	3	0	22
Total	86	51	405	9	12	3	428

In later chapters, additional information is presented on clients' out-of-pocket payment for services received and clients' participation in any health insurance programme that might decrease or defer out-of-pocket expenses at the time of service.

Key Findings

Twenty-three percent of facilities reported management committees meeting at least every six months and had documentation of those meetings. Hospitals were most likely (62 percent), and PMHs were least likely (only 2 percent). An additional 23 percent of facilities reported meeting at least every six months, but these meetings were not documented.

Quality assurance activities have been introduced in 21 percent of facilities, but only 14 percent were able to provide any documentation on this. Again, hospitals were the most likely to document activities.

Seventy percent of the facilities were subject to an external supervisory visit during the 6 months preceding the survey, and at least 50 percent of the interviewed staff were personally supervised in 56 percent of facilities. Hospitals and health centres were most likely to receive an external supervision.

In more than half (56 percent) of the facilities, at least 50 percent of the interviewed health care workers had received formal in-service training related to their service during the year preceding the survey.

Twenty-eight percent of the facilities have a mechanism for obtaining community input, but only 8 percent reported that they elicit client feedback and have implemented a system for review of that feedback. Private religious and public facilities are most likely to have these mechanisms in place.

Community participation in management meetings was reported in 23 percent of facilities. Health centres and clinics had the most community involvement, and hospitals and PMHs had the least.

Most facilities (86 percent) reported charges for curative care for adults, and about half (51 percent) had charges for curative care for children.

Very few of the facilities (3 percent) allowed credit or instalment payments, and 9 percent reported having discounts or exemptions for some clients.

3.2.5 Maintenance and Repair of Equipment

To provide quality services, a facility must have the means for ensuring that facility equipment and infrastructure are maintained in functioning condition. Some machinery should routinely receive preventive maintenance, and some equipment requires minor repairs or replacement. Buildings and infrastructure often require routine maintenance and periodic repair. The GSPA survey collected information on the existence of systems for maintenance and repair of the following:

- Major equipment
- Minor equipment.

An assessment of the actual presence and functioning condition of essential equipment for individual service areas (included in subsequent chapters of the GSPA survey report) will provide an indication of the effectiveness of the maintenance and repair systems.

Table 3.8 provides summary information on systems for maintenance, repair, or replacement for large and small equipment. Table A-3.7 provides detailed information on methods for maintaining major equipment

by type of facility, operating authority, and region, and Table A-3.8 provides details on methods used for maintenance or replacement of small equipment by background characteristics of the facilities.

Forty-four percent of all facilities indicated that they had preventive maintenance programmes for major equipment, such as generators or sterilizers (Table 3.8). As expected, this was most common in hospitals (89 percent) and least common in PMHs (24 percent). Private religious facilities were more likely to have a programme for maintenance of major equipment from public or other private. The existence of a preventive maintenance programme for major equipment varied between regions. It was particularly low in the Upper East (8 percent), Greater Accra (23 percent), and Volta regions (26 percent). Table A-3.7 indicates that of facilities with a preventive maintenance programme for major equipment, about the same proportion used either onsite staff (47 percent) or external technicians (46 percent).

Table 3.8 Facility systems for maintenance and repair of equipment			
Percentage of facilities that have a preventive maintenance programme for major equipment and percentage of facilities that have a system for repairing or replacing small equipment, by type of facility, operating authority, and region, Ghana SPA 2002			
Background characteristics	Percentage of facilities with:		Weighted number of facilities
	Preventive maintenance programme for major equipment	System to repair or replace small equipment	
Type of facility			
Hospital	89	100	43
Health centre	51	88	166
Clinic	35	83	125
PMH	24	90	95
Operating authority			
Public	48	88	288
Private religious	65	89	39
Other private	26	90	100
Region			
Western	68	91	39
Central	72	92	30
Greater Accra	23	97	28
Volta	26	96	74
Eastern	42	91	50
Ashanti	34	92	71
Brong Ahafo	50	91	54
Northern	53	67	41
Upper East	8	42	20
Upper West	100	100	22
Total	44	88	428

Eighty-eight percent of all facilities had a system for repairing or replacing small equipment such as stethoscopes or sphygmomanometers. Most facilities reported that they sent the equipment offsite for repair or replacement (72 percent). Other procedures were: equipment was repaired onsite (10 percent), the facility hired a technician (10 percent), the items were replaced by a donor (9 percent), or the facility bought new items (27 percent) (Table A-3.8).

3.3 Logistics Systems for Vaccines, Contraceptives, and Medicines (Pharmaceutical Commodities)

To ensure that necessary medical commodities are available, a facility needs to ensure that commodities are stored under conditions where they are protected from damage and that monitoring systems are adequate to minimize the risk that commodities are spoiled through expiration, as well as to ensure that supply availability is maintained. Specific components that were assessed to determine if logistic systems were sufficient for maintaining the quality and quantity of pharmaceutical commodities included the following:

- Storage conditions
- Storage of commodities by expiration date
- Absence of expired commodities
- Up-to-date inventory records.

Only selected items from each category (vaccines, contraceptive methods, and medicines) were checked for validity of all stock, for storage by expiration date, and for concordance with the inventory. If any of the checked items were found to be out of compliance, that indicator system was marked as not functioning.

Information on storage conditions and stock management systems for vaccines, contraceptive methods, and medicines are presented in Table 3.9 and Table 3.10. Information on each element assessed for monitoring the cold chain for vaccine storage is shown in Figure 3.7, and Table A-3.9 provides the same information by type of facility, operating authority, and region. Figure 3.8 shows items assessed for vaccine stock management. Similar information on storage conditions and stock monitoring systems for contraceptive methods and medicines is shown in Table A-3.10 and Table A-3.11 and Figure 3.9 and Figure 3.10.

3.3.1 Storage and Management Systems for Vaccines

Vaccines must be stored at an appropriate temperature to maintain potency. To ensure that the storage conditions are maintained, UNICEF policy is to monitor the temperature of a refrigerator (or cold box) at minimum twice daily and to record the temperature on a graph as proof of monitoring (World Health Organization, 1998). For evidence of adequate storage conditions, the vaccine storage system was assessed for the following items:

- A functioning thermometer in the refrigerator
- Temperature of 0° to 8°C⁶ at the time of the survey
- A completed temperature graph (completed twice a day) for the prior 30 days.

Facilities must also have in place systems to monitor stocks of vaccines. When assessing whether stock is monitored, the indicators are whether the supplies in question are stored according to expiration date (those that expire first are in front so that they will be used first) and whether there is a system for monitoring stock balance and usage. The stock monitoring system must indicate how much of each item is in stock at any given time. Ideally, it will also indicate the expiration date for each batch of medicines received and the date those medicines were distributed. Often, because of use and supply patterns for vaccines and medicines, all of the present stock of a given item may have the same expiration date. In that case, it cannot be ascertained whether the facility monitors and disburses according to expiration date. For

⁶ This is the UNICEF/WHO recommendation for vaccine storage.

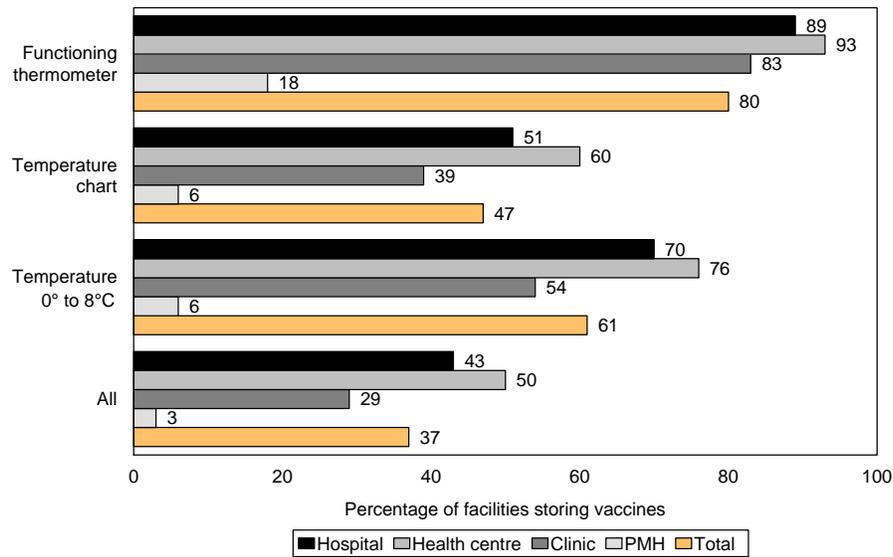
the purposes of the GSPA survey, if the item was seen, but monitoring of expiration date was uncertain because there was no variation in date for the supplies assessed, the facility is assumed to follow the system of storage by expiration date.

Table 3.9 and Figure 3.7 show that of 268 facilities storing vaccines, 37 percent had an adequate cold chain monitoring system. Only 6 percent of facilities storing vaccines had an adequate system for monitoring stocks (no expired items present, items stored by expiration date, and up-to-date inventory available), with the weakest element being an up-to-date inventory, which was present in only 12 percent of facilities (Table A-3.9 and Figure 3.8). The Expanded Programme on Immunization (EPI) has carried out several trainings, particularly in the public sector, to strengthen this key element, yet the results do not reflect this. Less than half of any of the types of facilities had an adequate cold chain monitoring system. The other private facilities had the weakest systems (only 3 percent had adequate monitoring).

Table 3.9 Storage conditions and stock monitoring systems for vaccines				
Among facilities that routinely store vaccines, percentage with adequate cold chain monitoring and stock monitoring system in place, by type of facility and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities with all assessed items for cold chain monitoring system ¹	Weighted number of facilities storing vaccines	Percentage of facilities with all assessed items for monitoring stock ²	Weighted number of facilities with observed stored vaccines ³
Type of facility				
Hospital	43	37	13	36
Health centre	50	137	6	130
Clinic	26	58	7	52
PMH	3	37	0	32
Operating authority				
Public	44	203	6	191
Private religious	37	27	13	26
Other private	3	38	0	32
Region				
Western	43	20	9	16
Central	40	20	6	19
Greater Accra	16	23	0	21
Volta	33	39	5	37
Eastern	50	32	12	31
Ashanti	30	43	14	38
Brong Ahafo	39	37	5	37
Northern	35	28	0	25
Upper East	69	8	0	7
Upper West	42	19	0	19
Total	37	268	6	250
¹ Functioning thermometer in refrigerator, temperature chart up to date, and refrigerator temperature at 0° to 8°C at time of survey				
² No expired items present, items stored by expiration date, and up-to-date inventory available				
³ Data were not available for 18 facilities.				

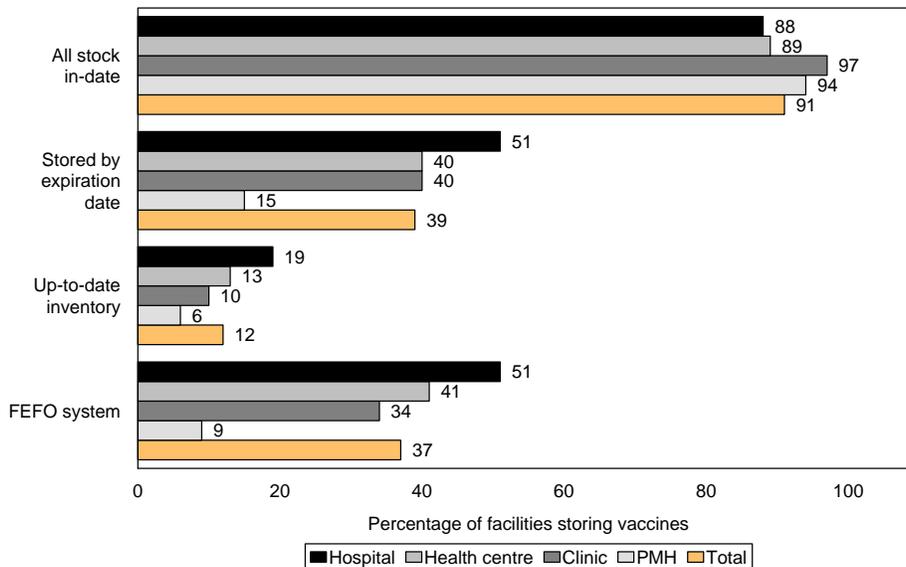
The GSPA survey observed whether specific activities were carried out (Table A-3.9 and Figure 3.7). In general, performance varied. For example, 80 percent of facilities had thermometers, but only 47 percent had up-to-date temperature monitoring charts. It was encouraging to note that although the first-expired, first-out (FEFO) system was used by only 37 percent of facilities, very few facilities (9 percent) had expired vaccines present (Figure 3.8). Hospitals were more likely to have expired vaccines, which is not surprising since the bulk of immunizations are carried out at the health centre level.

Figure 3.7 Elements for monitoring vaccine storage conditions among facilities storing vaccines (N=268)



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Figure 3.8 Elements for managing vaccine stock among facilities storing vaccines (N=268)



Note: In 18 facilities storing vaccines, the vaccines were not observed.

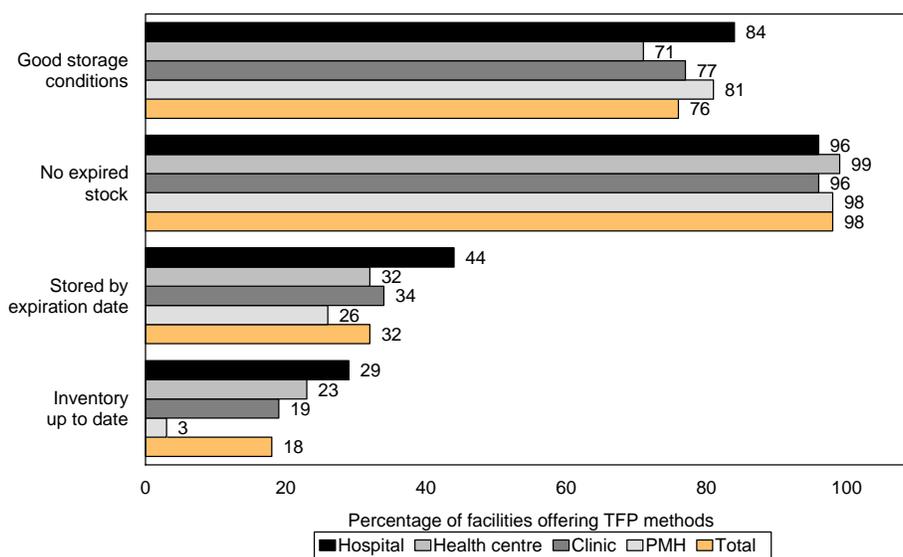
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3.3.2 Storage and Management Systems for Contraceptive Methods and Medicines

To prevent deterioration and contamination, facilities must store medications and contraceptives away from sunlight, under dry conditions, and in a manner that ensures they are protected from contamination by rodents.

The storage conditions and stock monitoring were good for contraceptives in all of the different types of facilities and different operating authorities. Ninety-seven percent of facilities had contraceptives protected from the sun, 94 percent stored contraceptives off the ground and protected from water, and 80 percent had no evidence of pests. The most common weakness was storage by expiration date (32 percent); however, very few facilities (2 percent) had any expired contraceptives in stock (Table A-3.10 and Figure 3.9).

Figure 3.9 Elements for storing and managing contraceptive methods among facilities offering temporary family planning (TFP) methods (N=372)

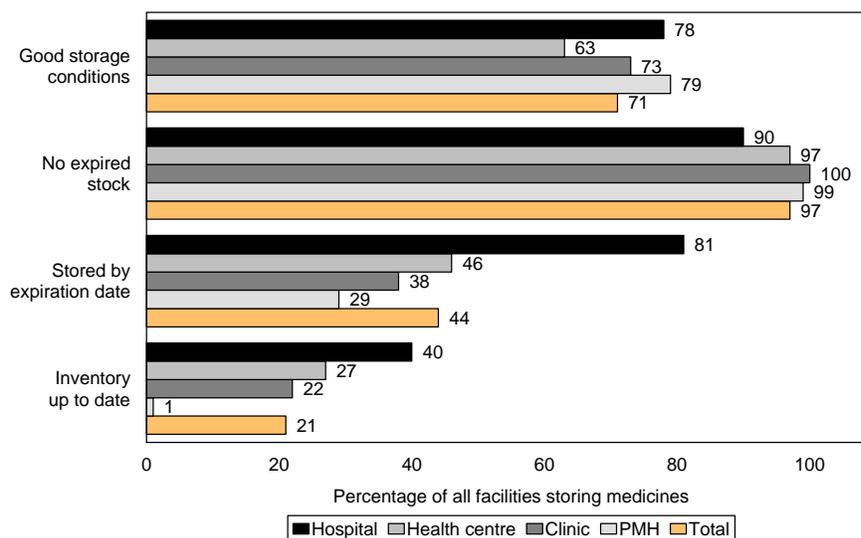


Note: Six facilities had no observed contraceptive methods.

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The storage of medicines was also found to be good, ranging from 78 percent of facilities with no evidence of pests in storage areas to 97 percent of facilities with medicines protected from the sun. The most common weakness was, again, storage by expiration date (44 percent) (Table A-3.11 and Figure 3.10), but only 3 percent of facilities had expired drugs in stock. In many of the public health facilities (82 percent), medicines and contraceptives are stored in different rooms and managed by different staff (data not shown). Public health nurses manage the contraceptives, and the pharmacists/dispensers manage the medicines. These results are encouraging because a lot of effort has been put into improving efficiency within the health sector as one of the main pillars of the health sector reform.

Figure 3.10 Elements for storing and managing medicine stock among facilities storing medicines (N=409)



Note: Twenty-three facilities had no observed medicines

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3.3.3 Systems for Ordering Health Commodities

To maintain an adequate supply of vaccine, contraceptive methods, and medicines, and to prevent waste due to excess stock, facilities must order replenishments in sufficient time to avoid a stock outage. To ensure this, facilities frequently adjust orders, depending on prior usage, current stock, and anticipated usage. Common ordering systems range from the most basic (a fixed amount of specific medicines are supplied at a given time interval) to ideal (individual facilities order or purchase the amounts required, based on usage patterns, when needed and receive their full order). The type of ordering system and the responsiveness of the health system to the facility needs frequently depends on management capacity, available sources of funding, and logistical considerations.

Details on systems used for ordering commodities are presented in Table A-3.12 for facilities that place their own orders and Table A-3.13 for facilities where someone outside of the facility does the ordering. Table A-3.14 provides information on different ordering methods used, by background characteristics.

Eighty-four percent of facilities indicated that they place their own orders for vaccines (Table A-3.12), whereas in 12 percent of facilities, the ordering was done by somebody outside the facility (Table A-3.13). Hospitals and health centres were more likely to place their own orders (more than 92 percent) than were private maternity homes (66 percent). Half of the facilities indicated that the system for receiving ordered vaccine stocks was very reliable. This was more so for private religious (63 percent) and other private facilities (84 percent) than for public facilities (42 percent) (Table A-3.12). Three out of four facilities based the amount they ordered on a mathematical formula. Ordering of vaccines was done as needed (59 percent) or every four weeks (52 percent). About a third of facilities waited until stock fell to the minimal accepted level (Table A-3.14). Seventy-six percent did not maintain a fixed stock, and 55 percent used their judgment to order vaccines. Sixty-one percent ordered as needed, and ordering was based on activity level in 58 percent. As mentioned before, however, very few had expired vaccines in stock. Only 6 percent of facilities had adequate systems for monitoring vaccines (no expired items

present, items stored by expiration date, and up-to-date inventory available) (Table 3.9). An up-to-date inventory and storage by expiration date were the weakest components (Table A-3.9).

Almost all facilities ordered their own stock of contraceptives (96 percent). An equal number of facilities ordering their own contraceptives thought that the system of receiving ordered stock for contraceptives during the three months preceding the GSPA survey was either very reliable or sometimes reliable (48 percent for each) (Table A-3.12). As with vaccines, the most common mode for determining how many contraceptives to order was based on a mathematical formula (64 percent); however, orders were more likely to be placed as needed (62 percent) (Table A-3.14). Only 10 percent of facilities had an adequate system for monitoring contraceptives (no expired items present, items stored by expiration date, and up-to-date inventory available) (Table 3.10). As found with vaccines, the weakest components were lack of an up-to-date inventory and not storing contraceptives by expiration date (Table A-3.10).

Background characteristics	Contraceptive methods				Medicines			
	Percentage with all assessed items for system of storing methods ¹	Weighted number of facilities storing contraceptive methods	Percentage with all assessed items for system of monitoring stock ²	Weighted number of facilities with observed stored contraceptive methods ³	Percentage with all assessed items for system of storing medicines ¹	Weighted number of facilities storing medicines	Percentage with all assessed items for system of monitoring stock ²	Weighted number of facilities with observed stored medicines ⁴
Type of facility								
Hospital	84	34	15	32	78	43	32	41
Health centre	71	153	11	151	63	164	18	163
Clinic	77	98	13	96	73	113	14	98
PMH	81	88	3	88	79	89	0	84
Operating authority								
Public	75	258	12	254	67	275	17	260
Private religious	73	21	12	19	81	39	32	37
Other private	81	93	4	93	79	95	0	89
Region								
Western	84	32	0	31	73	39	2	39
Central	100	27	0	27	95	29	4	27
Greater Accra	71	25	2	24	52	28	4	27
Volta	69	60	9	58	59	66	19	57
Eastern	88	45	14	45	92	50	11	47
Ashanti	93	61	10	59	86	65	27	61
Brong Ahafo	84	47	8	47	80	54	15	52
Northern	64	34	38	34	59	40	25	39
Upper East	70	18	8	18	70	18	14	16
Upper West	0	22	0	22	0	20	3	20
Total	76	372	10	366	71	409	15	386

Medicines were mostly ordered by facility staff (98 percent). The system for receiving drugs as ordered in the three months preceding the GSPA survey was reported to be very reliable in 47 percent of facilities and sometimes reliable in 41 percent of facilities (Table A-3.12). A mathematical formula was used for determining how much of each medicine to order in 65 percent of facilities. Stock was ordered as needed in 64 percent of facilities, and this was based on activity levels in 78 percent (Table A-3.14). The system for monitoring medicine stock levels was evaluated to be adequate in only 15 percent of facilities (Table 3.10).

Key Findings
<p>Forty-four percent of all facilities have a preventive maintenance programme for major equipment, and they are equally likely to use onsite staff (47 percent) or external technicians (46 percent).</p> <p>Only 37 percent of the facilities storing vaccines had an adequate cold chain monitoring system, with other private facilities being the weakest.</p> <p>Storage by expiration date was a weak component of the storage and management systems of vaccines, contraceptives, and medicines; despite this, however, very few facilities had expired items.</p> <p>Most of the facilities place their own orders for vaccines, contraceptives, and medicines. The ordering system most used is actual calculation (with a mathematical formula) based on current and anticipated demand and stock levels. The ordering systems used are generally perceived to be reliable.</p>

3.4 Systems for Preventing Transmission of Infection

“Universal precautions” is a term applied to measures for preventing cross-infection from blood and body fluids. The infection control measures should be used by all health workers who may come into contact with blood or other body fluids, under the assumption that anyone may have an infectious condition that can be transmitted unless precautionary measures are in place (CDC, 1987; JHPIEGO, 2003).

The components of general infection control and universal precautions assessed by the GSPA survey were as follows:

- Facility-level capacity to process⁷ and maintain the appropriate levels of disinfection of equipment.
- Availability of infection prevention items in relevant service delivery areas. These included 1) soap and water for hand-washing; 2) chlorine-based decontamination solution for immediate immersion of contaminated equipment that will be reused; 3) puncture proof, covered containers for disposing of needles, blades, or other sharp items (sharps containers), to prevent accidental injury and possible subsequent infection with HIV or hepatitis; and 4) clean latex gloves.
- Safe disposal of contaminated (biohazardous) materials.

⁷ Processing refers to either sterilization or high-level disinfection procedures.

3.4.1 Capacity for Processing Equipment for Reuse

For most examination equipment, either sterilization or high-level disinfection (HLD) procedures are sufficient to prevent the spread of infection. For killing the spores that cause illnesses such as tetanus, however, either dry sterilization or autoclaving (or less frequently, chemical sterilization⁸) is required. These systems are necessary for processing surgical equipment that will be reused, including blades and scissors used to cut an umbilical cord, and gloves.

For proper processing, equipment should first be decontaminated (soaked in a 0.5 percent chlorine solution for at least 10 minutes) and then brush scrubbed with soap and water. The equipment must then be processed at the required temperature for the required time, depending on the processing method used. It must be stored under sterile or HLD conditions (dry, stored in sterile wrapping or a sterile or HLD box that clasps shut), and the date of sterilization should be indicated since sterility cannot be ensured after one week unless the item is also sealed in plastic.

The elements assessed for supporting consistent quality sterilization or HLD processing were as follows:

- Functioning equipment, including a power source for heat
- Automatic timer that indicates when the required amount of time has elapsed
- A staff member who knows the proper processing time⁹ (and temperature, if relevant).

Table 3.11 and Figure 3.11 provide information on the availability of equipment, knowledge, and full capacity to routinely carry out proper sterilization or HLD procedures, as well as the practices for adequately storing processed equipment. Table A-3.15 provides details on various components related to processing, and Table A-3.16 provides details on storing equipment. Table 3.12 provides summary information on the availability of all assessed items for prevention of infection and adequate disposal systems for hazardous waste, and Table A-3.17 provides information on availability of individual items for prevention of infection. Table A-3.18 provides details on methods for disposing of hazardous waste.

Facilities often process equipment differently depending on the size of the facility and the functional status of the equipment. The GSPA survey assessed the highest level capacity for a facility, rather than their stated “most common method.” Depending on the size of a facility, equipment may be processed by different methods or in more than one site in the facility. Information presented in this chapter refers to the primary site in the facility where equipment is processed.

While 96 percent of hospitals had functioning equipment for sterilizing (either using dry heat or autoclave), only approximately half of other facilities had this equipment. However, among the other facilities, 48 percent of the health centres, 35 percent of the clinics, and 53 percent of PMHs had equipment for HLD processing (boiling or steaming) (Table A-3.15). When availability of equipment (or the appropriate chemical for chemical HLD processing) and knowledge of processing time (and temperature for dry heat sterilization) were assessed, 90 percent of hospitals, 58 percent of PMHs, 48 percent of health centres, and 34 percent of clinics had both the equipment or supplies and knowledge (Figure 3.11 and Table 3.11). In addition to equipment and knowledge of time, a timing device is also required for consistent adherence to proper procedures. Only 8 percent of all facilities (49 percent of hospitals) had all three items to support quality sterilization or HLD processing of equipment.

⁸ Formaldehyde or glutaraldehyde (Cydex)

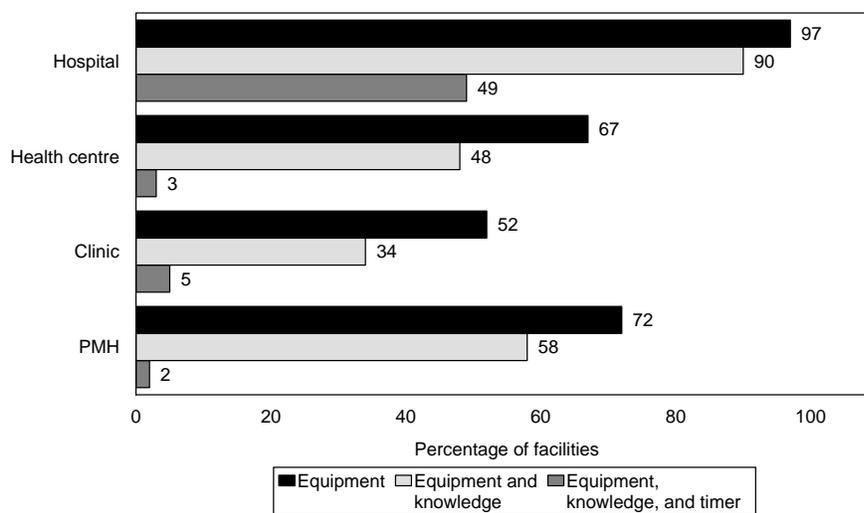
⁹ If equipment automatically set the temperature or time, this was acceptable even if the staff could not tell how long the processing took or the temperature for processing.

A negative finding for some items (e.g., a timer or knowledge of the processing time) does not necessarily mean that facilities do not follow proper procedures. It is possible that the staff who process the equipment were not present the day of the survey, and careful staff may use a watch to time processing. For assurance that procedures will be followed systematically, there needs to be a passive means to ensure that proper procedures are known by at least one on-duty staff member (e.g., written procedures that are easily accessed) and for ensuring that no mistake is made with the processing time (a timer that can be set to indicate when the necessary time has elapsed). For facilities where interviewed providers thought to refer to a manual, the GSPA survey accepted reports of processing procedures that were given after looking in a manual.

Table 3.11 Capacity for sterilization or high-level disinfection of equipment for reuse, and capacity for storing equipment to maintain processed status						
Percentage of facilities with functioning equipment (or appropriate chemical), functioning equipment and knowledge of minimum processing time (and temperature for dry heat sterilization), and functioning equipment, knowledge of minimum processing time, and an automatic timing device, for either sterilizing or HLD equipment for reuse, and percentage with equipment stored following procedures to maintain sterile/HLD status, by type of facility, operating authority, and region, Ghana SPA 2002						
Background characteristics	Percentage of facilities with capacity for proper sterilization or HLD processing ¹			Weighted number of facilities	Percentage with sterile storage conditions and processing dates on sterilized items ²	Weighted number of facilities with stored processed items
	Equipment	Equipment and knowledge of process time	Equipment, knowledge of process time, and automatic timer			
Type of facility						
Hospital	97	90	49	43	28	40
Health centre	67	48	3	166	1	139
Clinic	52	34	5	125	4	86
PMH	72	58	2	95	1	90
Operating authority						
Public	62	45	8	288	5	229
Private religious	83	66	23	39	15	31
Other private	73	59	3	100	2	94
Region						
Western	54	16	7	39	2	28
Central	92	79	18	30	2	28
Greater Accra	67	54	16	28	8	28
Volta	71	55	9	74	3	58
Eastern	52	48	9	50	4	49
Ashanti	69	58	9	71	2	62
Brong Ahafo	72	53	1	54	6	48
Northern	63	35	4	41	10	28
Upper East	37	18	3	20	0	6
Upper West	87	86	13	22	15	20
Total	67	51	8	428	5	355
¹ Processing area has functioning equipment and power source for method and reports the correct processing time (or the equipment automatically sets the time) and processing temperature (if applicable) for at least one method. Definitions for capacity for each method assessed were functioning equipment and processing conditions of the following: <ul style="list-style-type: none"> • Dry heat sterilization: temperature 160° to 169°C for at least 120 minutes or temperature at least 170°C and process at least 60 minutes • Autoclave: process wrapped items at least 30 minutes, unwrapped items at least 20 minutes • Boiling or steaming: process at least 20 minutes • Chemical: chlorine base or glutaraldehyde solution and soak for at least 20 minutes ² Items are wrapped and sealed with time-, steam-, and temperature-sensitive (TST) tape, or items are in sterile container with clasp, and processing time is written.						

The equipment and knowledge for boiling or steaming equipment was most often available (31 percent). Chemical HLD (equipment and knowledge) was available in 16 percent of facilities, most often in PMHs (28 percent). About half of the health centres, clinics, and PMHs had functioning equipment for autoclave or dry heat available; on the other hand, only about 1 in 20 of such facilities had both equipment and knowledge of minimum processing time (and temperature for dry heat sterilization), as reported in Table A-3.15.

Figure 3.11 Components to support quality processing of equipment (N=428)



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3.4.2 Appropriate Storage Conditions

The storage conditions that must be observed to maintain sterility or HLD status include 1) storing items in a dry location; 2) either wrapping items in sterile cloth or placing them in a sterile or high-level disinfected clasped box; and 3) writing the date of sterilization, since the sterility cannot be ensured after one week unless the item is also sealed in plastic. There are other common storage procedures that may be accepted practice in some settings but they may not ensure that the items remain sterile.

Eighty-three percent of all facilities had sterilized or disinfected items stored on the day of the survey. Although 68 percent of facilities had sterile storage conditions and 48 percent of facilities had clean but not sterile storage conditions,¹⁰ only 5 percent of facilities had dates on sterilized items (Table A-3.16). Therefore, only 5 percent had all components available (Table 3.11). Hospitals were clearly the best, with 28 percent having all the components available. Writing the processing date on the item was the major weakness.

3.4.3 Infection Prevention and Hazardous Waste Control in Service Delivery Area

Nosocomial infections (infections that are contracted from the health facility) are always possible and complicate care giving for any health system. Prevention measures and constant vigilance are routinely

¹⁰ Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, or sitting in disinfectant solution.

needed. Preventive measures that were assessed in the GSPA survey were for each of the following items to be available in the service delivery area:

- Soap and water for hand-washing
- Sharps box
- Disinfecting solution (in areas where reusable equipment might be contaminated by blood or body secretions)
- Clean latex gloves
- Disposal of hazardous waste.

Table A-3.17 provides information on the percentage of facilities where, for each service that was offered in the facility and the service area assessed by the GSPA survey (child immunization, curative child care, family planning, antenatal care, delivery services, and STI and HIV/AIDS services), the relevant infection control items were present in the service delivery area. Relevant infection control items were soap and water (all services), sharps box (all services except curative child care), and disinfecting solution and gloves (family planning, antenatal care, delivery, and STI and HIV/AIDS services). Table 3.12 provides information on the percentage of facilities that had an adequate system for disposal of contaminated waste. Table A-3.18 provides details on methods used for disposing of hazardous waste, by background characteristics.

<u>Table 3.12 Infection prevention and hazardous waste control</u>				
Percentage of facilities with all infection prevention items in service delivery areas assessed by the GSPA survey, single-use towels in service delivery area, and an adequate disposal system for contaminated waste, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities with:			Weighted number of facilities
	All infection control items in service delivery areas ¹	Single-use towels in service delivery areas	Adequate waste disposal system ²	
Type of facility				
Hospital	4	11	26	43
Health centre	5	8	28	166
Clinic	10	12	30	125
PMH	18	61	37	95
Operating authority				
Public	5	9	28	288
Private religious	10	16	31	39
Other private	19	60	36	100
Region				
Western	4	10	42	39
Central	24	49	41	30
Greater Accra	12	40	15	28
Volta	4	5	26	74
Eastern	11	26	40	50
Ashanti	7	29	18	71
Brong Ahafo	6	29	28	54
Northern	10	4	26	41
Upper East	0	15	42	20
Upper West	25	19	49	22
Total	9	21	30	428
¹ Soap and water, sharps box, disinfectant solution, and gloves present in all service delivery areas assessed in the facility				
² Final disposal of contaminated waste is incineration, burial, or removal offsite; waste is not visible or is kept under protected conditions on day of survey.				

Availability of all relevant items in the assessed service delivery areas was encouraging for soap (70 percent), water (68 percent), and gloves (54 percent) (Table A-3.17). Towels (21 percent) and disinfecting solution (24 percent), however, were notably low, especially in hospitals (11 percent each).

Contaminated waste includes items such as bandages, needles, and syringes that may be contaminated by blood or other biological waste and that may be infectious if touched. The most effective means for disposal is incineration and subsequent burial of the remains. Burying items in deep pits is also an effective means of disposal. The most important item to be assessed is whether there is a process for disposal that eliminates the possibility of contamination through contact. If the waste is visible and not protected from animals or people, either before or after processing, this increases the chances that people can inadvertently come in contact and risk subsequent infection.

Thirty percent of facilities had an adequate waste disposal system (Table 3.12). The most common method of waste disposal for needles and sharps was by burning in an open pit (54 percent) (Table A-3.18). All other methods were not as frequently used. Seventeen percent of facilities burned and buried their needles and sharps, and burning in an incinerator or burning and moving to an offsite dump were done by approximately one in ten facilities for both methods. Wet waste was mostly burned in an open pit (40 percent); it was burned and buried in 15 percent of facilities or thrown into an open pit/trash or pit latrine (7 percent each). Only 2 percent of facilities used reusable syringes and needles; therefore, data collected on how they were sterilized are not shown.

Key Findings
<p>Only 8 percent of all facilities had the capacity to carry out proper sterilization (equipment, knowledge of process time, and automatic timer), with hospitals (49 percent) being most likely. More than half of all facilities (51 percent), however, had the equipment and knowledge of process time.</p>
<p>Infection control is weak, since only 9 percent of all facilities have all the necessary items. The items most often missing were disinfectant (missing in 76 percent of the service areas) and a sharps box (missing in more than half of cases).</p>
<p>Thirty percent of facilities had an adequate hazardous waste disposal system. Burning in an open pit was the method most commonly used.</p>

3.5 Special Programmes

The GSPA survey also looked at several special programmes that are currently used in Ghana.

3.5.1 Special Programmes Targeting Adolescents for Reproductive Health Issues

The adolescent reproductive health programme is part of the national reproductive and family health programme. It was set up to address the specific reproductive health needs of adolescents. Table 3.13 shows that very few facilities had programmes targeting adolescents. Specific programmes looked for were self-directed learning, client-provider interaction, and adolescent reproductive health programmes (available in 10 percent of facilities). Other services were youth-oriented clinics and clubs (5 to 7 percent). Surprisingly, few facilities offered general education talks (14 percent), especially given the current focus on targeting youth for HIV/AIDS and STI services.

Table 3.13 Availability of programmes targeting adolescents for reproductive health issues					
Percentage of facilities with SDL/CPI/ARH programmes, youth-friendly clinics, young and wise or youth clubs, and general educational talks by type of facility, operating authority, and region, Ghana SPA 2002					
Background characteristics	Percentage of facilities with programmes targeting adolescents for reproductive health available				Weighted number of facilities
	SDL/CPI/ARH ¹	Youth-friendly clinics	Young and wise or youth clubs	General educational talks	
Type of facility					
Hospital	4	12	9	13	43
Health centre	3	4	6	10	166
Clinic	3	5	5	16	125
PMH	32	6	10	18	95
Operating authority					
Public	2	5	5	12	288
Private religious	5	2	4	11	39
Other private	32	9	13	19	100
Region					
Western	2	1	4	9	39
Central	0	3	7	1	30
Greater Accra	27	24	15	24	28
Volta	0	6	13	28	74
Eastern	23	5	4	8	50
Ashanti	7	6	9	9	71
Brong Ahafo	23	1	0	18	54
Northern	3	6	8	11	41
Upper East	0	0	0	2	20
Upper West	14	7	0	12	22
Total	10	5	7	14	428

¹ Self-directed learning/client-provider interaction/adolescent reproductive health

3.5.2 Community-based Health Planning and Services

Community-based Health Planning and Services (CHPS) is a strategy to provide primary health care services with community mobilization and participation. It targets communities and households as its social capital and uses behaviour change communication strategies for positive behavioural changes to prevent sickness and promote early appropriate health-seeking behaviour. It builds its approach on community needs assessment and employs evidence-based planning to tackle problems with subsequent community action. CHPS was developed by using research findings in Navrongo on how to involve the community in strategic planning for family planning and community health services.

All districts in the country are now urged to implement CHPS as part of their primary health care strategy. However, CHPS is not facility based and is made up of initiatives mainly for the public health sector. CHPS is meant to augment access to health care delivery in particularly remote areas and is thus expected to be more common in rural areas. It is not expected in every facility because catchment areas vary.

Findings on CHPS are shown in Table A-3.19, Table A-3.20, and Table A-3.21.

Public facilities were asked their status with regards to implementing CHPS and their general opinion on CHPS. Seventeen percent of these facilities indicated that they had begun implementing CHPS, with an additional 15 percent indicating that they were in the initial planning stages (Table A-3.19). Sixty-eight percent indicated that they had no plan for initiating the programme at this time. Sixteen percent indicated that they had village health committees or volunteers. Table A-3.20 provides details on the stage of

implementation of CHPS and the median number of nurses posted to the community for facilities that have started activities. Table A-3.21 indicates that 4 percent of government facilities had a positive opinion of CHPS, 11 percent had problems and that suggested they needed more government support, and an additional 5 percent described problems but suggested the need for more community support.

3.5.3 Revolving Drug Fund

After the Bamako Initiative was implemented, a revolving drug fund (RDF) was instituted in the overall public health sector but mainly in the health centres. Fifty-six percent of facilities said that the RDF met their local needs (Table A-3.22). Most of these facilities reported that they received their drugs from the regional health store (65 percent). Following the decentralization policy of the Ministry of Health, districts have been charged with setting up district medical stores to improve access to essential medications for the health facilities in their catchment areas, but only 26 percent of facilities with RDFs reported receiving their drugs from the district medical stores. A quarter of facilities reported buying drugs from the market or pharmacies, but as expected, this is fairly low for the public sector (17 percent), as compared with the other private (97 percent) and private religious (61 percent) institutions.

4.1 Background

4.1.1 Collection of Child Health Information

According to the World Health Organization (WHO), many sick children who are brought to the attention of health providers do not receive adequate assessment and treatment (WHO, 1999b). It is not uncommon for a provider to treat the symptom that is most evident, without conducting a full assessment of the health status of the child. One result of this practice is that the underlying cause of an illness and/or other existing health problems are often overlooked. For this reason, WHO and other agencies developed the strategy of Integrated Management of Childhood Illnesses (IMCI). The strategy promotes using every visit to a health care provider as an opportunity not only to conduct a full assessment of the child's current health and possible underlying problems, but also to provide preventive interventions such as immunization and growth monitoring, for early detection of faltering growth, to prevent or minimize progression to illness.

The Ghana Service Provision Assessment (GSPA) survey uses the IMCI guidelines as the basis for the assessment of child health services and uses the national Expanded Programme on Immunization (EPI) policy as the basis for assessment of childhood immunization services.

This chapter uses information obtained in the GSPA survey to address the following four central questions:

- What is the availability of outpatient services relevant to child health?
- To what extent do facilities offering immunization services for children have the capacity to support quality vaccination services?
- To what extent do the health facilities providing consultation services for sick children have the capacity to support quality services in adherence to the IMCI guidelines?
- To what extent is there evidence that health workers involved in the provision of care for sick children are adhering to standards for quality service provision?

4.1.2 Health Situation of Children in Ghana

The child health programmes aim to promote and maintain the optimal growth and development of children. The goals set to achieve these objectives include the need to provide adequate care for the newborn, ensure that children are fully immunized by the age of 12 months, and promote adequate and timely food supplementation and nutrition rehabilitation programmes. This includes exclusive breastfeeding for the first six months of life, continued breastfeeding for at least two years with appropriate complementary food and vitamin A supplementation. It also includes effective management of the sick child.

4.1.3 Vaccination Coverage

So far, immunization coverage has been encouraging. The proportion of children fully immunized by age one increased from 43 percent in 1993 (Ghana Statistical Service and Macro International, 1994) to 51 percent in the 1998 GDHS (Ghana Statistical Service and Macro International, 1999). Reported coverage among children age 0 to 11 months from the 1998 GDHS were as follows: BCG and first dose of DPT and polio vaccines (90 percent), measles (61 percent), and yellow fever (39 percent).

4.1.4 Childhood Mortality and Morbidity

The 1998 GDHS provides household-based child mortality data as well as information on illnesses and health service utilization during the two weeks before the household visit for this survey. Key findings include the following:

- The infant mortality rate was estimated at 61 deaths per 1,000 live births during the 10 years preceding the survey. The trend in infant mortality shows a decrease over the last 20 years.
- The under-5 mortality rate was estimated at 110 deaths per 1,000 live births. The trend in under-5 mortality also shows a decrease over the last 20 years.
- Twenty-six percent of Ghanaian children under 5 years were stunted (short for their age), and 9 percent were severely stunted. Children in rural areas were twice as likely to be stunted as children in urban areas.
- Ten percent of children under 5 years were wasted (low weight for their height), and 1 percent were severely wasted.
- Among children less than 3 years of age, the median exclusive breastfeeding duration was less than 1 month (0.7 months).
- Fourteen percent of children under 5 years had a cough and rapid breathing during the 2 weeks preceding the survey; of those, 26 percent were taken to a health facility.
- Eighteen percent of children less than 5 years had diarrhoea during the 2 weeks preceding the survey; in 58 percent of these cases, the amount of fluid given to the child was increased, and in 18 percent, it was decreased.
- Twenty-six percent of children under 5 years with diarrhoea were taken to a health facility, and 29 percent received solution prepared from oral rehydration salts (ORS).

4.2 Availability of Child Health Services

The IMCI strategy is predicated on the assumption that when sick children are brought for care, related services (immunization and growth monitoring) will also be available, so they can receive appropriate preventive assessments and interventions, as well as treatment for their illness.

The three essential preventive and curative child health services assessed by the GSPA survey are outpatient consultations for sick children, routine childhood immunization services, and routine growth monitoring services. Table 4.1 provides information on the availability of these child health services. Tables A-4.1 and A-4.2 provide details on the number of days per week services are available. Figure 4.1 summarizes the aggregate data from Table A-4.2.

Table 4.1 indicates that all three essential services were available in 63 percent of all facilities, mostly in hospitals and health clinics (81 percent for each) and less frequently in clinics (63 percent) and private maternity homes (PMHs) (25 percent). Almost all facilities offered outpatient consultations for sick children (94 percent), but growth monitoring was offered less frequently (65 percent of all facilities). PMHs and clinics were least likely to offer this service (25 and 65 percent, respectively). Child immunization was offered in 69 percent of facilities, either by facility staff (51 percent) or by external staff (18 percent). An additional 6 percent of the facilities offered immunizations through village-level outreach only (mainly clinics).

Almost all (98 percent) facilities providing sick children services offer this service at least 5 days per week (Table A-4.1). For immunization services and growth monitoring, the current policy in Ghana is that hospitals and health centres should provide these services every weekday and clinics and PMHs should provide them at least one day per week. This policy is still new, and because of financial,

logistical, and personnel constraints, this is not feasible in all facilities. This is reflected in the findings of the GSPA survey. Growth monitoring is offered 1 or 2 days per week in 61 percent of the facilities offering this service; hospitals are most likely to offer the service 5 or more days per week (still only 15 percent), and health centres are least likely (only 4 percent). More than half (54 percent) of the facilities offer child immunization services 1 or 2 days per week. Nineteen percent of the health centres offer the service 5 or more days per week, as stated in the policy documents. One possible explanation for this low coverage is that staff in health centres provide the EPI service through outreach in the community or at other clinics in the area and therefore may not be present at the facility daily. Another explanation might be that even if the staff members are present, because of limited resources, they do not feel they can open a vial of vaccine if few children are present, as this may result in vaccine wastage, even though this is against the present policy.

Table 4.1 Availability of child health services

Percentage of facilities offering outpatient curative care for the sick child at the facility or by outreach only, growth monitoring services at the facility or by outreach only, child immunization services at the facility performed by facility staff or by external staff, any child immunization services through outreach only or outreach combined with facility service, and all three services, by type of facility, operating authority, and region, Ghana SPA 2002

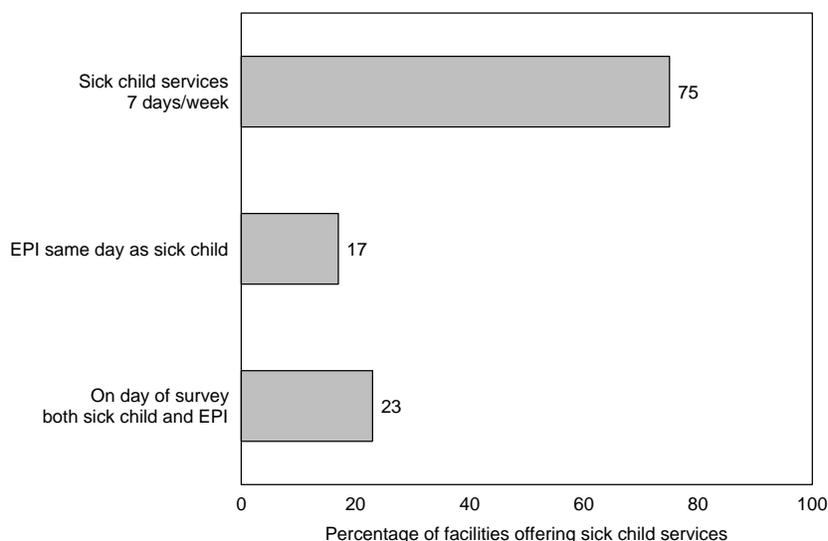
Background characteristics	Percentage of facilities offering:									Weighted number of facilities
	Outpatient curative care for child		Growth monitoring		Any childhood immunization at the facility		Any childhood immunization		All basic child health services ²	
	At facility	Outreach only	At facility	Outreach only	Facility provides	External staff provides ¹	Outreach only	Outreach and at facility	At facility	
Type of facility										
Hospital	98	0	85	2	66	25	0	73	81	43
Health centre	99	0	82	3	69	19	3	84	81	166
Clinic	85	1	65	12	51	17	12	57	63	125
PMH	97	0	25	5	15	14	5	1	25	95
Operating authority										
Public	94	1	78	6	64	18	6	75	75	288
Private religious	95	0	70	5	49	24	5	64	70	39
Other private	96	0	25	5	15	13	5	2	25	100
Region										
Western	100	0	63	0	56	4	0	52	56	39
Central	100	0	63	13	67	0	13	57	76	30
Greater Accra	97	0	65	0	40	24	0	33	55	28
Volta	85	0	58	0	31	40	0	66	42	74
Eastern	97	0	75	8	32	31	8	57	69	50
Ashanti	95	0	55	9	45	16	8	44	57	71
Brong Ahafo	97	0	56	4	66	11	4	56	59	54
Northern	91	0	78	8	68	8	8	66	78	41
Upper East	93	7	64	31	64	3	31	61	95	20
Upper West	100	0	95	0	91	5	0	82	95	22
Total	94	0	65	6	51	18	6	57	63	428

¹ Government staff external to a facility visit the facility to provide vaccines according to some agreed frequency.

² Growth monitoring for well children, any routine vaccinations for children at the facility, and curative care for children

Figure 4.1 indicates that 75 percent of all facilities provide sick child services every day. Only in 17 percent, however, are EPI services available every day that sick child services are offered (Table A-4.2). On the day of survey, 23 percent of the facilities were offering both sick child and EPI services. This means that the child has to come back another day if he/she needs a vaccination, which increases the risk of the child not receiving this preventive service, especially in remote areas, where the mother might have difficulties coming back because of logistic or cost constraints.

Figure 4.1 Availability of sick child services and EPI services among facilities offering sick child services (N=404)



Ghana SPA 2002

For increased accessibility and coverage, immunization services and growth monitoring are also offered through routine community outreach. Overall, more than half (57 percent) of the facilities provide outreach services for immunizations, most often health centres (84 percent), hospitals (73 percent), and clinics (57 percent). Some facilities offer growth monitoring (6 percent) and immunization services (6 percent) by community outreach only (Table 4.1).

Key Findings

The three essential child health services are present in 63 percent of all facilities, although rarely are the three services offered on the same day.

Outpatient curative care for children is available in almost all facilities (94 percent), and growth monitoring is available in 65 percent of the facilities. Childhood immunizations are available at 69 percent of the facilities, and an additional 6 percent provide this service only through village outreach activities.

Curative care is provided 5 days per week or more in almost all facilities offering this service (98 percent). Child immunizations are offered 1 or 2 days per week in 54 percent of the facilities and 5 days per week in 19 percent of the facilities, while growth monitoring is least frequently offered (61 percent of the facilities offer this service 1 or 2 days per week).

4.3 Capacity to Provide Quality Immunization Services

This section addresses elements that are important for quality immunization services including

- Capacity to maintain the quality of vaccines
- Availability of all vaccines

- Availability of equipment and supplies for vaccination session
- Availability of administrative components for monitoring immunization activities.

Table 4.2 provides a summary of the components necessary for quality immunization services that were present on the day of the survey in facilities that provide routine EPI services. Figure 4.2 summarizes the availability of various vaccines, and Table A-4.3 provides details on availability. Figure 4.3 and Table A-4.4 provide details on availability of specific equipment and supplies for vaccination services.

Table 4.2 Health system components required for childhood vaccination services								
Among facilities offering child vaccination services, percentage of facilities that have all equipment, infrastructure for infection prevention, records indicating good administrative practices, and all components for providing quality child immunization services; and among facilities providing child immunization services and storing vaccines, the percentage with all child vaccines present and all components for providing quality child immunization services present, by type of facility, operating authority, and region, Ghana SPA 2002								
Background characteristics	Percentage of facilities offering child immunization services that have:				Weighted number of facilities offering child immunization services ⁵	Percentage of facilities offering child immunization services and storing vaccines that have:		Weighted number of facilities offering child immunization services and storing vaccines
	All equipment ¹	All infection prevention elements ²	Administrative components ³	All components for providing quality child immunization services (not including vaccines) present ⁴		All child vaccines present ⁶	All components for providing quality child immunization services (including vaccines) present ⁷	
Type of facility								
Hospital	50	73	34	22	39	84	23	35
Health centre	47	64	48	21	145	75	20	133
Clinic	34	62	27	8	86	70	7	52
PMH	34	38	0	0	27	8	0	14
Operating authority								
Public	43	64	41	17	239	75	18	194
Private religious	46	69	32	13	29	78	12	25
Other private	36	39	1	1	28	12	2	14
Region								
Western	46	72	35	29	23	63	26	20
Central	33	88	45	8	20	75	8	19
Greater Accra	58	45	21	12	18	56	9	15
Volta	23	60	35	8	52	61	5	35
Eastern	43	66	41	16	32	85	19	26
Ashanti	57	55	22	11	43	72	15	33
Brong Ahafo	40	49	38	23	42	74	28	33
Northern	27	68	33	3	32	82	4	25
Upper East	58	67	49	35	13	73	38	8
Upper West	76	71	58	24	21	72	24	19
Total	43	62	36	15	297	71	16	233
¹ Blank immunization cards, syringes and needles, and cold box with ice packs (or facility reports purchasing ice)								
² Soap, water (any source), and sharps container								
³ Tally sheet or register indicating vaccines provided and documentation of either DPT dropout rate or measles coverage								
⁴ All equipment, all infection prevention elements, and all administrative components								
⁵ Facility-based immunization services								
⁶ Routine child vaccines are BCG, polio, DPT/HepB/Hib (or DPT), and measles								
⁷ All equipment, all infection prevention elements, all administrative components, and routine child vaccines								

4.3.1 Capacity to Maintain the Quality of Vaccines

Among facilities that offer routine child immunization services, 84 percent store vaccines (data not shown). This makes it possible for vaccines to be available 24 hours a day in the facilities. Lack of electricity or other fuel to maintain the cold chain is a common reason for a facility not to store vaccines.

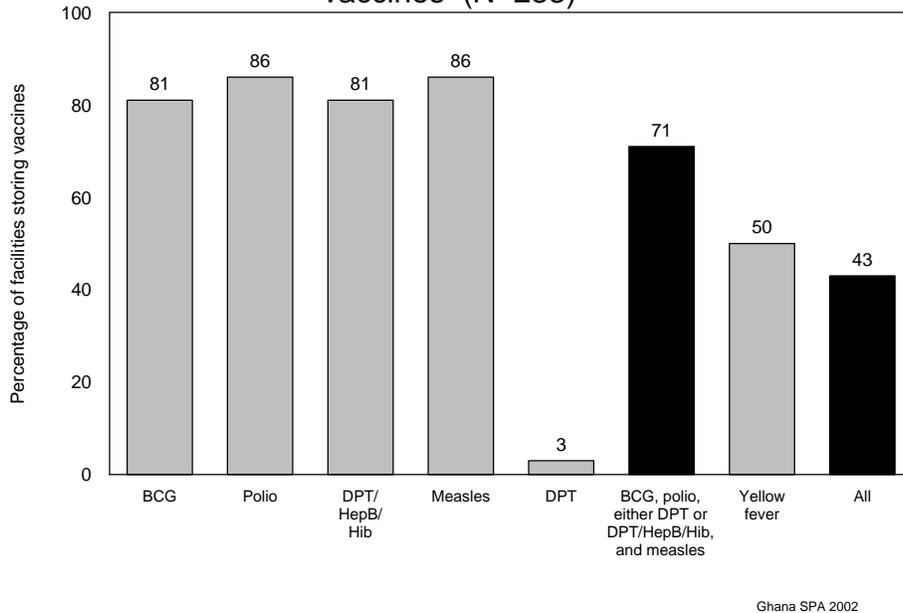
If a facility cannot store vaccines, it must collect the vaccines from a central location and maintain their temperature using ice packs and mobile vaccine carriers on the days of service. This results in limited ability to offer child vaccinations because the vaccines can be kept viable this way for only one or two days with any confidence that the cold chain has been maintained. As shown in Table 3.9, 37 percent of facilities storing vaccines had all elements for adequately monitoring the cold chain (functioning thermometer in the refrigerator, temperature chart up to date, and temperature 0° to 8°C at the time of survey), but only 6 percent had all elements for monitoring and storing the stock (no expired items present, items stored by expiration date, and up-to-date inventory available). Only 39 percent of facilities arranged the vaccines by expiry date, and 12 percent had an up-to-date inventory or system for rapidly calculating the current inventory in place; however, few facilities (9 percent) had expired vaccines in the refrigerators. Thirty-seven percent of the facilities used the FEFO (first expired, first out) system. Table A-3.9 provides details on the elements assessed.

4.3.2 Availability of Vaccines

In facilities that both offer child immunization services and store vaccines, information was collected on the availability of basic vaccines for childhood illnesses. The common childhood vaccines are BCG (for tuberculosis), OPV (oral polio vaccine), DPT (a combination of diphtheria, pertussis, and tetanus) and measles. In Ghana, the hepatitis B and yellow fever vaccines are also included as routine immunizations. DPT vaccine is being phased out and replaced by DPT/HepB/Hib, which combines DPT, hepatitis B, and *Haemophilus influenzae* type b vaccines.

Of all facilities storing vaccines, 71 percent had all basic child vaccines (BCG, polio, either DPT or DPT/HepB/Hib, and measles) available on the day of survey, and 43 percent had all basic child vaccines including yellow fever (Table A-4.3). Eighty-four percent of the hospitals, 75 percent of the health centres, and 70 percent of the clinics, but only 8 percent of the PMHs had all basic child vaccines. The public and private religious facilities had all vaccines available in approximately 8 out of 10 sites, while only 12 percent of other private facilities had all vaccines (Table A-4.3). BCG was missing in 19 percent of facilities, with 84 percent of the PMHs lacking this vaccine. Polio and measles were missing in 14 percent of facilities, and DPT/HepB/Hib was missing in 19 percent of facilities. Yellow fever was available in 50 percent of facilities. DPT was only available in 3 percent of facilities, which is expected because it is being phased out since the introduction of DPT/HepB/Hib in the beginning of 2002.

Figure 4.2 Availability of vaccines, among facilities storing vaccines (N=233)



4.3.3 Availability of Equipment and Supplies for Vaccination Sessions

The following items were assessed for quality EPI services:

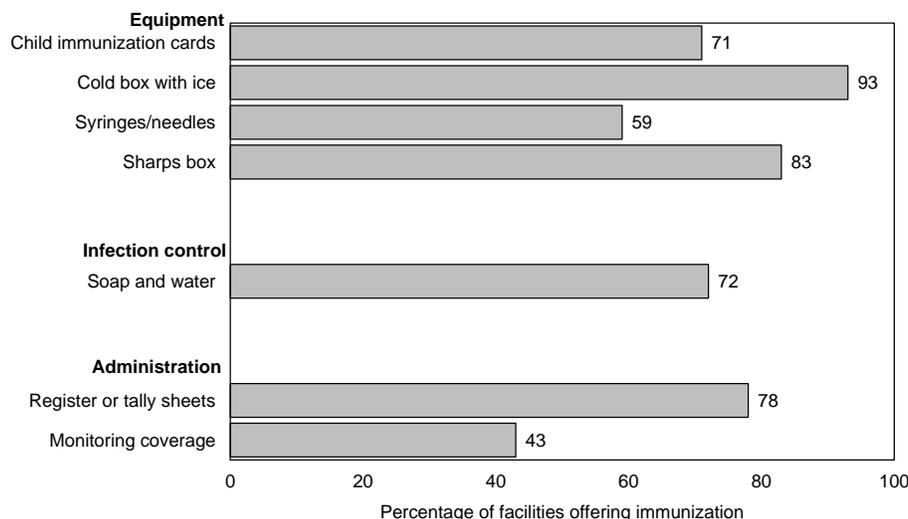
- Individual child immunization records
- Vaccine syringes
- Cold boxes and ice packs
- Items for infection prevention.

Individual child immunization records (cards or child health booklets where immunizations are recorded) are an integral part of immunization services and should be available wherever child immunizations are provided. Since mothers often keep their child’s health records, the GSPA survey checked for the availability of blank records, for new children. Overall, 71 percent of facilities had cards available, with very little difference between facilities, except the PMHs, where only half had cards (Figure 4.3 and Table A-4.4).

During vaccination sessions, vaccines are frequently stored in portable cold boxes to maintain the temperature for vaccines that are being used and to avoid frequent opening of freezers and refrigerators. Facilities must have either ice packs or purchase ice on the day of service to maintain the cold chain during immunization sessions. Ninety-three percent of facilities had boxes with ice packs, with no major differences between types of facilities and operating authorities (Figure 4.3 and Table A-4.4).

All health facilities should have the means to control and prevent infections when providing immunization services. Ghana uses disposable syringes and needles universally. On the day of survey, five or more syringes of both 1 or 0.5 ml and 2 or 3 ml were available in the service area in 6 out of 10 facilities offering child vaccination services. Where needles are used, a sharps box to safely dispose of the needles is required. This was available in 83 percent of all facilities. No major difference was observed between public (88 percent) and private religious facilities (83 percent), but in other private facilities, the sharps needle box was not in the service area in over half of the facilities (Table A-4.4).

Figure 4.3 Availability of materials for quality EPI programme among facilities offering immunization (N=277)



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Soap and water for hand-washing are important for infection control. Table A-4.4 demonstrates that in 72 percent of all facilities, this was available in the service area. There was no major difference between hospitals (80 percent), health centres (71 percent), and clinics (72 percent); in PMHs, soap and water were available in 63 percent of facilities. Water supply for the facilities was mainly piped (41 percent) or was drawn from a protected well/borehole (46 percent). In consultation areas, a bucket or basin was the most common means for providing water (43 percent), followed by 34 percent using a container with a tap (Veronica bucket), and 21 percent that responded as using piped water (data not shown).

4.3.4 Availability of Administrative Components for Monitoring Immunization Activities

The GSPA survey looked for evidence of recordkeeping that provides information for monitoring immunization activities. Specific items assessed were as follows:

- Documentation for immunizations provided
- Evidence of monitoring immunization coverage.

Figure 4.3 shows that almost 8 out of 10 facilities had either a register or tally sheets. Health centres were the best supplied (89 percent), and PMHs were the least supplied (37 percent). Table A-4.4 provides more detailed information, by type of facility, operating authority, and region.

Measures often used for monitoring immunization coverage include the DPT dropout rate (the difference between the number of children who receive the first dose of DPT and the number of those who completed the three doses of DPT) and vaccine coverage rates (the percentage of eligible children who have been fully immunized with a specific vaccine or with all vaccines). Measures of immunization coverage require an estimate of a target population. The GSPA survey specifically assessed whether the DPT dropout rate or measles coverage information was available.

Forty-three percent of facilities had documentation that showed they monitored either DPT dropout or measles coverage (Figure 4.3), with 57 percent of health centres and 33 percent of clinics having this information. Only 3 percent of PMHs were able to provide this documentation (Table A-4.4).

Overall, 15 percent of the facilities providing child immunization services had all components for providing quality child immunization services (not including vaccines), with the monitoring of coverage and adequate supplies of syringes and needles being the weakest. Of the facilities providing child immunization services and storing vaccines, 16 percent had all components for providing quality child immunization services (including vaccines) available on the day of survey. The hospitals and health centres were best supplied (23 and 20 percent, respectively), but only 7 percent of the clinics and none of the PMHs had all components (Table 4.2).

Key Findings
Eighty-four percent of the facilities that provide child immunization services also store vaccines. Thirty-seven percent of those had all elements for adequately monitoring the cold chain.
Routine childhood vaccines in Ghana include BCG, OPV, DPT/HepB/Hib, measles, and yellow fever; they were available in 43 percent of the facilities offering and storing childhood vaccines. Hospitals were most likely to have all vaccines (56 percent).
BCG was missing in 84 percent of the PMHs.
Fifty-nine percent of the facilities had an adequate supply of syringes and needles, and a sharps box was present in almost all facilities (83 percent).
Less than half (43 percent) of facilities documented either DPT dropout or measles coverage.

4.4 Capacity to Provide Quality Curative Care for Sick Children

To improve the diagnosis of illnesses and to minimize missed opportunities for providing preventive interventions, IMCI standards recommend that the following measures be part of any sick child consultation:

- Assess immunization status and provision of vaccines that are due
- Assess nutritional status and give feeding advice
- Completely assess current health status
- Ensure that the child receives the first dose of any antibiotic or antimalarial at the facility and leaves the facility with the necessary medications
- Ensure that the caretaker knows how to administer the necessary medications or treatments and knows about appropriate foods and how much the child needs both during this illness and when healthy.

The GSPA survey assessed the availability of equipment, supplies, and health system components necessary to adhere to the IMCI guidelines and to support quality consultation services for sick children. The following elements were assessed:

- Infrastructure and resources to support quality assessment and counselling
- Equipment and supplies for adhering to IMCI guidelines for assessment of the sick children

- Essential medicines for treating sick children, in adherence to IMCI guidelines.

The health system components available to provide quality care for sick children are summarized in Table 4.3. Figures 4.4 and 4.5 provide details of overall availability of various items, and Table A-4.5 gives a breakdown of different types of facilities and operating authorities.

Table 4.3 Selected essential components to support quality child health care						
Percentage of facilities offering curative care for sick children (SC) that had all essential equipment and supplies for examination, all first-line and prereferral medications, and items to support quality of services, by type of facility, operating authority, and region, Ghana SPA 2002						
Background characteristics	Percentage of facilities offering curative care for sick children that have:					Weighted number of facilities offering sick child services
	All essential equipment and supplies ¹	All essential medications		All other quality items ⁴	All equipment and supplies for providing quality curative child care ⁵	
	First-line ²	Pre-referral ³				
Type of facility						
Hospital	7	90	46	12	3	42
Health centre	19	68	6	27	1	164
Clinic	17	70	2	14	0	107
PMH	16	48	8	8	0	92
Operating authority						
Public	17	71	7	21	1	270
Private religious	12	76	33	15	1	38
Other private	16	48	7	8	0	96
Region						
Western	17	70	16	13	0	39
Central	22	78	8	17	0	30
Greater Accra	3	53	6	6	0	27
Volta	10	57	7	15	0	63
Eastern	28	69	21	15	4	49
Ashanti	16	53	14	19	0	67
Brong Ahafo	14	80	5	12	0	52
Northern	2	72	6	12	0	37
Upper East	0	77	2	26	0	18
Upper West	64	66	0	68	0	22
Total	17	66	10	18	1	404
¹ Equipment: infant and child weighing scale, minute timer, oral rehydration therapy (ORT) supplies (jar/pitcher, cup, and spoon), and thermometer						
² Oral rehydration salt (ORS) packet, an oral antibiotic (amoxicillin or co-trimoxazole), and an oral antimalarial (chloroquine)						
³ At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamicin), quinine, and intravenous solution (normal saline, Ringer's lactate, or dextrose and saline 0.9%) with infusion set						
⁴ Soap and water, individual child card or record, treatment protocols, and visual aids for teaching caretaker						
⁵ All essential equipment, infrastructure, supplies, all essential medication, and all other quality resources						

4.4.1 Infrastructure and Resources to Support Quality Assessment and Counselling for Sick Children

Items for supporting quality assessment and counselling for sick children include the following:

- Items for infection prevention
- Treatment protocols
- Individual child health cards

- Visual aids.

Soap and water were available in the service area where the sick child consultation took place in 9 out of 10 facilities providing curative care for sick children. Soap and water were least available in clinics (76 percent) (Table A-4.5).

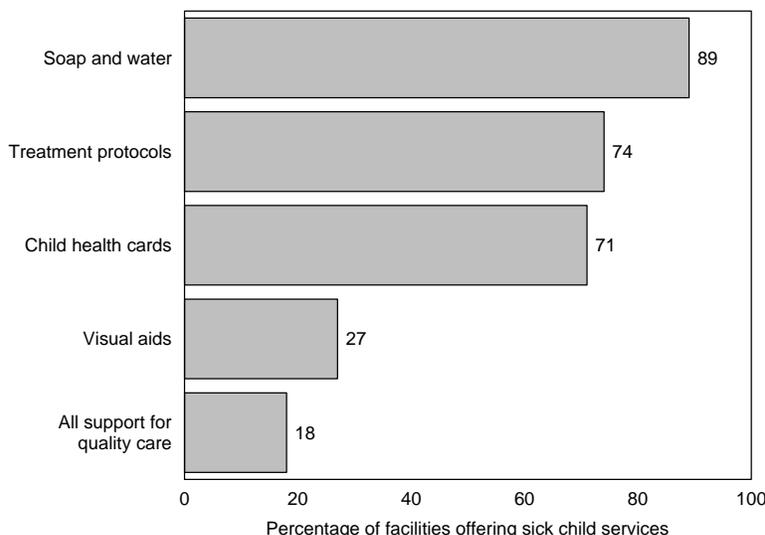
To be able to give the best treatment with the resources available, facilities should have treatment protocols. Seventy-four percent of facilities had any type of treatment protocols or standards related to childhood illnesses in the service room, with little variation among facilities. (Table A-4.5 and Figure 4.4) In most of the facilities, the protocol available was Standard Treatment, Guidelines 2000 (66 percent of the facilities), and only 3 percent had the IMCI booklet (WHO, 1996) available in the service area (data not shown).

Use of individual child health records is important for continuity of care. Since many facilities do not keep child health records, but give them to the caretaker to maintain, the GSPA survey assessed whether blank cards (for use with new clients) were available. New individual client cards were available in 71 percent of the facilities (Table A-4.5 and Figure 4.4).

For health education purposes, visual aids are very helpful. Only 27 percent of facilities offering curative services for sick children had any type of visual aid related to childhood illnesses available in the service room for educating caretakers. This was available in 32 percent of facilities in the public sector, but in only 15 percent of the other private facilities. Health centres were the best supplied, with 35 percent possessing visual aids (Table A-4.5 and Figure 4.4).

All items to support quality counselling mentioned above were present in only 18 percent of facilities, with visual aids being the weakest element (Figure 4.4). Table A-4.5 gives detailed information on the separate items, by type of facility and operating authority.

Figure 4.4 Availability of items to support quality sick child services, among facilities offering sick child (SC) services (N=404)



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4.4.2 Equipment and Supplies for Assessing and Providing Preventive Care for Sick Children

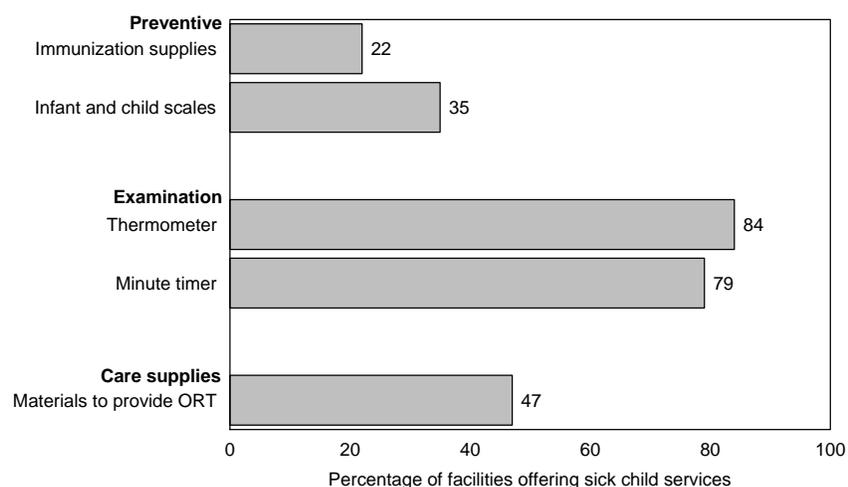
The GSPA survey collected information on the availability of the equipment and supplies necessary for assessing the status of sick children and for providing preventive interventions for these children. The elements considered are based on IMCI guidelines. Items assessed included the following:

- Equipment and supplies for providing immunization
- Equipment for growth monitoring
- Equipment for assessing the severity of illnesses.

As seen in Figure 4.1, on the day of survey, only 23 percent of facilities were offering both EPI and sick child services. Of all facilities providing curative care for sick children, 22 percent had the capacity to provide immunizations (all supplies necessary for quality immunization services: vaccines, equipment, immunization cards, and infection prevention items) on the day of the survey (Table A-4.5). Public (28 percent) and private religious (27 percent) facilities were best supplied. Of the other private facilities, only 6 percent had all items present on the day of the survey. This means that many facilities are not presently able to adhere to the IMCI guidelines for using every contact with the facility to provide needed immunizations.

Weighing scales are necessary for growth monitoring services and, in general, for assessing children's nutritional status and estimating correct medication dosage. As noted previously, most of the facilities (61 percent) offer growth monitoring only 1 or 2 days per week (Table A-4.1). While 48 percent of facilities had a scale appropriate for weighing an infant (100-gram increments) and 58 percent had a scale appropriate for measuring a child (maximum 250-gram increments), only 35 percent had scales for both infants and children (Figure 4.5 and Table A-4.5). Only 27 percent of the hospitals had an infant scale in the sick child service delivery room, but 51 percent of the clinics had this scale available. This difference might be because services are more integrated in clinics, and therefore, more equipment is located in one service area.

Figure 4.5 Availability of equipment and supplies for examination and treatment, among facilities offering sick child (SC) services (N=404)



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Evaluating fever by touch is sufficient to meet the IMCI standard, but a thermometer provides a more objective assessment. Thermometers were available in most facilities (84 percent) (Table A-4.5 and Figure 4.5). Ninety-seven percent of the PMHs had a thermometer, but in 28 percent of hospitals, it was lacking in the sick child service delivery area. For assessing the severity of respiratory illnesses, a clock or other timing device is necessary to count the respiratory rate. While a wristwatch with second hand is sufficient, the GSPA survey looked for a facility-supplied device (such as a wall clock with a second hand); this was found in 79 percent of all facilities (Figure 4.5 and Table A-4.5). There was no major difference between types of facilities.

One of the IMCI interventions is to provide oral rehydration therapy (ORT) onsite for children with specified degrees of dehydration. Materials for mixing and administering ORT onsite were assessed. Overall, they were found in only 47 percent of facilities (Table A-4.5 and Figure 4.5). In hospitals, this was found to be particularly low, with only 14 percent of the sick child service areas having materials for providing ORT, whereas these were found in approximately 5 out of 10 other facilities.

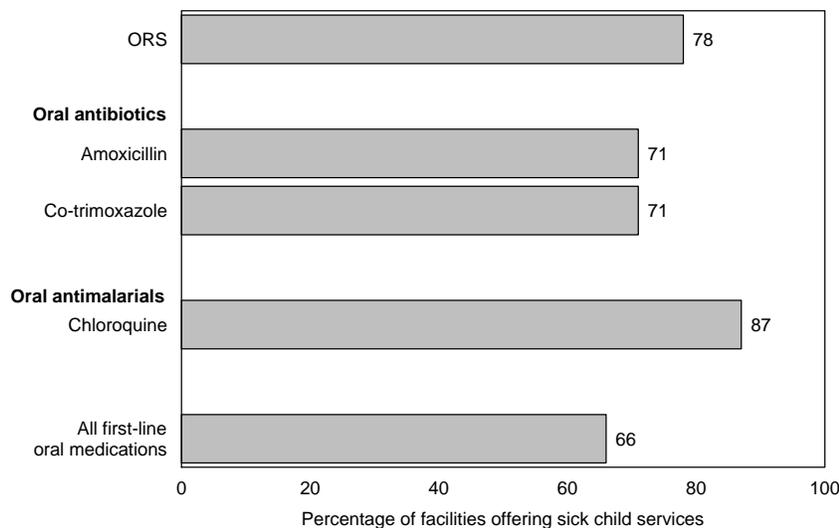
All essential equipment and supplies (both weighing scales, timer, ORT supplies, and a thermometer) were found in 17 percent of facilities (Table 4.3). There was no major difference between operating authorities or types of facilities, except for hospitals, where only 7 percent had all essential equipment and supplies, mainly because they lacked weighing scales and ORT supplies (Table A-4.5).

4.4.3 Essential Drugs for Treating Sick Children

The GSPA survey collected information to assess the availability of essential drugs for sick child services as defined in IMCI guidelines. According to IMCI guidelines, essential drugs for treating a sick child include first-line, prereferral, and other important medications. Availability of medicines for outpatient clients was assessed. There were some hospitals with separate inpatient and outpatient pharmacies. If the inpatient pharmacy medicines were not available to outpatients, the availability of medicines in the inpatient pharmacy was not assessed. Figures 4.6, 4.7, and 4.8 show the overall availabilities of first-line, prereferral, and other essential medicines, respectively, while Table A-4.6 gives a breakdown by type of facility and operating authority.

First-line medicines include ORS, an oral antibiotic against pneumonia (amoxicillin or co-trimoxazole) and dysentery (co-trimoxazole), and an oral antimalarial (chloroquine). All first-line oral medicines are on the essential drug list of Ghana. They were available in 66 percent of the facilities (Figure 4.6), with 9 out of 10 hospitals but only 5 out of 10 PMHs having all first-line medicines available (Table A-4.6).

Figure 4.6 Availability of first-line medicines for treating sick children, among facilities offering sick child (SC) services (N=404)

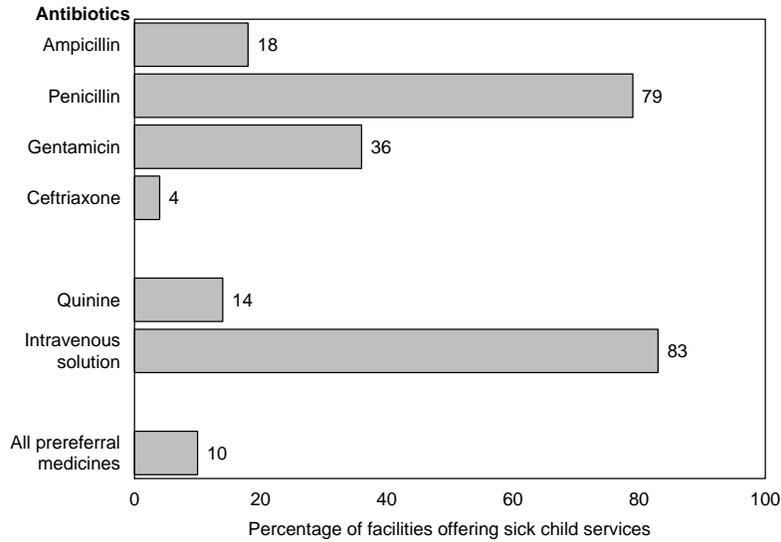


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Prereferral medicines include injectable medications for providing urgent treatment before transferring to another facility if necessary. IMCI guidelines define these medications as an injectable antimalarial (quinine), at least one first-line injectable antibiotic for serious infections (ampicillin or penicillin), at least one second-line injectable (ceftriaxone or gentamicin), and an intravenous solution with infusion sets for treating severe dehydration. Ampicillin and ceftriaxone are currently not on the list of prereferral medicines in Ghana, but chloramphenicol is. Unfortunately, this was not assessed during the time of the survey. In only one out of ten facilities were all prereferral medicines (one first-line and one second-line injectable antibiotic, quinine, and an intravenous solution with infusion set) present (Figure 4.7). The best supplied facilities were hospitals (46 percent). Health centres (6 percent), clinics (2 percent), and PMHs (8 percent) were not as well supplied. The private religious facilities (33 percent) were much better supplied than the public (7 percent) or other private facilities (7 percent). Ceftriaxone, quinine, gentamicin, and ampicillin are not on the essential drug list for all facilities. Because of limitations in provider training at certain levels, it is believed that provision of these medications might harm rather than benefit the patient.

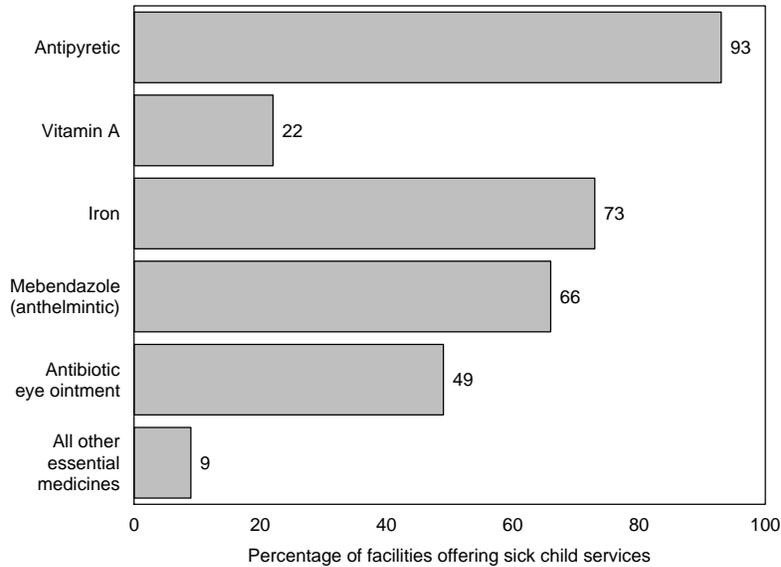
Other essential medicines are those that may not be essential for treating serious illnesses but are important for treating common symptoms and illnesses of sick children. These include antipyretics (paracetamol or aspirin), vitamin A and iron supplements, deworming medication (anthelmintic), and antibiotic eye ointment. All other essential medicines were found in 9 percent of facilities. In 2 out of 10 hospitals they were found for outpatients, but in only 9 percent of health centres and 11 percent of clinics. Paracetamol or aspirin was available in almost all facilities, but vitamin A (22 percent) and antibiotic eye ointment (49 percent) were least available (Table A-4.6). Vitamin A is currently distributed to children under five years during the National Immunization Days (NIDS) and is not yet on the essential drug list. It is expected that this will change in the near future and that it will be added to the list.

Figure 4.7 Availability of prereferral medicines (injectables) among facilities offering sick child (SC) services (N=404)



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Figure 4.8 Availability of other essential medicines among facilities offering sick child (SC) services (N=404)



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Key Findings

Treatment protocols were available in 74 percent of facilities, but only 27 percent had any type of visual aid related to childhood illnesses.

On the day of survey, child immunization services were offered at the same time as sick child services in only 23 percent of facilities, and of all facilities providing sick child services, 22 percent had the capacity to provide quality immunization services.

Materials for administering ORT were found in 47 percent of facilities but in only 14 percent of hospitals.

Medicines were lacking in many facilities, especially prereferral medicines. They were available in only 2 percent of clinics and 6 percent of health facilities.

4.5 Management Practices Supportive of Quality Sick Child Services

Management practices that were assessed for supporting quality curative care for sick children include the following:

- Facility documentation and records
- Practices related to user fees
- Supervision and staff development.

Summary information on the availability of these items is presented in Table 4.4. Figure 4.9 summarizes service education received by providers, and Tables A-4.7 and A-4.8 provide further details. Table A-4.9 gives details of out-of-pocket payments for consultations.

Maintenance of service statistics was verified by the presence of an up-to-date register (an entry in the past seven days) that indicated, at minimum, the child's age and primary diagnosis or symptom. Eighty-three percent of facilities had an up-to-date register. The median number of sick child consultations per month was 368 at hospitals, 61 at health centres, 35 at clinics, and 14 at PMHs (data not shown).

Quality child health services require adequate supervision and in-service training for providers. Supportive management practices for child health care providers were considered to be routinely provided by the facility if at least half of the interviewed providers had been personally supervised during the past 6 months and had received in-service training during the past 12 months.

Supervision of individual staff promotes adherence to standards and to identification of problems that contribute to poor-quality service. The GSPA survey collected information both on the frequency of supervision and on the activities of the supervisor. In 56 percent of the facilities, at least half of the interviewed child health providers were personally supervised during the previous 6 months (Table 4.4). Overall, 52 percent of all interviewed child health providers received supervision in the past 6 months (Table A-4.7), with a median of 2 visits (data not shown). In health centres, 58 percent were supervised; in clinics, 56 percent were supervised; and in hospitals and PMHs, less than half of the providers (46 and 41 percent, respectively) were supervised. When asked what the supervisor did, over 80 percent of the providers indicated that their supervisor checked records, observed their work, and discussed problems. Additionally, 64 percent indicated that the supervisor provided feedback, and 52 percent indicated that they had received information updates (data not shown).

Table 4.4 Management practices supportive of quality child health services

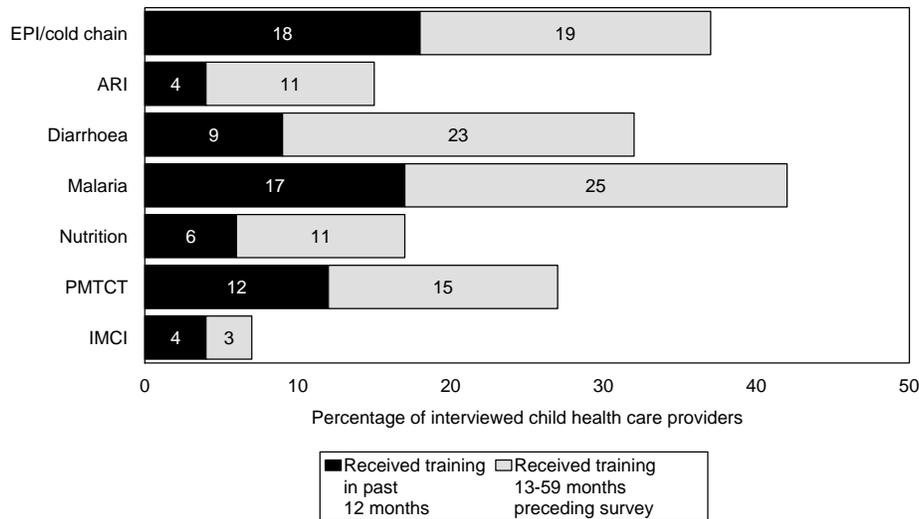
Percentage of facilities offering consultation services for sick children that had an up-to-date patient register, percentage where at least half of the interviewed providers of child health services were personally supervised during the past 6 months, received related in-service training during the past 12 months, and were both supervised in the past 6 months and received in-service training related to child health services during the past 12 months, and percentage where there is some charge for sick child services, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities where at least half of the interviewed child health service providers:					Weighted number of facilities offering sick child services
	Had up-to-date patient register ¹	Were personally supervised in the past 6 months	Received in-service training during past 12 months	Were personally supervised in past 6 months and received in-service training in past 12 months	Percentage of facilities with charges for sick child consultation	
Type of facility						
Hospital	81	33	35	8	44	43
Health centre	84	68	46	28	32	160
Clinic	81	61	43	29	43	118
PMH	85	42	28	16	86	92
Operating authority						
Public	83	62	44	26	34	279
Private religious	83	48	41	23	61	39
Other private	83	43	27	15	85	94
Region						
Western	84	45	35	14	36	39
Central	100	26	38	19	20	30
Greater Accra	93	63	41	25	72	27
Volta	69	59	34	20	70	69
Eastern	90	59	60	40	47	49
Ashanti	74	38	31	12	66	68
Brong Ahafo	81	70	46	34	62	53
Northern	75	71	33	24	24	36
Upper East	88	70	58	42	3	20
Upper West	97	83	38	10	9	22
Total	83	56	40	23	48	412

¹ There is an entry in the past 7 days that indicates, at minimum, the child's age and main symptom or diagnosis.

The other key component of supportive management is in-service training, which is crucial to maintaining provider knowledge and ensures that providers are kept aware of currently accepted treatment and diagnostic protocols. Information was obtained from health workers involved in delivering child health services on the types of in-service training they had received relevant to the delivery of child care services. In 40 percent of the facilities, at least half of the interviewed providers had received some in-service training related to child health during the past 12 months (Table 4.4). Overall, 37 percent of the interviewed providers had received in-service training in the past 12 months and that an additional 29 percent had received in-service training 13-59 months preceding the survey (Table A-4.7). Figure 4.9 shows that only 4 percent of providers had received in-service training on IMCI in the 12 months before the survey and that another 3 percent received this education 13-59 months preceding the survey. Looking at these percentages, it is worth noting that some providers had several training courses, but it is also possible that training is mentioned more than once under different topics (for example, IMCI and diarrhoea or IMCI and ARI). Table A-4.8 gives detailed information on the different topics by type of facility, operating authority, and region.

Figure 4.9 In-service training related to child health received by interviewed providers, by topic and timing of most recent education (N=1,138)



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In 23 percent of the facilities, half of the interviewed providers had been both personally supervised in the last 6 months and received in-service training in the 12 months preceding the survey (Table 4.4). There were no major differences between operating authorities; however, only 8 percent of the hospitals had supportive management practices for their providers, while 28 percent of the health centres, 29 percent of clinics, and 16 percent of PMHs had both components for supportive management (Table 4.4).

User fees may affect utilization positively (augmenting funds to improve services) or negatively (detering poor clients from using services). Table 4.4 shows that 48 percent of facilities providing curative child care charge routinely for sick child consultation. The official exemption policy in Ghana is that in facilities below the district hospital level, children under five years of age should not pay for services for acute illnesses; but, this policy is interpreted and applied in many different ways throughout the health system. Table A-4.9 shows that 75 percent of the interviewed caretakers mentioned that they paid out of pocket for child health visits. This included not only the consultation, but also laboratory tests, medicines, or other expenses paid at the facility related to the visit. Few caretakers reported belonging to a prepaid system (4 percent). Contrary to expectation, the median out-of-pocket payment for child health services, on the day of survey, was 9,046 cedis for those belonging to a prepaid system; this was higher than the payment for those not belonging to a prepaid system, who only paid 9,006 cedis. More details on out-of-pocket payments can be found in Table A-4.9, by type of facility and operating authority.

Key Findings

Maintenance of registers for service statistics was found in most facilities (83 percent).

At least half of the interviewed providers had been personally supervised in the past 6 months in 56 percent of the facilities. Health centres (68 percent) and clinics (61 percent) were most likely to have at least half of their interviewed providers of child health services being supervised, and hospitals were least likely (only 33 percent).

Thirty-seven percent of the interviewed providers received in-service training during the past 12 months, and an additional 29 percent received in-service training 13-59 months preceding the survey.

Only 7 percent of the interviewed providers received in-service training on IMCI in the past 5 years.

Almost half of the facilities reported routinely charging for consultations of sick children.

4.6 Adherence to Standards for Quality Service Provision

The observations of sick child consultations conducted in the GSPA survey provide the basis for assessing whether providers are adhering to standards for providing quality service. The observation checklists were based on IMCI guidelines and collected information on whether the consultation process included the following:

- Full assessment of the child's illness, including a physical examination, according to IMCI guidelines
- Assessment of immunization and nutritional status
- Instruction about preventive measures and how to provide any prescribed treatment
- Adherence to practices to support continuity of care.

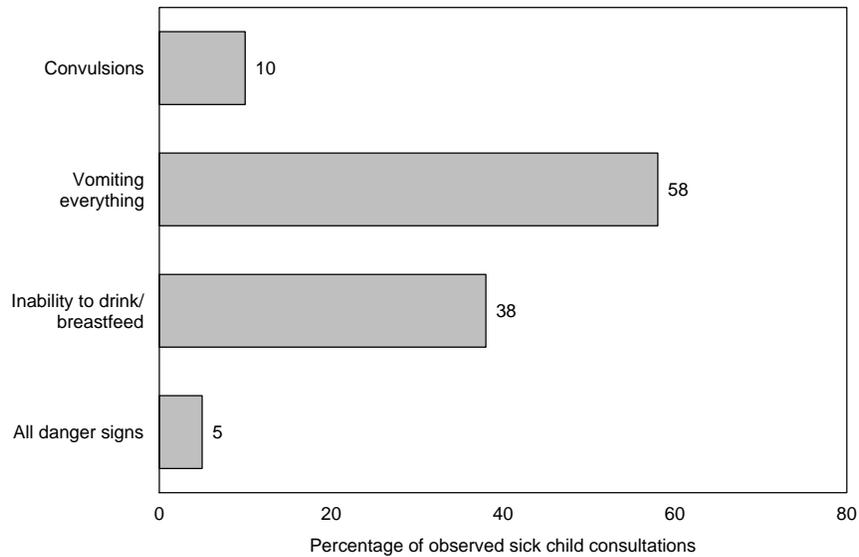
Observers watched the process utilized when sick children were seen at the facility, noting information shared and procedures or examinations conducted. The objective was to note whether information on a topic was shared (process information). An assessment of whether the information was correct or whether findings were appropriately interpreted was not a component of the observation. Table A-4.5 provides summary information. Figures 4.10 through 4.14 provide information on practices observed during sick child consultations. Tables A-4.10 through A-4.12 provide further details on observed practices and information given.

4.6.1 Full Assessment of Illnesses

According to IMCI guidelines, major danger signs that must be assessed include whether the child had convulsions at home or in the facility, whether the child vomits everything, and whether the child is able to drink or breastfeed. If there is any doubt, the provider should attempt to give the child something orally to see if the child can take anything. Assessments for all danger signs were rarely carried out (5 percent of consultations). Ten percent of children were assessed for convulsions; 38 percent were assessed for whether they drank anything, including breast milk; and 58 percent were assessed for whether they vomited all food and drink (Figure 4.10 and Table A-4.10). No major differences were found between different types of facilities.

The observation checklist identifies all IMCI components for assessing a sick child. It is understood, however, that a provider will use judgment based on the child's signs and symptoms. For example, a provider seeing a child who appears to have a common cough or skin rash and who is clearly alert without fever would not be expected to ask whether the child is having convulsions. Thus, findings of low percentages for some categories of assessment do not necessarily indicate poor practices. Table A-4.10 presents detailed information on each component of the observed assessment of the sick children, by type of facility and operating authority.

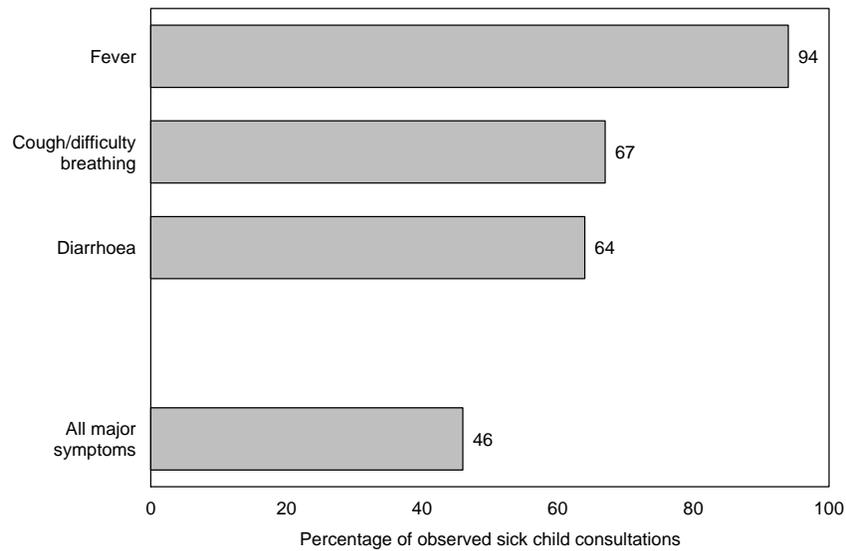
Figure 4.10 Major danger signs assessed during observed sick child consultation (N=1,434)



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Regardless of the reason for the consultation, each child should be evaluated for the major symptoms of respiratory difficulty, diarrhoea, and fever. The caretaker of the sick children usually discusses the reason for the visit (for example, diarrhoea or cough), and the provider must probe for other symptoms. Fever was the most commonly assessed symptom (94 percent), followed by respiratory symptoms (67 percent) and diarrhoea (64 percent). All three major symptoms were assessed for almost half (46 percent) of all observed children (Figure 4.11 and Table A-4.10).

Figure 4.11 Major symptoms assessed during observed sick child consultation (N=1,434)

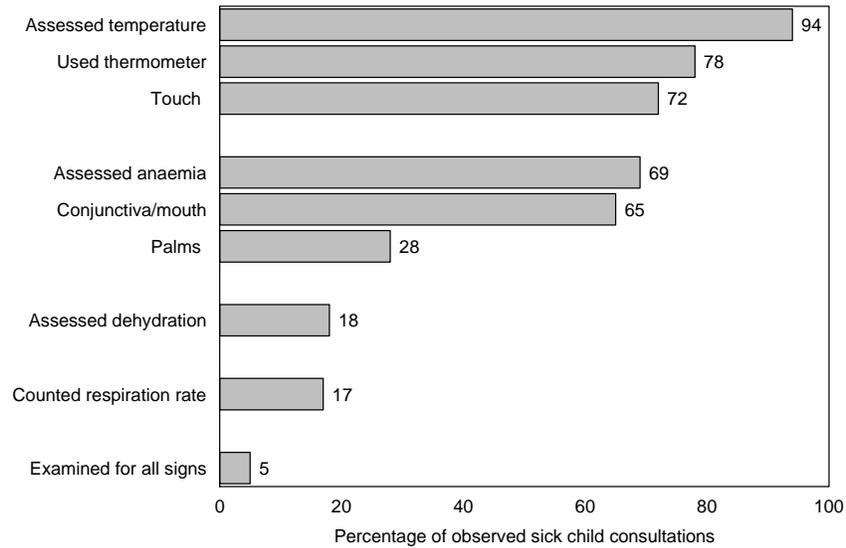


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After questioning the various signs and symptoms of an illness, a physical examination should be conducted. This should include a hands-on evaluation of the child to verify the presence of fever (by touch or by taking the temperature), to measure the state of dehydration (pinching the abdominal skin), to check visually whether the child has anaemia, and to count the rate of respiration for every child with a cough or difficulty breathing. Temperature was assessed for almost all sick children (94 percent), either by touch (72 percent) or using a thermometer (78 percent) (Table A-4.10 and Figure 4.12). Anaemia was also assessed regularly (for 7 out of 10 children). Less frequently assessed were dehydration and the respiration rate, which could be acceptable practice if the history given by the child's caretaker did not indicate a direct need for these assessments (for example, a skin rash). Overall, only 5 percent of the observed sick children were examined according to all components of the IMCI guidelines.

There is a direct relationship between nutritional status and health. It is not uncommon for a child to be caught in a cycle of malnutrition and illness, where malnutrition makes the child more susceptible to illness, and illness contributes to malnutrition. The tendency for sick children to eat and drink less, as well as the not uncommon practice of the sick child's caretaker limiting consumption of liquids and foods, aggravates this cycle. Among children younger than 24 months of age, 45 percent were evaluated for breastfeeding practices during illness. Only 10 percent of children were specifically checked for their ability to breastfeed or to drink anything (Table A-4.10).

Figure 4.12 Elements of physical examination conducted during observed sick child consultation (N=1,434)

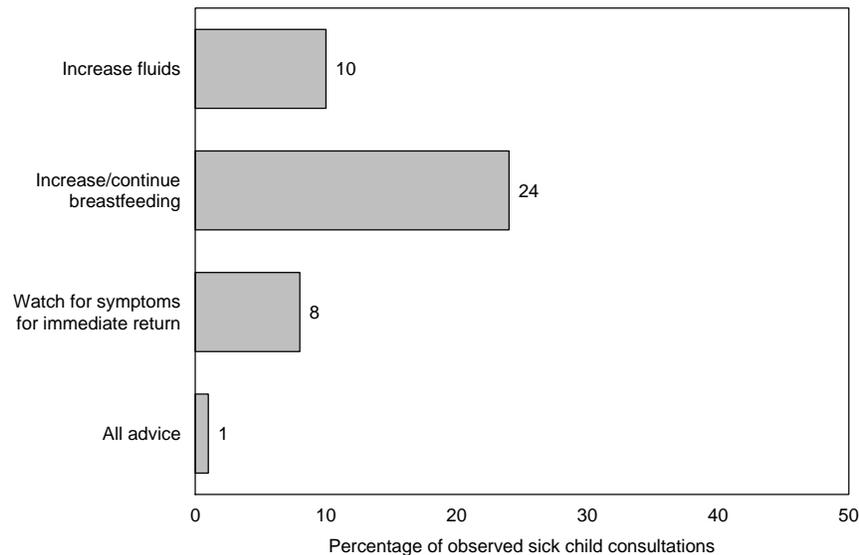


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Not infrequently, health care providers target only children with diarrhoea as those requiring extra fluids. It is important that providers encourage extra fluids as a lifesaver for other sick children too, especially when they have a high fever or are breathing fast. As a general rule, the frequency of feeding sick children should be increased during and after illness to help the child compensate for weight loss during the illness and, therefore, prevent malnutrition. The IMCI strategy identifies essential advice that the child's caretaker should receive. This includes encouraging the caretaker to 1) continue to feed the child, 2) provide extra fluids to the sick child, and 3) watch for signs and symptoms for which the child should be brought back to a health care provider immediately. Figure 4.13 indicates that advice to increase fluids was given to 1 out of 10 children, with very little difference between types of facilities. Advice to continue or increase feeding was given more often (to one out of four children). Providers in clinics were most likely to give this advice (Table A-4.10) Symptoms for immediate return were explained for only 8 percent of the observations, and all three essential messages were explained for only 1 percent of the observations.

After concluding the sick child consultation, observed providers were asked about the diagnosis and major symptoms upon which the prescribed treatment was based. This information provided a measure for assessing the quality of care the sick children received. Based on the diagnosis or major symptom, the directives of the IMCI indicate in which specific cases antibiotics should be prescribed and in which cases children should be admitted to the facility or referred to a higher level of care.

Figure 4.13 Essential advice provided to caretaker during observed sick child consultation (N=1,434)



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While a simple observation does not provide enough information to determine the appropriate diagnosis and treatment, several points should be noted. For severe respiratory illnesses such as pneumonia, the assessment should include counting the respiratory rate; this specific assessment occurred for 35 percent of children with these diagnoses (Table 4.5). Dehydration was assessed in only 11 percent of these children. In most of these cases, resource to antibiotics is warranted, and practically all of the children (97 percent) were given or prescribed antibiotics: 43 percent by injection, 68 percent orally, and some children by both forms. Often, children with pneumonia or other severe respiratory illnesses require hospitalization (IMCI recommends admission in severe pneumonia cases), but among the cases identified by the provider as severe respiratory illness, only 2 percent were admitted or referred. There are many barriers to clients receiving and/or accepting referrals or admission to facilities that may influence a provider’s decision to refer or not to refer. One should therefore only use this information as an indicator of a need to conduct a more detailed assessment to determine the quality of care for children with severe respiratory illness.

Among children with cough or other respiratory problems—but without the diagnosis of other severe symptoms—the use of antibiotics was lower, but still 7 out of 10 sick children received an antibiotic (only 1 percent received an injectable). None of the children with these diagnoses were admitted or referred (Table 4.5).

Table 4.5 shows that the most common diagnosis among observed sick children was malaria. In those children, temperature was checked for almost all (94 percent), dehydration was checked for only 2 out of 10, and anaemia was checked for 7 out of 10 children. An antimalarial was given to 96 percent of the children with malaria, and an antibiotic was given to 31 percent. Almost half (45 percent) of the children diagnosed with severe fever but no malaria received antibiotics. In countries such as Ghana, where malaria is endemic, IMCI guidelines recommend the use of an antimalarial for all children with fever, regardless of the diagnosis. The GSPA survey found that 82 percent of all observed children were given

either an oral or injectable antimalarial. It was noted, however, that only 73 percent of the children with severe fever (not diagnosed as malaria), 87 percent of the children diagnosed with measles, and 53 percent of the children diagnosed with other fever (without other severe diagnosis or cough) received some form of antimalarial.

Table 4.5 Assessments, examinations, and treatment for children, classified by diagnosis or major symptom										
Percentage of observed sick children who were diagnosed by the provider with the indicated illness or symptom and for whom the indicated assessment, examination, and/or treatment was provided, Ghana SPA 2002										
Assessment, exams and treatments	Percentage of observed sick children with:									Percentage for all observed sick children ⁶
	Respiratory problems			Fever			Diarrhoea			
	Pneumonia or other severe respiratory illness ¹	Cough or other respiratory problem without other severe diagnosis ²	Severe fever not malaria ³	Malaria	Measles	Other fever without other severe diagnosis or cough ⁴	Severe or persistent diarrhoea or any dehydration with diarrhoea	Other diarrhoea without other severe diagnosis ⁵	Other diagnosis	
IMCI assessment										
Three major symptoms	64	55	47	46	49	56	50	47	42	96
Three major danger signs	2	5	21	5	6	10	4	4	2	5
Current eating/drinking	51	36	38	46	41	51	49	52	38	45
Advise continue feeding/increase food or drink	5	5	0	6	9	9	11	22	2	6
Physical exam										
Temperature	94	86	100	95	81	92	93	81	97	94
Respiratory rate	35	20	31	18	9	20	20	14	6	17
Dehydration	11	4	35	20	9	11	34	14	8	18
Anaemia	82	61	81	70	53	60	76	71	51	69
Treatment										
Refer or admit	2	0	11	1	0	3	1	3	2	1
Any antibiotic	97	69	45	31	85	35	42	20	6	32
Injectable antibiotic	43	1	26	3	9	6	3	0	1	3
Oral antibiotic	68	69	32	31	85	32	41	20	6	31
Any antimalarial	72	26	73	96	87	53	83	20	4	82
Injectable antimalarial	17	1	40	17	9	7	20	0	0	15
Oral antimalarial	66	26	67	93	87	48	81	20	4	80
Oral rehydration	2	1	4	5	0	3	27	12	0	5
Intravenous fluid	2	0	12	1	0	0	6	2	0	1
Weighted number of observed sick children	38	53	28	1,178	14	59	177	42	67	1,434
Note: Major diagnoses and treatments were reported by the provider at the end of the consultation. Where two diagnoses were relevant (e.g., pneumonia and malaria), the child is classified under both categories of illness. Diagnoses or symptoms are those assessed by the provider and have not been validated.										
¹ Severe pneumonia and pneumonia										
² Cough, cold, asthma, or ARI without pneumonia, severe fever, malaria, measles, or severe or persistent diarrhoea										
³ Very severe febrile disease or convulsions other than malaria										
⁴ Fever without malaria, pneumonia, cough, or measles										
⁵ Diarrhoea without pneumonia, cough, severe fever, malaria, or measles										
⁶ Some children are classified under more than one illness category.										

Among children diagnosed with severe diarrhoea or with any dehydration linked to diarrhoea, only 34 percent were physically assessed for dehydration using the skin-pinch test. Forty-two percent of these children were given antibiotics, although less than 1 percent of the children were classified as having dysentery (data not shown). Using antibiotics inappropriately can prolong diarrhoea and will decrease the stock of antibiotic unnecessarily. Another issue of concern when assessing treatment is that ORS was

given to only 27 percent of children diagnosed with severe or persistent diarrhoea or any dehydration with diarrhoea, and 6 percent received intravenous fluids (Table 4.5).

IMCI guidelines recommend that the first dose of a medicine (particularly an antibiotic or antimalarial) should be provided at the facility, so that treatment begins immediately. This practice also provides an opportunity to reinforce the dosage to the caretaker and to ensure that the child is able to take the medicine. Twenty-eight percent of caretakers reported that their child received the first dose of the prescribed oral medicine at the facility (Table A-4.11). This was supported by observers who reported medicines being administered for 28 percent of the children (data not shown). Differences among facilities were rather large. In hospitals, only 12 percent of caretakers reported that the child received the first dose of medication; in health centres, 28 percent; in clinics, 41 percent; and in PMHs, 44 percent. Of all the caretakers who received or were prescribed medicines, 91 percent reported that they were told how to give the medicines at home, and 88 percent indicated that they felt comfortable with their knowledge of how to provide the medicines at home. Seventy-seven percent of caretakers reported that they received all medicines prescribed, with the highest percentage in private religious facilities (89 percent) (Table A-4.11).

Key Findings
For almost half (48 percent) of the observed children, all 3 major symptoms were assessed, but for only 5 percent were all three danger signs evaluated.
Giving advice on continuing to provide food and fluids and discussing symptoms for immediate return to a facility is not a common practice.
Comparison between observed assessment, prescribed treatment, and final diagnosis, determined by the provider, shows that antibiotics may be prescribed too often and antimalarials and ORS not often enough.
Provision of the first dose of a medicine by the facility was only done for 28 percent of the observed children.

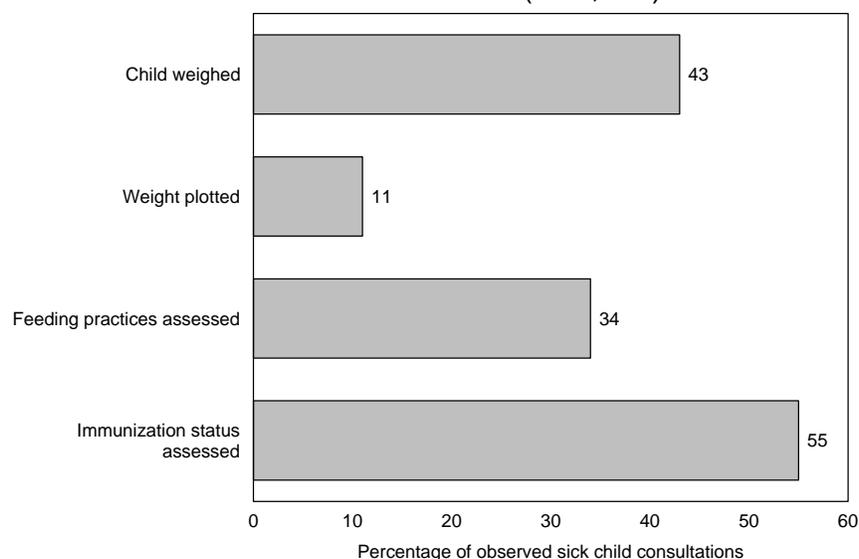
4.6.2 Reducing Missed Opportunities for Promoting Child Health Care

According to the IMCI approach, an evaluation of a child's growth is recommended to provide an objective evaluation of the child's current nutritional status and to detect any chronic latent nutritional problems. Growth monitoring includes comparing the child's current weight with a standard (either height or age), and eliciting information on feeding patterns to determine whether the normal diet is adequate for the child's age and whether the current feeding patterns pose any additional risk to the child's current health status. The provider should take advantage of the consultation with the child and the caretaker to provide advice if there appears to be any nutritional problem and to offer encouragement for continuing good practices if the evaluation shows that the growth of the child is proceeding well. IMCI recommendations concerning feeding practices of children include exclusive breastfeeding until six months of age, followed by breastfeeding until two years of age with the introduction of locally available foods, based on a balanced nutritional plan.

Only 43 percent of all children were weighed. This is a finding of considerable concern because weight is used to assess the child's growth, and it is also needed to calculate the right dose of medication. Only 11 percent of the observed children had their weight plotted (Figure 4.14). Children most likely to be weighed were those attending hospitals (60 percent). Feeding practices (39 percent) and immunization

status (51 percent) were more often assessed in children younger than 24 months than in children older than 24 months (27 and 38 percent, respectively) (Table A-4.10). Overall, feeding practices were assessed in 34 percent of cases, and immunization status was assessed in 55 percent of cases, either by the provider or by the system before entering the consultation area (Figure 4.14). Clinics were more likely to assess the immunization status than other facilities were (Table A-4.10). Vaccination status was assessed either by checking the child's immunization card or by asking the caretaker.

Figure 4.14 Preventive measures conducted during observed sick child consultation (N=1,434)



Ghana SPA 2002

Key Findings

Preventive practices, such as assessing nutritional status through weighing (43 percent), and assessing feeding practices (34 percent), and assessing immunization status (55 percent), are not done routinely.

4.6.3 Counselling on Child Health Issues

Visual aids were used in only 2 percent of the observed consultations. This is not surprising since only 27 percent of facilities had any type of visual aid related to child health illnesses in the service delivery room (Table A-4.5).

4.6.4 Supporting Continuity of Care

Frequently, health services are organized in such a way that measurements of temperature, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. Thirty-six percent of facilities were observed to routinely weigh children, and 7 percent were observed to plot the weight before the consultation (Table A-4.10). Thus, if a provider does not look at the child health card or record, this information is not available for the consultation. For continuity of care, the history, examination, diagnosis, and treatment

should also be registered every visit, so the provider has information on what illnesses the child has already had and the treatment the child received. In almost all observations, the provider referred to the card (87 percent); however, in PMHs, the card was referred to for only 6 out of 10 children (Table 4.6). In 92 percent of the observations, the provider wrote on the card after the consultation.

Table 4.6 Provider practices related to health education and continuity of care				
Percentage of observations of sick child consultations where visual aids were used when providing health education to the caretaker, where the observer noted that the provider referred to the child health card, and where the provider wrote on the child health card, by type of facility and operating authority, Ghana SPA 2002				
Background characteristics	Percentage of observations with visual aids used for health education	Use of individual child health card		Weighted number of observed sick children
		Percentage of providers who:		
		Referred to card during consultation	Wrote on card after consultation	
Type of facility				
Hospital	1	93	99	412
Health centre	2	92	95	597
Clinic	2	83	90	287
PMH	2	60	67	138
Operating authority				
Public	2	90	95	1,065
Private religious	1	91	97	227
Other private	2	61	67	142
Total	2	87	92	1,434

Key Findings

Visual aids were used in only 2 percent of observed consultations.

Individual client cards were used for approximately nine out of ten children.

4.7 Caretaker Opinion from Exit Interviews

Before leaving the facility, caretakers of sick children were interviewed for their opinions on the consultation process and on the quality of the providers' services, as well as on the principal problems encountered on the day of the visit. The caretaker was first asked to mention any major problems, without prompting. A list of specific common issues related to client satisfaction was then read, and the caretaker was asked to rate the issue as big, small, or no problem. Table A-4.12 shows that the main complaint was the long waiting time to see the provider (10 percent).

5.1 Background**5.1.1 Collection of Family Planning Service Information**

Use of contraceptive methods to plan families may be desirable for many reasons including the following:

- Couples may wish to limit family size or delay a desired pregnancy.
- Prevention of unwanted pregnancies.
- Appropriate spacing of births benefits maternal and child health. Studies have shown that spacing births at least two to three years apart contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too-frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies that may worsen chronic or acute illnesses, including HIV/AIDS, benefits women's health.

Key factors contributing to the appropriate, efficient, and continuous use of contraceptive methods (Murphy and Steele, 2000) include the following:

- The availability of a variety of contraception methods to address client preferences and client-specific suitability of method (from the point of view of society and health)
- Counselling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method
- Availability of infrastructure and resources necessary for providing quality family planning services (e.g., equipment for client examinations, guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and procedures for preventing infections)
- Availability of other health services relevant to family planning clients. These include education and services for sexually transmitted infections (STIs) and programmes geared toward groups with special needs to improve access and appropriate use of family planning services.

So that the appropriate use of family planning can be increased, contraceptive services and counselling should ideally be available wherever maternal health, reproductive health, or child health services are provided.

This chapter uses information obtained in the Ghana Service Provision Assessment (GSPA) survey to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?
- To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?

5.1.2 Family Planning Services in Ghana

The Reproductive and Child Health Unit of the Ghana Health Service (GHS) is responsible for all family planning service delivery in the country; however, other implementing agencies are present as well. For

example, private-sector outlets also exist. The family planning service seeks to provide information to individuals (including sexually active adolescents) and couples to enable them to decide freely and responsibly the number and spacing of their children. It is also focused on providing affordable contraceptive services, making available a full range of safe and effective methods, and preventing STIs, including HIV/AIDS.

The National Population Policy of 1994 includes the following objectives:

- To reduce the total fertility rate to 5.0 by 2000, to 4.0 by 2010, and to 3.0 by 2020
- To increase modern contraceptive prevalence rate from 10 percent to 15 percent by 2000, to 28 percent by 2010, and to 50 percent by 2020
- To achieve a minimum birth spacing of at least 2 years for all births by 2020.

The knowledge and practice of family planning has made significant inroads in Ghana. Ninety-three percent of currently married women have heard of at least one modern method of contraception and there has been a decline in the fertility rate for women age 15-49 years from 6.4 in 1993 to 4.6 in 1998 (Ghana Statistical Service and Macro International, 1999). Despite these gains, family planning continues to be relevant to the National Population Policy and national aspirations, as the actual use of contraception is quite low; only 22 percent of currently married women are currently using contraception (both traditional and modern methods), with the pill (4 percent) being the most widely used modern method, followed closely by injectables and condoms (3 percent each). The two most important reasons cited for the very low contraceptive prevalence among currently married women are the desire for more children (19 percent) and the fear of side effects (18 percent) (Ghana Statistical Service and Macro International, 1999).

In 1993 and 1996, a Situation Analysis Study of Family Planning was carried out in Ghana (Ghana Statistical Service, 1997). Some key results of the 1996 Situation Analysis Study were the following:

- More than half (54 percent) of service delivery points offered 5 days of family planning services per week, and a further 28 percent offered services during the weekend (primarily private maternity homes [PMHs] and community health centres).
- The methods most often provided were combined oral contraceptives (91 percent), injectables (88 percent), condoms (89 percent), spermicide (85 percent), and progesterone-only oral contraceptives (73 percent).
- Intrauterine devices (IUDs) were provided in 56 percent of facilities, and both implants and diaphragms were provided in 7 percent.
- Stock-outs of different contraceptive methods in the previous 6 months ranged between 7 and 22 percent.
- Most facilities had family planning information, education, communication (IEC) materials (70 percent had flipcharts, 44 percent had brochures, 84 percent had posters, 78 percent had contraceptive samples, and 40 percent had anatomic models).
- Fifty-one percent of facilities had disposable gloves, 77 percent had antiseptic lotion, 93 percent had syringes and needles, 87 percent had a blood pressure machine, and 89 percent had an adult weighing scale.
- Seventy-one percent of the facilities were supervised in the last six months.
- STI-related subjects were discussed with 15 percent of clients during counselling, and sexual behaviour was discussed with 20 percent of clients.

5.2 Availability of Family Planning Services

Methods of family planning differ in how they function, their effectiveness, their side effects, the ease with which they can be administered, and, in view of these issues, their acceptability and desirability to the users. To meet the varying needs and demands for contraception, facilities should make various methods available at a frequency to meet common needs. (Curtis and Bright, 1997).

Summary information on the availability of family planning services is provided in Table 5.1. Figure 5.1 provides details on the availability of each method of contraception, and Tables A-5.1 and A-5.2 provide further details on method availability by type of facility and operating authority. Table 5.2 gives information on the number of days per week when services are available.

The temporary methods most commonly used are

- Contraceptive pills (either combined estrogen/progesterone or progesterone only), taken daily
- Contraceptive injections (either progesterone only, taken every two to three months, or, more recently, a combined injection, taken monthly)
- Condoms (male and, more recently, female)
- IUDs (Copper T-320, inserted once every five to ten years)
- Rhythm method (natural method based on prediction of when female ovulation occurs).

Other methods less commonly used, but also assessed for availability at facilities in the GSPA survey include the diaphragm, implants, emergency contraception, and spermicides. The methods that are offered at the facility must be consistently available to ensure that there is no gap in supply and no need to substitute methods less desirable to the client.

Table 5.1 provides information on the availability of different contraceptive methods at facilities offering family planning services.

A facility that offers all methods, including sterilization, is best able to meet the needs of clients. However, some variation in the availability of methods at facilities is expected because of differences in the level of the health system of which the facility is part, the qualifications and training required for health workers, and the infrastructure that must be present to provide contraceptive methods safely. The most common methods, and those requiring minimal training to provide safely, are contraceptive pills, injections, and condoms. Implants and IUDs require a higher level of skill and a more developed infrastructure to administer safely.

Eighty-nine percent of all facilities offered one or more temporary modern methods of contraception. Seven out of ten offered at least four temporary modern methods, including contraceptive pills, injections, implants, the IUD, condoms, spermicides, the diaphragm, and emergency contraceptive pills (Table A-5.1). No major differences between the types of facilities and operating authorities were found, except in the private religious facilities, where less than 3 out of 10 were offering a variety of at least four modern temporary methods. Counselling on rhythm methods was offered in 5 out of 10 facilities, most often in other private facilities. Permanent methods, which include male and female sterilization, were offered in only 9 percent of facilities (76 percent of hospitals) (Table 5.1). Methods most commonly offered were the progesterone-only injectable (88 percent), combined oral contraceptives (84 percent), and the male condom (81 percent). Less frequently offered were female sterilization (9 percent), male sterilization (2 percent), and the diaphragm (1 percent) (Table A-5.1).

Table 5.1 Availability of family planning services				
Percentage of facilities offering one or more temporary modern methods of contraception, percentage offering counselling on the rhythm method, and percentage offering permanent methods of contraception, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage offering service			Weighted number of facilities
	Temporary modern methods of contraception ¹	Rhythm method	Permanent methods of contraception ²	
Type of facility				
Hospital	78	60	76	43
Health centre	92	44	2	166
Clinic	83	42	4	125
PMH	97	59	0	95
Operating authority				
Public	92	46	11	288
Private religious	52	41	20	39
Other private	97	61	0	100
Region				
Western	83	52	12	39
Central	92	32	9	30
Greater Accra	94	65	11	28
Volta	85	38	6	74
Eastern	90	70	8	50
Ashanti	87	59	14	71
Brong Ahafo	90	53	8	54
Northern	87	33	6	41
Upper East	98	17	8	20
Upper West	100	45	8	22
Total	89	49	9	428

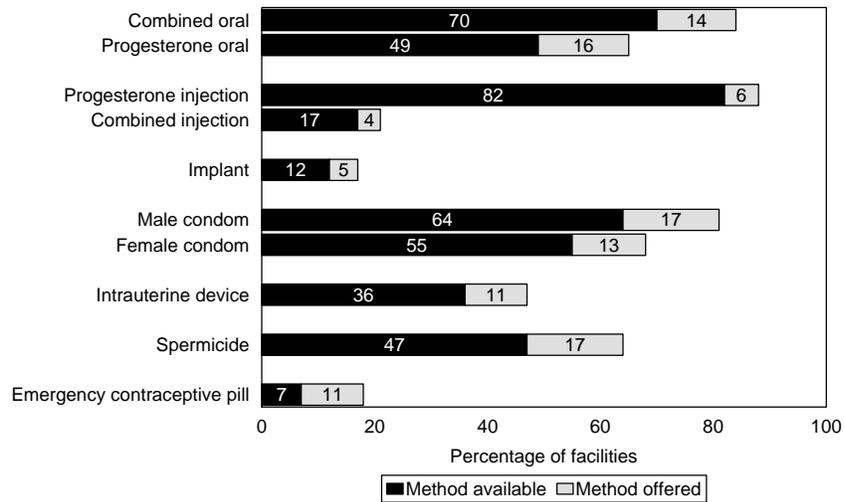
¹ Any of the following methods: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, IUDs, condoms (male or female), spermicides, diaphragm, or emergency contraceptive pill

² Male or female sterilization

Figure 5.1 demonstrates the methods of contraception being offered by the facilities and their actual availability on the day of survey. The methods offered most frequently—progesterone-only injections, combined oral pills, and male condoms—were available in approximately 80 percent of facilities offering the indicated method. Combined injections and emergency contraceptive pills were less available, which is not surprising, since they were only introduced recently (Tables A-5.1 and A-5.2).

In addition to providing a range of methods, it is important that family planning services be offered on a regular basis so that clients can depend on services being available when needed and on providers being available to answer questions and to respond to concerns. Limited finances and resources (e.g., human resources, space) may result in family planning services being offered only 1 or 2 days per week. While this may meet basic needs, it is less convenient for clients and may result in late visits and subsequent nonuse of methods.

Figure 5.1 Method of contraception offered and availability of method on the day of survey (N=428)



Ghana SPA 2002

Table 5.2 shows that among facilities providing family planning, most facilities (95 percent) offer family planning services five or more days per week. Little difference was found between types of facilities, operating authorities, and regions.

Table 5.2 Frequency of availability of temporary family planning method services

Among facilities offering temporary methods of family planning, percentage of facilities where temporary methods of family planning are offered 1 or 2 days per week and percentage where they are offered 5 or more days per week, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:		Weighted number of facilities offering temporary methods of family planning
	Family planning available 1-2 days per week	Family planning available 5 or more days per week	
Type of facility			
Hospital	3	97	36
Health centre	6	94	153
Clinic	5	90	105
PMH	0	100	92
Operating authority			
Public	4	94	264
Private religious	12	88	25
Other private	1	99	97
Region			
Western	4	96	32
Central	0	100	27
Greater Accra	0	100	26
Volta	10	84	64
Eastern	8	92	46
Ashanti	3	97	63
Brong Ahafo	3	97	49
Northern	2	98	37
Upper East	0	92	19
Upper West	0	100	22
Total	4	95	386

Key Findings

Temporary methods of contraception are available in 89 percent of all facilities. The service is offered by all types of facilities and is available in almost all facilities (95 percent) five or more days a week.

Permanent methods are available in 76 percent of hospitals.

Sixty-nine percent of all facilities offer at least four modern temporary methods of contraception. Private religious facilities offer the least variety in methods.

Progesterone-only injectables, combined oral contraceptives, and male condoms are the methods most commonly reported as offered, and they were available in approximately 80 percent of the facilities offering these methods.

5.3 Components Supporting Quality Family Planning Services

Components that were assessed for quality family planning services were as follows:

- Infrastructure and resources to support quality assessment and counselling
- Infrastructure and resources for examinations
- Provision of STI treatment with family planning

- Availability of equipment and supplies for specific methods.

Aggregated information on the availability of items for each of the above components is provided in Table 5.3. Figures 5.2 through 5.4 provide summary information on the availability of each item for counselling, pelvic examinations, and safe provision of different methods. Details on the availability of infrastructure and resources for each of the items can be found in Table A-5.3, and Table A-5.4 provides information on the availability of medicines for various STIs. Finally, details on the availability of equipment and infrastructure for specific methods are provided in Tables A-5.5 through A-5.7.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counselling for Family Planning Clients¹

Items for supporting quality assessment and counselling for family planning include the following:

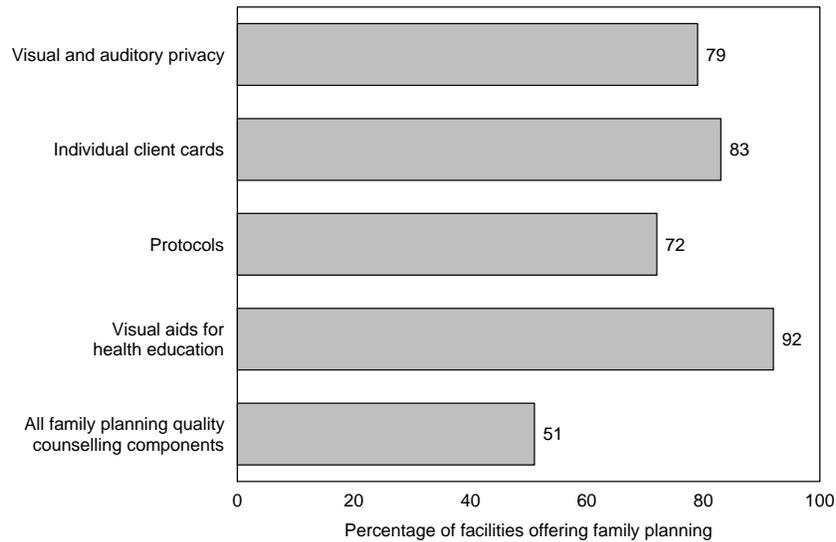
- Some level of auditory or visual privacy for counselling
- Individual client health cards or records
- Written guidelines or protocols
- Visual aids or written information for client education.

Family planning is often a sensitive topic, and assurance that any client-provider discussion is confidential improves communication and, ultimately, the probability that the method of contraception selected will be effective and suitable for the client. Visual privacy is also desirable for counselling to increase the client's assurance that confidentiality is being maintained.

Figure 5.2 shows that almost all facilities (79 percent) counselled family planning clients in a private room. In an additional 5 percent of all facilities, counselling took place in a room where a screen was present (Table A-5.3). Individual client cards were available in 83 percent of the facilities. Written family planning guidelines or protocols for family planning that included information on screening for eligibility of different methods had to be available in the family planning service delivery area or in an immediately adjacent area to be considered available for use. They were available in the service delivery area in 72 percent of facilities and were more often available at public and other private facilities (70 and 84 percent, respectively) than at private religious facilities (43 percent) (Table 5.3).

¹ Counselling about family planning often takes place in a different location than where procedures (e.g., pelvic examinations) are conducted, thus the conditions for counselling are assessed separately from those for procedures.

Figure 5.2 Availability of items for quality family planning counselling among facilities offering family planning (N=386)



Ghana SPA 2002

Visual aids related to family planning were available in the service delivery area in 92 percent of facilities. (Visual aids and/or a model for demonstrating use of condoms were available in 96 percent (Table 5.3).) All conditions for quality counselling (visual and auditory privacy, individual client health cards, written protocols, and visual aids) were met in half of all facilities, but in only 42 percent of clinics and 67 percent of hospitals. Written protocols or guidelines for family planning were the items most commonly missing (absent from 28 percent of facilities) (Table A-5.3).

Table 5.3 Availability of infrastructure and resources to support quality services for temporary methods of family planning

Percentage of facilities with protocols or guidelines for temporary family planning methods, percentage with visual aids, percentage with all items for: Infection prevention, percentage with all conditions for quality pelvic examination, and percentage where treatment for sexually transmitted infections (STIs) is provided by family planning service providers, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:					Weighted number of facilities offering family planning
	Protocols or guidelines for family planning	Visual aids ¹	All items for infection prevention ²	Conditions for quality pelvic examination ³	STI treatment provided	
Type of facility						
Hospital	85	98	32	49	25	36
Health centre	68	97	10	13	28	153
Clinic	64	90	16	7	29	105
PMH	83	98	33	13	79	92
Operating authority						
Public	70	96	13	15	27	264
Private religious	43	84	28	16	19	25
Other private	84	98	33	13	80	97
Region						
Western	74	92	6	5	40	32
Central	74	100	45	20	26	27
Greater Accra	83	96	37	41	59	26
Volta	66	97	4	12	26	64
Eastern	79	97	34	14	49	46
Ashanti	72	100	15	21	36	63
Brong Ahafo	78	97	31	10	40	49
Northern	51	92	7	6	34	37
Upper East	45	71	0	6	33	19
Upper West	99	100	18	16	81	22
Total	72	96	19	15	40	386

¹ Model for demonstrating use of condom or other visual aids for health education or family planning
² Soap, water, clean gloves, disinfection solution, and sharps box
³ Visual and auditory privacy, examination bed, examination light, and vaginal speculum

Key Findings

Counselling on family planning took place in a private room in approximately 80 percent of facilities.

Visual aids for health education were available in almost all facilities.

Protocols and guidelines for family planning were available in only 72 percent of all facilities.

5.3.2 Infrastructure and Resources for Examinations

Frequently, a physical examination, often including a pelvic examination, is necessary to determine the suitability of a contraceptive method, to insert a contraceptive method, or to evaluate problems associated with a method. The following were assessed for quality conditions for examination of family planning clients:

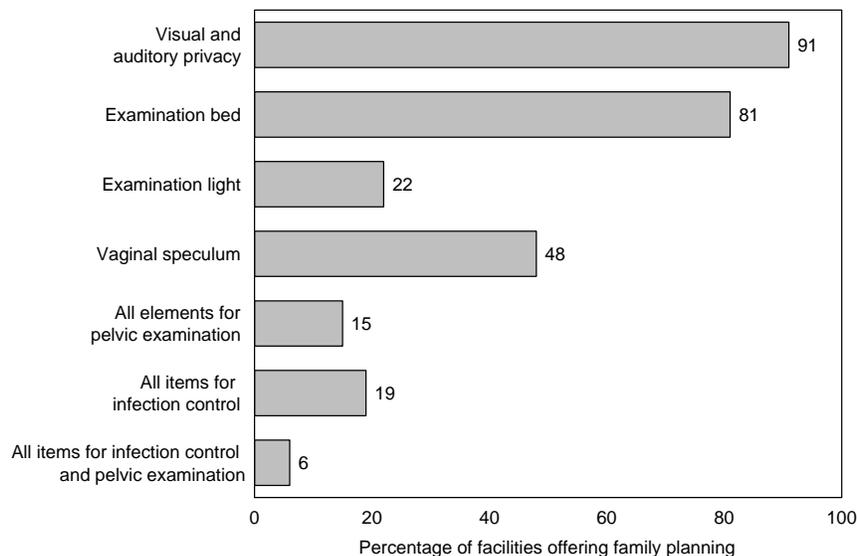
- Items for infection prevention
- Visual privacy
- Bed for examination

- Spotlight source for visualizing procedures
- Vaginal speculum.

The GSPA survey assessed the presence of infection prevention items in the area where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection) most often took place. All items for infection prevention (water, soap, clean or sterile latex gloves, disinfecting solution, and a sharps box) were available in one out of five facilities (Table 5.3). The items most often missing were water and disinfecting solution (absent from 59 and 60 percent of the service areas, respectively) (Table A-5.3). Approximately two out of three health centres and clinics did not have any disinfecting solution in the service area. However, soap was available in almost all facilities (87 percent). The single-use towel, which was recently introduced in Ghana, was available in 88 percent of all facilities, with little difference between types of facilities and operating authorities (Table A-5.3).

Family planning clients frequently require a pelvic examination. Only 15 percent of facilities had all items defined as important for a pelvic examination, with a spotlight source—for visualizing the cervix or procedure site—most commonly missing (absent from 78 percent of all facilities and 89 percent of clinics) (Figure 5.3 and Table A-5.3). Vaginal speculums were missing in half of the family planning service delivery areas and were most frequently missing in private religious facilities (65 percent); they were most commonly available in other private facilities (67 percent). All items for infection prevention and pelvic examination were available in only 6 percent of facilities offering family planning services. Twenty-eight percent of hospitals had all the items mentioned and 2 to 5 percent of health centres, clinics, and PMHs had all items (Table A-5.3).

Figure 5.3 Availability of items for quality pelvic examination among facilities offering family planning (N=386)



Ghana SPA 2002

Key Findings

All infection control items (soap, water, clean gloves, disinfecting solution, and sharps box) were present in one out of five facilities. Items most often missing were water (missing from 59 percent of facilities) and disinfecting solution (missing from 60 percent).

Furniture and equipment for pelvic examination were present in 15 percent of facilities offering temporary family planning methods, and they were most likely to be found in hospitals (49 percent). The examination light was the item most often missing (absent from 78 percent of facilities). A vaginal speculum was missing in half of the facilities.

5.3.3 Provision of STI Treatment for Family Planning Clients

Because family planning clients are sexually active, they are at risk for contracting STIs. Consequently, counselling for prevention of STIs and diagnosis and treatment of STIs constitute essential components of quality family planning services. If these services are provided at the same time and in the same location as the family planning services, it is more likely that STIs will be identified and clients will receive treatment.

Table 5.3 shows the percentage of facilities offering family planning services that provide STI treatment, by type of family planning provider. Four out of ten facilities provide STI treatment as part of family planning services. Most commonly, family planning providers offer STI treatment in PMHs (79 percent); only about one in four other facilities offers this service. Visual aids on STIs were available in 23 percent of facilities, and information pamphlets for clients to take home were available in 15 percent of facilities, with hospitals (27 percent) having the greatest availability (data not shown).

The GSPA survey also assessed the availability of medicines to treat the most common STIs. Twenty-three percent of facilities had at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis (Table A-5.4). Most commonly available were metronidazole (75 percent) and either benzathine or procaine penicillin (68 percent). Private religious (42 percent) and other private facilities (29 percent) were better supplied (at least one medicine for each STI) than public facilities.

Key Findings

STI treatment is integrated with family planning services in four out of ten facilities.

Medicines most commonly available for treating STIs were metronidazole (in 75 percent of facilities) and either benzathine or procaine penicillin (68 percent).

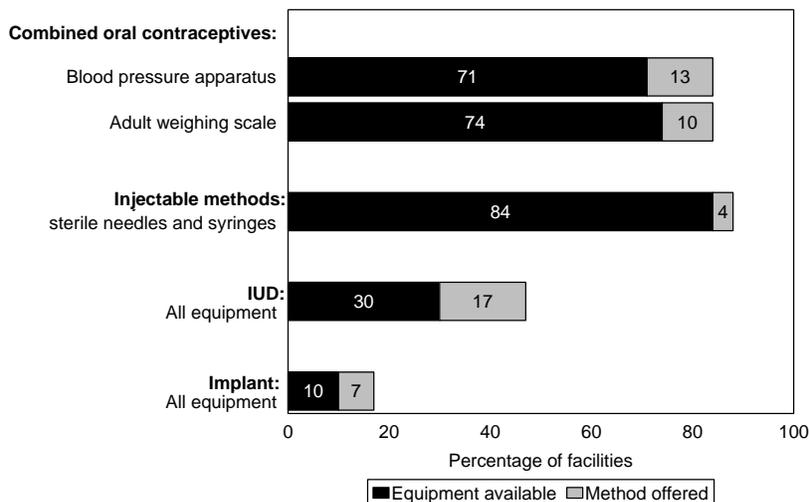
5.3.4 Availability of Equipment and Supplies for Specific Methods

Different contraceptive methods require different equipment to provide the method safely and to monitor the client. This equipment includes blood pressure apparatus (and a weighing scale) for clients being assessed and followed up for estrogen-based contraceptives and specific equipment for insertion and removal of IUDs and implants. Methods such as the IUD and implants also require an appropriate infrastructure to provide quality services in the delivery of family planning methods.

Eighty-four percent (Figure 5.1) of all facilities offered combined oral contraceptives, and among those, 84 percent had blood pressure apparatus and 88 percent had a weighing scale available. Among facilities providing injectables, 95 percent had sterile needles and syringes (Figure 5.4).

Equipment assessed for the IUD and implant methods included not only the specific items for insertion, but also the relevant forceps and disinfectant for cleaning before insertion and removal. Among those providing IUDs (47 percent of facilities), 63 percent had the equipment necessary for insertion and removal (Figure 5.4 and Table A-5.5), but only 9 percent had the equipment plus all conditions for quality pelvic examinations, including infection prevention, mainly because of the low percentage of facilities that had an examination light, a speculum, disinfecting solution, and water (Table A-5.3). Table A-5.6 shows the individual items required for IUD insertion and removal and their availability, by type of facility and operating authority. The GSPA survey defines clean or sterile gloves as required for infection prevention for IUD insertion. They were available in 92 percent of facilities offering IUDs. Among those providing implants, 60 percent had all the equipment, and 17 percent had both the equipment and the infrastructure for insertion and removal, including infection prevention items (Table A-5.5). For facilities offering implants, the requirement was sterile gloves (clean gloves were not adequate), which were present in 84 percent of facilities. Details on the equipment for insertion of implants or their removal are provided in Table A-5.7, by type of facility and operating authority.

Figure 5.4 Availability of equipment relevant to safe provision of contraceptive methods among facilities offering the indicated method (N=428)



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Key Findings

Blood pressure and weighing equipment were widely available in facilities providing contraceptive methods with estrogen.

Needles and syringes were available in 95 percent of facilities providing injectable methods.

Equipment for IUD and implant insertion were available in almost two-thirds of facilities offering these methods.

5.4 Management Practices Supportive of Quality Family Planning Services

Management practices that were assessed for supporting quality family planning services include the following:

- Facility documentation and records
- Practices related to user fees
- Supervision and staff development.

Summary information on each of these items is provided in Table 5.4. Further details on personal supervision and the timing of in-service training are given in Table A-5.8. Figure 5.5 and Tables A-5.9a and A-5.9b provide more details on the topics of in-service training, by facility type, operating authority, and region. Finally, Table A-5.10 provides details of out-of-pocket payments for services.

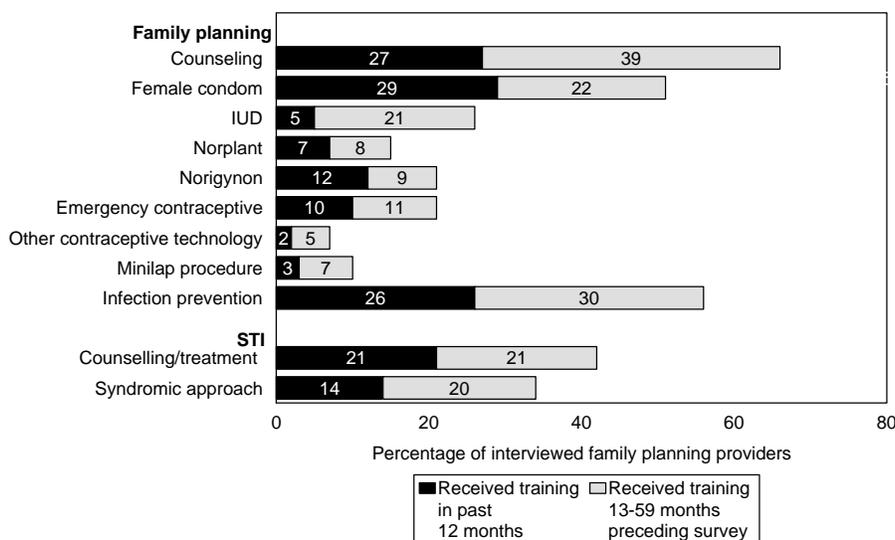
Table 5.4 Facility-based supportive management practices						
Percentage of facilities with up-to-date family planning registers, percentage where at least half of the interviewed providers of family planning services were personally supervised during the past 6 months, received related in-service training during the past 12 months, and were both supervised in the past 6 months and received in-service training related to family planning services during the past 12 months, and percentage where there is a charge for services, by type of facility, operating authority, and region, Ghana SPA 2002						
Background characteristics	Percentage of facilities:					Weighted number of facilities offering family planning services
	With up-to-date register ²	Where at least half of the interviewed family planning service providers: ¹			With charges for family planning services	
		Were personally supervised in past 6 months	Received in-service training in past 12 months	Were personally supervised in past 6 months and received in-service training in past 12 months		
Type of facility						
Hospital	93	66	61	37	18	36
Health centre	84	72	57	41	18	153
Clinic	73	67	42	28	19	105
PMH	61	43	53	28	46	92
Operating authority						
Public	81	69	53	36	17	264
Private religious	84	69	48	34	29	25
Other private	62	45	54	29	46	97
Region						
Western	83	59	71	55	19	32
Central	83	35	66	28	13	27
Greater Accra	68	73	56	40	7	26
Volta	78	63	29	22	9	64
Eastern	73	58	50	24	26	46
Ashanti	75	52	50	29	51	63
Brong Ahafo	75	75	50	32	25	49
Northern	79	78	47	34	59	37
Upper East	73	72	72	54	0	19
Upper West	83	75	79	63	5	22
Total	77	63	53	34	25	386

¹ Seven facilities offering family planning did not have a provider interviewed.

² Register has an entry in the past 7 days; entry indicates method provided and the client's status.

The GSPA survey assessed the availability of up-to-date registers where family planning services are recorded. This is most often the source of health information system data. A register was defined as up to date if there was an entry within the past seven days, and the entry, at a minimum, reported the method or service provided and the client's status. Three out of four facilities (77 percent) had up-to-date registers; they were found in 93 percent of hospitals but in only 61 percent of PMHs (Table 5.4).

Figure 5.5 In-service training received by interviewed family planning providers, by topic and timing of most recent training (N=665)



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The types of contraceptive methods that are available, as well as knowledge of their benefits and side effects, change over time. In-service training for providers aims to improve their quality of counselling, management of complications or side effects, and judgment and skills in assessing which contraceptive methods are most suitable for client needs. Among all interviewed providers of family planning services, 51 percent had received related in-service training during the past 12 months, and an additional 29 percent received this education 13-59 months preceding the survey (Table A-5.8). In 53 percent of facilities, at least half of the family planning providers had received in-service training related to family planning during the 12 months preceding the survey (Table 5.4).

Supervision of individual staff helps promote adherence to standards and identify problems that contribute to poor-quality services. The GSPA survey collected information both on the frequency of supervision and on the activities of the supervisor. Similar to findings in other services, supervision of family planning providers is common, with at least half of the interviewed family planning providers being supervised in the past 6 months in 63 percent of facilities (Table 5.4) and 59 percent of the individual providers being supervised in the 6 months preceding the survey. Thirty-two percent of interviewed providers received supportive management, defined as being both personally supervised in the past 6 months and receiving any related in-service training in the past 12 months (Table A-5.8). The median number of times staff were supervised in the past 6 months was twice, and the most commonly reported activities of supervisors were checking records, discussing problems, and observing work (data not shown).

One out of four facilities reported that they charge for family planning services, with major differences between regions and operating authorities (Table 5.4); however, 93 percent of the interviewed family

planning clients reported that they paid out of pocket for the family planning visit (Table A-5.10). Only 2 percent belonged to a prepaid programme, and their median out-of-pocket payment was 1,535 cedis, compared with 2,058 cedis for those not belonging to a prepaid programme.

Key Findings
Up-to-date registers were found in more than three-quarters of facilities, most commonly in hospitals (93 percent) and least commonly in PMHs (61 percent).
In-service training is fairly common, with 51 percent of the providers having received some related in-service training during the past 12 months and an additional 29 percent having received training 13-59 months preceding the survey.
Six in 10 providers (59 percent) were personally supervised during the past 6 months.

5.5 Adherence to Standards for Quality Service Provision

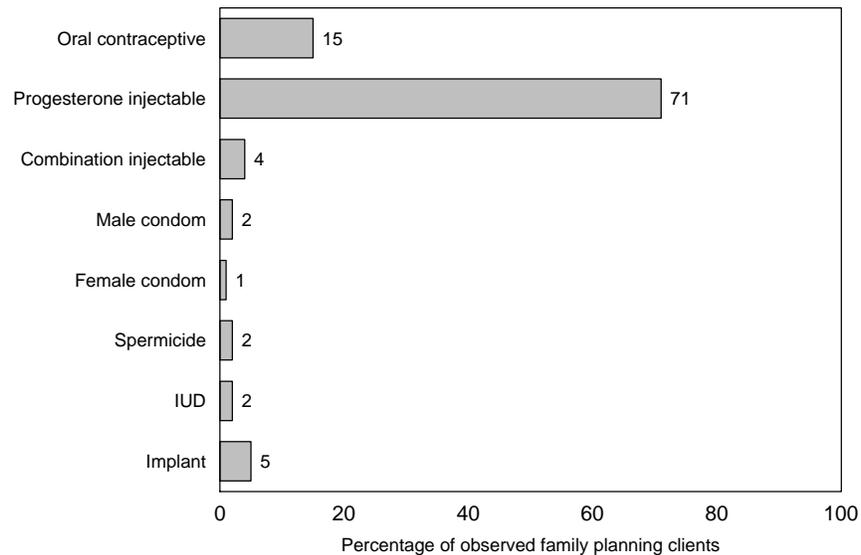
Observations of family planning consultations included in the GSPA survey provide the basis for assessing whether providers are adhering to standards for providing quality services. The observation checklist was based on commonly accepted guidelines for screening and counselling family planning clients and collected information on whether the consultation process answered the following questions:

- Were essential items relevant to determining appropriateness of various family planning methods discussed and were essential physical examinations for screening a client for method appropriateness conducted?
- Did the conditions and procedures followed for provision of specific methods meet the criteria defined for quality?

Observers watched the process utilized when family planning clients were seen at the facility, noting information shared and procedures or examinations conducted. The objective was to note whether information on a topic was shared (process information). An assessment of whether the information was correct or findings were appropriately interpreted was not a component of the observation.

Table A-5.11 provides details on the observed family planning clients. Almost all clients were female (more than 99 percent). It was the first visit for 23 percent of the clients, and almost all of the observed clients (97 percent) received a family planning method during the observation (data not shown). Nineteen percent received the same method they were using before the visit (data not shown). Seventy-one percent of the observed family planning clients left the facility with a prescription for the progesterone-only injection or were given the injection (Figure 5.6). Fifteen percent of the clients received a prescription for oral contraceptives or were given the pills. More details on the methods received and the distribution, by type of facility, operating authority, and region are presented in Table A-5.11.

Figure 5.6 Methods prescribed to observed family planning clients (N=602)



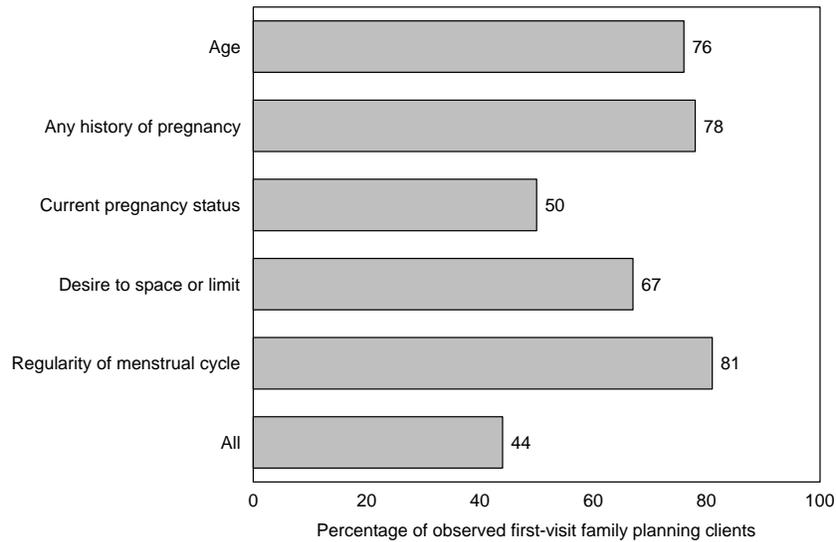
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5.5.1 Assessment of Relevant History, Examination, and Counselling

The information recorded by the GSPA survey observers during family planning consultations provides the means to evaluate whether the consultations included the degree of information exchange necessary to determine and respond to the client's need for contraceptive services. Specifically, the following components were assessed.

It was observed whether the information exchange elicited basic information relevant to the client's reproductive history. For new family planning users, providers should be aware of factors relevant to the choice of method. These include age, parity, pregnancy status, breastfeeding status, and the regularity of the menstrual cycle. Besides breastfeeding, which was not included as an essential question, all details were addressed in 44 percent of first-visit family planning clients. The history of pregnancies (78 percent) and the regularity of the menstrual cycle (81 percent) were asked most frequently, while the current pregnancy status (50 percent) was asked least frequently. (Table A-5.12 and Figure 5.7).

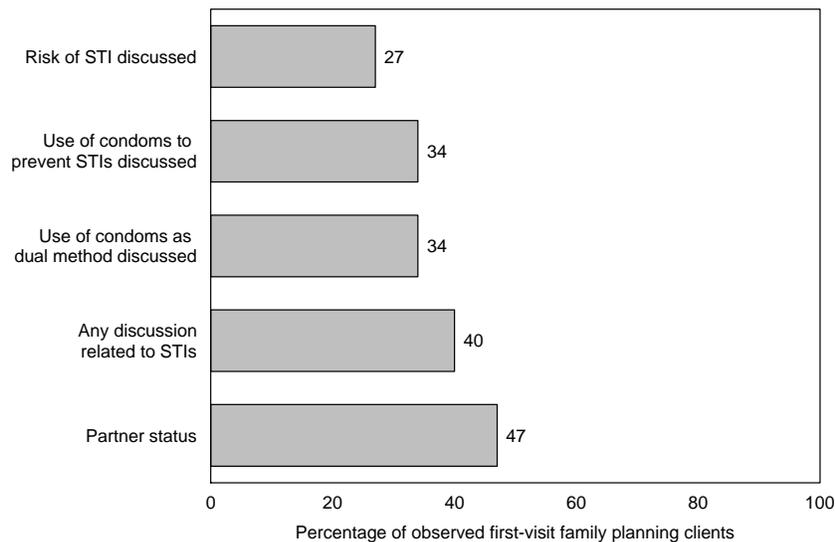
Figure 5.7 Details of client history observed for first-visit family planning clients (N=140)



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The study assessed whether there was any information shared that specifically addressed STIs, HIV/AIDS, or use of condoms. Information on the client’s social history is relevant for the choice of method and for ensuring that the client receives appropriate counselling related to STIs. Figure 5.8 shows that during counselling of observed first-visit family planning clients, the risk of STIs (27 percent), the use of condoms to prevent STIs (34 percent), and the use of condoms as a dual method (34 percent)—for protection against STI infection and as a family planning method for prevention of pregnancy—were discussed infrequently. The number of partners for the client or the client’s partner was discussed with less than half of all clients (47 percent). More detailed information, by type of facility and operating authority, is available in Table A-5.12.

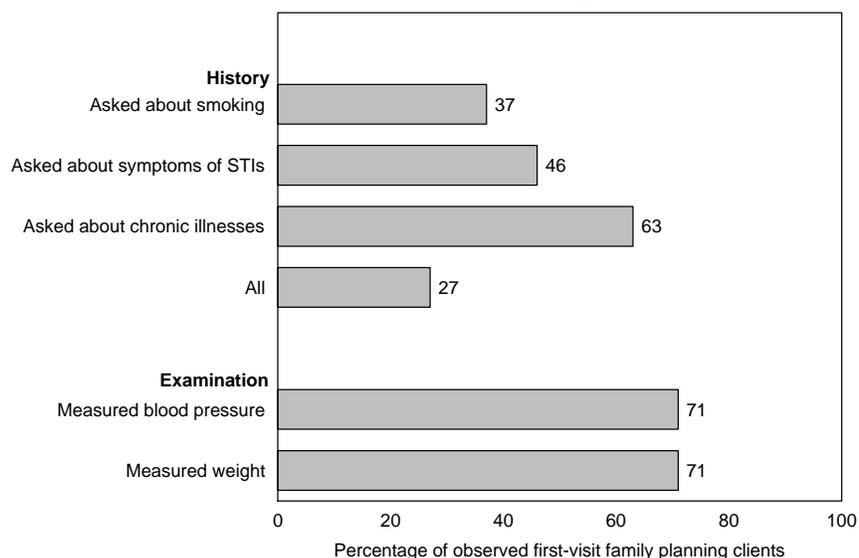
Figure 5.8 Details of STI-related counselling observed for first-visit family planning clients (N=140)



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It was also necessary to find out whether basic physical assessments were conducted and whether information relevant to the client’s general health was shared. The provider should elicit basic information from new family planning clients relating to their general health, including information on current health status, use of tobacco, any history of chronic illnesses, and presence of symptoms of STIs. All relevant medical history questions were asked in 27 percent of the observed first-visit clients (Figure 5.9). Basic physical assessment should also be a standard component of a consultation with a new family planning client. Blood pressure and weight were measured in approximately 7 out of 10 clients (Figure 5.9). Information by type of facility and operating authority is presented in Table A-5.12.

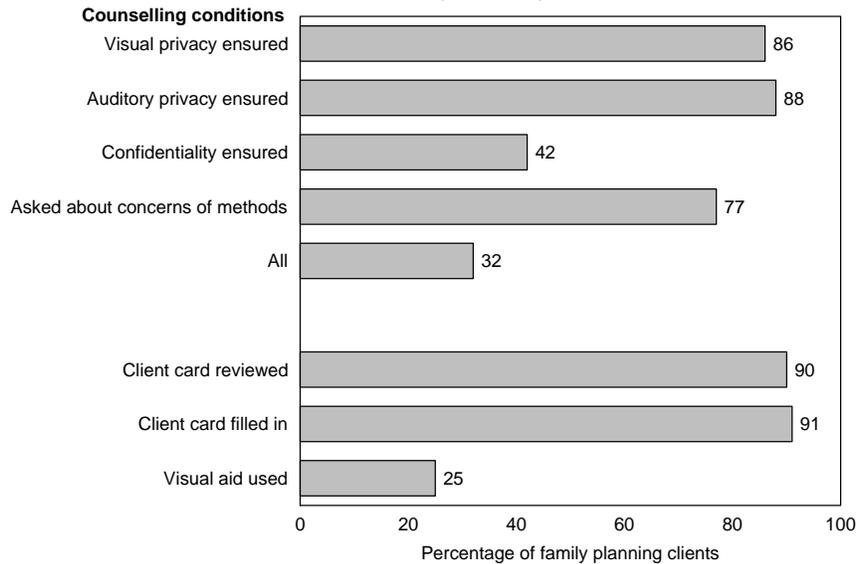
Figure 5.9 Details of client medical history and examination observed for first-visit family planning clients (N=140)



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The conditions for counselling should ensure client confidentiality, encourage information exchange, and include the use of a client card/record to promote continuity of care. It was necessary, therefore, to assess whether the conditions and procedures followed during client counselling were appropriate. Figure 5.10 and Table A-5.13 present the counselling conditions of all observed family planning clients. Although visual and auditory privacy was assured for almost 9 out of 10 clients (86 percent), only 42 percent of clients were assured of the confidentiality of their discussion. Seventy-seven percent of clients were asked about any concerns they might have about the methods discussed or currently used. The usage of an individual client card was widespread (approximately 90 percent of clients), but the usage of visual aids was low. Only one out of four observed family planning client consultations included visual aids (Table A-5.13), whereas they were available in 92 percent of all facilities offering temporary methods (Table A-5.3).

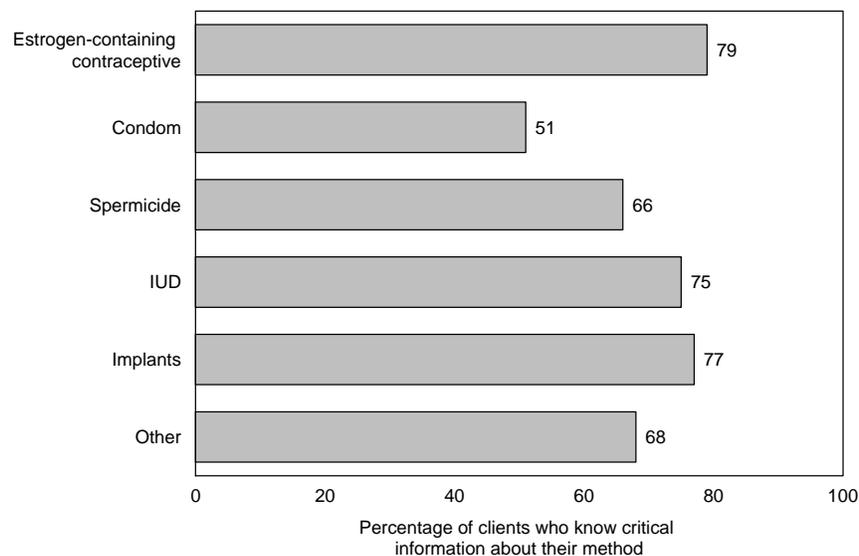
Figure 5.10 Counselling conditions observed for family planning clients (N=611)



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Informing the client about the side effects of methods and how to deal with them can build confidence in the client and promote effective use. The GSPA survey assessed whether clients left the counselling session with an appropriate understanding of the method provided. Figure 5.11 shows the level of client knowledge of family planning after counselling. Tables A-5.14 and A-5.15 provide more details on what specific information the provider gave to the client and what information the client was able to recall, by method received.

Figure 5.11 Client knowledge of contraceptive method provided



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Key Findings

A complete client history was obtained for 44 percent of first-visit clients; a history was most likely to be obtained in public facilities (48 percent) and least likely to be obtained in other private facilities (25 percent).

In only four out of ten first-visit clients was any discussion related to STIs observed.

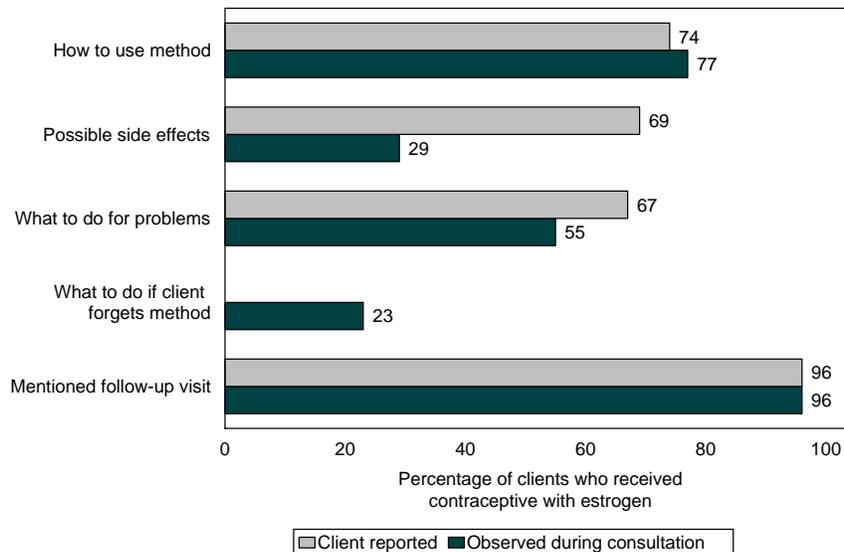
Blood pressure and weight were taken for 71 percent of clients.

Clients' knowledge of their specific method could be improved. Depending on the method, between 51 and 79 percent of clients questioned after counselling were able to give critical information about their method.

5.5.2 Method-Specific Counselling

Whether for new users or continuing users, certain information should be reconfirmed during consultations. The GSPA survey specifically assessed whether the provider explained how to use the method, explained possible side effects, explained what to do for problems, and assessed whether the provider mentioned a follow-up visit. Table A-5.14 provides details on information observed being provided and client's knowledge of methods other than hormonal ones and Table A-5.15 provides the same details, but for hormonal methods. As noted in Figure 5.12, there was some consistency between what was observed during the visit and what the client reported being told about hormonal methods (estrogen or progesterone). That clients reported higher levels of knowledge of possible side effects and what to do if problems occur than was observed during consultations, may reflect knowledge obtained during previous visits. In addition, each client was asked a specific question about correct utilization of the hormonal method. Seventy-nine percent could correctly answer the question (Table A-5.15).

Figure 5.12 Information and knowledge among hormonal method users: Client reports and observations (N=538)



Ghana SPA 2002

5.5.3 Method-Specific Assessments and Examinations

Among all clients receiving family planning methods with estrogen, which requires monitoring for hypertension, 88 percent had their blood pressure measured, and 91 percent had their weight measured (Table A-5.15).

Specific procedures were observed to ascertain whether the procedure followed defined steps for quality, whether infection control practices were followed, and whether explanations on the procedure were given to the client.

Among women who received pelvic examinations (6 clients), IUD insertions (10 clients), or implant insertions (17 clients), all (100 percent) were conducted under conditions where both visual and auditory privacy were protected (data not shown). Instruments that were sterile or high-level disinfected were used in 64 percent of pelvic examinations and in 100 percent of IUD insertions, implant insertions, and injections (426 clients). Hand-washing before a procedure was done in most cases, except before administering an injectable and removing an IUD (16 and 19 percent, respectively). Hand-washing after procedures was also done in most cases, again except after giving an injection (data not shown). These results, despite the small sample size in some instances, give an indication of the current situation.

In general, explanations of what the providers did during procedures was lacking for pelvic examinations (given in 42 percent only) and implant insertions (given in 31 percent of the observed clients) (data not shown).

Key Findings
Counselling on side effects was observed for only 29 percent of clients receiving a family planning method containing estrogen; instructions on what to do if the client forgets to take the method were observed for 23 percent of clients.
Pelvic examinations and IUD and implant insertions were all performed in private rooms.
The explanations given to clients before and during the procedures could be improved, especially for pelvic examinations and implant insertions.

5.6 Client Opinion from Exit Interview

After the observed consultation, the client was asked to participate in an exit interview in which feedback on issues commonly identified as related to client satisfaction was sought. Clients were asked whether they had a problem with their method when they arrived at the facility and whether the provider discussed the problem with them. The client was first asked to identify issues without prompting. Then specific issues were probed, and the client was asked to comment on whether these issues were a major problem, a small problem, or not a problem at all for them. Very few issues were considered major problems. The one area identified as a problem was the long waiting time to see the provider (3 percent). More information is presented in Table A-5.16.

A special question added to the GSPA survey was the issue of substituting the oral contraceptives Lo-Femenal and Ovrette with other brands in public-sector facilities (Microgynon and Micronor). Table A-5.17 gives the views of the provider on this matter, as well as the opinion of clients. Nine percent of providers were of the opinion that clients would strongly dislike this, and 17 percent of the interviewed clients said that it would indeed be a major problem for them. Sixty-five percent of providers and 76 percent of clients thought it would either be acceptable or give only slight problems.

6.1 Background

6.1.1 Collection of Maternal Health Information

Maternal health is an issue that not only affects the woman, but also has a direct bearing on the health of the newborn. About 15 percent of all pregnant women experience life-threatening complications as a result of their pregnancy (Maternal and Neonatal Health Programme, 2001b). Many complications and subsequent poor outcomes for women and infants can be prevented or minimized with early recognition of problems and appropriate interventions.

With an international focus on decreasing maternal morbidity and mortality, during recent years, there have been shifts in the emphasis placed on some traditional maternal health interventions. Some of the critical thinking and subsequent changes in programme emphasis are described below:

- **Antenatal care.** Because all pregnant women are at risk of developing complications and many of these complications are unpredictable, it is important to ensure that all pregnant women have access to preventive interventions, early diagnosis and treatment for problems, and emergency care when needed. It is now emphasized that antenatal care should focus on early detection and skilled and timely interventions for factors having proven impacts on maternal and infant outcome (Maternal and Neonatal Health Programme, 2001a).
- **Postnatal care.** There is increasing emphasis placed on ensuring that women receive postnatal care within a few days of birth for early diagnosis of postpartum complications. Postnatal care also provides an opportunity to counsel the new mother on care for herself and her newborn, on family planning, and on assessing the newborn for any problems.
- **Delivery care.** Because every pregnancy may have complications, the emphasis is to promote use of skilled and trained delivery care providers and to ensure that all women have access to life-saving emergency interventions at the time of labour and delivery. In many countries, deliveries occur at home, attended by traditional birth attendants (TBAs). Previously, there were extensive efforts and funds expended toward upgrading the skills of TBAs, but safe motherhood programme initiatives have concluded that in almost all cases “the level of skill among ‘skilled birth attendants’ is lower than is ‘safe’ for safe motherhood. In-service training cannot improve the skill level of trained providers to the level of competency desired in all skills” (Maternal and Neonatal Health Programme, 2001b). With this conclusion has come a shift in the definition of qualified delivery providers to persons with “midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose and manage or refer complicated cases” (MotherCare Policy Brief #3) (Koblinsky, 2000).
- **Postabortion care.** Morbidity and mortality associated with unsafe abortion (spontaneous or induced) are major contributing factors to maternal deaths and illnesses and pose a major threat to reproductive health. Postabortion care is now an integral part of the safe motherhood service package.

- **Newborn care.** More attention has also been given recently to newborn care, with the increased awareness of common practices that are detrimental to newborn health and a focus on those good practices that should be promoted.

Internationally accepted guidelines define the maternal health services necessary for safe delivery and improved maternal and newborn outcome as follows (MotherCare Policy Brief #1) (Koblinsky, 1999):

- **Basic essential obstetric care (BEOC).** BEOC includes preventive services as well as medical interventions and procedures that can be provided by well-trained primary care physicians as well as nonphysician providers. This includes antenatal care—with preventive interventions—early detection and treatment of common problems of pregnancy, and the ability to manage both simple problems of pregnancy and to provide first aid for complications of pregnancy and labour to minimize the need for emergency interventions.
- **Emergency obstetric care (EmOC).** EmOC specifically covers life-saving interventions of blood transfusion and surgery.

Together, these guidelines form the basis of what is considered comprehensive essential obstetric care (CEOC).

Maternal and newborn health services represent a wide range of interventions depending on whether the mother and newborn are healthy or experiencing problems. The Ghana Service Provision Assessment (GSPA) survey drew upon the findings and recommendations of Safe Motherhood initiatives such as the Maternal and Neonatal Health Programme (MNH) and MotherCare, promoted by the World Health Organization (WHO) and other international organizations, to determine which aspects of maternal health to assess.

This chapter uses information obtained in the GSPA survey to address six central concerns regarding maternal health services:

- The availability of antenatal care
- The extent to which facilities have the capacity to support quality antenatal care services
- The extent to which evidence exists that health service providers adhere to standards for provision of quality antenatal care services
- The extent to which postnatal care¹ is available where antenatal care is offered, and whether facilities have the capacity to support quality postnatal care services
- The availability of delivery services and the extent to which facilities have the capacity to support quality delivery services
- The common newborn care practices in facilities providing delivery services.

6.1.2 Maternal Health and the Utilization of Services in Ghana

Reproductive health services are focused on the health care and education given during and after pregnancy. They involve three stages: antenatal care, delivery care, and postnatal care. The objectives, among others, are to make childbearing safe for all women and contribute to the improvement of infant health. They aim to promote and maintain the physical, mental, and social health and well-being of

¹ For the GSPA survey, any report of offering routine outpatient postnatal examination and services was accepted as postnatal care. Details on the content of postnatal care were not collected. Capacity was assessed by whether the facility could identify and manage postpartum infections and whether the newborn weight could be measured.

mother and baby; encourage sexually transmitted infection (STI) prevention, including HIV/AIDS; recognize the danger signs of pregnancy; and promote personal hygiene.

In Ghana, antenatal care seeks to encourage frequent visits (at least four) to a health provider during pregnancy. Activities outlined for a pregnant woman include monitoring of normal pregnancy; identification and management of high-risk pregnancy and complications; referrals; immunization; and education on nutrition and family planning. During labour, there is a need to ensure safe delivery; proper management of the four stages of labour; and early identification, proper management, treatment, and/or referral of complications. Postnatal activities are important to the early stages of child health. It is necessary, therefore, to establish breastfeeding (and if possible, exclusive breastfeeding), immunization of the baby, and family planning counselling and services to promote birth spacing and ensure good care of the newborn.

Antenatal care utilization is high in Ghana, with mothers receiving care from a doctor, nurse, or midwife for 87 percent of births (Ghana Statistical Service and Macro International, 1999). In terms of deliveries, only two in five births were recorded as delivered in a medical facility, and a trained TBA assisted one in four births. Another crucial component of safe motherhood is postnatal care, which is very low. In only 4 percent of home deliveries did the mother go to a health facility to receive postnatal care within the first two days of delivery. One in two noninstitutional deliveries did not include postnatal care (Ghana Statistical Service and Macro International, 1999).

The maternal mortality ratio in 2002 was estimated by United Nations Children's Fund (UNICEF) at 210 maternal deaths per 100,000 live births (UNICEF, 2002). The Ministry of Health uses an estimate of 214 deaths per 100,000 live births (655 deaths per 100,000 in 1994), ranging from 98 for Volta Region to 452 for Upper West Region.

6.2 Antenatal Care

6.2.1 Availability of Antenatal Care and Postnatal Care Services

To support appropriate antenatal care, services should be available with sufficient frequency to meet the needs of most pregnant women. Antenatal care services are commonly offered only one or two days per week. While this strategy may facilitate the management of health care services and personnel, particularly where there is limited space and equipment, this can create missed opportunities to provide antenatal care. A pregnant woman may be at the facility for another purpose (for a sick child or a child receiving preventive services, or even for herself if she is sick) and if she cannot receive the antenatal care services at the same time, she might be disinclined to return another day for antenatal care because of time, financial, or other factors.

Table 6.1 describes the overall availability of antenatal care, postnatal care, and postabortion care and the percentage of facilities where antenatal care was available on the day of survey, at the same time as other commonly used family health services. Table A-6.1 shows the frequency of antenatal care services and the availability of tetanus toxoid (TT) vaccine on the same day.

Almost all facilities (88 percent) offer antenatal care services, with hospitals (94 percent) and private maternity homes (PMHs) (96 percent) most likely to offer these services (Table 6.1). Seven out of ten offer postnatal care services, with hospitals (85 percent) and PMHs (83 percent) most likely to offer these services. Of the different operating authorities, public facilities are the least likely to offer both antenatal care (85 percent) and postnatal care (67 percent), compared with private religious and other private facilities. Specific postabortion care services are still in development and, therefore, only one out of five facilities provided this service at the time of the survey. Sixty-three percent of facilities offered both

antenatal care and TT vaccination on the day of the survey. Curative child care was offered with antenatal care in most facilities (78 percent) on the day of the survey, but child immunization was offered much less frequently (only in 23 percent of facilities) at the same time as antenatal care services. Family planning was offered on the day of the survey in 62 percent of facilities that also offered antenatal care on that day. Overall, Table 6.1 shows that clinics are least likely to have both antenatal care services and other services available, which is likely because clinics tend to be more specialized.

In the GSPA survey, facilities were asked the number of days per week that they normally provide antenatal care and other services. Seventy-eight percent of facilities offering antenatal care offer the service 5 or more days per week, and only 18 percent offer the service 1 or 2 days per week (Table A-6.1). PMHs offer the service most frequently. Tetanus toxoid vaccine was offered every day antenatal care was offered—in approximately 8 out of 10 facilities (78 percent)—and is most likely to be offered in hospitals (95 percent) and least likely to be offered in PMHs (59 percent).

Table 6.1 Availability of antenatal and postnatal care

Among all health facilities surveyed, percentage offering antenatal care, percentage offering postnatal care, percentage offering post-abortion care, among facilities offering antenatal care services, percentage providing services on the day of the survey, and among facilities offering antenatal care, percentage offering other family health services, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering any of the indicated services:				Percentage providing antenatal care the day of survey	Among facilities providing antenatal care, percentage where indicated service was also provided the same day:				Weighted number of facilities offering antenatal care the day of the survey
	Antenatal care	Postnatal care	Post-abortion care	Weighted number of facilities		Family planning	Curative care for children	Child immunization	Tetanus toxoid vaccine	
Type of facility										
Hospital	94	85	54	43	85	70	83	52	82	40
Health centre	90	74	13	166	83	65	81	28	72	149
Clinic	76	50	14	125	69	47	60	19	51	94
PMH	96	83	33	95	91	67	88	6	53	91
Operating authority										
Public	85	67	17	288	81	64	76	28	68	246
Private religious	88	70	23	39	64	27	62	34	52	35
Other private	93	80	33	100	90	67	87	6	53	94
Region										
Western	79	53	34	39	96	69	91	26	54	31
Central	95	95	14	30	91	45	91	26	79	28
Greater Accra	95	81	20	28	93	93	93	23	76	26
Volta	72	54	20	74	71	60	64	26	47	53
Eastern	96	80	34	50	92	70	88	24	80	48
Ashanti	96	87	26	71	73	39	66	17	53	68
Brong Ahafo	85	70	16	54	81	62	78	21	55	46
Northern	87	57	16	41	78	67	73	26	67	36
Upper East	81	19	8	20	61	52	61	11	61	16
Upper West	100	100	10	22	86	8	86	27	82	22
Total	88	70	21	428	82	62	78	23	63	375

Key Findings

Antenatal care is available in most (88 percent) facilities and, among these, is available 5 days per week in 78 percent of facilities.

Postnatal care is less available, offered in 70 percent of facilities, most often in hospitals (85 percent) and PMHs (83 percent).

Postabortion care is available in only one out of five facilities.

On the day of survey, curative child care was offered in 78 percent of facilities where antenatal care was offered, but child immunization was available in only one 1 of 4 of these facilities. Family planning was available in 62 percent of facilities where antenatal care was offered on the day of survey.

Tetanus toxoid vaccination services were available on the same day as antenatal care services in 78 percent of facilities, most commonly in hospitals (95 percent).

6.3 Capacity to Provide Quality Prenatal and Postnatal Care

Antenatal care aims to promote healthy behaviours in pregnant women and to provide early detection for and treatment of complications. Specific items that were assessed include the following:

- Infrastructure and recourses to support quality of care
- Equipment and recourses for quality antenatal care and postnatal care services.

6.3.1 Infrastructure and Recourses to Support Quality Assessment and Counselling of Antenatal Care Clients

The following items were assessed that support quality antenatal care services:

- Individual client cards
- Guidelines or protocols for antenatal care
- Visual aids for client education.

Table 6.2 provides information on the availability of infrastructure and recourses to support quality counselling and examination for antenatal care. Table A-6.2 presents information on the availability of specific equipment and supplies for quality assessment of antenatal care clients. Figure 6.1 shows the availability of items for quality antenatal care counselling.

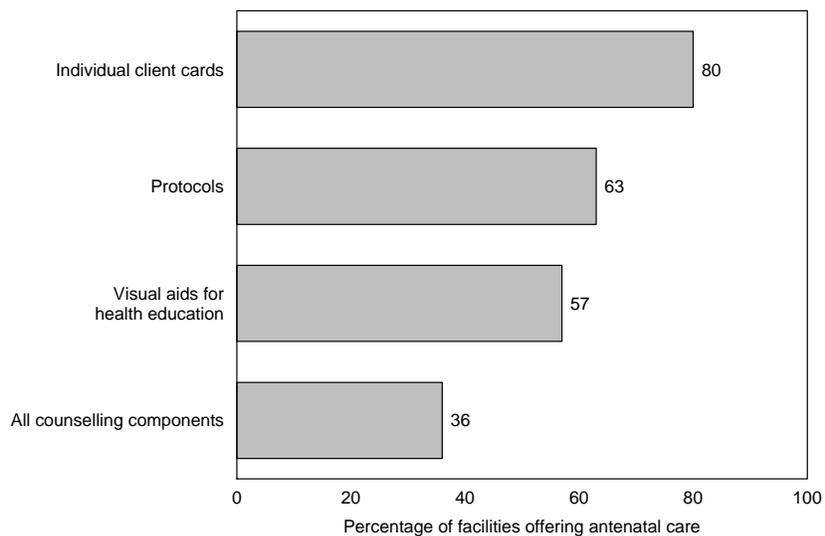
Individual client cards, important for recording information to allow monitoring and follow up of a woman's pregnancy and health status over time, were available in 80 percent of facilities (Figure 6.1) and were more likely to be available in PMHs (91 percent) and hospitals (85 percent) (Table A-6.2). Written antenatal care guidelines or protocols that included management of common problems during pregnancy were available in the antenatal care service delivery area in 63 percent of facilities. Visual aids related to antenatal care for client education were available in 57 percent of facilities (Figure 6.1). Each of the items assessed for quality services were less often in public and private religious facilities than in other private facilities (Table A-6.2). Thirty-six percent of facilities had all items for quality counselling (visual aids for health education, protocols or guidelines for antenatal care, and individual client card) (Table 6.2).

Table 6.2 Availability of infrastructure and recourses to support quality counselling and examinations for antenatal care

Background characteristics	Percentage of facilities that have all items for the indicated services:				Weighted number of facilities offering antenatal care
	Quality counselling ¹	Infection prevention ²	Quality physical exam ³	Essential supplies for basic antenatal care ⁴	
Type of facility					
Hospital	27	18	11	81	40
Health centre	31	21	18	53	149
Clinic	24	21	5	41	94
PMH	59	34	7	40	91
Operating authority					
Public	30	20	13	51	246
Private religious	16	21	19	66	35
Other private	58	34	7	40	94
Region					
Western	44	23	12	50	31
Central	23	38	6	51	28
Greater Accra	51	23	4	64	26
Volta	20	10	21	23	53
Eastern	32	30	7	44	48
Ashanti	31	22	6	57	68
Brong Ahafo	65	26	17	73	46
Northern	15	27	13	49	36
Upper East	31	0	0	19	16
Upper West	60	38	16	62	22
Total	36	24	11	50	375

¹ Visual aids for health education, protocols or guidelines for antenatal care, and individual client card
² Clean gloves, soap and water, disinfecting solution, and sharps box
³ Visual privacy, examination light, and examination table
⁴ Iron and folic acid, tetanus toxoid, blood pressure apparatus, and faetoscope (Pinard)

Figure 6.1 Availability of items for quality antenatal care counselling among facilities offering antenatal care (N=375)



Ghana SPA 2002

The common physical examinations for antenatal care include palpating the abdomen, auscultation, and, when necessary, conducting a pelvic examination. Pelvic examinations are not considered a routine component of antenatal care in Ghana. The GSPA survey assessed the presence of infection prevention items in the area where antenatal care examinations took place. Eighty-eight percent of the service areas had soap, and the same percentage had water (Table A-6.2). As some antenatal care service facilities also provide injections and check haemoglobin levels for anaemia, a box for disposal of sharp items was considered important for infection prevention in this service setting. Sharps boxes were available in 63 percent of facilities, while clean latex gloves for pelvic examinations were lacking in 29 percent. Hospitals (40 percent) were least likely to have clean gloves in the antenatal care service area. Disinfecting solution was present in the service area in only 37 percent of facilities and was most likely to be found in PMHs (55 percent). Single-use towels were present in 42 percent of facilities. Other private facilities were more likely to have all infection prevention items (34 percent) than public (20 percent) and private religious facilities (21 percent) (Table 6.2).

The basic components assessed for examination of the antenatal care client were visual privacy (present in 92 percent of facilities), a bed (50 percent), and an examination light (15 percent) (Table A-6.2) . All items were found in only 11 percent of facilities and were most likely to be found in private religious facilities (19 percent) (Table 6.2).

Basic equipment essential for any level of antenatal care was defined as a functioning blood pressure apparatus (found in the antenatal care service area in 90 percent of facilities), a faetoscope (95 percent), iron tablets (88 percent), folic acid tablets combined with iron (79 percent), and tetanus toxoid vaccine (69 percent) (Table A-6.2). The importance of the missing faetoscope is debatable, as an adult stethoscope can be used to listen for the foetal heartbeat; the absence of folic acid and iron tablets (assessed in the facility pharmacy), however, is important. All of these items (blood pressure apparatus, faetoscope, iron and folic acid tablets, and tetanus toxoid vaccine were found in half of the facilities, though hospitals (81 percent) were far more likely to have all items. Clinics (41 percent) and PMHs (40 percent) were least likely to have all of these items (Table 6.2).

Key Findings

Individual client cards were available in eight out of 10 facilities.

Written antenatal care protocols or guidelines and visual aids for health education were available in more than half of facilities (63 and 57 percent, respectively), with the other private facilities better supplied.

Water, soap, and clean gloves were available in most facilities (88, 88, and 71 percent, respectively).

Iron and folic acid tablets were lacking in 11 and 21 percent of facilities, respectively.

Other private facilities were better equipped and better supplied than public and private religious facilities.

6.3.2 Equipment and Recourses for Quality Antenatal Care and Postnatal Care Services

Table 6.3 demonstrates facility practices and recourses for diagnosis and management of common complications during pregnancy, and Table A-6.3 provides detailed information on specific medicines and standards for antenatal care services. Figure 6.2 shows the percentage of facilities offering antenatal care where specified tests, malaria prophylaxis, and STI treatment are routine components of antenatal care services, and it shows their availability on the day of survey.

Table 6.3 Facility practices and recourses for diagnosis and management of common complications of pregnancy							
Percentage of facilities where antenatal care providers can diagnose and treat STIs, percentage of facilities with medicines to manage common complications of pregnancy, and percentage of facilities with testing capacity for urine protein, anaemia, syphilis, and HIV/AIDS, by type of facility, operating authority, and region, Ghana SPA 2002							
Background characteristics	Percentage where STI treatment is provided by antenatal care providers	Percentage with medicines to manage common complications of pregnancy ¹	Percentage of facilities with testing capacity for:				Weighted number of facilities offering antenatal care
			Urine protein ²	Anaemia ³	Syphilis ⁴	HIV/AIDS ⁵	
Type of facility							
Hospital	18	26	99	92	52	84	40
Health centre	36	1	45	49	2	2	149
Clinic	34	3	61	45	5	8	94
PMH	79	8	73	65	1	0	91
Operating authority							
Public	32	3	55	51	8	12	246
Private religious	34	20	75	70	27	45	35
Other private	80	8	73	65	1	0	94
Region							
Western	43	12	58	63	7	15	31
Central	40	8	86	73	8	14	28
Greater Accra	65	2	69	55	20	4	26
Volta	37	1	50	48	8	12	53
Eastern	56	12	69	72	8	11	48
Ashanti	31	2	82	62	7	18	68
Brong Ahafo	54	8	83	78	8	8	46
Northern	34	4	29	19	7	9	36
Upper East	9	4	21	28	0	6	16
Upper West	73	5	13	35	0	8	22
Total	44	6	62	57	8	12	375
¹ Antibiotic for antenatal care or postnatal care infections (amoxicillin or co-trimoxazole), metronidazole, nystatin, a deworming medicine, an antimalarial, and at least one medication for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis ² Clinistix or "other urine test" (usually flame and acetic acid) ³ Includes any test (haemoglobinometer, or calorimeter, or centrifuge with capillary tubes, or filter paper methods) ⁴ Venereal disease research laboratory (VDRL) kit and functioning microscope or rapid plasma reagin (RPR) kit ⁵ Any HIV test (specific ones assessed were rapid test, enzyme-linked immunosorbent assay (ELISA), Western blot, and HIV SPOT test)							

Hypertensive disorder of pregnancy (preeclampsia), anaemia, malaria, STIs, and worm or vaginal infections are conditions that are directly related to both maternal and newborn health. Basic essential obstetric care (BEOC) requires a facility to provide early treatment for the common problems and complications of pregnancy to prevent progression to more serious problems.

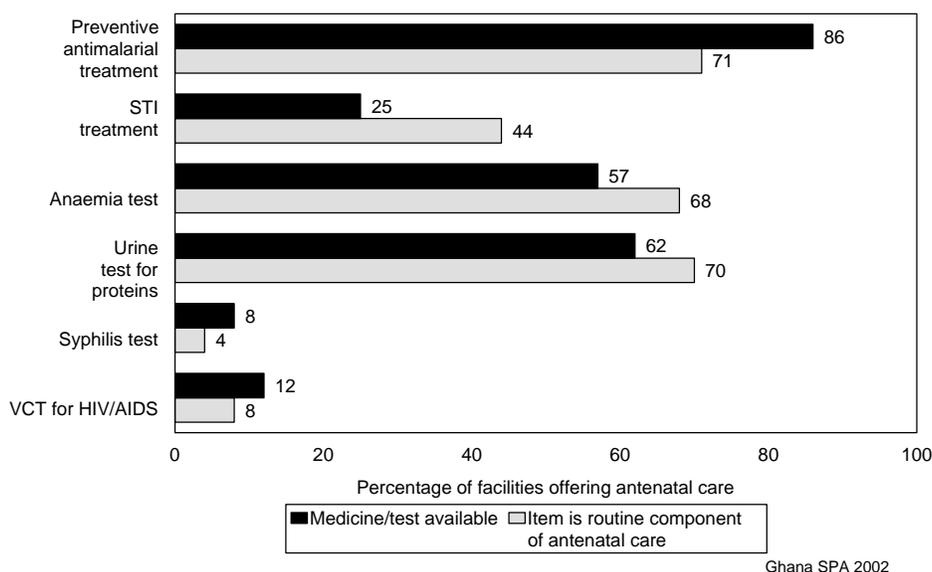
Treatment of STIs by antenatal care providers, where antenatal care providers can diagnose and prescribe treatment for clients with symptoms without referring the clients elsewhere, was a routine component of antenatal care in 44 percent of facilities (Table 6.3). In only 18 percent of hospitals were these services

integrated, which is not surprising because specialized services are more common in hospitals. In 8 out of 10 PMHs, STI treatment was offered by providers that also offered antenatal care services.

Eighty-two percent of facilities had an antibiotic (either amoxicillin or co-trimoxazole) for managing urinary tract infections or postpartum infections, and 25 percent had medicines to manage the four major STIs (trichomoniasis, chlamydia, syphilis, and gonorrhoea), with a medicine for treating gonorrhoea most often lacking (Table A-6.3). An antimalarial was available in 86 percent of facilities. Only 11 percent of facilities had a medicine for candidiasis—a common vaginal infection—and treatment for worms (anthelmintic) was available in 68 percent of facilities. Only 6 percent of facilities offering antenatal care services had all medicines to manage common complications of pregnancy—an antibiotic for antenatal care or postnatal care infections (amoxicillin or co-trimoxazole), metronidazole, nystatin, a deworming medicine, an antimalarial, and at least one medication for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis. Hospitals and private religious facilities were best supplied (Table 6.3).

Some health issues are exacerbated during pregnancy or can have an impact on the newborn. Laboratory tests for anaemia, urine protein (for preeclampsia), and urine glucose (diabetes) can either identify or facilitate early detection of these conditions. It is helpful to have a picture of the proportion of facilities that indicate they routinely provide these tests during pregnancy and those that were observed to have the laboratory capacity (all equipment and, where applicable, reagents) to conduct the test in house. Figure 6.2 shows that malaria prophylaxis was available in 86 percent of facilities but was reported to be a routine component of antenatal care in only 71 percent. Approximately 7 out of 10 facilities report routinely including anaemia testing and urine testing for protein in antenatal care. The tests for anaemia and protein, however, were actually available in only 57 and 62 percent of facilities, respectively.

Figure 6.2 Percentage of facilities offering antenatal care where indicated item is routine component of antenatal care and medicine or test was available the day of the survey (N=375)



Testing urine for sugar was reported as routine in only half of all facilities (Table A-6.3). Voluntary counselling and testing (VCT) for HIV/AIDS (8 percent) and syphilis testing (4 percent) are clearly not routine components of antenatal care in Ghana. Only 30 percent of the hospitals report syphilis testing as routine, and 24 percent report VCT for HIV/AIDS as a routine part of antenatal care services. The low

percentage cannot be totally explained by a shortage of test materials because, for both tests, the percentage of facilities having the test available was higher than those for which it was a routine component. Another possible explanation could be that the staff are not trained to provide VCT at antenatal care services. Until now, staff have only been trained when a prevention of mother-to-child transmission (PMTCT) programme exists at the facility.

Finally, 71 percent of facilities indicated that discussion of family planning was a routine component of antenatal care during the last trimester of pregnancy (Table A-6.3).

The GSPA survey did not collect detailed information on postnatal care, although in most facilities, if a woman comes for routine postnatal care, she will be seen by the same provider, in the same service area, as for antenatal care. Information on the infrastructure and recourses for counselling, physical examination, and management of common complications during pregnancy is therefore relevant to the capacity to provide quality routine postnatal care. In addition, there should be an infant weighing scale for the newborn and a thermometer to assess postpartum infection. A thermometer was in the antenatal care service delivery area for 81 percent of facilities, while a functioning infant scale was available in only 66 percent of facilities. Health centres and PMHs were most likely to have an infant scale in the antenatal care area (70 percent) (Table A-6.3).

Key Findings
<p>The lack of medicines to manage common complications during pregnancy was obvious in all facilities, including hospitals. Most commonly missing was treatment for gonorrhoea and vaginal candidiasis.</p> <p>Forty-four percent of facilities offering antenatal care services reported that antenatal care providers were prescribing STI treatment, with PMHs most likely and hospitals least likely to have this service integrated.</p> <p>Anaemia testing (68 percent), testing protein in urine (70 percent), and malaria prophylaxis prescriptions (71 percent) were commonly reported as routine components of antenatal care. However, syphilis testing (4 percent) and VCT for HIV/AIDS (8 percent) were not. Hospitals were most likely to routinely include all tests in antenatal care services.</p> <p>Family planning counselling was part of antenatal care in 71 percent of facilities.</p> <p>Sixty-six percent of facilities had an infant weighing scale for newborns, and 81 percent had a thermometer for postnatal care.</p>

6.4 Management Practices Supportive of Quality Antenatal Care and Postnatal Care Services

Management practices that were assessed include the following:

- Facility documentation and records
- Charging practices for antenatal care
- Supervision and staff development.

Table 6.4 provides information on each of these components, while Figure 6.3 provides details of specific training topics. Tables A-6.4 and A-6.5 give details on when providers received in-service training and the type of education received by type of facility, operating authority, and region.

Up-to-date antenatal care registers that included an entry in the past seven days and indicated, at minimum, whether the visit was a first or follow up visit were available in 88 percent of facilities (Table 6.4). A register for postnatal care clients was observed in 40 percent of facilities. The median number of antenatal care visits per month was 60 for all facilities, ranging from 310 for hospitals to between 30 and 78 for other types of facilities. The median monthly postnatal care visits were considerably lower, ranging from 45 for hospitals to 7 for PMHs (data not shown).

The GSPA survey also assessed whether the facility had any documentation indicating that it monitors the proportion of eligible women in its catchment areas who receive antenatal care services, either at the facility or by facility staff. Twenty-seven percent of all facilities had documentation indicating that they monitored their antenatal care coverage, with health centres (43 percent) more likely to monitor this than others (Table 6.4).

Table 6.4 Management practices supportive of quality maternal health services							
Percentage of facilities with up-to-date antenatal care and postnatal care registers, percentage with documented monitoring of antenatal care coverage, percentage where at least half of the interviewed providers of family planning services were personally supervised during the past 6 months, received related in-service training during the past 12 months, and were both supervised in the past 6 months and received in-service training related to family planning services during the past 12 months, by type of facility, operating authority, and region, Ghana SPA 2002							
Background characteristics	Percentage of facilities:						
	With up-to-date register for: ¹		With documented monitoring of antenatal care coverage	Where at least half of interviewed antenatal care providers: ²			Weighted number of facilities offering antenatal care
	Antenatal care	Post-natal care		Were personally supervised in past 6 months	Received in-service training in past 12 months ³	Were personally supervised in past 6 months and received in-service training in past 12 months	
Type of facility							
Hospital	92	65	29	40	51	20	40
Health centre	93	43	43	62	50	32	149
Clinic	83	27	21	58	41	26	94
PMH	84	35	5	47	50	30	91
Operating authority							
Public	90	42	35	59	48	29	246
Private religious	92	38	24	48	41	24	35
Other private	83	35	4	47	51	30	94
Region							
Western	98	19	19	50	58	43	31
Central	96	63	20	33	59	27	28
Greater Accra	96	50	17	63	44	29	26
Volta	82	27	22	57	34	20	53
Eastern	86	38	35	47	43	22	48
Ashanti	86	38	30	42	37	18	68
Brong Ahafo	86	57	27	74	45	34	46
Northern	93	34	17	69	49	31	36
Upper East	61	35	20	61	100	61	16
Upper West	100	42	60	67	71	46	22
Total	88	40	27	55	48	29	375

¹ Register has entry within previous 7 days and indicates, at minimum, whether this was the first or a follow-up visit for antenatal care and number of days postpartum for postnatal care register.

² Six facilities that offer antenatal care did not have an antenatal care provider interviewed.

³ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

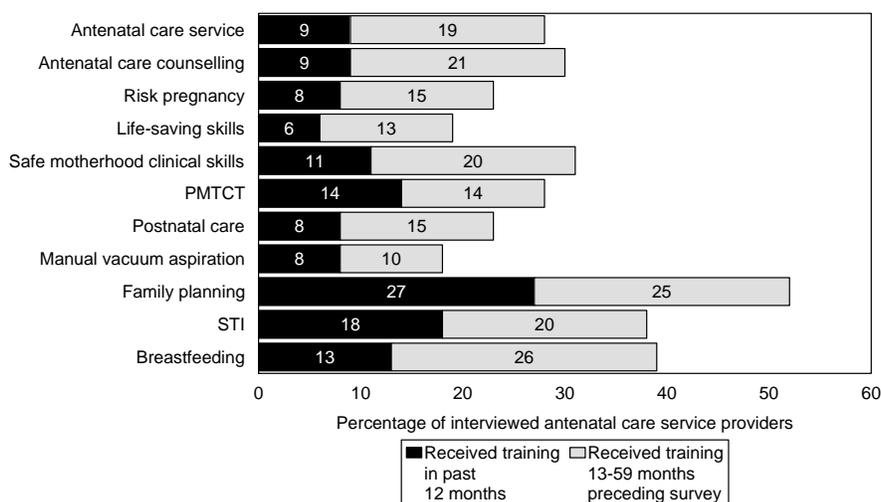
User fees may provide additional funds to improve services, or they may act as a deterrent to utilization. The official policy of the Ghana Health Service is that the first four antenatal care visits are free at district level and below; however, this does not include all laboratory tests and medicines. Among the observed and subsequently interviewed first-visit antenatal care clients, 83 percent reported paying out-of-pocket charges (includes any amount paid out of pocket, including payments for consultations, medicines, laboratory tests, or other) for this visit (Table A-6.6). The median out-of-pocket payment was 2,043 cedis for those belonging to a prepay programme and 7,076 cedis for those who did not. Of the follow up antenatal care clients, 79 percent paid any out-of-pocket expenses, with a median payment of 2,096 cedis for those belonging to a prepay programme and 5,039 cedis for those who did not (data not shown).

In 48 percent of facilities, at least half of the interviewed antenatal care service providers indicated that they had received some formal in-service training during the 12 months before the survey (Table 6.4). Forty-one percent of all interviewed antenatal care providers had received in-service training during the past 12 months (Table A-6.4). An additional 32 percent of providers indicated that they had not received formal in-service training during the past 12 months but had received it 13-59 months preceding the survey. Figure 6.3 and Table A-6.5 give an overview of the different topics and the percentage of interviewed providers receiving specific in-service training.

In 55 percent of facilities, at least half of the interviewed antenatal care service providers had been personally supervised during the 6 months preceding the survey (Table 6.4). Fifty-one percent of all interviewed antenatal care service providers had been supervised (Table A-6.4). The staff were visited a median of two times during the past 6 months, and when asked what their supervisor had done, providers said that they had checked their records (87 percent), observed their work (82 percent), provided feedback (65 percent), provided information updates (57 percent), and discussed problems (91 percent) (data not shown).

At least half of the interviewed antenatal care service providers in 29 percent of the facilities providing antenatal care services were personally supervised during the past 6 months and received in-service training during the past 12 months.

Figure 6.3 In-service training received by interviewed antenatal care service providers, by topic and timing of most recent training (N=777)



Ghana SPA 2002

Key Findings

Up-to-date registers for antenatal care were available in 88 percent of facilities that provide antenatal care services, and registers for postnatal care were available in 40 percent of facilities offering antenatal care services.

Monitoring antenatal care coverage is not a routine activity (occurring in only 27 percent of facilities offering antenatal care services). Health centres are most likely to carry this out (43 percent), and PMHs are least likely (5 percent).

Forty-one percent of providers received formal, in-service training during the past 12 months, and an additional 32 percent received related in-service training during the 13-59 months preceding the survey.

Approximately half of the antenatal care service providers were personally supervised during the past 6 months.

6.5 Adherence to Standards for Quality Antenatal Care Service Provision

Observers watched the process used when antenatal care clients were seen at the facility, noting information shared and procedures or examinations conducted. Checklists based on elements of focused antenatal care and additional elements that are part of the antenatal care process in Ghana were used to collect information on whether the consultation process during antenatal care included the following:

- Appropriate assessment and examination for the visit number and gestational age
- Health education provided with appropriate content to promote health
- Adherence to practices to support continuity of care.

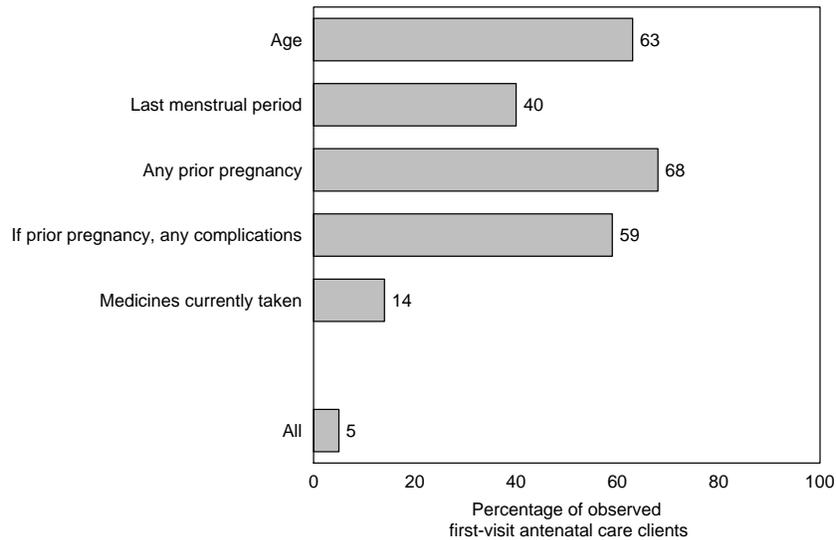
The objective in the observations of consultations was to note whether information on a topic was shared (process information). An assessment of whether the information was correct or findings were appropriately interpreted was not a component of the observation.

Because of the limited days per week when antenatal care services were routinely available, special efforts were made to schedule the survey for the day of antenatal care. This was possible for 82 percent of facilities (Table 6.1). The rest of the facilities were revisited on an antenatal care day solely for the purpose of observing the care process.

Among the observed antenatal care clients, it was the first visit for 43 percent of the women (Table A-6.7) and the first pregnancy for 27 percent. Eighteen percent of the women were estimated to be less than 5 months pregnant, and 32 percent were estimated to be at least 8 months pregnant.

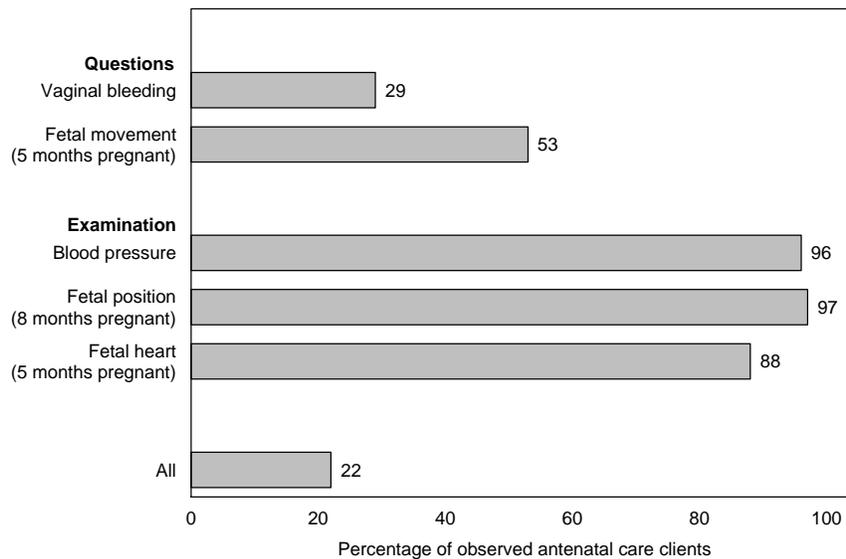
Figures 6.4 and 6.5 summarize the content of consultation for antenatal care clients, and Figure 6.6 provides details of specific preventive and diagnostic interventions provided. Table A-6.7 gives characteristics of observed ANC clients, and Table A-6.8 provides details about other complications of prior pregnancies that were asked about, by facility type. Tables A-6.9 and A-6.10 give further details on the content of consultations, by facility type and operating authority.

Figure 6.4 Content of consultation for observed first-visit antenatal care clients (N=756)



Ghana SPA 2002

Figure 6.5 Content of antenatal care consultation and examination for observed antenatal care clients (N=1,846)



Ghana SPA 2002

6.5.1 Assessment for Early Identification of Risk Signs or Symptoms

Among the first-visit clients, information was elicited about age (63 percent), date of last menstrual period (40 percent), and any prior pregnancy (68 percent) (Figure 6.4). Information about any complications with prior pregnancies was sought for 59 percent of women who had previously been pregnant. Only 14 percent of clients were asked about medicines being taken, and all relevant items were asked for 5 percent of the first-visit women.

Specific elements that were noted for quality assessment of the current health status of the antenatal care client were 1) checking for vaginal bleeding, 2) measuring blood pressure, 3) checking foetal heart rate (for women at least 5 months pregnant), 4) assessing foetal movement (for women at least 5 months pregnant), and 5) palpating foetal position (for women at least 8 months pregnant).

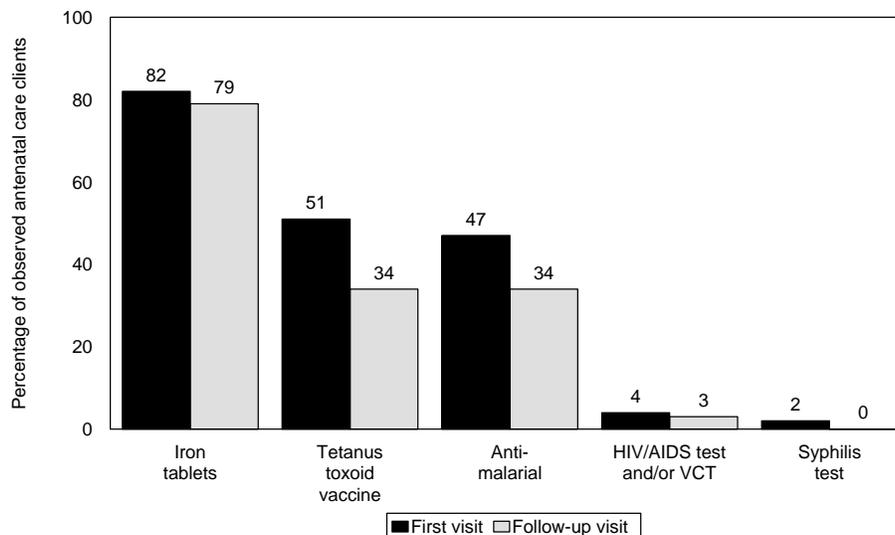
Among all observed antenatal care clients, 29 percent were asked about vaginal bleeding, and 53 percent of women at least 5 months pregnant were asked about foetal movement (Table A-6.9 and Figure 6.5). Almost all women (96 percent) had their blood pressure taken, and the foetal position was palpated for an equal proportion (96 percent) of women at least 8 months pregnant. The foetal heart was listened to in 88 percent of those at least 5 months pregnant. Twenty-two percent of women were subjected to all relevant components for monitoring pregnancy, with the examination being the part most frequently carried out. Table A-6.9 provides more details by type of facility and operating authority.

In addition to the basic examinations, weight was measured for 96 percent of women, and the fundal height was either palpated or measured for 94 percent (Table A-6.9).

Laboratory facilities and cold chain maintenance capability are required for some screening and preventive interventions. Where a facility does not have the capacity to provide the service itself, it should have a referral site that will provide the service to the antenatal care client. Some interventions, however, such as provision of iron tablets, require minimal support and should be available universally.

Figure 6.6 indicates that approximately eight out of ten antenatal care clients were given or prescribed iron tablets. Tetanus toxoid was given or prescribed for 51 percent of first-visit clients and 34 percent of follow up clients; about the same percentage of clients were given an antimalarial (47 and 34 for first-visit and follow up clients, respectively). As already discussed, syphilis or HIV/AIDS testing was not commonly ordered (both less than 5 percent). Table A-6.10 provides details on the prescription of preventive medicines and screening tests.

Figure 6.6 Preventive and diagnostic interventions received by observed first-visit (N=797) and follow-up visit (N=1049) antenatal care clients



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6.5.2 Supporting Continuity of Care

For quality antenatal care, continuity in care, which includes monitoring changes between visits, is important. One of the more reliable means to achieve this is to maintain a record of relevant history, findings, interventions, and treatments provided. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place before the client is seen by the antenatal care provider responsible for the consultation and the information is recorded on a client record.

Individual client cards were reviewed and written on for almost all observed antenatal care consultations. Table A-6.11 provides details on the use of the individual client cards, by facility type, operating authority, and first- or follow up-visit status.

Key Findings

Assessment of first-visit antenatal care clients does not uniformly include all items defined as important. The date of the last menstrual period (40 percent) and the current use of medication (14 percent) were assessed least frequently. Complications during prior pregnancies were assessed in 59 percent of the observed first-visit clients with prior pregnancy.

A complete assessment of the current health status was done in 22 percent of all observed antenatal care clients. Blood pressure and weight were measured in almost all clients (96 percent). The occurrence of vaginal bleeding and foetal movement was assessed least frequently (not carried out in 71 and 47 percent of consultations, respectively).

Most clients were prescribed or given iron tablets (approximately 80 percent), but preventive treatment with antimalarials was prescribed less frequently (47 percent for first-visit and 34 percent for follow up antenatal care clients).

Preventive screening for syphilis and HIV was done in less than 5 percent of antenatal care clients.

Individual client cards were used for almost all observed antenatal care consultations.

6.5.3 Counselling to Promote Healthy Outcome

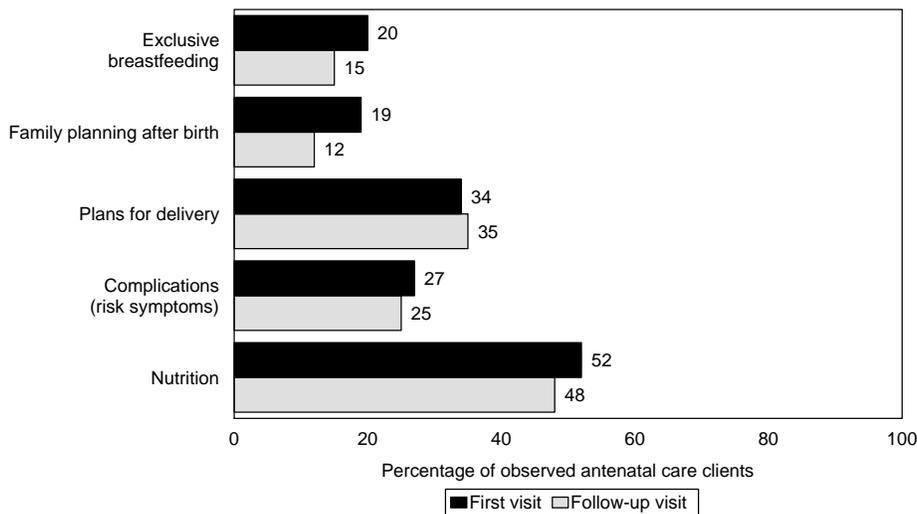
The common preventive interventions for antenatal care are provision of iron and folic acid tablets, TT vaccine, and prophylactic antimalarial treatment. To improve the chances that a client will accept preventive medicines and take them as required, providers should inform clients as to why the medicine is important and how to take it appropriately. Among the women who received or were prescribed iron or folic acid, 28 percent were observed receiving an explanation of the purpose of the medicine, and 65 percent were observed receiving information on how to take the pills (Table A-6.12). Among those who received or were prescribed tetanus toxoid vaccine, 28 percent were observed being told why it was necessary. The purpose of the antimalarial medicines was explained for 31 percent of clients, and instructions for use were provided to 71 percent of clients who received the medicines. There were no major differences in the frequency of explanations given between types of facilities, operating authorities, or regions.

Pregnant women also need to be aware of specific risk signs for which they should seek help, nutrition for a healthy pregnancy, and issues related to safe delivery and care of the newborn. Education related to

these issues should be a routine component of antenatal care counselling. It is interesting to know not only what was shared during the consultation, but also what the client understood and remembered after the consultation. The GSPA survey therefore collected information by observing the consultation and by interviewing the observed client after she had completed her visit. It is not unreasonable to assume that not all components of counselling are discussed each visit, given that a woman makes multiple antenatal care visits. Thus, the content of counselling for first and follow up visits was assessed separately.

Figure 6.7 provides information on topics discussed during the observed antenatal care consultation, both for first visit or follow-up visits. Exclusive breastfeeding was discussed in 20 percent of first visits and in 15 percent of follow-up visits. Discussion about family planning was not common (19 percent for first visit and 12 percent for follow-up visits). Discussion of the progress of the pregnancy and delivery plans was observed for over one-third of the observed antenatal care clients. Risk symptoms for seeking help (vaginal bleeding, fever, shortness of breath, swelling of hands or face, headache, or blurred vision) were discussed with 27 percent of first-visit antenatal care clients and 25 percent of follow up antenatal care clients. Nutrition was the topic most commonly discussed, and it was part of approximately half of all antenatal care client consultations, both for the first visit and follow-up visits (Table A-6.13). More detailed information on specific risk symptoms, discussed by type of facility and operating authority, is in Table A-6.13.

Figure 6.7 Health education topics discussed with observed first-visit (N=797) and follow-up-visit (N=1,049) antenatal care clients

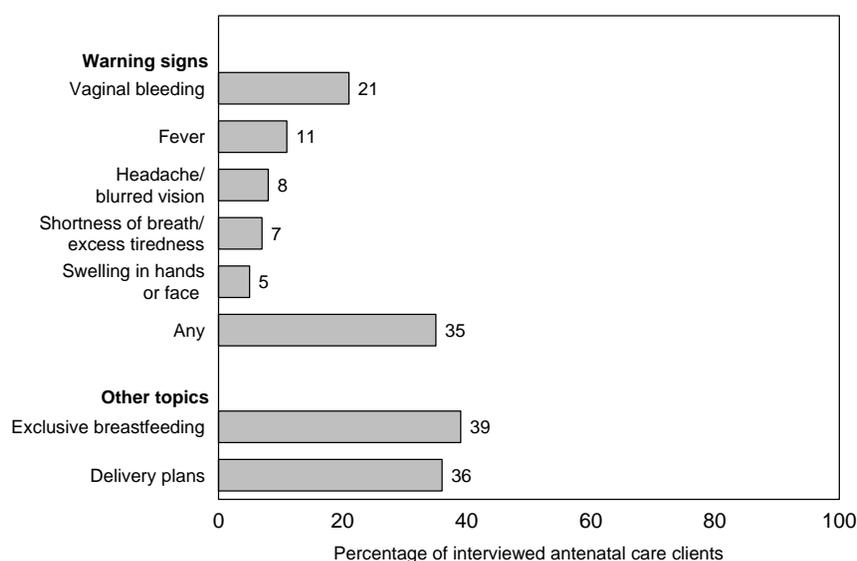


Ghana SPA 2002

While 35 percent of the interviewed clients said that they had been told about warning signs (either during this or a prior visit), when asked to name any risk symptoms (without prompting), only 21 percent mentioned vaginal bleeding as a risk sign (Table A-6.13 and Figure 6.8). This does not necessarily mean that they are unaware of this risk sign (on exiting, many clients are in a hurry to leave and so may not reflect in depth of their responses), but it does imply that it is not a symptom that comes quickly to mind. Eleven percent of the women mentioned fever, 8 percent mentioned headache or blurred vision, 7 percent mentioned tiredness or breathlessness, and 5 percent noted swollen face or hands as risk symptoms. Thirty-nine percent of the interviewed antenatal care clients reported that exclusive breastfeeding was discussed, and all said that they were advised about exclusive breastfeeding for six months (data not shown).

It is expected that there will be differences between observed information sharing and what a client recalls. This may be due to a client forgetting or not understanding elements of counselling, a client recalling information shared during a prior visit or received elsewhere as information from the current visit, or an observer not hearing some elements of counselling. In the case of exclusive breastfeeding, the difference was quite obvious (39 percent reported by client, versus 20 and 15 percent observed for first and follow up visits, respectively). In the case of discussions on nutrition and delivery plans, there were no major differences (Table A-6.11).

Figure 6.8 Topics discussed during antenatal care consultation, reported by interviewed antenatal care clients (N=1,819)



Ghana SPA 2002

Key Findings

Nutrition during pregnancy was the topic most often discussed during counselling (in approximately half of all antenatal care client consultations).

Advice on risk symptoms is not a routine component of antenatal care counselling (observed for 27 percent of first-visit clients and 25 percent of follow-up clients and reported by 35 percent of all clients).

Counselling on exclusive breastfeeding was observed in 20 percent of first visits and 15 percent of follow up antenatal care visits.

Discussion on family planning was not common (19 percent for first-visit antenatal care clients and 12 percent for follow-up antenatal care clients).

6.6 Client Opinion from Exit Interviews

Observed antenatal care clients were interviewed before leaving the facility for their opinions on the services and about problems encountered on the day of the visit. Similar to findings from other services, much dissatisfaction was not noted; however, the issue of greatest concern was a long waiting time (8 percent of clients). Table A-6.14 provides details on client feedback.

When asked where they planned to deliver, 68 percent indicated that they would deliver at the facility where they were receiving antenatal care, 10 percent indicated another facility, 9 percent said a private home (their own home or home of relatives/friends), and 13 percent were uncertain (data not shown). These findings are different from the actual reported patterns for delivery noted in the 1998 GDHS, where only 43 percent of the women indicated that they gave birth in facilities, and more than half said that they delivered at home. This difference could be due to the difference in women surveyed. The GDHS surveyed women at home, while the GSPA surveyed women who had already visited a facility and, therefore, might be more likely to deliver at a facility.

Among the observed antenatal care clients, 81 percent went home after their consultation, 14 percent were referred within the facility for additional consultation or treatment, 1 percent was referred outside the facility, and 1 percent was admitted to the facility (data not shown).

6.7 Availability of Delivery Services and Capacity to Provide Quality Delivery Care

The availability of emergency obstetric care services and the presence of standards, equipment and supplies, and health system components to support quality delivery services were assessed. Specific items that were assessed include the following:

- Components of comprehensive essential obstetric care services
- Support for safe home deliveries
- Infrastructure and recourses to support quality delivery services.

Because of recourse and logistic constraints, it is not possible to find facilities that cannot provide all services required to meet comprehensive essential obstetric care (CEOOC) standards. When facilities cannot provide all necessary services, they should have systems in place to help a woman receive the required services. For example, a facility that does not provide emergency obstetric care (EmOC) should have an emergency transportation plan that supports appropriate referrals to ensure access to life-saving interventions.

6.7.1 Availability of Components of Comprehensive Essential Obstetric Care Services

Almost all facilities offer antenatal care (88 percent) and normal delivery services (83 percent), and 79 percent offer both. PMHs and hospitals are most likely and clinics are least likely to provide both services. Caesarean sections are mainly provided in hospitals (92 percent). Specific details on the differences by types of facilities, operating authorities, and regions are presented in Table 6.5.

A system for rapidly transferring a critically ill maternity case to a higher level of care is essential for improving maternal and infant health, especially since caesarean section services are not widely available. Without a facility system, the client and family are left to their own devices to arrange for transportation during an emergency. Only 41 percent of facilities reported that they had some system to support transportation for maternity emergencies requiring transfer. Hospitals were more likely to have a system for emergency transportation (88 percent) than clinics (21 percent) or other types of health facilities. Among the facilities that did have some arrangement for emergency transportation, the arrangements

were described as a dedicated emergency vehicle located at the facility (44 percent), an official arrangement where the vehicle was based elsewhere (usually at a hospital), the referring facility (most often a health centre or clinic) calling for the vehicle when needed (14 percent), or other means (multipurpose vehicle or funds to pay for a hired vehicle) (79 percent). The responses indicate that some facilities use several systems and that they most likely have a backup system for instances when the facility-based vehicle is not available (Table A-6.15).

Table 6.5 Availability of maternal health services									
Percentage of facilities that provide antenatal care, delivery services, caesarean sections, both antenatal care and delivery services, antenatal care, delivery services, and caesarean sections, percentage having a system for emergency transportation, percentage providing any home delivery services, and percentage with documentation of activities with traditional birth attendants (TBAs), by type of facility, operating authority, and region, Ghana SPA 2002									
Background characteristics	Percentage of facilities with:								
	Ante-natal care	Normal delivery services	Caesarean section	Antenatal care and normal delivery services	Antenatal care, normal delivery, and caesarean section	Emergency transportation support for maternity emergencies ¹	Any home delivery services ²	Documented official programme supportive of TBAs ³	Weighted number of facilities
Type of facility									
Hospital	94	96	92	91	87	88	6	15	43
Health centre	90	88	2	85	2	21	34	44	166
Clinic	76	62	4	57	4	45	18	25	125
PMH	96	97	1	94	1	50	45	1	95
Operating authority									
Public	85	79	11	75	11	32	25	35	288
Private religious	88	90	42	84	37	82	18	23	39
Other private	93	93	1	90	1	51	43	2	100
Region									
Western	79	82	17	69	17	33	15	10	39
Central	95	99	11	95	11	28	27	31	30
Greater Accra	95	90	11	87	11	77	13	8	28
Volta	72	62	8	58	8	24	14	25	74
Eastern	96	84	9	84	9	39	25	39	50
Ashanti	96	98	19	95	19	54	31	20	71
Brong Ahafo	85	89	7	82	6	47	44	28	54
Northern	87	82	9	79	8	65	44	25	41
Upper East	81	52	8	49	6	20	25	27	20
Upper West	100	100	8	100	8	9	66	59	22
Total	88	83	11	79	11	41	29	26	428

¹ Any system where the facility provides some support for emergency transportation to referral site, or facility is referral site
² This may be either a routine service or only for emergency cases
³ Any official activity with TBAs for which the facility has any documentation

The median transportation time (starting from the time the vehicle was called for, if the vehicle was based at another facility) was 31 minutes, and no major variation was reported between seasons (Table A-6.15).

6.7.2 Support for Safe Home Deliveries

In countries where a large proportion of deliveries take place at home, frequently with the assistance of TBAs, a support system from a facility may increase the chances of a safe delivery. The following support systems are commonly used: the facility staff routinely attend home births, the facility staff provide emergency assistance for home births, and the facility staff develop other programmes to support TBAs. While women are encouraged to choose delivery providers who are trained to a higher skill level than most TBAs, the reality is that for a variety of reasons, many women continue to choose TBAs for

their delivery care. Where home deliveries by TBAs are common, formal links with health facilities are often encouraged. Some evidence exists that TBAs with some link to the formal health sector are more likely to refer women appropriately and adopt safer delivery practices (Maternal and Neonatal Health Programme, 2002a).

The Ministry of Health (MoH) and some nongovernment organizations (NGOs) have programmes to train and develop links between the health system and TBAs to promote general health and improve delivery services. In addition to the official MoH-sponsored training, a facility may have its own, less formal programmes to work with TBAs. The GSPA survey looked for documentation of some official relationship between the TBA and the facility (minutes or attendance from a meeting) for some assurance that the relationship was more structured than simply accepting TBA referrals or letting TBAs know they could call for help. Twenty-six percent of all facilities were able to demonstrate documentation of their programme with TBAs. As expected, health centres were most likely to have a documented official programme supportive of TBAs (44 percent). PMHs (1 percent) and hospitals (15 percent) were least likely to have such a programme.

Twenty-nine percent of all facilities indicated that they provide home delivery services, with only 2 percent saying that they routinely conducted home deliveries and 27 percent indicating that this was offered as an emergency service only. Health centres and PMHs were most likely to offer this emergency service (data not shown).

Key Findings
<p>Delivery services are available in 83 percent of all facilities, but caesarean sections are available in only 11 percent. Ninety-two percent of hospitals provide this service.</p> <p>Emergency transportation for maternity emergencies is available in less than half of the facilities (41 percent).</p> <p>Twenty-nine percent of facilities provide home delivery services, most frequently in private maternity homes and health centres; however, only 2 percent of facilities provide this service routinely.</p>

6.7.3 Infrastructure and Recourses to Support Quality Delivery Services

Infection is one of the most common causes of maternal and neonatal morbidity and mortality. Thus, infection prevention practices are essential for quality delivery care.

The GSPA survey assessed the presence of infection prevention items in the service area where deliveries are conducted. All items for infection prevention (water and soap, clean or sterile latex gloves, disinfecting solution, and a sharps box) were available in one out of three facilities (Table 6.6 and Figure 6.9). Water (90 percent), soap (91 percent), and clean gloves (87 percent) were available in almost all facilities (Table A-6.16). Disinfecting solution (59 percent) and sharps boxes (57 percent) were less commonly available. Single-use towels were available in half of all delivery service areas.

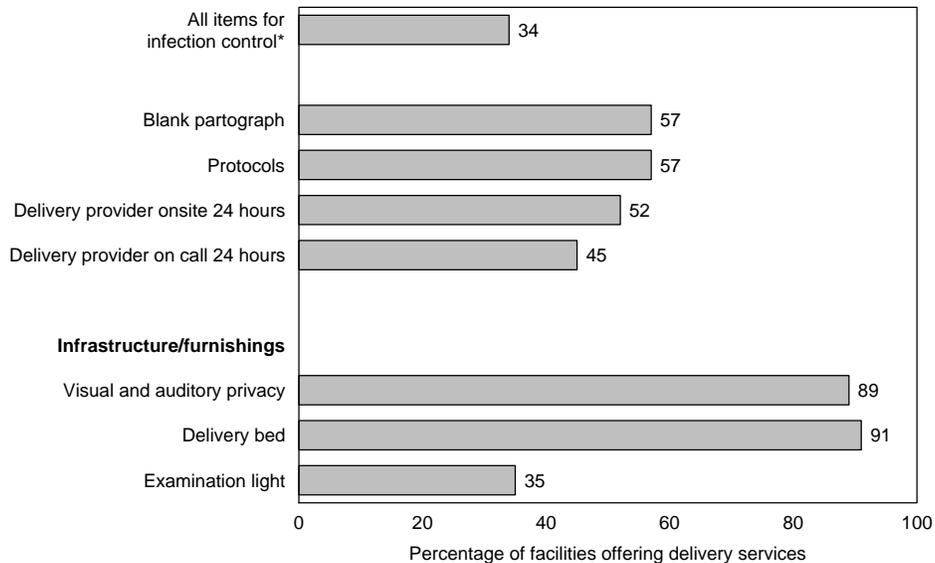
Table 6.6 Availability of elements for quality delivery services									
Percentage of facilities offering delivery services that had all items for infection prevention, all items to support quality delivery services, all delivery room infrastructure and furnishings, all basic supplies and medicines for delivery, all emergency medicines, and all items for complicated delivery, by type of facility, operating authority, and region, Ghana SPA 2002									
Background characteristics	Percentage of facilities with:								Weighted number of facilities offering delivery services
	All infection prevention items ¹	All items to support quality delivery services ²	All delivery room infrastructure and furnishings ³	All basic supplies for delivery ⁴	All basic medicines and equipment for normal delivery ⁵	All items for normal delivery ⁶	All emergency medicines ⁷	All items for complicated delivery ⁸	
Type of facility									
Hospital	70	77	53	41	75	16	43	10	41
Health centre	30	37	20	14	47	0	7	0	146
Clinic	24	12	17	12	44	0	2	0	78
PMH	33	55	51	17	54	1	8	0	92
Operating authority									
Public	32	36	24	13	47	2	8	1	228
Private religious	50	34	25	49	73	9	33	5	35
Other private	33	55	51	17	54	1	8	0	93
Region									
Western	22	25	44	21	50	0	16	0	32
Central	61	61	16	9	58	4	8	4	29
Greater Accra	37	53	44	20	55	4	6	2	25
Volta	16	37	35	14	46	1	9	1	46
Eastern	40	33	31	26	52	3	23	3	42
Ashanti	33	53	25	11	47	0	14	0	69
Brong Ahafo	32	43	41	14	69	5	5	1	48
Northern	43	16	25	17	26	0	6	0	34
Upper East	9	57	20	6	54	0	3	0	10
Upper West	40	32	22	45	66	7	0	0	22
Total	34	41	31	17	51	2	10	1	357
¹ Soap, water, sharps box, disinfecting solution, and clean gloves ² Partographs, protocols, and 24-hour delivery provider ³ Bed, examination light, and visual and auditory privacy ⁴ Scissors or blade, cord clamp, suction bulb, antibiotic eye ointment for newborn, and skin disinfectant ⁵ Needles and syringes, intravenous solution with infusion set, oral antibiotic (co-trimoxazole, amoxicillin, or ampicillin), injectable oxytocic, suture material, and needle holder ⁶ All items for infection prevention, to support quality, delivery room infrastructure, and basic medicines and supplies ⁷ Injectable: anticonvulsant (Valium or magnesium sulfate), antibiotic (penicillin and ampicillin, or gentamicin), and quinine ⁸ All items for normal delivery plus emergency medications									

Blank partographs were among the items assessed that support quality delivery services. The partograph, a document used to monitor a woman's labour, is being promoted internationally as a means to improve quality of care. It provides guidelines for monitoring and early identification of complications (Maternal and Neonatal Health Programme, 2002b). The blank partograph was found in more than half (57 percent) of the delivery service areas (Figure 6.9). Almost all hospitals (94 percent) were able to demonstrate the document, but only 4 out of 10 clinics were able to do so (Table A-6.16). Protocols or guidelines for deliveries and management of complications of deliveries were also available in more than half (57 percent) of the delivery service areas, and hospitals and PMHs were most likely to be able to show them.

The availability of a qualified delivery service provider for 24 hours, either onsite or on call with an on-call schedule observed, was assessed. In Ghana, any person with midwifery skills was defined as a qualified person to conduct deliveries. Over half (52 percent) of all facilities offering delivery services had a delivery provider onsite 24 hours (Figure 6.9 and Table A-6.16). Most of those providers were

medical doctors or midwives (45 percent), and the rest (7 percent) were other types of providers with midwifery skills (data not shown). In an additional 45 percent of facilities, the provider was on call for 24 hours, and a schedule was observed. Again, most providers were doctors or midwives (40 percent) (data not shown). It is assumed that an official schedule indicates that the health system expects a person to be available. Where there is no official schedule, the consistency with which a provider could routinely be found at night is uncertain.

Figure 6.9 Availability of specific items for quality delivery of services (N=357)



*Soap & water, latex gloves, disinfecting solution, sharps box

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Finally, the basic infrastructure and furnishings for the delivery room were assessed for a bed, an examination light, and visual and auditory privacy. In many countries, women cite lack of privacy as a reason for not using health facilities for delivery services. Almost all facilities (89 percent) provided visual and auditory privacy. An additional 2 percent provided visual privacy only, which means a screen or a curtain to separate the client from the rest of the service area. Essentially, all facilities (91 percent) had a delivery bed, but an examination light that could be aimed to visualize the perineum was lacking in 65 percent (Table A-6.16). All elements of infrastructure and furnishing for the delivery room were present in 31 percent of facilities, with hospitals and PMHs being best equipped (Table 6.6).

Key Findings

All infection prevention items were available in approximately one out of three facilities. Items most often lacking were the sharps box (missing in 43 percent of facilities) and disinfecting solution (missing in 41 percent of facilities).

Blank partographs were available in almost all hospitals (94 percent) but only in 57 percent of all facilities.

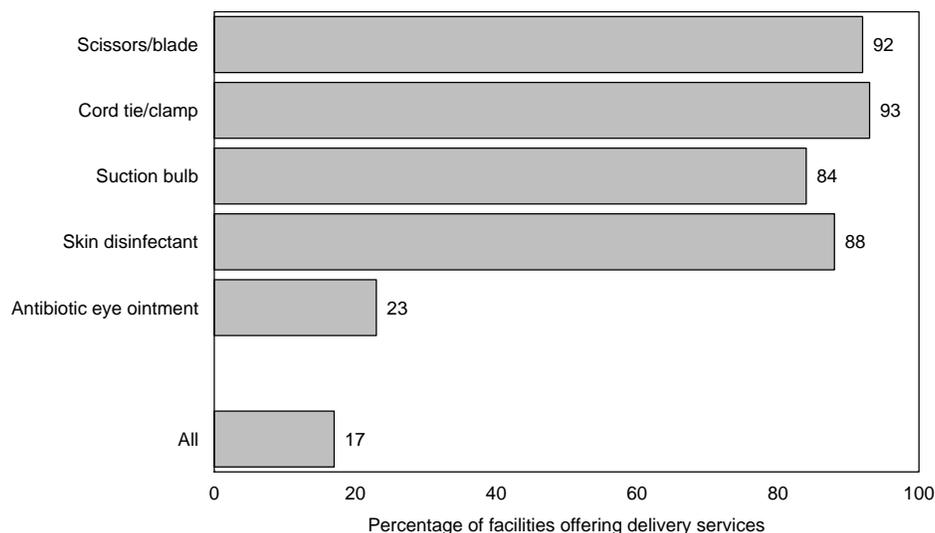
Delivery providers were onsite 24 hours in 52 percent of facilities, and an additional 45 percent of facilities had a provider on call, with a schedule present in the facility.

Visual and auditory privacy for delivery was ensured in 89 percent of facilities. An examination light was available in 35 percent of facilities.

6.7.4 Equipment and Recourses to Allow Quality Delivery Services

Almost all of the basic items assessed for delivery care were commonly available, as shown in Figure 6.10. These were scissors or a blade (92 percent) to cut the umbilical cord and, if necessary, conduct an episiotomy; materials to clamp or tie the umbilical cord (93 percent); a suction bulb or other means for suction of the newborn (84 percent); and a disinfectant to clean the perineal area (88 percent) (Table A-6.17). Antibiotic eye ointment, however, was available only in one out of four facilities. Therefore, all basic supplies were available in only 17 percent of facilities, with hospitals (41 percent) and private religious facilities (49 percent) being the best supplied (Table 6.6).

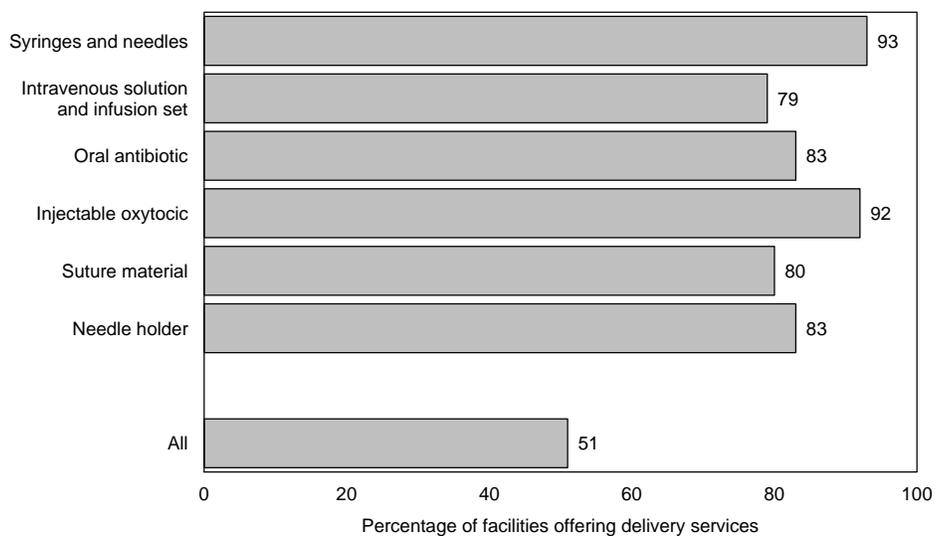
Figure 6.10 Availability of basic supplies and medicines for delivery (N=357)



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The medicines and supplies that are needed to manage common complications were assessed for availability, specifically in the delivery room where emergency use might be required, as well as in facility pharmacies. As indicated in Figure 6.11, syringes and needles were available in almost all (93 percent) (Table A-6.17 and Figure 6.11) delivery areas, and intravenous solution (dextrose and normal saline, normal saline, or Ringer's lactate) with infusion sets was available in 79 percent of the delivery areas (Table A-6.17). Also available in most delivery service areas were oral antibiotics (amoxicillin, ampicillin, or co-trimoxazole) (83 percent), injectable oxytocic medication (92 percent), suture materials (80 percent), and a needle holder for the suture procedure (83 percent). All equipment and medicines for basic treatment interventions were available in 51 percent of facilities; however, they were primarily available in hospitals (75 percent) (Table 6.6).

Figure 6.11 Availability of other supplies and medicines for delivery (N=357)



Ghana SPA 2002

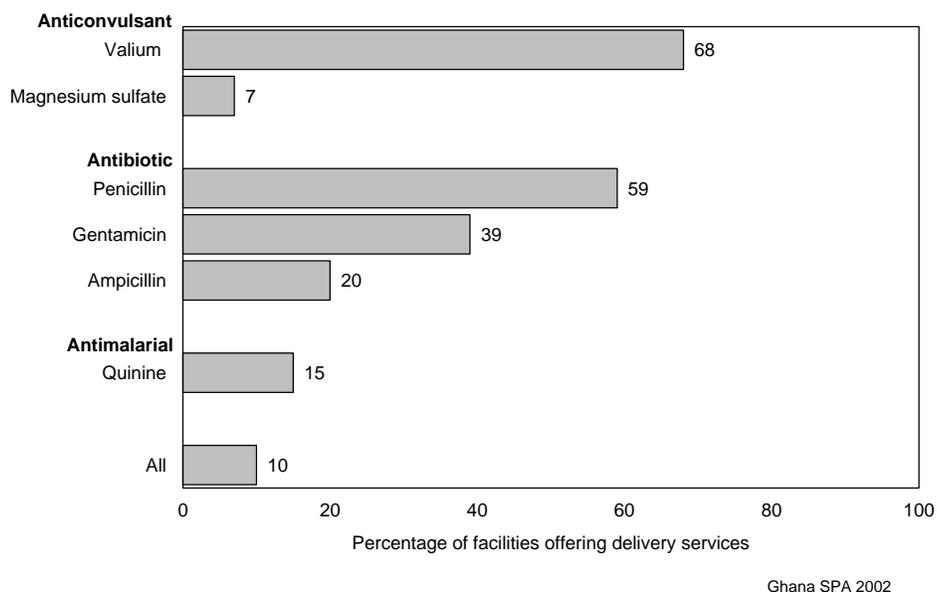
Medicines that were assessed for emergency situations were an anticonvulsant for eclampsia (Valium or magnesium sulfate), injectable antibiotics for sepsis (gentamicin, or both ampicillin and penicillin), and injectable quinine for malaria (which is endemic to Ghana). All were assessed for their availability in the facility pharmacy. Injectable Valium was available in 68 percent of facilities, with hospitals (86 percent) and private religious facilities (81 percent) most likely to have the medicine (Table A-6.17 and Figure 6.12). Magnesium sulfate was available in 7 percent of facilities and was most likely to be found in hospitals (41 percent). Of the injectable antibiotics, procaine penicillin was available in more than half of the facilities (59 percent), gentamicin in 39 percent, and ampicillin in 20 percent of the facilities offering delivery services. Injectable quinine was available in only 15 percent of pharmacies. All emergency medicines (an anticonvulsant, an antibiotic, and quinine) were available in only one out of ten facilities, with hospitals and private religious facilities being better supplied than others.

In addition to the previously mentioned equipment and supplies, a facility that provides delivery services should have the capacity to assist the delivery when contractions are ineffective (using either forceps or, preferably, a vacuum extractor) and should be able to provide postabortion care by removing retained materials from the uterus that contribute to haemorrhage and infection (dilatation and curettage [D&C] equipment or a vacuum aspirator). In cases where life-saving emergency obstetric care is required, the

capacity to provide a caesarean section and transfuse blood is essential. Sometimes a need develops for special equipment to support the newborn.

The GSPA survey found that one in four facilities had a vacuum extractor, and 3 percent had forceps (Table A-6.18). To remove retained products, 65 percent indicated that they were able to perform manual removal of a retained placenta, 11 percent indicated that they had a vacuum aspirator, but only 2 percent had a D&C kit. Hospitals and PMHs were most likely to have a vacuum extractor and vacuum aspirator. The percentage of facilities with a D&C kit seems very low (13 percent of hospitals and none of the other types of facilities). Therefore, further research might be required.

Figure 6.12 Availability of injectable emergency medicines among facilities providing delivery services (N=357)



Fifteen percent of facilities offer blood transfusion services, with almost all hospitals (96 percent) providing this service (Table A-6.18). Of those facilities, 71 percent have a blood bank, and 29 percent offer transfusions, but have no blood stored. The median number of units transferred in the month prior to the survey was 22, and 64 percent of those units were tested for HIV (data not shown).

Eleven percent of all facilities provide caesarean sections (Table 6.5), and most of these (88 percent) had an operating table and light, a scrub area adjacent to the operating room, and sterilized equipment (13 percent of all facilities offering delivery services) (Table A-6.18). In an additional 6 percent of facilities, the items were reported but not actually observed. All facilities had a provider either present or on call the day of survey to perform the caesarean section (data not shown).

Key Findings

All basic supplies that should be available for every delivery were available in only 17 percent of facilities offering delivery services. The item least available was antibiotic eye ointment, which was lacking in 77 percent of facilities.

All medication and equipment for basic treatment interventions were available in more than half of the facilities. Hospitals were best supplied (75 percent had all items). The intravenous solution with infusion set was most lacking (missing in 21 percent).

Injectable oxytocic medication was available in 92 percent of all facilities, and an anticonvulsant was available in 68 percent. Private religious facilities were best supplied.

Sixty-five percent of all facilities reported being capable of manual removal of a retained placenta, but only 11 percent indicated having a vacuum aspirator. Twenty-four percent had a vacuum extractor to assist complicated deliveries. Hospitals and PMHs were most likely to have the indicated equipment.

Fifteen percent of facilities offer blood transfusion services; hospitals are most likely to provide these services (96 percent).

Eleven percent of facilities provide caesarean section, and almost all (88 percent) had the necessary equipment.

6.8 Newborn Care Practices

The GSPA survey assessed equipment that provides emergency respiratory support (a resuscitator or ambu bag). An external heat source to maintain the body temperature in a premature newborn (incubator, heat lamp, or other device) was also assessed. Thirty-eight percent of facilities had equipment to give newborn respiratory support, and 11 percent had an external heat source. Private religious facilities were much better equipped than public or other private facilities were. Table A-6.19 provides information by type of facility, operating authority, and region.

The GSPA survey interviewed delivery service providers about routine newborn care practices at facilities. Information on these practices, by type of facility and operating authority, is provided in Table A-6.20. The use of catheter suction to stimulate respiration in newborns who are not breathing is not an uncommon practice. However, this should not be a routine practice for normal newborns. Twenty-one percent of facilities offering delivery services (38 percent of hospitals) indicated that they routinely suction the mouth and nose of the newborn with a catheter.

Hypothermia is a contributing factor to increased morbidity and death for newborns. To prevent hypothermia, full-immersion bathing should be avoided for the first few hours after birth; instead, the newborn should be dried and immediately given to the mother for skin-to-skin contact or be wrapped in a warm blanket. However, immediate, full-immersion bathing is a common practice in Ghana (82 percent of facilities).

Weighing the newborn provides health information to monitor postnatal care. Birth weight is also an indicator for risk of infant death. While almost all facilities (94 percent) indicated that they routinely weigh the newborn, only 85 percent had a functioning infant scale on the day of the survey.

Vitamin A supplementation in depleted children has been shown to decrease risk of infection and death. The safest and surest means for newborns to receive a healthy amount of vitamin A is through breast milk. Since pregnant women are at risk of developing vitamin A deficiency in areas where vitamin A deficiency is a problem, providing vitamin A to the mother immediately postpartum not only replaces depleted vitamin A in the mother, but also increases the vitamin A available to the newborn through breast milk. At the time of the survey, vitamin A was not yet on the essential drug list in Ghana, and postpartum vitamin A supplementation was not yet a national policy. This is reflected in the low percentage (12 percent) of facilities that provide vitamin A to mothers. Vitamin A has now been added to the essential drug list, and implementation is soon to start.

UNICEF advocates that the newborn receive a dose of oral polio vaccine (OPV) (considered as dose 0), after birth, for extra protection. The newborn should also receive BCG vaccine (for tuberculosis) before being sent home. OPV is provided to newborns in 44 percent of facilities, and BCG is provided in 34 percent. Private religious facilities are most likely to provide these services.

Rooming in, where the infant routinely stays with the mother (a practice to support exclusive breastfeeding and maternal-child bonding), is routinely practiced in most facilities (91 percent) (Table A-6.20).

Key Findings
<p>Thirty-eight percent of facilities had equipment to give newborn respiratory support, with private religious facilities (67 percent) being most likely to provide the service.</p> <p>One in five facilities indicated that they routinely use catheter suction to stimulate respiration in newborns, and 82 percent indicated that full-immersion bathing is a routine practice.</p> <p>Weighing the newborn and rooming in are routinely practiced in almost all facilities.</p> <p>OPV after birth (44 percent) and BCG before the newborn is sent home (34 percent) are routinely given in less than half of the facilities.</p> <p>Only 12 percent of facilities provide vitamin A to mothers.</p>

6.9 Management Practices Supportive of Quality Delivery Services

Practices assessed that support quality delivery services were:

- Facility documentation and records
- Systems for quality assurance
- Practices related to user fees
- Supervision and staff development.

Table 6.7 provides information on these items. Table A-6.21 breaks down training and supervision by type of facility, operating authority, and region. Figure 6.13 details specific training topics and their timing. Table A-6.22 gives details on specific topics included in in-service training, by type of facility, operating authority, and region.

A delivery register was defined as being up to date if there was an entry in the past 30 days (assuming there should be at least one birth per month in facilities that provide the service) and the entry, at a minimum, provided the birth outcome. Seventy-six percent of facilities had an up-to-date register (Table

6.7). The median number of deliveries per month in facilities reporting these data was 9, with a median of 65 for hospitals and 6 to 9 for other facilities. The median number of caesarean sections was eight per month (data not shown).

Facilities frequently have catchment populations for which they are responsible for providing services. Delivery coverage statistics are required for a facility to be able to monitor the proportion of births delivered by trained staff. The GSPA survey assesses whether the facility has any documentation indicating that it monitors the delivery coverage for its catchment population. One out of four facilities has the indicated documentation, with hospitals and health clinics being most likely to have it.

One quality assurance measure is to systematically review all maternal and newborn deaths or near deaths to develop interventions to decrease or prevent these events. The GSPA survey does not assess the quality of these review programmes, but it does assess whether facilities have implemented the process. One in five facilities had some documentation to indicate that they conduct reviews of maternal or newborn deaths or near deaths. This was more likely to occur in hospitals (77 percent) (Table 6.7).

The GSPA survey documents the percentage of facilities where user fees are collected for delivery services. Almost all facilities charged routinely for normal delivery services (89 percent).

Table 6.7 Facility-based supportive management practices

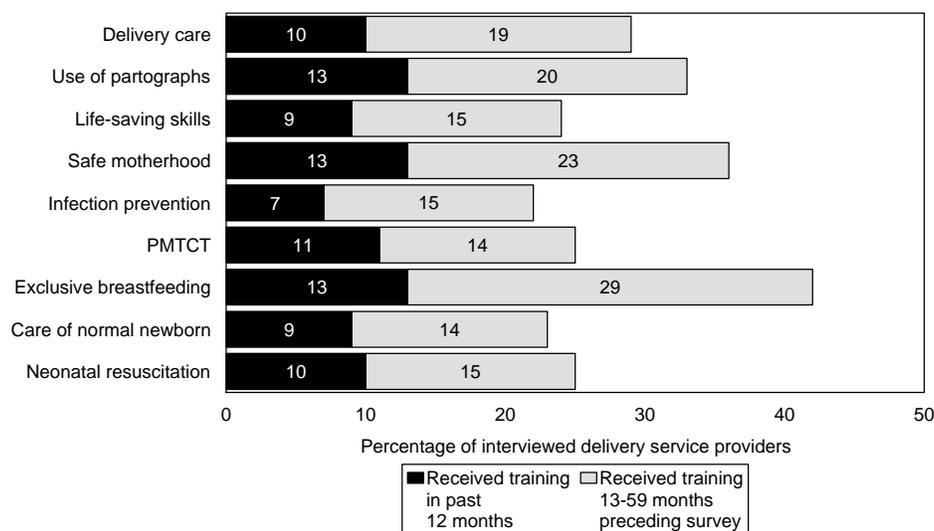
Among facilities providing delivery services, percentage with an up-to-date delivery register, percentage with documented monitoring of delivery coverage, percentage of facilities that monitor maternal and newborn deaths or near misses, percentage where at least half of the interviewed delivery service providers were supervised at least once in the past 6 months and received any related in-service training in the 12 months preceding the survey, and percentage of facilities that charge for normal deliveries, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities:							
	Where at least half of interviewed antenatal care providers ²							
	With up-to-date register ¹	With documented monitoring of delivery coverage	That review maternal/newborn deaths or near misses	Were personally supervised in past 6 months	Received in-service training in past 12 months ³	Were personally supervised in past 6 months and received in-service training in past 12 months	Percentage of facilities that charge for normal deliveries	Weighted number of facilities with delivery services
Type of facility								
Hospital	84	32	77	42	31	9	97	41
Health centre	73	37	17	59	30	23	78	146
Clinic	69	19	7	53	17	9	90	78
PMH	82	4	9	48	36	23	99	92
Operating authority								
Public	73	31	21	57	26	18	83	228
Private religious	74	33	36	37	28	15	94	35
Other private	82	4	9	48	36	23	99	93
Region								
Western	81	18	24	53	38	28	100	32
Central	100	15	11	28	27	4	100	29
Greater Accra	81	13	12	60	27	21	100	25
Volta	74	22	16	51	27	17	100	46
Eastern	72	41	32	53	24	17	97	42
Ashanti	82	27	20	40	28	12	98	69
Brong Ahafo	67	20	13	64	18	14	99	48
Northern	57	8	18	68	22	19	49	34
Upper East	66	17	20	70	94	70	77	10
Upper West	71	53	33	64	41	38	15	22
Total	76	24	20	53	29	19	89	357

¹ Register has an entry in the past 30 days; entry indicates delivery outcome.
² Eleven facilities that offer delivery services did not have a delivery services provider interviewed.
³ This refers to structured in-service sessions and does not include individual instructions received during routine supervision.

In 29 percent of facilities, at least half of the interviewed delivery service providers indicated that they had received some formal in-service training during the previous 12 months. Twenty-eight percent of all interviewed delivery service providers (Table A-6.21) received in-service training during the past 12 months. An additional 31 percent of providers indicated that they had no formal in-service training in the past 12 months but had received in-service training 13-59 months preceding the survey. Specific topics offered and the percentage of providers who received in-service training are shown in Figure 6.13 by facility type and region in Table A-6.22.

Figure 6.13 In-service training received by interviewed delivery service providers, by topic and timing of most recent training (N=705)



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In 53 percent of facilities, at least half of the interviewed delivery service providers had been personally supervised during the 6 months preceding the survey (Table 6.7). In total, 47 percent of all interviewed delivery service providers had been personally supervised (Table A-6.21). Among the delivery service providers who had been personally supervised, the median number of visits received during the previous 6 months was two. When asked what their supervisor had done, providers said that they had checked their records (83 percent), observed their work (83 percent), provided feedback (63 percent), provided information updates (60 percent), and discussed problems (91 percent) (data not shown).

At least half of the interviewed providers in 19 percent of the facilities offering delivery services were personally supervised in the past 6 months and received in-service training in the past 12 months.

Key Findings

Three-quarters of facilities had an up-to-date register, but only one-fourth had documentation on delivery coverage monitoring. Hospitals and PMHs were most likely to have an up-to-date register, and hospitals and health centres were most likely to have documentation on delivery coverage.

Only one in five facilities reviews maternal or newborn deaths, with this being most likely in hospitals (77 percent).

Most facilities (89 percent) routinely charge for delivery services.

Twenty-eight percent of delivery providers received formal in-service training related to delivery services in the past 12 months, and an additional 31 percent received related in-service training 13-59 months preceding the survey.

Supervision of delivery service providers with supportive activities was reported by approximately half of the providers (47 percent).

7.1 Background**7.1.1 Collection of Information on Sexually Transmitted Infections and HIV/AIDS Services**

Sexually transmitted infections (STIs) are a major public health problem throughout the world. These illnesses affect millions of men, women, and children and can cause infertility, serious illness, and death. STIs have also been shown to increase the risk of HIV/AIDS (AIDSCAP/FHI, 1996). Most people infected with STIs do not have symptoms, but they can still transmit the disease to their sexual partners. Pregnant women with STIs are more likely to have low-birth-weight babies, premature babies, and stillbirths (Cotch et al., 1997; AIDSCAP/FHI, 1996).

As of December 2002, more than 40 million people worldwide were living with HIV/AIDS (UNAIDS and WHO, 2002). In sub-Saharan Africa, an estimated 29 million people have been infected with HIV/AIDS, which has become a leading cause of adult mortality in the region. Most people infected with HIV do not know that they are infected and, as a result, may unknowingly infect others. However, with the development of powerful antiretroviral drugs, many people who are HIV positive are living longer, and many infected mothers are giving birth to infection-free babies. Consequently, the role of health systems in addressing the HIV/AIDS epidemic has expanded to include a range of care and support services for people living with HIV/AIDS.

Although sexual contact is not the only means of transmission of HIV/AIDS, it is the most common (UNAIDS and WHO, 2000); thus, preventive measures for STIs are equally relevant to HIV/AIDS. However, the initial symptoms of a person with HIV/AIDS differ from those of clients with other STIs. Diagnosis and management of clients with HIV/AIDS requires additional resources that may not yet be incorporated as a part of routine STI services. As services for management and treatment of HIV/AIDS develop, they may be offered by different personnel and at sites other than those offering services for other STIs. Therefore, this report presents information on services specific to HIV/AIDS and the providers of those services separately from general information on STI services.

This chapter uses information obtained in the GSPA survey to address the following four central concerns:

- The availability of STI services
- The extent to which facilities offering STI services have the capacity to support quality STI services
- The availability of specific HIV/AIDS services
- The extent to which facilities offering HIV/AIDS services have the capacity to support quality HIV/AIDS services.

Availability of STI services was defined as any type of service provided in the health facility related to STIs, including any method of diagnosing and any level of treatment.

7.1.2 Health Situation Related to STIs and HIV/AIDS in Ghana

The Ministry of Health first reported AIDS cases in 1986. The number of cases reported each year has increased steadily since then. The total number of reported cases, representing only 30 percent of actual

cases, was 41,229 in September 2000. In Ghana, it is a generalized epidemic with a prevalence rate of more than 1 percent in antenatal clients at HIV sentinel sites. The national estimated prevalence rate increased from 2.6 percent in 1994 to 3.6 percent in 2001, and a number of sentinel sites have a prevalence rate above 5 percent (NACP, 2000). The HIV prevalence rate among commercial sex workers has been persistently high, ranging between 75.8 percent in Accra-Tema and 82 percent in Kumasi (Ministry of Health, 2000a). Some studies indicate varying prevalence rates in different population groups such as clients of sex workers and STI patients.

Awareness of HIV/AIDS is almost universal in Ghana (Ghana Statistical Service and Macro International, 1999); however, many misconceptions exist, and knowledge of transmission routes and prevention strategies vary with sex, age, and educational status, as do personal risk perceptions and actual behaviour changes due to HIV/AIDS. Awareness of STIs, on the other hand, is rather limited; most Ghanaians are aware of gonorrhoea and syphilis but have little or no knowledge of other STIs (Ghana Statistical Service and Macro International, 1999). Recommendations have been made to improve behaviour change communication for STIs (Dzokoto et al., n.d.).

Management of STIs has been ongoing since training in STI management started in 1984, which included etiological and syndromic management. Currently, a syndromic approach is advocated, especially in peripheral or primary-level facilities where laboratory testing may not be available.

The Government of Ghana's response to AIDS started in 1985 with the establishment of the National Technical Committee on AIDS to advise the government on implementation measures to contain the epidemic. Following this action, the National AIDS Control Programme (NACP) was established in 1987 to plan and coordinate HIV/AIDS activities by the Ministry of Health, other government institutions, and nongovernment organizations (NGOs). The programme coordinated the government's response and resulted in the development of a short-term plan (1987-1988) and two medium-term plans. The main objectives of the programme are to reduce the number of new HIV infections and to reduce the impact of HIV/AIDS on individuals, families, and communities. Activities on STIs and HIV/AIDS were carried out in collaboration with the Ministries of Education and Information, the Social Welfare Department, and NGOs with support from donor agencies.

In 2002, a National Strategic Framework was drafted to put in place multisector collaboration for the HIV/AIDS response. This programme is coordinated by the supraministerial body, the Ghana AIDS Commission. Implementation strategies of NACP include advocacy; information, education, and communication (IEC); condom promotion; blood screening and testing; epidemiological surveillance; clinical nursing and home-based care; counselling; STI control and management; and palliative care.

In the health sector strategic framework (2001-2005), a number of new activities have been added to existing strategies. These activities include access to care, such as management of opportunistic infections, antiretroviral therapy, prevention of mother-to-child transmission (PMTCT), and voluntary counselling and testing (VCT). These activities will be provided at health facilities and integrated into existing services. At some level, STI services have been integrated into other reproductive health services, such as family planning and antenatal care services. Similarly, HIV services have been integrated into STI services; at higher levels, specialized clinics do exist.

7.2 Availability of STI Services

The integration of STI diagnosis and treatment services into relevant health services increases opportunities for case detection and follow up on treatment. The GSPA survey assessed STI service availability in facilities. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient department (OPD). Less commonly, there is a specific STI service area.

Both antenatal care and family planning services are commonly used by sexually active women and are services through which STI diagnosis and treatment can be offered. Including STI screening and treatment as a component of these services can increase early detection and improve follow through on treatment, because women may be more comfortable discussing symptoms of STIs during a regular antenatal care or family planning visit with a provider with whom she is familiar. If she must go elsewhere for STI service, there is a greater chance that she may decide not to seek follow up care.

Table 7.1 describes the availability of STI services and the location where the service is provided within the facility. Facility respondents were asked if they offer any STI services, without a specific definition. The service could be counselling only, testing only, or diagnosis and treatment. STI services were reported by 67 percent of facilities, and 26 percent reported HIV/AIDS services. Hospitals are more likely than other types of facilities to provide either of the services (100 and 96 percent, respectively). Most STI services are offered in the general outpatient clinic (95 percent), although 12 percent of hospitals delivered STI services in a special clinic. This reflects the policy in Ghana, where STI services are integrated at the periphery or at the primary care level to avoid or decrease the risk of stigma or being recognized as a person who comes for services. In about half of the facilities, STI services are offered by family planning and antenatal care providers. The private maternity homes (PMHs) seem to have integrated the different services most successfully. In almost all facilities, STI services are available at least five days per week (Table 7.1).

It was noted that among facilities reporting that they do not offer STI services, the providers of antenatal care and family planning services reported that they do offer the services to their clients. Among the 142 facilities that reported do not offer routine STI services, 13 and 12 percent indicated that the services were available for family planning clients and antenatal care clients, respectively (data not shown). Anecdotal information suggests that the likely explanation for this finding is that facilities that do not normally have clients coming to the OPD with STI symptoms report that they do not provide STI services, while family planning and antenatal care providers see clients with symptoms of STIs and provide the necessary services. For the GSPA survey, information specifically related to STI services was only collected from facilities indicating that the service was routinely provided (either in the OPD or a special clinic). Information on STI services offered through family planning and antenatal care services is discussed in chapters 5 and 6.

Table 7.1 Availability of STI services

Background characteristics	Percentage of facilities that offer:				Percentage of facilities providing STI services: ¹				Percentage of facilities where STI services are available at least 5 days per week	Weighted number of facilities offering STI services
	Any STI service	Any HIV/AIDS service	Both STI and HIV/AIDS services	Weighted number of facilities	In general OPD	In special clinic	By family planning provider	By antenatal care provider		
Type of facility										
Hospital	100	96	96	43	85	12	21	17	99	43
Health centre	72	17	17	166	99	0	29	40	99	120
Clinic	42	16	16	125	92	5	45	52	92	53
PMH	75	23	23	95	96	1	96	99	99	71
Operating authority										
Public	63	22	22	288	95	3	32	39	98	180
Private religious	75	57	57	39	94	2	16	34	100	29
Other private	76	24	24	100	94	3	96	95	97	76
Region										
Western	61	28	28	39	93	3	34	42	100	24
Central	81	28	28	30	99	1	30	47	100	24
Greater Accra	87	52	52	28	94	6	64	71	96	24
Volta	48	12	12	74	98	2	41	54	100	36
Eastern	75	26	26	50	91	1	53	59	96	38
Ashanti	68	34	34	71	93	6	47	46	97	48
Brong Ahafo	71	23	23	54	94	2	51	62	92	38
Northern	68	28	28	41	95	5	39	46	100	28
Upper East	36	5	5	20	100	0	29	8	100	7
Upper West	90	29	29	22	100	0	80	71	100	20
Total	67	26	26	428	95	3	48	54	98	286

¹ Services may be available at multiple sites in the same facility if they are integrated.

Key Findings

STI services are offered in 67 percent of all facilities and HIV/AIDS services are offered in approximately one out of four facilities. All hospitals provide STI services, and 96 percent provide HIV/AIDS services.

STI services are mostly located in the general OPD (95 percent), and in about half of the facilities, STI services are offered by family planning (48 percent) and antenatal care providers (54 percent) as well.

Most facilities provide STI services at least five days per week.

7.3 Capacity to Provide Quality STI Services

Equipment, supplies, and health system components defined as important for supporting quality STI services were assessed. They included the following:

- System components to support use of services
- Infrastructure and resources to support quality assessment and counselling
- Infrastructure and resources for physical examinations
- Essential supplies for basic STI services
- Additional equipment and supplies for STI services.

Table 7.2 provides information on system components and resources for STI services. Table A-7.1 gives detailed information on the availability of various items and conditions to support counselling and physical examinations. Figures 7.1 and 7.2 summarize the availability of specific items for STI counselling and physical examinations.

7.3.1 System Components to Support Use of Services

Special efforts should be made to encourage clients with STIs to seek modern medical help, because of the stigma that is frequently associated with having an STI and because many people with STIs have no symptoms and do not know they need treatment. The GSPA survey assessed the presence of programme strategies and service delivery components that contribute to the availability and improved use of STI services.

One essential condition for encouraging the use of services is to ensure client confidentiality. Adherence to confidentiality standards is supported when a facility has an official written confidentiality policy that is shared with all staff. Only 13 percent of all facilities providing STI services were able to demonstrate such a document, most frequently in PMHs (23 percent) (Table A-7.1). An additional 12 percent said that they had the document, but were not able to show it on the day of the survey (data not shown).

For effective interruption of STI transmission, sexual partners of STI patients must also be tested and, if infected, treated. The client is usually asked to notify his/her sexual partner(s) and ask them to be physically examined; this is classified as passive follow up. If the clients feel uncomfortable or ashamed to inform their partner(s) that they may be infected, the clients may allow local health authorities to contact the partner(s) to inform them of the risk of infection and to seek care; this is called active follow up. Passive follow up was done in 6 out of 10 facilities (61 percent), and active follow up was conducted in 35 percent of the facilities offering STI services. Smaller facilities located closer to the community (clinics) tend to do better in active partner follow up than larger facilities that are less connected to the community (Table A-7.1).

7.3.2 Infrastructure and Resources to Support Quality STI Services

The World Health Organization (WHO) recommends the use of two approaches in providing STI services at the primary care facilities: etiologic and syndromic (World Health Organization, 2001a). An etiologic approach uses laboratory tests for diagnosing STIs. This method is more precise than syndromic diagnosis; however, laboratory facilities are often scarce. Therefore, the syndromic approach is recommended in facilities with no laboratory. The syndromic approach assesses the presence of specific symptoms and signs and then uses an algorithm to determine the treatments to provide. Where neither a laboratory nor the syndromic approach is used, providers often diagnose and prescribe medication based on their clinical judgment and the patient's symptoms (often referred to as clinical diagnosis). Studies have shown that when providers do not have a specific protocol (such as the syndromic approach) or laboratory results to use when diagnosing and prescribing for STIs, mistreatment is common (Lande, 1993).

Table 7.2 shows that almost all facilities (89 percent) use the syndromic approach, with no major differences between types of facilities and operating authorities. In 28 percent of facilities, the etiologic approach is used. Hospitals are more likely to use this method (75 percent) than health centres (16 percent) and PMHs (13 percent). The clinical method is used in 57 percent of facilities. Many facilities use more than one method, possibly for different symptoms/diagnoses or depending on the availability of tests.

Table 7.2 Availability of infrastructure and resources to support quality counselling and examinations for STIs

Among facilities offering STI services, percentage using etiologic methods for diagnosis, percentage using syndromic methods for diagnosis, percentage using clinical methods for diagnosis, percentage with all conditions to provide quality counselling for STI clients, percentage with all conditions to provide quality physical examination, percentage with medicine to treat four major STIs, and percentage with laboratory capacity to conduct a test for syphilis and gonorrhoea, a wet mount examination, and HIV/AIDS tests, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:										Weighted number of facilities offering STI services
	Method for diagnosing STIs			All conditions to provide quality counselling ¹	All conditions to provide quality physical examination ²	All medicines for STIs ³	Testing capacity for:				
	Etiologic	Syn-dromic	Clinical				Syphilis ⁴	Gonorrhoea ⁵	Wet mount ⁶	HIV/AIDS ⁷	
Type of facility											
Hospital	75	87	71	13	4	72	52	86	94	85	43
Health Centre	16	89	63	17	4	20	2	5	11	2	120
Clinic	35	81	44	26	8	21	8	9	23	15	53
PMH	13	94	50	67	24	35	1	1	3	0	71
Operating authority											
Public	27	87	59	17	4	27	10	18	25	16	180
Private religious	57	81	71	15	5	54	36	52	67	61	29
Other private	16	94	49	69	24	34	1	1	3	0	76
Region											
Western	21	68	94	38	6	38	9	22	28	20	24
Central	30	95	17	27	1	25	9	11	16	16	24
Greater Accra	19	82	21	42	14	41	19	21	33	5	24
Volta	37	100	69	15	10	34	12	19	33	20	36
Eastern	26	93	25	41	2	43	12	13	15	15	38
Ashanti	47	82	88	28	9	32	10	26	35	27	48
Brong Ahafo	20	97	44	34	20	42	12	12	16	12	38
Northern	12	93	66	9	9	11	9	14	14	14	28
Upper East	13	87	100	33	0	13	4	13	25	17	7
Upper West	20	79	70	50	14	11	0	9	9	9	20
Total	28	89	57	31	9	32	10	17	23	16	286

¹ Visual and auditory privacy, any guidelines or protocols, and any visual aids or educational materials

² All infection prevention items (soap, water, gloves, disinfecting solution, and sharps box), visual privacy, and examination bed and examination light

³ At least one medicine to treat syphilis, gonorrhoea, trichomoniasis, and chlamydia

⁴ Either venereal disease research laboratory (VDRL) test and functioning microscope, or rapid plasma reagin (RPR) test kit

⁵ Gram stain reagents and functioning microscope or culture capacity

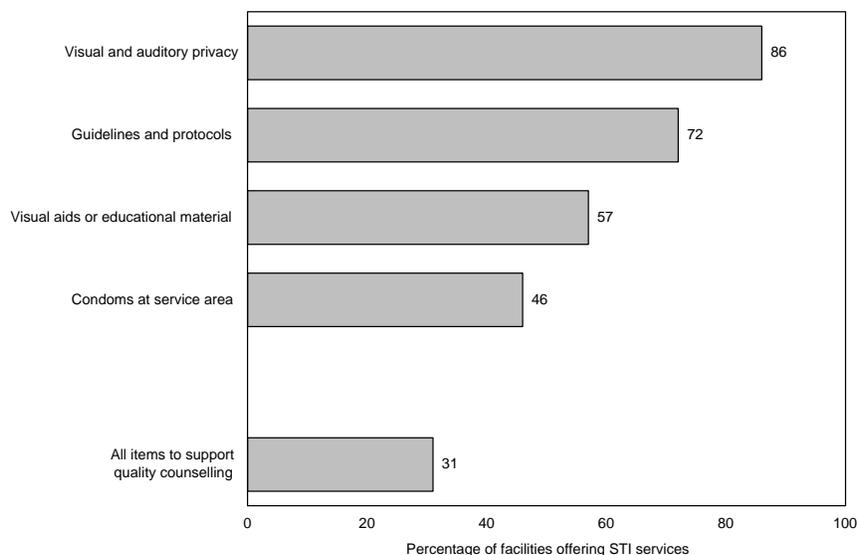
⁶ Functioning microscope and slides

⁷ Enzyme-linked immunosorbent assay (ELISA), Western blot, Rapid test or HIV SPOT

Quality counselling for STIs requires complete privacy to facilitate open communication between the provider and the client. Since counselling for diagnosis and prevention of STIs often takes place in a different location than the physical examination, the conditions for counselling were assessed separately from those for physical examinations. Complete privacy is necessary when discussing client history because of the discomfort many clients feel when talking about issues related to their partner(s) and their sexual practices. Ensuring auditory and visual privacy is required to encourage the use of services by the client and adherence to protocols and standards by the provider. Without these conditions, the provider may not ask the appropriate questions or carry out the appropriate examinations. Counselling areas with visual and auditory privacy were found in the majority of all facilities (86 percent), with little difference between types of facilities (Figure 7.1 and Table A-7.1). Seven percent did not have visual privacy. Guidelines or protocols were available in 72 percent of facilities, mostly in PMHs (92 percent). Specific guidelines for the syndromic diagnosis of STIs were available in more than half (53 percent) of facilities, again, mostly in PMHs (83 percent). For health education purposes, 57 percent of facilities had visual aids or other types of educational materials, and 46 percent of facilities had condoms available in the counselling area. The availability of condoms at the service delivery site allows the provider to demonstrate how to use them and to ensure that the client leaves with them. Sixty-nine percent of

hospitals had condoms available in the facility, but only 19 percent had them in the counselling area. Almost all PMHs had condoms available in the facility and the counselling area (Table A-7.1). All items to support quality counselling (visual and auditory privacy, any guidelines or protocols, any educational materials, and condoms) were present in 31 percent of facilities, with major differences found between types of facilities and operating authorities. PMHs were most likely to have all items (67 percent), and hospitals were least likely (13 percent).

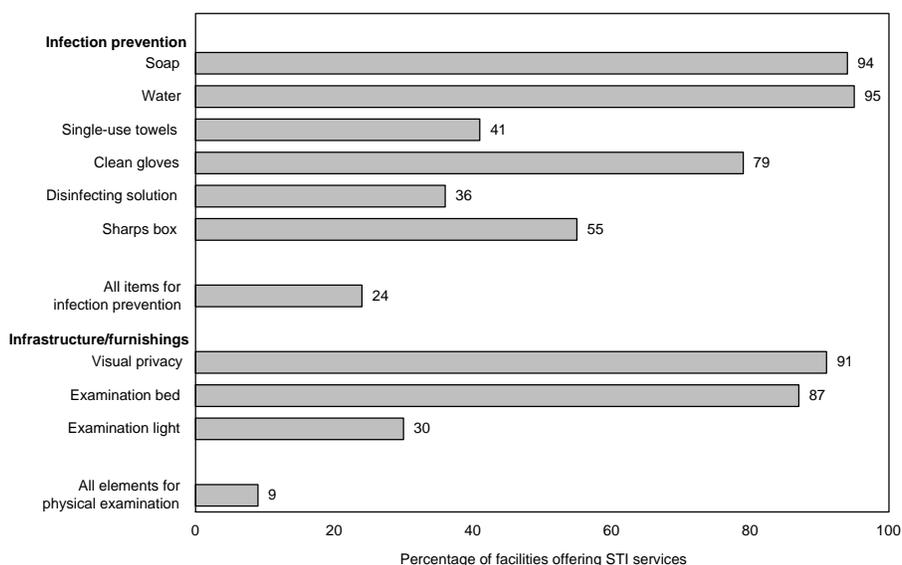
Figure 7.1 Availability of items for quality counselling among facilities offering STI services (N=286)



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Quality physical examination requires the presence of infection prevention measures, a bed and an examination light for pelvic examinations, and visual privacy. Soap (94 percent) and water (95 percent) were available in the service provision areas in almost all facilities (Figure 7.2). Single-use towels were available in four out of ten facilities. Least likely to be present was disinfecting solution, especially in hospitals (present in 36 percent of all facilities and 22 percent of hospitals). All items for infection prevention (soap, water, clean gloves, disinfecting solution, and sharps box) were available in one out of four facilities. Visual privacy for physical examinations was assured in 91 percent of all facilities. An examination bed was present in 87 percent of facilities, but an examination light was found in only 30 percent and was most likely in to be found in PMHs (52 percent). All elements for physical examination together with all infection prevention items were present in only one out of ten facilities, with the examination light most often missing (Table A-7.1).

Figure 7.2 Availability of items for quality physical examination among facilities offering STI services (N=286)



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Key Findings

Passive partner follow up systems exist in 61 percent of facilities, and active partner follow up is performed in 35 percent of all facilities. Clinics are more likely to use an active approach compared with other types of facilities.

The syndromic approach is the method most frequently used for diagnosing STIs (89 percent).

Guidelines or protocols for STIs were found in 72 percent of the service delivery areas. Specific guidelines for syndromic diagnosis of STIs were available in more than half of the facilities (53 percent). Other private facilities were best supplied.

Visual aids for health education were present in 57 percent of service delivery areas, and condoms were available in 46 percent.

One out of four facilities had all items for infection prevention, with disinfecting solution and a sharps box missing most often (absent from 64 and 45 percent of service delivery areas, respectively).

All infection prevention items, visual privacy, and an examination bed and light were available in only 9 percent of facilities.

7.3.3 Availability of Equipment and Resources to Support Quality Examinations and Interventions for STIs

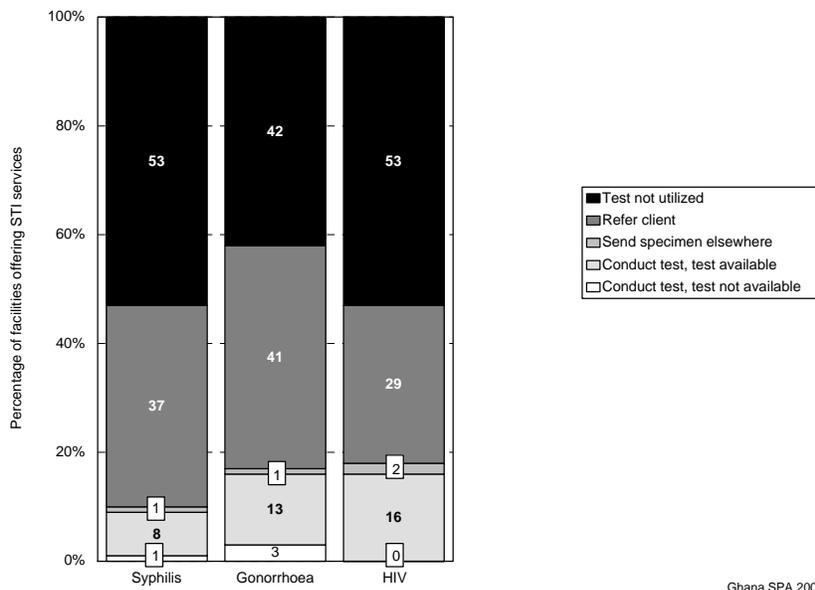
In addition to general conditions for quality STI counselling and examination of a client, the GSPA survey assessed the capacity of facilities to provide an etiologic diagnosis for STIs. Table A-7.2 details the availability of specific items and medicines for etiologic diagnosis and treatment of various STIs. Figure 7.3 summarizes the data for diagnostic tests for syphilis, gonorrhoea, and HIV, and Tables A-7.3

and A-7.4 give a more detailed breakdown of the same information. Finally, Figure 7.4 summarizes the availability of different medicines.

The most reliable means to ensure that clients receive a laboratory test is for the facility to conduct the test in house. Another alternative is to take the specimen and send it to another facility for the test. A referral to another facility is the least reliable method of ensuring that clients receive a laboratory test. Ten percent of facilities offering STI services had the laboratory capacity to test for syphilis, 17 percent were able to conduct a Gram stain or culture for gonorrhoea, 23 percent could conduct a microscopic examination of a specimen, and 16 percent had the capacity to test for HIV/AIDS (Table 7.2). The tests were primarily available in hospitals and private religious facilities. Table A-7.2 presents information on test availability and availability of a vaginal speculum (44 percent of all facilities offering STI services) and swab sticks for taking a specimen (8 percent).

Among the facilities offering STI services, 37 percent indicated that they refer clients needing syphilis testing, 1 percent indicated that they send a specimen elsewhere for the syphilis test when needed, 9 percent indicated that they actually conduct the test, and 8 percent indicated that they conduct the test and also had the test available on the day of the survey (Table A-7.3 and Figure 7.3). Sixteen percent of facilities indicated that they conducted laboratory tests for gonorrhoea, and 13 percent said that they conducted the test and had the capacity to provide the test. Sixteen percent of facilities indicated that they conducted HIV tests and had the test available on the day of the survey (either ELISA, Western blot, HIV SPOT, or Rapid test), and 29 percent indicated that they refer clients needing HIV tests. Table A-7.4 provides information on microscopic wet mount laboratory test, and genital herpes and chlamydia tests.

Figure 7.3 Availability and usage of diagnostic tests among facilities offering STI services (N=286)



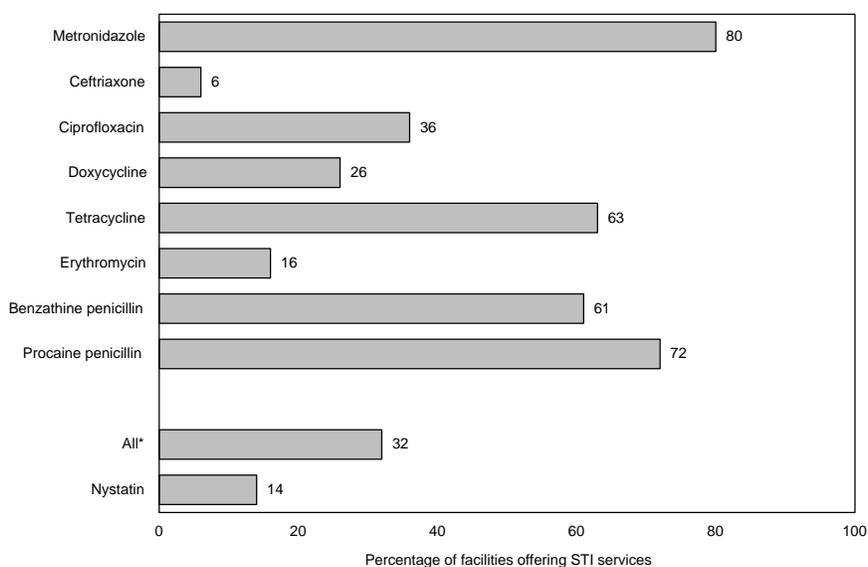
The GSPA survey assessed the availability of medicines to treat STIs in each facility. The availability of at least one of the following medicines for treating each indicated STI was considered essential to provide quality STI treatment:

- Trichomoniasis: Metronidazole

- Gonorrhoea: Ceftriaxone, ciprofloxacin
- Chlamydia: Doxycycline, tetracycline, or erythromycin
- Syphilis: Benzathine penicillin, procaine penicillin, doxycycline, tetracycline, or erythromycin

At least one medicine to treat syphilis, chlamydia, gonorrhoea, and trichomoniasis was available in one out of three facilities (Table A-7.2 and Figure 7.4). Metronidazole was most commonly available (80 percent of all facilities). The different penicillins and tetracycline were also commonly available. Ciprofloxacin and ceftriaxone, used for the treatment of gonorrhoea, were only available in 36 and 6 percent of facilities, respectively. Hospitals and private religious facilities were most likely to have at least one medicine for each of the indicated STIs (Table A-7.2).

Figure 7.4 Availability of medicines among facilities offering STI services (N=286)



*At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis

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Key Findings

Laboratory tests for the different STIs were not widely available. Hospitals and private religious facilities were most likely to perform the tests.

Forty-four percent of hospitals offered and conducted a syphilis test, 69 percent offered and conducted tests for gonorrhoea, and 84 percent offered and conducted HIV tests.

Medicines for treatment of STIs were available in 32 percent of facilities. Hospitals were most likely to have at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis.

7.4 Management Practices Supportive of Quality Services

Management practices that were assessed include the following:

- Facility documentation and records

- Charging practices for STI services
- Supervision and staff development.

Summary information on management practices supportive of quality STI services is provided in Table 7.3. Figure 7.5 gives summary information on topics of in-service training received by providers. Information on out-of-pocket payments is given in Table A-7.5, and Tables A-7.6 and A-7.7 provide details on supervision and the timing and content of training given to providers.

WHO considers recordkeeping and reporting of STIs and STI service use to be key elements in STI surveillance and necessary for the improvement of STI programme management (WHO, 1999a). The GSPA survey assessed the availability of an up-to-date register where STI service statistics were maintained. An STI register was considered up to date if there was an entry in the past seven days and if symptoms or a diagnosis consistent with an STI were written. Since most STI services are provided in OPDs, outpatient records were checked for STI client entries. One out of four facilities offering STI services was able to demonstrate an up-to-date register, with hospitals (38 percent) slightly more likely than other types of facilities (Table 7.3).

Specific STIs are classified as notifiable diseases in many countries where the public health system monitors illnesses of public health significance. The most commonly reported STIs are syphilis, gonorrhoea, and HIV/AIDS. Statistics on newly diagnosed cases and service use provide information for assessing changes in disease patterns. The GSPA survey found that 83 percent of facilities report STIs (Table 7.3). The main source of information for this reporting is the consultation register. The median number of STI clients reported per month was six for hospitals and two for all facilities (data not shown).

The effect of charging fees for services can be negative (the cost is deemed too high) or positive (free items are often perceived as being inferior to items that are paid for). Table 7.3 shows that almost all facilities offering STI services indicated that they charge routinely for STI services (89 percent), and of the interviewed STI clients who received treatment on the day of survey, 85 percent claimed to have paid out of pocket for this visit. Twelve percent of the observed clients said that they belong to a prepaid programme and paid more out of pocket than those not belonging to a prepaid plan (an average of 20,041 cedis versus 15,858 cedis) (Table A-7.5).

In 43 percent of facilities, at least half of the interviewed STI service providers had received formal in-service training related to STIs during the past 12 months (Table 7.3). Overall, 37 percent of the interviewed STI service providers had received recent (in the past 12 months) in-service training (Table A-7.6). An additional 30 percent of providers had received in-service training related to STIs 13-59 months preceding the survey. Figure 7.5 shows the topics for in-service training and the timing (in the past 12 months or 13-59 months preceding the survey) of the in-service training. Table A-7.7 provides details on in-service training by facility type and region.

In 64 percent of facilities, at least half of the interviewed STI service providers indicated that they had been personally supervised in the past 6 months (Table 7.3). Health centres were most likely to have at least 50 percent of their interviewed providers supervised (74 percent), and hospitals were the least likely to do so (45 percent). Overall, 52 percent of the providers had been supervised, with a median number of 2 supervisions (data not shown). The activities carried out most frequently by the supervisors were the following: discussed problems (92 percent), checked records (85 percent), and observed work (80 percent) (data not shown). Supportive management was defined as being personally supervised in the past 6 months and receiving any related in-service training in the past 12 months. Twenty-one percent of providers received supportive management (Table A-7.6).

Table 7.3 Management support for quality STI services

Among facilities providing STI services, percentage with an up-to-date STI register; percentage that report STIs; percentage where at least half of the interviewed providers of STI services were personally supervised in the past 6 months, received related in-service training in the past 12 months, and were supervised in the past 6 months and received in-service training related to STI services in the past 12 months; percentage of facilities that have referral forms; and percentage of facilities having a routine charge for STI services, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities:							
	Where at least half of the interviewed STI service providers: ³							
	With up-to-date register ¹	Reporting STIs ²	Were personally supervised in past 6 months	Received in-service training in past 12 months	Were personally supervised in past 6 months and received in-service training in past 12 months	With referral form, or facility is referral site	Charging routine fee for STIs ⁴	Weighted number of facilities offering STI services
Type of facility								
Hospital	38	91	45	38	19	3	87	43
Health centre	24	77	74	39	31	3	98	120
Clinic	28	80	63	46	29	5	82	53
PMH	20	90	59	50	27	9	82	71
Operating authority								
Public	26	80	68	40	29	3	94	180
Private religious	34	84	46	40	23	5	84	29
Other private	21	91	61	49	27	10	81	76
Region								
Western	13	92	63	63	47	0	88	24
Central	12	92	54	50	24	0	84	24
Greater Accra	26	85	66	61	35	3	69	24
Volta	32	88	61	35	26	0	98	36
Eastern	18	88	74	53	36	8	84	38
Ashanti	29	91	48	30	12	10	87	48
Brong Ahafo	31	97	69	35	23	9	94	38
Northern	32	38	61	32	21	0	94	28
Upper East	50	4	92	38	33	4	100	7
Upper West	23	91	90	44	44	9	100	20
Total	26	83	64	43	28	5	89	286

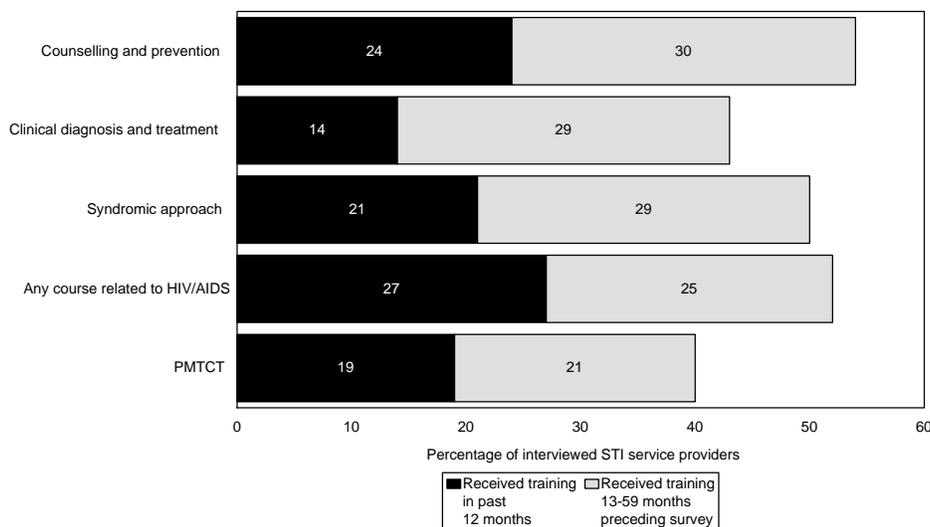
¹ Register has entry within past 7 days

² Facility submits an official report externally

³ Fifteen facilities did not have providers interviewed

⁴ Facility routinely charges for STI services

Figure 7.5 In-service training received by interviewed STI service providers, by topic and timing of most recent education (N=513)



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Key Findings

Twenty-six percent of the facilities offering STI services had up-to-date registers.

The majority (89 percent) of facilities charged routinely for STI services.

In-service training was received in the past 12 months by 37 percent of the interviewed STI care providers, and an additional 30 percent received in-service training 13-59 months preceding the survey.

Sixty-four percent of facilities had at least half of their providers supervised, with health centre providers being most likely supervised (74 percent).

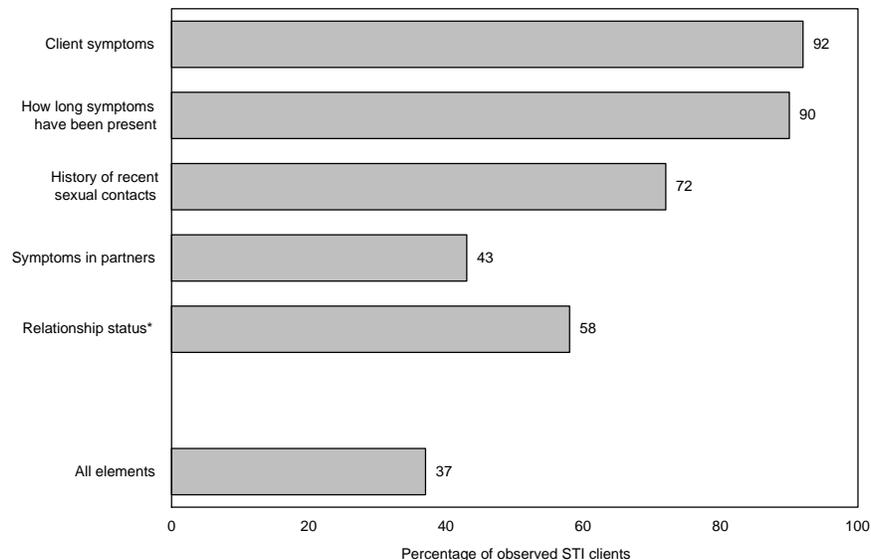
7.5 Adherence to Standards for Quality Service Provision

Observers watched clients being assessed for possible STIs and noted information shared and procedures or examinations conducted. The objective was to note whether information on the topic was shared (process information). An assessment of whether the information given was correct or findings were appropriately interpreted was not a component of the observation. Checklists based on elements of care generally accepted in the literature (AIDSCAP/FHI, 1996; WHO, 2001a) were used to collect information on whether the consultation process included the following:

- Information related to the client's history and relevant social information
- Appropriate physical examinations and laboratory tests
- Client counselling that addressed relevant curative and preventive practices.

Of all the observed STI clients, 83 percent were female and 17 percent were male (data not shown). Figure 7.6 shows the data on information shared during consultation, and Table A-7.8 breaks down the data by type of facility and operating authority. The conditions under which consultations and physical examinations for male and female clients are carried out are given in Tables A-7.9 to A-7.11. The components of STI consultations, including specific information on HIV/AIDS and condom use, are given in Tables A-7.12 to A-7.15, and Figures 7.7 and 7.8 summarize these same data.

Figure 7.6 Elements of client history for observed STI clients (N=68)



*Monogamous, multiple partners, nonmonogamous partner

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7.5.1 Assessment of Relevant History and Examination

Any client with a possible STI should be assessed for signs and symptoms and for social factors that relate to the risk of contracting an STI. In almost all observations, the provider asked about the symptoms (92 percent) and how long they had been present (90 percent). Questions about symptoms in partners (43 percent) and relationship status (58 percent) were asked less frequently. Thirty-seven percent of the observed STI clients had a full history recorded (client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in partner(s), and relationship status) (Table A-7.8 and Figure 7.6).

In addition to assessing the symptoms and social history relevant to STIs, a physical examination provides more objective information on symptoms, which contributes to a proper diagnosis. Of all observed female STI clients, 47 percent (26 out of 56 clients) (Tables A-7.8 and A-7.9) were physically examined. Of those, 77 percent had their external genitalia examined, and 69 percent received a pelvic examination (Table A-7.9). Table A-7.10 demonstrates that during pelvic examinations, privacy was ensured in all observations, and 17 percent received an examination with all required procedures, which included the following: using a speculum, explaining the speculum procedure, using instruments that were sterilized or high-level disinfected (HLD), preparing all instruments before starting, inspecting the cervix, and performing a bimanual examination. Caution should be used in drawing conclusions about differences between facilities and operating authorities because of the small number of observations per facility. Of all observed male STI clients, 64 percent were physically examined (7 out of 11 clients). Of

those, 37 percent had been circumcised. The examination took place under auditory privacy in 61 percent of the observations and under visual privacy in 85 percent. Genitals were fully exposed in 71 percent, but in only 39 percent was the foreskin retracted (if the client was not circumcised) (data not shown).

Infection control procedures varied. Sixty percent of the providers examining female clients washed their hands with soap before the physical examination, and 82 percent wore gloves (Table A-7.9). During pelvic examinations, 60 percent of providers washed their hands with soap before the procedure, 91 percent washed their hands after the procedure (Table A-7.10), and all wore gloves. Forty percent wiped the contaminated surfaces with disinfectant, and 65 percent decontaminated materials after the procedure. During examination of male STI clients, approximately half of the providers washed their hands with soap before the examination (49 percent) and wore gloves during the examination (51 percent) (data not shown).

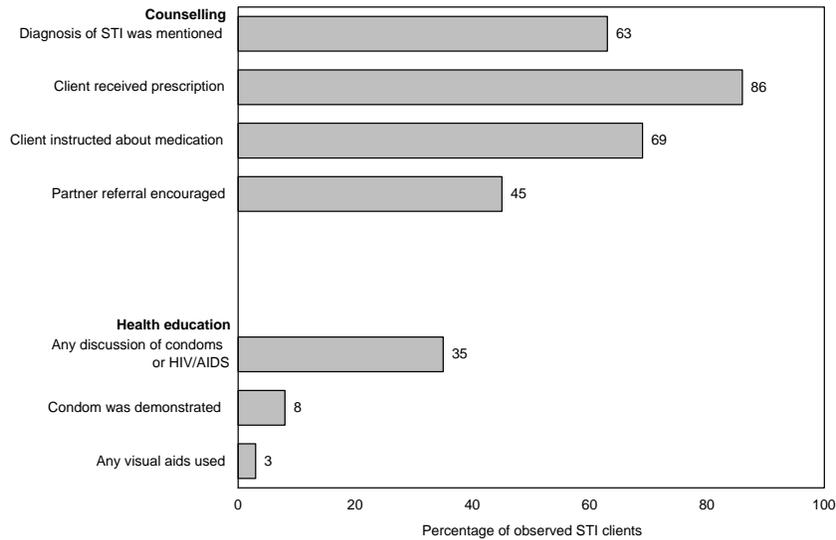
Laboratory testing offers a more accurate diagnosis of STIs than physical examination alone. Table A-7.11 provides information on the use of laboratory testing among observed STI clients. Fifty-seven percent of the observed STI clients were prescribed or had a laboratory examination. Clients from health centres were most likely to have a laboratory test prescribed or performed (69 percent). Most often, a microscopic examination of a specimen was mentioned (37 percent). A blood test was mentioned for 14 percent of clients, and an HIV/AIDS test and VCT were mentioned for 2 percent of observed STI clients.

Individual client cards were used almost universally (97 percent) (Table A-7.11).

7.5.2 Client Counselling and Knowledge

Figure 7.7 shows that diagnosis of a likely STI was mentioned in only 63 percent of consultations and is most likely to occur in hospitals (71 percent) (Table A-7.11). Eighty-six percent of observed clients received a prescription or medication, and 80 percent of these received instructions about the medication (69 percent of all observed consultations). Partner referral was encouraged in less than half of the clients (45 percent). For only one out of three patients (35 percent) was any type of discussion of condoms or HIV/AIDS observed, with patients in other private facilities more likely to receive this type of health education than patients in private religious facilities (55 and 17 percent, respectively). The use of a condom was demonstrated to only 8 percent of clients. Visual aids were rarely used (3 percent) (Table A-7.11 and Figure 7.7). Caution should be used in drawing conclusions about differences between facilities and operating authorities because of the small number of STI clients observed per facility.

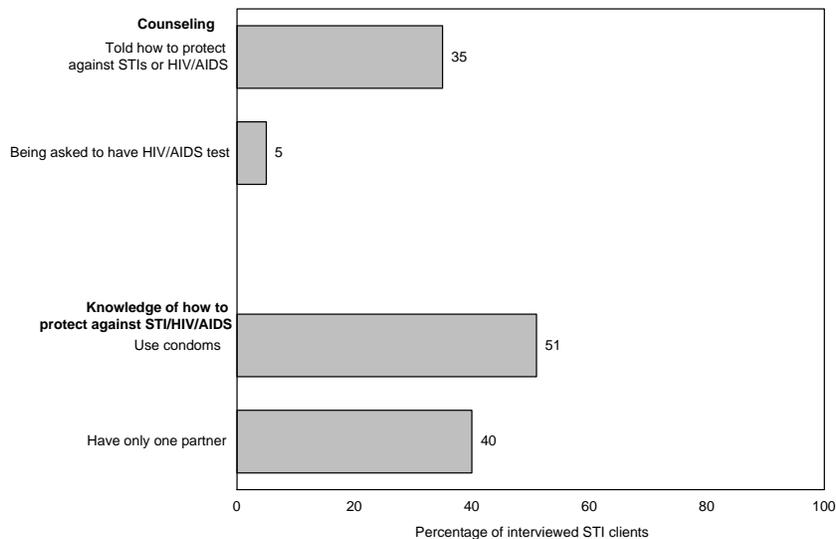
Figure 7.7 Client counselling and health education for observed STI clients (N=68)



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After the observed consultation, the client was asked to participate in an exit interview. Approximately one out of three clients (35 percent) reported being told how to protect himself/herself against STIs and HIV/AIDS, and 5 percent reported being asked to undergo an HIV/AIDS test (Figure 7.8). One out of five (22 percent) clients said that they did not know why the laboratory test was carried out. Table A-7.13 shows that 50 percent of women and 58 percent of men indicated using a condom as a method to protect themselves against STIs and HIV. Forty-one percent of women and 34 percent of men mentioned having

Figure 7.8 Client counselling and knowledge for interviewed STI clients (N=61)



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only one partner as another protection method. Table A-7.14 presents findings on knowledge and experience related to condom use among interviewed STI clients. Nearly half (46 percent) said that they had used a condom before. Only 20 percent said that they talked about condoms with the health care provider, and none received condoms on the day of survey.

Key Findings

Components of client history regarding partner and relationship status are not addressed sufficiently.

Physical examination of STI clients is not done routinely. Sixty-four percent of male clients and 47 percent of female clients were examined. Of the female clients examined, 69 percent had a pelvic examination.

Infection prevention practices varied. Hand-washing before an examination ranged between 49 and 60 percent. Gloves were not universally worn. During a pelvic examination, 71 percent of providers used sterilized or HLD-processed instruments.

Laboratory tests were performed or prescribed for more than half of the observed clients.

The majority of clients (86 percent) received medication or a prescription, and most of them (80 percent) were given instructions on how to take the medication.

In only 35 percent of the observed STI consultations were HIV/AIDS or condoms discussed.

7.6 Client Opinion from Exit Interview

During the exit interview, the client was also asked to give feedback on issues commonly identified as being related to client satisfaction. The client was first asked to identify issues without prompting. Then specific issues were probed with the client, who was asked to comment on whether these were a big problem, a small problem, or not a problem. Twenty-two percent of the interviewed clients indicated that the waiting time was too long, especially in hospitals (34 percent) (Table A-7.15).

7.7 Availability of Services Related to HIV/AIDS

7.7.1 Collection of Information on HIV/AIDS Services

During the past decade, the emphasis of HIV/AIDS-related activities was on awareness and prevention. With the development of new methods of detection and antiretroviral therapies, and better knowledge of HIV transmission and prevention, comprehensive HIV services that include treatment and prevention and support are being advocated (Lampthey and Gayle, 2001).

The package of services for comprehensive HIV services generally includes the following:

- Programmes and strategies for prevention and early detection
 - Voluntary counselling and testing (VCT) services—VCT provides counselling on prevention, tests to determine the HIV status of a person, and, if positive, counselling on how to mitigate the impact of HIV. There are studies that provide evidence that people who receive HIV testing with preventive counselling make behaviour changes that contribute to a reduction in HIV transmission rates (CDC, 2001).

- Prevention of mother-to-child transmission (PMTCT)—Offering VCT services to pregnant women allows for early identification of infected women and early intervention to prevent transmission to the baby. PMTCT programmes also provide counselling and advice on breastfeeding, delivery practices, and other measures to decrease transmission. Where available, use of antiretroviral treatment is advisable, and some PMTCT programmes offer formula to provide a safe alternative to breast milk.
- Improving the quality of life for HIV-positive clients through providing preventive and curative medical interventions. These interventions include the following:
 - Antiretroviral treatment (ART)
 - Preventive or curative antibiotics for opportunistic infections
 - Palliative care for the end-stage AIDS patient (either in a facility or through home care).
- Improving the quality of life for HIV-positive clients, their family, and their surviving children through social and psychological support. Specific target groups for support and assistance include the following:
 - Infected persons living with HIV/AIDS (PLHA)
 - Orphans and vulnerable children (OVC).

Because of the high cost of highly active antiretroviral therapy (HAART) and laboratory supplies, the lack of an effective structure, and the lack of funds needed to provide the social care and support activities required by PLHA, all components of this care and support package are not yet available in many countries, including Ghana. It is important, however, to periodically monitor and evaluate the extent to which the package is becoming available.

7.7.2 Availability of Services for HIV/AIDS

Where HIV/AIDS services are not well developed, providers may still see clients who they suspect of being infected with HIV. The GSPA survey defined services for HIV/AIDS as any care for someone suspected of being infected with HIV. The respondent at a facility (most often either the person in charge or the head of the OPD) was asked if the facility offered any services related to HIV/AIDS, including diagnosis, treatment, or counselling.

Table 7.1 shows that 26 percent of all facilities offer HIV/AIDS services. Table 7.4 shows that of those facilities, more than half offer any component of VCT services (59 percent), and approximately half offer treatment for any opportunistic infections (OIs) (50 percent), tuberculosis (TB) services (45 percent), any palliative management for pain or debilitation (45 percent), and any component of prevention of mother-to-child transmission (PMTCT) (44 percent). Counselling and psychosocial services were offered in approximately four out of ten facilities. Only 2 percent of facilities offering HIV/AIDS services also offered antiretroviral therapy. As expected, hospitals were most likely to provide the above-mentioned services, and private religious facilities were more likely to offer the services than other operating authorities were.

Most of the services are offered on both an inpatient and outpatient basis. Details on where the different components of care are provided in facilities offering any care for HIV-positive clients are shown in Table A-7.16.

Table 7.4 Availability of HIV/AIDS services

Background characteristics	Percentage of facilities offering:									Weighted number of facilities providing any HIV/AIDS services
	VCT	PMTCT	TB services	Treatment for OIs	ART	Palliative management for pain or debilitation	Psycho-social services	Counselling or training for home care	Temporary family planning methods	
Type of facility										
Hospital	83	80	89	90	5	84	67	71	84	41
Health centre	23	16	16	19	0	24	20	20	100	28
Clinic	69	34	25	43	0	36	26	30	83	20
PMH	51	23	18	18	0	9	14	23	100	22
Operating authority										
Public	56	46	46	52	3	47	42	41	98	64
Private religious	73	63	71	78	0	81	50	62	63	23
Other private	55	20	16	16	0	8	13	22	100	24
Region										
Western	75	24	36	30	6	36	21	26	86	11
Central	17	61	68	53	0	53	53	42	86	8
Greater Accra	80	35	35	39	0	25	21	32	94	14
Volta	93	83	83	93	0	76	64	87	74	9
Eastern	68	57	44	66	11	66	47	60	97	13
Ashanti	57	51	50	63	0	50	40	40	92	24
Brong Ahafo	43	43	34	34	0	41	44	43	86	12
Northern	56	29	29	29	0	29	29	23	100	11
Upper East	0	0	67	33	0	67	33	33	100	1
Upper West	28	9	28	28	0	28	18	18	100	6
Total	59	44	45	50	2	45	37	41	91	111
ART = Antiretroviral treatment OI = Opportunistic infections PMTCT = Prevention of mother-to-child transmission TB = Tuberculosis VCT = Voluntary testing and counselling										

7.7.3 Capacity to Provide Quality Services for HIV/AIDS Clients

Treatment services specific to HIV/AIDS are available in many health facilities in Ghana, but the level of care depends on facility capacity. Ghana follows the WHO guidelines in identifying three levels of care: essential, intermediate, and comprehensive care (WHO, 2001a). However, in all facilities, it can be assumed that, in most cases, clients with illnesses that may be related to HIV/AIDS are seen either in the OPD when seeking care for illness or where STI services are provided (most frequently in the OPD). The infrastructure and many of the health system components that support STI services, therefore, are applicable for HIV/AIDS services.

The GSPA survey looked at services that are components of most health systems that, while not specific to HIV/AIDS, are services required to support the HIV-infected client. Specific items assessed included the following:

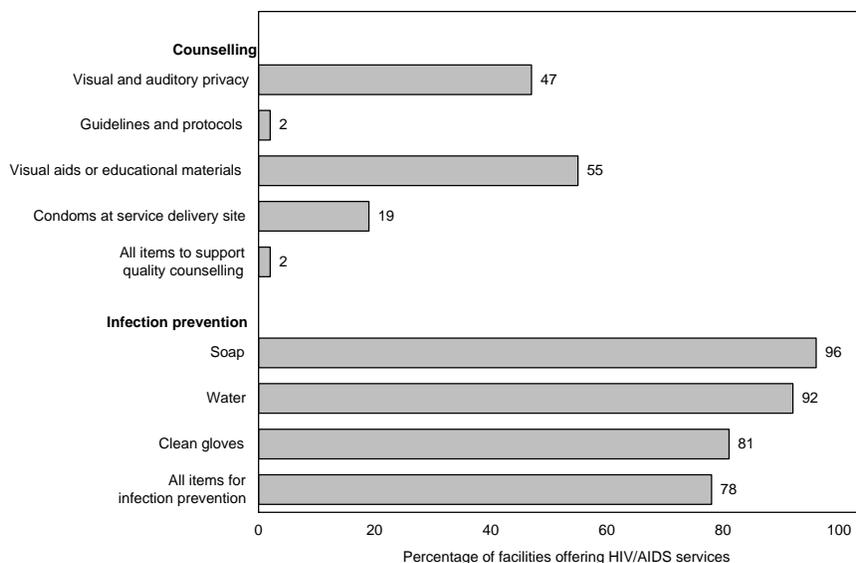
- Infrastructure and resources to support quality services related to HIV/AIDS
- Facility-level implementation of universal precautions
- Services and resources for diagnosis and management of HIV/AIDS-related illnesses
- Management practices supportive of quality services for HIV/AIDS.

Provision of specific HIV-related services by facilities is given in Table 7.4, and Table A-7.16 details whether services are available on inpatient, outpatient, or referral-only basis. Figure 7.9 summarizes the provision of items for quality counselling and infection prevention. Table A-7.17 provides detailed information on items to support counselling and treatment, and Table A-7.18 provides information on follow up services for HIV/AIDS.

7.7.4 Infrastructure and Resources to Support Quality of Services Related to HIV/AIDS

Because of the social stigma accompanying HIV/AIDS, clients should be assured of the confidentiality of test results. Confidentiality practices are reinforced where a facility has a written confidentiality policy that has been shared with the staff. In 2 percent of facilities offering HIV services a written confidentiality policy was available (Table A-7.17). In an additional 5 percent of facilities, the document was reported to exist but was not actually observed (data not shown). Figure 7.9 shows that visual and auditory privacy (a private room) was ensured in 47 percent of facilities. An additional 51 percent ensured visual privacy only (protected by a screen in a larger room). Testing for HIV/AIDS should only be conducted after fully informing clients of 1) information regarding the test and its benefits and consequences, 2) risk for transmission and how HIV can be prevented, 3) the importance of obtaining test results and explicit procedures for doing so, 4) the meaning of the test results, and 5) where to obtain relevant services (CDC, 2001). An informed consent protocol for HIV clients was available in 4 percent of the facilities and was reported but not actually observed in an additional 6 percent (data not shown) of the facilities providing HIV services (Table A-7.17).

Figure 7.9 Availability of items for quality counselling and infection prevention among facilities offering HIV/AIDS services (N=111)



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Protocols for the treatment of common opportunistic infections and other health problems will help ensure that providers give the most appropriate treatment in view of drug resistance and drug availability. Protocols also help providers identify situations where preventive therapies should be introduced and recognize AIDS-related conditions that they might not immediately identify if they are not familiar with the illness patterns commonly found in AIDS patients. Guidelines or protocols specific for HIV/AIDS

were found in only 2 percent of facilities, whereas guidelines and protocols for STIs in general were available in 32 percent of the service delivery areas (Table A-7.17).

Preventive education messages promoting behaviour change to decrease HIV transmission risk are an important part of HIV/AIDS services. Visual aids, written pamphlets, and other educational materials should be available in the client counselling area. Educational materials specific to HIV/AIDS were observed in 39 percent of all facilities providing HIV/AIDS services, being most likely found in hospitals (65 percent) and private religious facilities (56 percent). Condom use is one of the most effective means of prevention of transmission of sexually transmitted HIV, and providing condoms and demonstrating their proper use increase the chances of them being used. This prevention method is facilitated if the facility has condoms readily available to give to clients. Condoms were available at the service delivery site in only one out of five facilities offering HIV/AIDS services, while they were available within the facility in four out of five facilities. A model for teaching the correct use of a condom was available in one in five facilities (Table A-7.17).

All conditions to provide quality counselling (visual and auditory privacy, any guidelines or protocols, any visual aids or educational materials, and condoms) were present in 4 percent of hospitals and 6 percent of clinics (Table 7.5). Items missing most often were the guidelines and protocols (Table A-7.17).

The needs of HIV-infected clients are extensive, and one facility can rarely provide the services to meet all needs. When a facility does not provide the required service, clients should be given referrals, and there should be an official mechanism for follow up to ensure that the referral is effectively implemented. Therefore, counsellors should be familiar with resources that exist both inside and outside the facility to provide preventive interventions, treatments, and other care and support for HIV patients and their families. Written protocols for referrals for HIV clients were available in only 2 percent of facilities (Table A-7.17). Referral forms, however, were observed in 21 percent of facilities (includes facilities that are referral facilities) (Table A-7.18) and were reported but not observed in an additional 23 percent (data not shown). A list of care and support services for referrals was reported in 14 percent of facilities but observed in only 4 percent. Twelve percent of facilities stated that they have a formal partnership with a PLHA support group (Table A-7.18).

To further reduce transmission, sexual partners of HIV-infected clients must be counselled and tested. Passive partner follow up, in which the client notifies his/her sexual partner(s) and refers them to the facility for counselling, was performed at 65 percent of facilities (Table A-7.17). Active partner follow up, where the client authorizes the health care provider to contact partners and advise them to seek counselling and testing, was carried out in 33 percent of facilities. Health centres and PMHs were most likely to have an active partner follow-up system in place, and hospitals and clinics were most likely to have a passive system.

Key Findings

Written confidentiality policies and informed consent protocols were rarely present (missing in 98 and 96 percent, respectively).

Forty-seven percent of facilities offered counselling in a private room. In 51 percent of facilities, counselling took place in an area where visual privacy was ensured.

All conditions to provide quality counselling (visual and auditory privacy, any guidelines or protocols, any visual aids or educational materials, and condoms) were available in only 4 percent of facilities offering HIV services, with guidelines and protocols most often lacking.

7.7.5 Facility-Level Implementation of Universal Precautions

Because many HIV-infected persons are not aware of their status, the risk of transmission of HIV is possible whenever someone comes in contact with infected blood or body secretions, regardless of whether services related to HIV/AIDS are being provided or not. In a high-risk environment such as a health facility, ensuring that no one becomes inadvertently infected is critical. An essential step in preventing transmission of HIV (as well as hepatitis B or C) is to ensure that any potentially contaminated items are appropriately disinfected, thus eliminating this method of transmission. It is recommended, therefore, that universal precautions be applied throughout all service delivery areas in all health facilities. Use of sharps containers and procedures for immediately disinfecting used equipment are two critical components for preventing inadvertent transmission.

The Ministry of Health has issued protocols for universal precautions. While asepsis (absence of infection-causing microorganisms) is a basic concept in Ghanaian medical and paramedical schools and thus knowledge of this exists among providers, experience has shown that providers who do not work in an environment that actively promotes universal precaution practices are frequently lax in implementing those practices (Pittet et al., 1999; Williams et al., 1994). Poor compliance with universal precautions can be expected unless there is a facility-level strategy to promote adherence. Table A-7.1 presents information on availability of infection control items in the STI service delivery area.

Soap (96 percent), water (92 percent), and gloves (81 percent) were available in the service delivery areas in almost all facilities offering HIV/AIDS services (Figure 7.9). Single-use towels were present in less than half (45 percent) of the facilities (Table A-7.17).

Key Findings
Soap, water, and gloves were available in almost all facilities.

7.7.6 Resources for Diagnosis and Management of HIV/AIDS and Related Illnesses

Quality diagnosis and management of HIV/AIDS and related illnesses require the following services:

- Antiretroviral therapy
- Testing capacity for HIV/AIDS
- Testing and treatment for opportunistic infections (TB and syphilis)
- Counselling and services for family planning.

Table 7.5 summarizes information on the availability of resources required to support quality counselling and examination for HIV/AIDS. Figure 7.10 summarizes the availability of tests for HIV, STIs, and TB, with more details provided in Table A-7.19. Table A-7.20 provides information on the specific types of HIV test offered with the same data summarized in Figure 7.11. Information specific to TB services and medicines is given in Tables A-7.21 and A-7.22.

Antiretroviral therapy is not widely available in Ghana. During the time of the survey, only 2 percent of all facilities offered this treatment. As expected, this was only in hospitals (Table 7.4).

Although AIDS can be diagnosed without a laboratory test, it is essential to identify people infected with HIV before they develop AIDS. Among facilities offering HIV/AIDS services, 41 percent had the capacity to test for HIV (Table 7.5). Approximately half of the facilities providing HIV/AIDS services

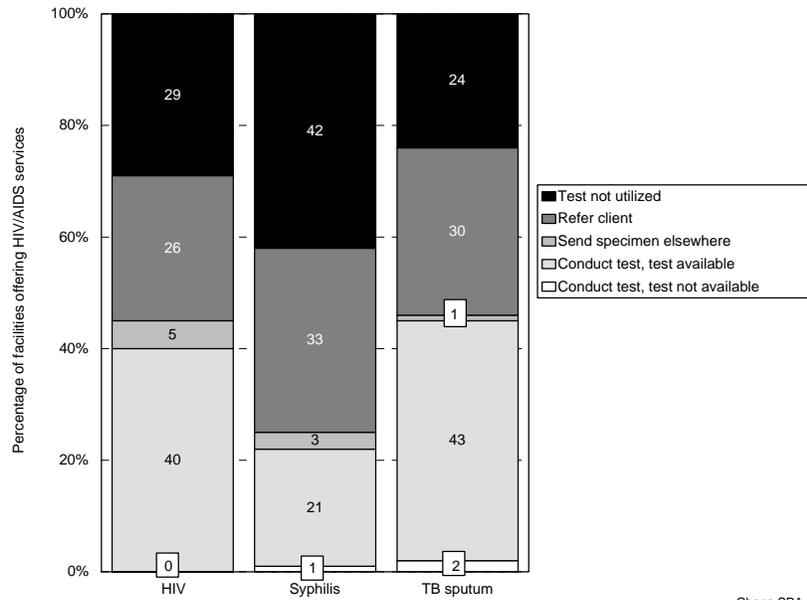
either referred the patient (26 percent) or did not actually test for HIV (29 percent) (Figure 7.10). Five percent said that they sent the specimen elsewhere for testing. Hospitals and clinics were most likely to conduct the test (86 and 33 percent, respectively) (Table A-7.19). None of the PMHs were conducting the test at the time of the survey. The tests most frequently used for HIV were the Rapid test and the HIV SPOT test (34 and 30 percent, respectively) (Figure 7.11 and Table A-7.20). Enzyme-linked immunosorbent assay (ELISA) was used in 5 percent of the facilities providing HIV/AIDS services, and Western blot was used in 2 percent. The CD4 count and HIV viral load are important parameters for determining the initiation time and effectiveness of ART. Treatment is still rare in Ghana, and tests for CD4 count (3 percent) and HIV viral load (1 percent) are not common. Interestingly, none of the facilities providing ART use either of the tests (data not shown).

Background characteristics	Percentage of facilities with:					Weighted number of facilities offering HIV/AIDS services
	All the conditions to provide quality counselling ¹	All items for infection prevention ²	Testing capacity for:			
			Syphilis	HIV/AIDS	TB	
Type of facility						
Hospital	4	84	54	87	99	41
Health centre	0	71	3	9	19	28
Clinic	6	81	22	39	56	20
PMH	0	76	5	0	10	22
Operating authority						
Public	4	76	26	44	59	64
Private religious	0	84	47	78	84	23
Other private	0	79	4	0	9	24
Region						
Western	0	71	19	43	62	11
Central	0	73	26	47	47	8
Greater Accra	0	89	31	8	50	14
Volta	0	73	50	79	79	9
Eastern	0	94	33	44	44	13
Ashanti	5	78	20	54	75	24
Brong Ahafo	0	76	26	36	36	12
Northern	8	75	21	34	34	11
Upper East	0	67	33	33	33	1
Upper West	9	63	0	28	28	6
Total	2	78	25	41	53	111

¹ Visual and auditory privacy, any guidelines or protocols, any visual aids or educational materials, and condoms
² Soap, water, and gloves

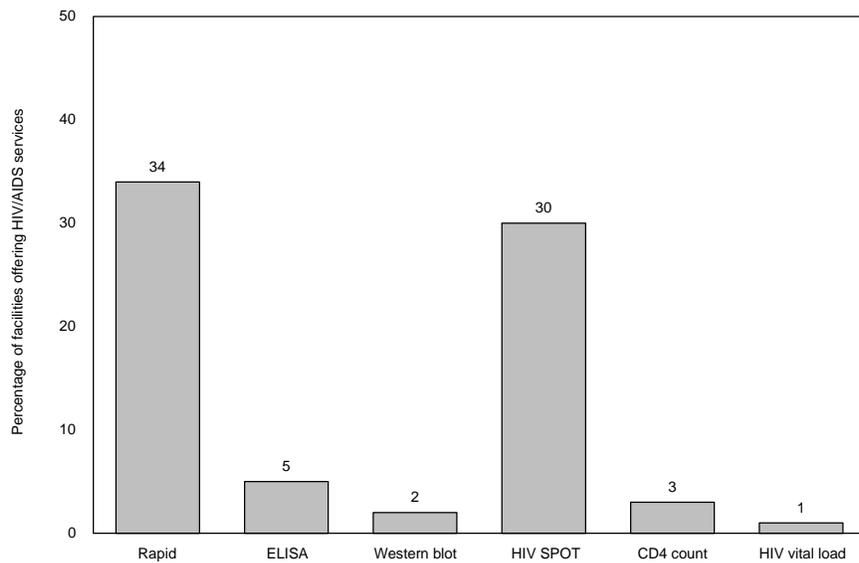
One out of five (21 percent) facilities providing HIV/AIDS services indicated that they conduct syphilis tests and had the test available on the day of survey. Forty-two percent said that they do not use the test at all, and 33 percent mentioned a referral for the client (Figure 7.10).

Figure 7.10 Availability and usage of diagnostic tests among facilities offering HIV/AIDS services (N=111)



Ghana SPA 2002

Figure 7.11 Availability of various HIV diagnostic tests among facilities offering HIV/AIDS services (N=111)



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TB is one of the most common opportunistic infections in AIDS patients. Routine testing for TB and, if there is risk of exposure, providing preventive treatment with isoniazid is recommended (CDC, 2002b). For the facilities that provide TB services, the GSPA survey assessed the ability to conduct a sputum examination and the availability of medications for short-course, standard, and prophylactic treatment. The test most commonly used for TB testing in Ghana is the acid-fast bacillus (AFB) test.

Half of the facilities providing HIV/AIDS services had the ability to conduct sputum tests for TB (slides and a microscope were present; the verification of availability of reagent was not carried out properly and therefore not included) (data not shown). Of the facilities that have TB services as a routine component of HIV/AIDS services, 84 percent had the ability to conduct the sputum test (Table A-7.21). In the same facilities, all medication for the short course of treatment (streptomycin, pyrazinamide, isoniazid, rifampicin, and red and blue tablet) was available in 13 percent of hospitals and in none of the other types of facilities. Medicines for standard treatment (streptomycin and red and blue tablet) were available in 18 percent of hospitals, and isoniazid alone, for prophylaxis, was available in 72 percent of hospitals and in 57 percent of all facilities providing TB services as a routine component of HIV/AIDS services. This situation demonstrates a serious threat to the continuity of treatment. If medication is not available, a discontinuation of treatment for a shorter or longer period with the risk of development of resistance against the medication might occur.

Family planning counselling is recommended for all HIV/AIDS-infected clients to discuss options and the advisability of preventing pregnancy. Ninety-one percent of facilities offering HIV/AIDS services offer temporary family planning methods (Table 7.4).

Key Findings
Of facilities offering HIV/AIDS services, only 41 percent are capable of testing for HIV/AIDS. Twenty-nine percent indicated that they do not actually use the test. The Rapid test and HIV SPOT test are the tests most frequently used.
One out of five facilities offering HIV/AIDS services has the capacity to test for syphilis.
Of facilities that have TB services as a routine component of HIV/AIDS services, 84 percent had the ability to conduct a sputum test.
TB drugs are not widely available, and this is of great concern.
Family planning services are available in almost all facilities offering HIV/AIDS services.

7.8 Management Practices Supportive of Quality Services

Table 7.6 provides information on up-to-date registers, supportive management for HIV/AIDS providers, and referral forms. Figure 7.12 provides details of the timing and content of specific training received, and Tables A-7.22 and A-7.23 give further information, based on type of facility, operating authority, and region.

An up-to-date service register was available in only 6 percent of facilities, most commonly in hospitals (28 percent). For a register to be considered up to date, the last entry has to be within the past 7 days, and for many facilities, especially the smaller ones, this is a limiting factor. For example, among facilities providing VCT services, 46 percent reported having a register; 38 percent were able to display it on the

day of survey; but only 18 percent had an entry within the past 7 days (data not shown). The average number of new clients for VCT in the past 12 months was 75 per facility (data not shown).

Table A-7.22 shows the different services provided by the HIV/AIDS providers, by type of facility, operating authority, and region. Approximately three-fourths of providers (74 percent) reported that they provide counselling or support services, with PMH providers most likely to provide this service. More than half (52 percent) of all providers said that they provide medical care. Of those, 64 percent provide special treatment for OIs (data not shown). Thirty percent reported that they provide diagnostic services, and 2 percent provide ART.

Table 7.6 Management support for quality HIV/AIDS services						
Among facilities providing HIV/AIDS services, percentage with an up-to-date HIV/AIDS register; percentage where at least half of the interviewed providers of HIV/AIDS services were personally supervised in the past 6 months, received related in-service training in the past 12 months, and were both supervised in the past 6 months and received in-service training related to HIV/AIDS services in the past 12 months; and the percentage of facilities that have a referral form or are referral sites, by type of facility, operating authority, and region, Ghana SPA 2002						
Background characteristics	Percentage of facilities:					Weighted number of facilities offering HIV/AIDS services
	With up-to-date service register ¹	Where at least half of the interviewed family planning service providers: ²			With referral form, or facility is referral site	
		Were personally supervised in the past 6 months	Received in-service training in the past 12 months	Were personally supervised in the past 6 months and received in-service training in the past 12 months		
Type of facility						
Hospital	28	41	39	19	35	41
Health centre	4	60	36	23	11	28
Clinic	12	59	41	27	19	20
PMH	4	60	82	48	10	22
Operating authority						
Public	13	54	40	23	23	64
Private religious	28	33	35	15	26	23
Other private	5	64	79	48	11	24
Region						
Western	16	34	42	25	19	11
Central	7	59	44	35	7	8
Greater Accra	11	39	74	30	11	14
Volta	26	34	17	17	0	9
Eastern	37	69	54	30	45	13
Ashanti	15	57	34	14	26	24
Brong Ahafo	0	61	72	40	29	12
Northern	0	45	34	25	13	11
Upper East	0	33	67	33	33	1
Upper West	18	79	79	58	28	6
Total	14	51	47	27	21	111

¹ Register has entry within past 7 days
² Twenty facilities did not have providers interviewed.

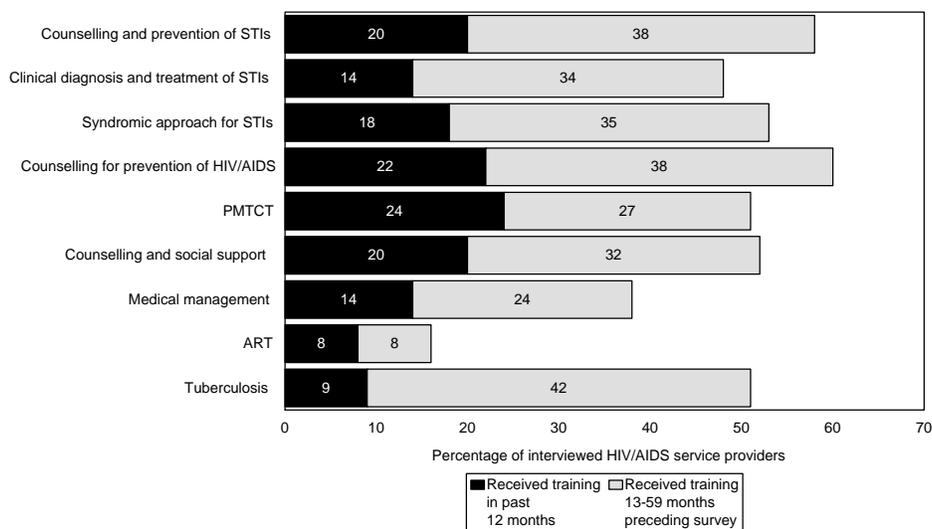
In 27 percent of the facilities providing HIV/AIDS services, at least half of the interviewed HIV/AIDS providers received supportive management, which means that they were personally supervised in the past 6 months and received in-service training related to STI services in the past 12 months (Table 7.6). Forty percent of all interviewed HIV/AIDS providers were personally supervised in the past 6 months (Table A-7.22), with a median number of two visits. The activities carried out most frequently by the supervisor

were the following: discussed problems (92 percent), checked records (85 percent), observed work (80 percent), provided feedback (69 percent), and provided updates (72 percent) (data not shown).

Because prevention and control measures for HIV/AIDS are evolving, it is necessary that providers regularly receive continuing education on topics related to this service. Thirty-eight percent of all interviewed providers received some in-service training in the 12 months preceding the survey, and an additional 42 percent received in-service training 13-59 months preceding the survey (Table A-7.23). In 47 percent of all facilities, at least half of the providers received in-service training (Table 7.6).

Figure 7.12 presents the topics and timing of the most recent in-service training.

Figure 7.12 In-service training received by interviewed HIV/AIDS service providers, by topic and timing of most recent training (N=281)



Ghana SPA 2002

Key Findings

Seventy-four percent of providers indicated that they provide counselling or support services, and more than half (52 percent) said that they provide medical care. Of those, 64 percent provide special treatment for OIs.

Forty percent of all interviewed HIV/AIDS providers were personally supervised during the 6 months preceding the survey.

Thirty-eight percent of all interviewed providers received some type of in-service training in the 12 months preceding the survey, and an additional 42 percent received in-service training 13-59 months preceding the survey.

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Chapter 1

Table A-1.1 Description of facility sample frame and final sample selection

Number of facilities in sample frame and number of facilities selected for the SPA, by type of facility and region, Ghana SPA 2002

	MoH hospitals		MoH health centres/clinics		Private religious hospitals		Private religious health centres/clinics		PPAG clinics		GRMA private maternities	
	Total	SPA	Total	SPA	Total	SPA	Total	SPA	Total	SPA	Total	SPA
Western	13	6	83	18	5	2	4	1	1	1	26	7
Central	7	4	57	14	3	2	4	1	3	3	22	6
Greater Accra	13	7	30	11	1	0	3	0	2	1	49	15
Volta	12	6	190	44	8	2	9	3	2	2	28	9
Eastern	12	5	95	26	5	4	10	4	3	2	45	15
Ashanti	18	6	107	25	10	2	18	12	1	1	84	23
Brong Ahafo	6	3	107	26	9	4	5	4	1	1	54	14
Northern	9	3	97	26	2	1	21	10	2	2	8	3
Upper East	4	2	54	11	1	1	11	7	0	0	2	0
Upper West	4	2	55	9	2	1	2	6	0	0	5	2
Total	98	44	875	210	46	19	87	48	15	13	323	94

Table A-1.2 Sample numbers by types of health facilities

Weighted percentage of facilities in the total sample, and weighted and unweighted numbers of facilities, by type of facility, Ghana SPA 2002

Type of facility	Weighted percentage of total sample	Weighted number of facilities	Unweighted number of facilities
MoH hospitals	7	29	44
MoH health centres/clinics	61	259	210
Private religious hospitals	3	14	19
Private religious health centres/clinics	6	26	48
PPAG clinics	1	4	13
GRMA private maternities	22	96	94
Total	100	428	428

Table A-1.3 Facility catchment area		
Median population in assigned catchment areas for facilities providing data on a known catchment population, by type of facility, operating authority, and region, Ghana SPA 2002		
Background characteristics	Median population in catchment area	Weighted number of facilities
Type of facility		
Hospital	65,992	23
Health centre	14,744	124
Clinic	9,845	61
PMH	8,033	22
Operating authority		
Public	12,991	187
Private religious	27,310	19
Other private	8,053	24
Region		
Western	15,575	17
Central	27,274	17
Greater Accra	95,662	9
Volta	7,110	42
Eastern	14,744	33
Ashanti	18,593	36
Brong Ahafo	11,802	24
Northern	25,339	21
Upper East	12,111	12
Upper West	7,054	20
Total	13,193	230

Table A-1.4 Staffing patterns for GSPA facilities							
Median number of health service providers assigned to outpatient services, by staff qualification, type of facility, operating authority, and region, Ghana SPA 2002							
Background characteristics	Median number of providers assigned to each facility ¹						Weighted number of facilities
	Total staff	Physicians	Medical assistants	Qualified nurses	Auxiliary	Other	
Type of facility							
Hospital	31	3	2	14	11	8	43
Health centre	4	2	2	2	3	3	166
Clinic	3	2	2	2	2	2	125
PMH	3	na	na	2	2	2	95
Operating authority							
Public	4	3	2	2	3	3	288
Private religious	11	3	2	4	6	6	39
Other private	3	na	na	2	2	2	100
Region							
Western	4	2	2	2	3	2	39
Central	7	3	2	2	4	6	30
Greater Accra	4	5	3	2	3	3	28
Volta	3	2	2	2	2	2	74
Eastern	5	5	2	2	3	3	50
Ashanti	4	2	2	2	3	3	71
Brong Ahafo	4	3	2	2	3	2	54
Northern	4	3	2	2	3	3	41
Upper East	3	4	2	2	2	2	20
Upper West	3	4	2	2	2	2	22
Total	4	3	2	2	3	3	428
¹ Numbers were provided by facility administrators. Staff who routinely rotate between inpatient and outpatient services are included. na = Not applicable							

Chapter 2

Region	MoH institutions						Quasi government institutions					Christian health associations		Nongovernment institutions				All health facilities				Percent reg. distribution of all institutions (V)
	Regional hospital (A)	District hospital (B)	Health centre/post (C)	MCH centre (D)	Leprosy/psych (E)	Others/community initiated clinics (F)	All MoH institutions (G)	University hospital (H)	Military hospital (i)	Police/prisons/hospital/clinic (J)	Others (e.g., mines) (K)	Hospital (L)	Clinic (M)	Planned Parenthood Association of Ghana (N)	Ghana Reg. Midwives Association (O)	Private medical practitioners (P)	Clinic (Q)	Hospital +H+I+J +L+P (R)	Health centre/post C (S)	Clinic D+F+K+M+O+Q (T)	All health institutions (U)	
Ashanti	1	20	85	21	2	9	138	1	1	3	6	14	33	12	101	43	64	85	85	246	416	18.4
Brong Ahafo	1	5	84	13	0	0	103	0	1	1	0	9	9	3	46	4	6	21	84	77	182	8.0
Central	1	6	39	14	2	26	88	1	0	2	1	3	7	6	27	4	62	19	39	143	201	8.9
Eastern	1	9	46	122	6	14	198	3	0	0	2	4	15	10	47	5	23	28	46	233	307	13.6
Greater Accra	1	3	29	13	2	14	62	1	2	3	4	2	3	2	87	37	142	51	29	265	345	15.3
Northern	1	6	73	9	0	9	98	0	2	0	0	3	18	2	6	0	2	12	73	46	131	5.8
Upper East	1	3	21	7	0	40	72	0	0	1	0	1	9	0	2	1	11	7	21	69	97	4.3
Upper West	1	3	41	5	0	0	50	0	0	0	0	2	15	0	5	3	5	9	41	30	80	3.5
Volta	1	10	141	48	1	4	205	0	1	0	0	6	11	3	29	6	23	25	141	118	284	12.6
Western	1	10	63	10	0	12	96	6	1	2	3	4	16	4	51	11	25	35	63	121	219	9.7
Number of facilities	10	75	622	262	13	128	1,110	12	8	12	16	48	136	42	401	114	363	292	622	1,348	2,262	
Percentage of all health facilities							49.1					2.1		8.1		40.7						100.0

Chapter 3

Table A-3.1 Availability of basic services by type of facility and operating authority

Percentage of facilities offering basic outpatient services curative care for sick children (SC), any services for sexually transmitted infections (STIs), child immunization (EPI), well-child growth monitoring (GM), antenatal care (ANC), temporary methods for family planning (TFP), percentage of facilities offering facility-based normal-delivery services, with at least one qualified staff, percentage offering all basic services plus minimum frequency, delivery services, and qualified staff, by type of facility and operating authority, Ghana SPA 2002

Services	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
SC	98	99	87	97	94	95	96	95
STI	100	72	42	75	63	75	76	67
EPI	88	81	70	26	79	74	26	66
GM	87	85	77	30	84	75	30	71
ANC	94	90	76	96	85	88	93	88
TFP	85	92	84	97	92	63	97	90
DEL	97	85	59	94	76	89	90	81
At least one qualified staff ¹	100	90	74	99	84	94	98	88
All basic services ²	70	57	27	15	49	39	15	40
All basic services, minimum frequency ³	54	44	14	6	36	22	7	28
All services, minimum frequency, and delivery services	52	42	11	6	33	22	7	26
All services, minimum frequency, delivery services, and qualified staff	52	41	11	6	33	22	7	26
Weighted number of facilities	43	166	125	95	288	39	100	428

¹ The definition for qualified staff in Ghana: medical doctor, medical assistant, public health nurse, professional midwife or professional nurse

² Some level of each of the following services: curative care for children, any STI services, temporary methods of family planning, antenatal care, immunization, and child growth monitoring

³ Curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least 1 day per week

Table A-3.2 Availability of basic services by region

Percentage of facilities offering basic outpatient services curative care for SC, any services for STI, EPI, well-child GM, ANC, TFP, percentage of facilities offering facility-based normal-delivery services with at least one qualified staff; percentage offering all basic services plus minimum frequency, delivery services, and qualified staff, by region, Ghana SPA 2002

Services	Region										Total
	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo	Northern	Upper East	Upper West	
SC	100	100	97	85	97	95	97	91	100	100	95
STI	61	81	87	48	75	68	71	68	36	90	67
EPI	57	76	60	54	65	58	63	85	99	95	66
GM	63	76	65	58	83	64	60	86	96	95	71
ANC	79	95	95	72	96	96	85	87	81	100	88
TFP	83	92	94	87	92	89	90	89	99	100	90
DEL	79	99	87	59	79	96	88	77	52	92	81
At least one qualified staff ¹	91	100	100	75	93	95	81	80	84	100	88
All basic services ²	38	63	52	16	42	32	34	59	30	86	40
All basic services, minimum frequency ³	28	59	37	6	31	14	15	43	28	86	28
All services, minimum frequency, delivery services	28	59	29	6	29	14	15	38	28	77	26
All services, minimum frequency, delivery services, and qualified staff	28	59	29	6	29	14	15	35	28	77	26
Weighted number of facilities	39	30	28	74	50	71	54	41	20	22	428

¹ The definition for qualified staff in Ghana: medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse

² Some level of each of the following services: curative care for children, any STI services, TFP, antenatal care, immunization, and child growth monitoring

³ Curative services for children provided 5 days per week, STI services offered at least 1 day per week, preventive or elective services (temporary methods of family planning, antenatal care, immunization, and growth monitoring) provided at least 1 day per week

Table A-3.3 Facility infrastructure supportive of client utilization and quality services

Percentage of facilities with client amenities, electricity, water supply, staff, and furnishings to support 24-hour emergency services, by type of facility and operating authority, Ghana SPA 2002

Components	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Client comfort amenities								
Client latrine	89	64	67	91	65	90	91	73
Protected waiting area	98	95	86	89	91	99	90	92
Clean facility	94	84	77	96	82	91	96	86
All client comfort items ¹	86	53	56	79	54	84	79	63
Facility infrastructure								
No electricity or generator	0	34	47	10	38	13	10	29
Generator w/fuel (with or w/out electricity)	53	4	8	5	6	46	7	10
Regular electricity or generator	77	35	23	42	32	64	43	38
Onsite water (may be seasonal)	96	67	55	69	64	81	69	66
Regular water supply (onsite/year round)	61	33	34	44	35	57	43	39
Regular water and electricity ²	46	11	12	18	12	40	18	16
All client amenities, regular water, and electricity	41	7	8	15	8	40	15	13
Staff and furnishings								
Duty staff onsite 24 hours	97	45	37	54	45	82	52	50
Duty staff on call 24 hours ³	0	12	2	2	8	1	2	6
Two or more qualified staff ⁴	100	58	29	15	50	74	16	44
Overnight patient beds ⁵	97	84	61	91	77	87	87	80
Emergency communication ⁶	88	20	18	52	25	48	53	33
Basic components supporting 24 hours ⁷	72	5	7	7	11	39	6	13
Basic components plus regular water and electric ⁸	32	1	4	3	3	29	3	5
Weighted number of facilities	43	166	125	95	288	39	100	428
¹ Clean, functioning client latrine, waiting area protected from sun and rain, and basic level of cleanliness								
² Year-round, onsite water and electricity available 24 hours a day or a generator with fuel								
³ A duty schedule or other documentation of official duty status was observed								
⁴ The definition for qualified staff in Ghana: medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse								
⁵ Either routine inpatient services or beds for overnight care for emergencies								
⁶ Communication device either in facility or within a 5-minute walk and available 24 hours a day								
⁷ At least two qualified staff (medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse), duty staff onsite or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and any onsite water source								
⁸ At least two secondary-level qualified staff (medical doctor, medical assistant, public health nurse, professional midwife, or professional nurse), duty staff onsite or on call 24 hours a day, overnight beds, patient latrine, access to 24-hour emergency communication, and regular water and electricity								

Table A-3.4 Quality assurance activities with documentation observed

Among facilities having quality assurance (QA) activities, percentage that both reported the method for QA used and had some documentation for the method, by type of facility and operating authority, Ghana SPA 2002

Background characteristic	Percentage of facilities with:							Weighted number of facilities reporting QA activities
	Supervisory checklist for health-system components	Supervisory checklist for observation of service	System for identifying quality of care	Mortality review	Auditing of medical records or registers	QA committee	Health management teams	
Type of facility								
Hospital	29	21	40	38	36	59	46	29
Health centre	20	20	13	4	43	13	26	35
Clinic	23	20	18	0	28	15	21	24
PMH	0	0	0	0	0	0	0	1
Operating authority								
Public	26	23	24	14	36	26	35	74
Private religious	9	9	19	17	40	49	14	11
Other private	20	0	20	0	30	0	0	3
Total	23	20	23	14	36	28	31	89

Table A-3.5 Supportive management practices at the health-worker level

Percentage of interviewed providers who were personally supervised in the 6 months preceding the survey, percentage who received in-service training during the 12 months preceding the survey, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed providers
	Who were personally supervised during the past 6 months	Who received in-service training during the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	48	48	24	32	638
Health centre	55	52	34	20	391
Clinic	57	49	31	25	270
PMH	41	49	24	20	98
Operating authority					
Public	54	51	30	27	1,071
Private religious	39	44	21	25	225
Other private	42	49	25	21	102
Region					
Western	30	52	24	25	141
Central	23	33	17	15	106
Greater Accra	68	41	25	33	225
Volta	48	41	24	34	178
Eastern	56	61	33	29	205
Ashanti	42	47	21	25	218
Brong Ahafo	58	61	37	13	139
Northern	60	49	38	31	107
Upper East	67	72	49	14	32
Upper West	73	67	47	24	47
Total	51	49	28	26	1,397

Table A-3.6 Facility-level supervision and in-service training for interviewed providers

Percentage of facilities where, among all interviewed health service providers, none, at least half, or all of the providers were personally supervised in the past 6 months, percentage where none, at least half, or all of the providers received in-service training relevant to maternal, child, or reproductive health services in the past 12 months, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers who were personally supervised in the past 6 months			Percentage of providers who received in-service training ¹ in the past 12 months			Weighted number of facilities with interviewed providers
	None	At least 50 percent	100 percent	None	At least 50 percent	100 percent	
Type of facility							
Hospital	2	37	1	0	51	5	43
Health centre	11	65	29	10	61	21	163
Clinic	20	61	34	23	55	31	124
PMH	32	43	28	23	49	37	95
Operating authority							
Public	14	61	28	13	59	24	286
Private religious	10	47	18	14	43	12	39
Other private	32	44	29	23	50	38	100
Region							
Western	18	46	23	13	62	27	39
Central	34	18	5	15	49	16	30
Greater Accra	10	73	16	14	49	15	28
Volta	13	58	28	18	42	21	71
Eastern	22	58	29	12	71	35	50
Ashanti	26	38	22	17	42	26	71
Brong Ahafo	4	70	42	9	61	33	54
Northern	17	67	39	34	51	13	41
Upper East	18	70	18	10	81	31	20
Upper West	17	83	42	8	88	49	22
Total	18	56	27	16	56	26	425

¹ This refers to structured in-service sessions and does not include individual instruction received during routine supervision.

Table A-3.7 Facility systems for maintenance of major equipment

Percentage of facilities that report having a preventive maintenance programme for major equipment; among facilities with preventive maintenance programmes for large equipment, percentage that report having onsite staff, external technicians, or both for conducting the repair work, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:				Weighted number of facilities with preventative maintenance for large equipment	Weighted number of facilities
	A preventative maintenance programme for major equipment ¹	Preventive maintenance plan that uses:				
		Onsite staff	External technicians	Both onsite staff and external technicians		
Type of facility						
Hospital	89	51	32	17	38	43
Health centre	51	57	40	3	85	166
Clinic	35	34	57	9	44	125
PMH	24	22	69	9	23	95
Operating authority						
Public	48	55	40	5	139	288
Private religious	65	29	53	18	26	39
Other private	26	20	70	10	26	100
Region						
Western	68	56	41	2	26	39
Central	72	24	73	2	21	30
Greater Accra	23	0	73	27	6	28
Volta	26	30	53	18	19	74
Eastern	42	37	43	20	21	50
Ashanti	34	24	62	13	24	71
Brong Ahafo	50	56	40	4	27	54
Northern	53	73	27	0	22	41
Upper East	8	80	20	0	1	20
Upper West	100	77	23	0	22	22
Total	44	47	46	8	190	428

¹ Major equipment refers to generators and other large equipment where routine maintenance is recommended to extend the life of the machine.

Table A-3.8 Facility systems for maintenance and repair of small equipment

Percentage of facilities that report having a system for repairing or replacing small equipment; among facilities with systems for repairing small equipment, percentage that repair equipment onsite, send outside to repair or replace, hire a technician, buy new, have donor replace, or other, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:							Weighted number of facilities with system for small equipment repair	Weighted number of facilities
	A system for repairing or replacing small equipment ¹	Method used for repairing or replacing small equipment							
		Onsite repair	Send outside to repair or replace	Hire technician	Buy new	Replaced by donor	Other		
Type of facility									
Hospital	100	41	47	29	41	2	0	43	43
Health centre	88	10	72	3	19	15	1	146	166
Clinic	83	3	81	5	20	9	0	104	125
PMH	90	4	73	18	41	1	1	86	95
Operating authority									
Public	88	11	74	5	20	12	1	253	288
Private religious	89	22	55	21	37	9	0	35	39
Other private	90	4	72	18	40	1	1	90	100
Region									
Western	91	25	79	9	35	0	0	36	39
Central	92	19	50	34	22	0	0	27	30
Greater Accra	97	16	66	25	51	3	10	27	28
Volta	96	3	70	12	16	13	0	71	74
Eastern	91	10	89	7	6	9	0	46	50
Ashanti	92	5	91	4	45	0	0	65	71
Brong Ahafo	91	7	73	5	23	11	0	49	54
Northern	67	27	59	0	14	0	0	28	41
Upper East	42	7	57	11	36	0	0	8	20
Upper West	100	0	27	0	32	66	0	22	22
Total	88	10	72	10	27	9	1	378	428

¹ Small equipment refers to stethoscopes, sphygmomanometers, and other small equipment where either minor repairs or replacement are common when broken.

Table A-3.9 Storage conditions and stock monitoring systems for vaccines

Among facilities that routinely store vaccines, percentage with a functioning thermometer in the refrigerator where vaccines are stored, percentage with an up-to-date temperature chart, percentage with recommended refrigerator temperature (0° to 8°C), percentage with adequate cold-chain monitoring system, percentage with no expired vaccines, percentage with vaccines stored by expiration date, percentage with up-to-date vaccine inventory, and percentage using FEFO (first expired, first out), by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:				Weighted number of facilities storing vaccines	Percentage of facilities with:				Weighted number of facilities storing vaccines in which the vaccines were observed ¹
	Functioning thermometer in refrigerator	Temperature chart up to date	Temperature 0°-8°C at time of survey	Adequate cold-chain monitoring system		No expired vaccines present	Vaccines stored by expiration date	Inventory up to date	FEFO system used	
Type of facility										
Hospital	89	51	70	43	37	88	51	19	51	36
Health centre	93	60	76	50	137	89	40	13	41	130
Clinic	83	39	54	26	58	97	40	10	34	52
PMH	18	6	6	3	37	94	15	6	9	32
Operating authority										
Public	91	55	69	44	203	90	41	12	40	191
Private religious	83	45	75	37	27	96	51	20	49	26
Other private	19	6	7	3	38	95	15	7	9	32
Region										
Western	76	50	53	43	20	91	26	13	22	16
Central	94	46	81	40	20	94	13	27	13	19
Greater Accra	40	21	25	16	23	93	27	5	28	21
Volta	85	38	69	33	39	84	42	9	38	37
Eastern	89	50	79	50	32	100	76	12	81	31
Ashanti	69	44	49	30	43	88	28	24	24	38
Brong Ahafo	80	56	47	40	37	97	16	11	12	37
Northern	86	51	63	35	28	88	75	3	67	25
Upper East	100	73	96	69	8	100	96	0	88	7
Upper West	98	58	82	42	19	81	15	10	25	19
Total	80	47	61	37	268	91	39	12	37	250

¹ Data was not available for 18 facilities.

Table A-3.10 Storage conditions and stock monitoring systems for contraceptives

Among facilities that store clinical methods of contraception, percentage in which good storage conditions were observed, percentage in which no expired items were observed, percentage in which items were stored by expiration date, and percentage with up-to-date inventory, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:			Weighted number of facilities storing items	Percentage of facilities with:			Weighted number of facilities storing items with observed items ¹
	Medicines off the ground and protected from water	Medicines protected from sun	No evidence of pests		No expired items present	Medicines stored by expiration date	Inventory up to date	
Type of facility								
Hospital	91	94	87	34	96	44	29	32
Health centre	94	99	75	153	99	32	23	151
Clinic	97	96	79	98	96	34	19	96
PMH	92	98	88	88	98	26	3	88
Operating authority								
Public	95	98	78	258	98	33	22	254
Private religious	89	92	74	21	100	33	23	19
Other private	92	97	89	93	98	28	4	93
Region								
Western	92	95	92	32	98	0	7	31
Central	100	100	100	27	100	0	32	27
Greater Accra	71	100	93	25	94	34	2	24
Volta	93	95	74	60	96	47	10	58
Eastern	96	92	89	45	100	74	17	45
Ashanti	98	98	93	61	96	25	24	59
Brong Ahafo	100	100	84	47	100	17	14	47
Northern	93	100	68	34	100	58	44	34
Upper East	87	98	80	18	92	20	8	18
Upper West	100	100	0	22	100	7	8	22
Total	94	97	80	372	98	32	18	366

¹ Data was missing for six facilities providing clinical methods of family planning.

Table A-3.11 Storage conditions and stock monitoring systems for medicines

Among facilities that store medicines, percentage in which good storage conditions were observed, percentage in which no expired items were observed, percentage in which items were stored by expiration date, and percentage with up-to-date inventory, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:			Weighted number of facilities storing items	Percentage of facilities with:			Weighted number of facilities storing items with observed items ¹
	Medicines off the ground and protected from water	Medicines protected from sun	No evidence of pests		No expired items present	Medicines stored by expiration date	Inventory up to date	
Type of facility								
Hospital	84	99	93	43	90	81	40	41
Health centre	86	97	70	164	97	46	27	163
Clinic	90	94	79	113	100	38	22	98
PMH	91	100	86	89	99	29	1	84
Operating authority								
Public	86	96	75	275	97	46	25	260
Private religious	94	99	85	39	98	67	41	37
Other private	91	99	87	95	99	30	2	89
Region								
Western	77	96	86	39	95	18	2	39
Central	95	100	100	29	100	9	41	27
Greater Accra	52	95	80	28	96	25	4	27
Volta	79	94	65	66	99	58	22	57
Eastern	99	97	94	50	94	81	16	47
Ashanti	92	96	95	65	98	47	37	61
Brong Ahafo	98	100	82	54	97	39	20	52
Northern	94	97	64	40	97	63	30	39
Upper East	90	98	79	18	100	48	23	16
Upper West	100	100	0	20	100	8	4	20
Total	88	97	78	409	97	44	21	386

¹ Data was not available for 23 facilities.

Table A-3.12 Perceived reliability of ordering system for commodities where order is placed by facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentage in which decisions on when to order the commodity are made by facility staff, and percentage of facilities reporting that their supplies were very reliable, sometimes reliable, or rarely reliable in the past 3 months, by type of facility and region, Ghana SPA 2002

Background characteristics	Percentage of facilities:				Weighted number of facilities with orders determined by facility staff	Weighted number of facilities that store indicated items
	With orders determined by facility staff	That report reliability of receiving ordered stock in the past 3 months is:				
		Very reliable	Sometimes reliable	Rarely reliable		
VACCINES						
Type of facility						
Hospital	92	49	51	0	38	41
Health centre	94	45	54	0	146	155
Clinic	78	40	58	1	86	110
PMH	66	85	15	0	46	70
Operating authority						
Public	89	42	57	1	240	269
Private religious	81	63	37	0	29	36
Other private	66	84	16	0	47	72
Region						
Western	87	50	44	0	21	25
Central	79	74	26	0	21	26
Greater Accra	81	70	30	0	22	27
Volta	93	31	69	0	60	64
Eastern	81	67	33	0	37	45
Ashanti	79	68	29	3	49	62
Brong Ahafo	82	33	67	0	39	48
Northern	80	27	73	0	31	38
Upper East	80	38	62	0	15	19
Upper West	100	60	40	0	21	21
Total	84	50	49	0	316	376
CONTRACEPTIVE METHODS						
Type of facility						
Hospital	95	34	61	3	32	34
Health centre	95	42	55	0	145	153
Clinic	97	38	57	4	95	98
PMH	99	75	20	0	86	88
Operating authority						
Public	95	39	56	2	247	258
Private religious	98	33	67	0	21	21
Other private	98	76	20	0	91	93
Region						
Western	96	35	52	0	31	32
Central	100	63	33	0	27	27
Greater Accra	87	65	35	0	22	25
Volta	94	24	76	0	56	60
Eastern	98	70	28	2	44	45
Ashanti	95	53	40	2	58	61
Brong Ahafo	100	40	53	3	47	47
Northern	97	25	69	3	33	34
Upper East	100	63	37	0	18	18
Upper West	100	75	25	0	22	22
Total	96	48	48	1	359	372

Continued...

Table A-3.12—Continued

Background characteristics	Percentage of facilities:					Weighted number of facilities with orders determined by facility staff	Weighted number of facilities that store indicated items
	With orders determined by facility staff	That report reliability of receiving ordered stock in the past 3 months is:					
		Very reliable	Sometimes reliable	Rarely reliable			
MEDICINES							
Type of facility							
Hospital	98	33	61	3	42	43	
Health centre	98	31	54	0	161	164	
Clinic	98	48	42	3	110	113	
PMH	100	79	8	1	89	89	
Operating authority							
Public	98	33	54	2	269	275	
Private religious	99	58	35	0	39	39	
Other private	100	80	8	1	95	95	
Region							
Western	100	39	44	0	39	39	
Central	96	59	41	0	27	29	
Greater Accra	98	65	29	2	27	28	
Volta	96	28	50	0	64	66	
Eastern	97	61	32	2	49	50	
Ashanti	100	61	34	2	65	65	
Brong Ahafo	100	43	41	2	54	54	
Northern	97	22	52	4	39	40	
Upper East	100	44	46	0	18	18	
Upper West	100	56	44	0	20	20	
Total	98	47	41	1	402	409	

Table A-3.13 Perceived reliability of ordering system for commodities where order is placed by someone outside the facility

Among facilities that provide vaccinations, contraceptive methods, or medicines, percentage in which decisions on when to order the commodity are made by someone outside the facility and percentage of facilities reporting that their supplies were very reliable, sometimes reliable, or rarely reliable in the past 3 months, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities:			Weighted number of facilities with orders determined by someone outside the facility	Weighted number of facilities that store indicated items	
	With orders determined by someone outside the facility	That report reliability of receiving ordered stock in the past 3 months is:				
		Very reliable	Sometimes reliable	Rarely reliable		
VACCINES						
Type of facility						
Hospital	7	80	20	0	3	41
Health centre	5	10	74	0	8	155
Clinic	16	46	16	5	18	110
PMH	25	53	35	0	17	70
Operating authority						
Public	9	38	36	0	23	269
Private religious	15	46	21	17	5	36
Other private	25	53	33	0	18	72
Region						
Western	13	21	0	0	3	25
Central	19	53	47	0	5	26
Greater Accra	13	77	23	0	4	27
Volta	5	28	18	27	3	64
Eastern	17	23	77	0	8	45
Ashanti	14	35	20	0	9	62
Brong Ahafo	14	59	41	0	7	48
Northern	15	49	14	0	6	38
Upper East	12	87	13	0	2	19
Upper West	0	na	na	na	0	21
Total	12	44	33	2	46	376
CONTRACEPTIVE METHODS						
Type of facility						
Hospital	5	0	100	0	2	34
Health centre	5	69	31	0	8	153
Clinic	1	100	0	0	1	98
PMH	1	100	0	0	1	88
Operating authority						
Public	4	60	40	0	11	258
Private religious	2	100	0	0	0	21
Other private	1	100	0	0	1	93
Region						
Western	3	100	0	0	1	32
Central	0	na	na	na	0	27
Greater Accra	13	49	51	0	3	25
Volta	4	50	50	0	3	60
Eastern	2	100	0	0	1	45
Ashanti	5	57	43	0	3	61
Brong Ahafo	0	na	na	na	0	47
Northern	3	100	0	0	1	34
Upper East	0	na	na	na	0	18
Upper West	0	na	na	na	0	22
Total	3	65	35	0	12	372

Continued...

Table A-3.13—Continued

Background characteristics	Percentage of facilities:			Weighted number of facilities with orders determined by someone outside the facility	Weighted number of facilities that store indicated items
	With orders determined by someone outside the facility	That report reliability of receiving ordered stock in the past 3 months is:			
		Very reliable	Sometimes reliable	Rarely reliable	
MEDICINES					
Type of facility					
Hospital	1	0	100	0	43
Health centre	2	32	68	0	164
Clinic	1	100	0	0	113
PMH	0	na	na	na	89
Operating authority					
Public	2	49	51	0	275
Private religious	1	0	100	0	39
Other private	0	na	na	na	95
Region					
Western	0	na	na	na	39
Central	4	100	0	0	29
Greater Accra	0	na	na	na	28
Volta	2	0	100	0	66
Eastern	3	0	100	0	50
Ashanti	0	na	na	na	65
Brong Ahafo	0	na	na	na	54
Northern	3	100	0	0	40
Upper East	0	na	na	na	18
Upper West	0	na	na	na	20
Total	1	46	54	0	409
na = Not applicable					

Table A-3.14 System for ordering vaccines, contraceptives, and medicines

Among facilities that provide vaccines, contraceptive methods, and medicines and order their own supply, percentage where the indicated items are the basis upon which decisions are made regarding how much to order and when to order, among facilities where ordering decisions are made elsewhere, percentage where the indicated items are the basis upon which decisions are made regarding how much to provide, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities												Weighted number of facilities with ordering system making their own orders	Percentage of facilities			Weighted number of facilities with ordering system where others decide	
	Basis for determination of how much to order						Basis for determination of when to order							Basis for determination of how much to provide				
	Maintain a fixed stock	Same amount each time	Mathematical formula	Utilization judgment	Other	Don't know/missing	When stock falls to a predetermined level	More often than once a month	Every 4 weeks	Less often than once a month	As needed	Other		Don't know/missing	Activity level	Fixed supply		Don't know/missing
VACCINES																		
Type of facility																		
Hospital	37	2	83	47	0	0	38	0	61	5	68	0	2	38	40	0	60	3
Health centre	29	0	75	40	1	0	36	1	55	7	62	3	2	146	54	0	46	8
Clinic	24	0	74	35	0	0	28	0	54	6	48	1	9	86	28	0	72	18
PMH	24	0	51	55	0	2	27	0	30	6	61	2	11	46	58	13	29	17
Operating authority																		
Public	26	0	76	39	1	0	32	0	55	6	59	3	5	240	35	0	65	23
Private religious	46	2	72	39	2	0	44	0	64	6	59	0	0	29	43	0	57	5
Other private	24	0	52	54	0	2	27	0	30	6	61	2	11	47	56	12	32	18
Region																		
Western	6	0	51	69	0	0	25	0	35	0	78	6	0	21	0	0	100	3
Central	50	0	48	10	0	0	28	0	64	0	36	0	6	21	34	0	66	5
Greater Accra	51	0	80	61	0	0	50	0	65	7	63	8	8	22	77	0	23	4
Volta	41	0	87	35	0	2	43	0	51	10	65	4	10	60	18	0	82	3
Eastern	22	0	95	24	0	0	17	3	55	7	70	0	0	37	75	0	25	8
Ashanti	9	0	75	30	0	0	13	0	45	1	73	0	4	49	20	12	68	9
Brong Ahafo	8	2	77	32	0	0	20	0	58	11	49	0	6	39	58	17	24	7
Northern	62	0	69	47	0	0	80	0	54	0	36	0	10	31	62	0	38	6
Upper East	2	0	59	98	13	0	38	0	0	0	96	9	0	15	13	0	87	2
Upper West	22	0	24	71	0	0	23	0	80	20	12	0	0	21	na	na	na	0
Total	28	0	72	42	1	0	33	0	52	6	59	2	5	316	44	5	51	46

Continued...

Table A-3.14—Continued

Background characteristics	Percentage of facilities												Weighted number of facilities with ordering system making their own orders	Percentage of facilities			Weighted number of facilities with ordering system where others decide	
	Basis for determination of how much to order						Basis for determination of when to order							Basis for determination of how much to provide				
	Maintain a fixed stock	Same amount each time	Mathematical formula	Utilization judgment	Other	Don't know/missing	When stock falls to a predetermined level	More often than once a month	Every 4 weeks	Less often than once a month	As needed	Other		Don't know/missing	Activity level	Fixed supply		Don't know/missing
CONTRACEPTIVES																		
Type of facility																		
Hospital	28	2	72	36	0	5	43	1	39	23	62	0	5	32	100	0	0	2
Health centre	44	5	66	45	2	0	48	2	46	14	63	2	0	145	86	14	0	8
Clinic	42	2	68	33	0	1	41	0	36	20	58	0	3	95	100	0	0	1
PMH	40	1	54	46	5	1	48	0	34	8	63	1	3	86	100	0	0	1
Operating authority																		
Public	41	4	69	39	1	1	44	1	43	17	62	1	1	247	90	10	0	11
Private religious	43	3	45	41	2	7	42	1	33	19	48	0	7	21	100	0	0	0
Other private	42	1	56	46	5	1	50	0	33	8	64	1	2	91	100	0	0	1
Region																		
Western	19	2	35	60	8	2	30	0	18	8	81	4	2	31	100	0	0	1
Central	56	0	43	9	4	4	48	0	54	0	21	0	8	27	na	na	na	0
Greater Accra	65	0	96	47	4	0	58	0	32	33	87	4	0	22	100	0	0	3
Volta	67	7	79	35	0	0	71	0	57	15	76	0	0	56	100	0	0	3
Eastern	31	0	86	38	0	2	39	2	42	9	80	0	2	44	100	0	0	1
Ashanti	5	0	68	28	1	2	14	2	29	10	65	0	3	58	100	0	0	3
Brong Ahafo	28	0	66	35	2	0	31	0	37	28	57	0	0	47	na	na	na	0
Northern	68	18	58	49	0	2	83	0	48	14	26	0	2	33	0	100	0	1
Upper East	35	0	67	82	8	0	77	2	0	0	92	8	0	18	na	na	na	0
Upper West	73	0	12	73	0	0	29	0	63	36	18	0	0	22	na	na	na	0
Total	41	3	64	41	2	1	45	1	40	15	62	1	2	359	91	9	0	12

Continued...

Table A-3.14—Continued

Background characteristics	Percentage of facilities												Weighted number of facilities with ordering system making their own orders	Percentage of facilities			Weighted number of facilities with ordering system where others decide		
	Basis for determination of how much to order:						Basis for determination of when to order:							Basis for determination of how much to provide					
	Maintain a fixed stock	Same amount each time	Mathematical formula	Utilization judgment	Other	Don't know/missing	When stock falls to a predetermined level	More often than once a month	Every 4 weeks	Less often than once a month	As needed	Other		Don't know/missing	Activity level	Fixed supply		Don't know/missing	
MEDICINES																			
Type of facility																			
Hospital	51	3	80	43	4	0	56	1	27	28	71	0	0	42	100	0	0	0	
Health centre	43	2	69	48	4	2	59	0	16	32	62	3	2	161	68	32	0	3	
Clinic	37	3	63	46	0	2	44	0	22	26	64	1	3	110	100	0	0	1	
PMH	43	1	52	55	1	0	46	0	32	8	66	1	4	89	na	na	na	0	
Operating authority																			
Public	41	2	68	48	2	1	54	0	17	31	64	2	1	269	76	24	0	5	
Private religious	43	5	77	40	4	3	48	1	31	20	61	2	5	39	100	0	0	0	
Other private	44	1	52	55	1	0	48	0	32	8	67	1	3	95	na	na	na	0	
Region																			
Western	2	3	53	64	7	0	31	0	9	29	74	3	3	39	na	na	na	0	
Central	60	0	57	4	0	0	65	0	12	19	33	0	0	27	100	0	0	1	
Greater Accra	69	0	86	70	7	0	62	0	51	18	89	7	0	27	na	na	na	0	
Volta	63	2	73	47	0	6	77	0	17	20	70	0	4	64	100	0	0	1	
Eastern	61	0	63	54	0	2	61	0	30	8	81	0	3	49	100	0	0	1	
Ashanti	12	2	69	38	2	0	20	0	20	23	68	0	3	65	na	na	na	0	
Brong Ahafo	22	0	76	39	0	0	37	0	26	35	56	0	2	54	na	na	na	0	
Northern	65	10	65	40	3	0	80	0	29	24	43	2	0	39	0	100	0	1	
Upper East	57	0	64	97	8	2	80	2	0	2	98	16	2	18	na	na	na	0	
Upper West	45	0	3	78	0	0	22	0	20	80	19	0	0	20	na	na	na	0	
Total	42	2	65	49	2	1	52	0	22	24	64	2	2	402	78	22	0	5	
na= Not applicable																			

Table A-3.15 Sterilization capabilities

Percentage of facilities that have functioning equipment, equipment and knowledge of appropriate processing time (and temperature for dry heat sterilization), and an automatic timing device, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:								Weighted number of facilities
	Equipment ¹		Equipment and knowledge ²				Functioning automatic timing device ³		
	Boiling or steaming	Autoclave/dry heat	Chemical decontamination	Chemical HLD	Boil/steam	Autoclave		Dry heat sterilization	
Type of facility									
Hospital	26	96	85	11	17	82	15	57	43
Health centre	48	54	77	14	35	4	1	5	166
Clinic	35	41	63	11	22	6	1	8	125
PMH	53	56	97	28	43	1	1	2	95
Operating authority									
Public	40	51	73	13	27	11	1	11	288
Private religious	49	76	68	7	35	40	13	26	39
Other private	52	56	96	28	43	3	1	3	100
Region									
Western	36	54	76	0	3	13	0	12	39
Central	77	89	96	5	65	19	4	20	30
Greater Accra	46	64	100	11	36	13	0	19	28
Volta	39	49	65	24	30	11	0	9	74
Eastern	23	36	84	25	21	12	5	14	50
Ashanti	44	57	81	18	34	17	7	11	71
Brong Ahafo	49	59	85	18	42	7	1	5	54
Northern	41	48	59	16	18	8	0	4	41
Upper East	34	37	49	0	15	6	3	3	20
Upper West	66	69	96	25	62	8	0	13	22
Total	43	55	78	16	31	12	2	10	428

¹ Functioning equipment and power source for the method are present.

² Functioning equipment and power source or appropriate chemical are present, and knowledge of minimum processing time (and temperature for dry heat sterilization) is present.

³ This refers to a passive timer that can be set to indicate when a set time has passed. This may be part of the high-level disinfection (HLD) or sterilization equipment.

Table A-3.16 Storage practices for sterilized items

Percentage of facilities with sterilized or disinfected instruments present; among facilities where sterilized items are present, percentage with specific storage conditions for processed items, by type of facility, operating authority, and region, SPA Ghana 2002

Background characteristics	Percentage of facilities with sterilized or disinfected items present	Weighted number of facilities	Percentage of facilities with:				Weighted number of facilities with stored processed items
			Sterile storage conditions ¹	Clean, but not sterile, storage conditions ²	Processing dates observed on sterilized items	Sterile storage conditions and processing dates on sterilized items	
Type of facility							
Hospital	93	43	91	40	28	28	40
Health centre	84	166	62	51	1	1	139
Clinic	69	125	58	46	4	4	86
	95	95	77	48	1	1	90
Operating authority							
Public	79	288	63	48	5	5	229
Private religious	79	39	80	53	15	15	31
Other private	94	100	78	47	2	2	94
Region							
Western	71	39	71	21	2	2	28
Central	96	30	89	49	2	2	28
Greater Accra	100	28	56	69	8	8	28
Volta	78	74	54	34	3	3	58
Eastern	98	50	69	56	4	4	49
Ashanti	88	71	77	66	2	2	62
Brong Ahafo	89	54	77	18	6	6	48
Northern	68	41	51	58	10	10	28
Upper East	30	20	70	0	0	0	6
Upper West	92	22	66	85	15	15	20
Total	83	428	68	48	5	5	355

¹ Items are wrapped and sealed with time sensitive tape (TST) or are in a sterile/HLD box that clasps shut.

² Items may be wrapped but not sealed, unwrapped on a tray under a cloth, unwrapped on a tray in the sterilizer or autoclave, sitting in disinfecting solution.

Table A-3.17 Infection control items

Percentage of facilities where the indicated item was available on the day of survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:						Weighted number of facilities
	Soap	Water	Single-use towels	Sharps box	Gloves	Disinfectant	
Type of facility							
Hospital	71	76	11	18	42	11	43
Health centre	70	63	8	47	47	12	166
Clinic	64	64	12	46	48	26	125
PMH	79	79	61	33	81	49	95
Operating authority							
Public	66	64	9	44	45	17	288
Private religious	74	73	16	34	51	14	39
Other private	80	80	60	36	82	49	100
Region							
Western	82	69	10	37	36	17	39
Central	92	88	49	42	50	40	30
Greater Accra	71	73	40	17	73	43	28
Volta	81	76	5	45	42	9	74
Eastern	59	57	26	37	60	26	50
Ashanti	66	69	29	25	65	20	71
Brong Ahafo	65	63	29	29	51	35	54
Northern	57	74	4	65	60	32	41
Upper East	58	43	15	57	61	0	20
Upper West	70	56	19	89	52	35	22
Total	70	68	21	41	54	24	428

Table A-3.18 Hazardous waste disposal methods

Percentage of facilities that dispose of hazardous materials through specific methods, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities where hazardous materials are:								Weighted number of facilities
	Burned in incinerator	Burned and buried	Burned in open pit	Burned and removed to offsite dump	Thrown in trash/open pit	Thrown in pit latrine	Removed as is to offsite dump	Other	
NEEDLES AND SHARPS									
Type of facility									
Hospital	31	10	44	1	5	0	7	2	43
Health centre	9	11	71	3	3	0	2	1	166
Clinic	6	18	53	8	6	1	5	0	125
PMH	5	30	29	21	2	3	6	3	95
Operating authority									
Public	9	13	63	5	4	0	4	1	288
Private religious	24	13	48	4	5	5	2	0	39
Other private	4	29	31	21	2	3	6	3	100
Region									
Western	8	4	73	3	3	6	3	0	39
Central	25	4	60	2	5	4	2	0	30
Greater Accra	2	33	27	27	3	0	5	3	28
Volta	2	18	69	6	1	0	3	0	74
Eastern	8	24	41	14	0	0	5	5	50
Ashanti	14	19	36	12	7	2	8	2	71
Brong Ahafo	12	14	53	9	7	0	0	2	54
Northern	12	24	53	5	4	0	2	0	41
Upper East	7	3	64	0	7	2	16	0	20
Upper West	3	19	77	0	0	0	1	0	22
Total	9	17	54	8	4	1	4	1	428
WET WASTE									
Type of facility									
Hospital	20	9	27	2	13	10	14	4	43
Health centre	3	14	55	2	4	6	4	12	166
Clinic	5	12	40	5	8	10	5	12	125
PMH	1	22	18	13	8	3	16	18	95
Operating authority									
Public	4	13	48	3	6	7	6	12	288
Private religious	21	10	27	3	9	19	2	6	39
Other private	1	21	19	13	8	3	16	18	100
Region									
Western	2	23	40	4	5	7	3	17	39
Central	19	0	51	0	12	4	6	8	30
Greater Accra	0	6	19	7	4	0	58	7	28
Volta	2	8	61	8	4	5	3	6	74
Eastern	6	21	42	10	1	0	7	14	50
Ashanti	3	15	12	5	8	18	8	31	71
Brong Ahafo	1	21	37	6	15	9	0	9	54
Northern	16	19	43	4	10	0	0	5	41
Upper East	0	24	42	0	7	7	16	2	20
Upper West	5	8	55	0	0	18	0	13	22
Total	5	15	40	5	7	7	8	13	428

Table A-3.19 Community-based Health Planning and Services

Among public facilities, percentage that have started the Community-based Health Planning and Services (CHPS) programme, that are planning to start the CHPS programme, that have no plan at this time for implementing the CHPS programme, that have village health committees or volunteers and, among all facilities, percentage that have a revolving drug fund, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:			Village health committees or volunteers	Weighted number of government health facilities	Percentage of facilities with revolving drug fund	Weighted number of facilities
	CHPS programme:		Not planned				
	Started	Planned					
Type of facility							
Hospital	27	17	56	27	27	78	43
Health centre	16	15	69	14	158	85	166
Clinic	16	14	70	16	83	46	125
PMH	na	na	na	na	0	21	95
Operating authority							
Public	17	15	68	16	267	76	288
Private religious	na	na	na	na	na	28	39
Other private	na	na	na	na	na	21	100
Region							
Western	8	26	66	8	24	55	39
Central	0	9	91	0	13	44	30
Greater Accra	16	22	62	16	10	85	28
Volta	18	7	75	14	56	53	74
Eastern	9	11	80	6	31	60	50
Ashanti	25	26	49	25	36	50	71
Brong Ahafo	28	20	52	28	33	56	54
Northern	3	14	83	3	30	60	41
Upper East	46	8	46	46	17	52	20
Upper West	10	10	79	10	17	100	22
Total	17	15	68	16	267	59	428
na = Not applicable							

Table A-3.20 Community-based Health Planning and Services activities

Percentage of facilities that participate in the CHPS activities, with full coverage or partial coverage, the median number of nurses posted to community-based positions, with plans to increase the number of nurses, who are at the indicated level of CHPS implementation, by type of facility, Ghana SPA 2002

Participation in CHPS activities	Percentage of facilities that participate in CHPS activities by type of facility			
	Hospital	Health centre	Clinic	Total
Level of participation in CHPS activities				
Full coverage	55	26	49	37
Partial coverage	45	74	51	63
Facility plans to increase number of nurses	70	66	79	70
Level of CHPS implementation				
Strategic planning ¹	0	8	31	13
Programme planning ²	34	12	10	15
Programme implementation ³	12	11	0	8
Volunteer programme implementation ⁴	45	55	49	52
Median number of nurses posted to community-based positions	2	1	1	1
Weighted number of facilities	7	25	13	45
¹ Analyze situation and select communities, consult and sensitize health workers or dialogue with community leaders and district authority ² Inform community durbar, select and train community health officers, select and orient community health committee or compile community profile ³ Construct community health compound, mobilize logistics, or launch CHPS durbar ⁴ Select community volunteers, approve community health volunteers durbar, train community health volunteers, mobilize logistics, or launch community health volunteer programme durbar				

Table A-3.21 Opinions about CHPS				
Percentage of government facilities with a positive opinion of CHPS, that suggest they need more government support, and that suggest they need more community support, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities with:			Weighted number of government facilities
	Positive opinion	Problems described, suggested more government support	Problems described, suggested more community support	
Type of facility				
Hospital	5	8	3	27
Health centre	4	11	6	158
Clinic	5	13	1	83
Operating authority				
Public	4	11	5	267
Region				
Western	0	8	0	24
Central	0	9	0	13
Greater Accra	8	0	8	10
Volta	8	7	5	56
Eastern	16	14	11	31
Ashanti	0	24	4	36
Brong Ahafo	4	11	0	33
Northern	0	4	3	30
Upper East	0	29	8	17
Upper West	0	0	10	17
Total	4	11	5	267

Table A-3.22 Information on revolving drug funds

Percentage of facilities with a revolving drug fund (RDF) that meets local needs, for which the drug source is the regional health store, the district central medical store, a nongovernmental organization (other private) store, or that buy drugs from a market or pharmacy when needed, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities where:					Weighted number of facilities with RDF
	RDF meets local needs	Drug source is:			Market or pharmacy representative when needed	
		Regional health store	District, central medical store	Other private store		
Type of facility						
Hospital	52	98	2	13	59	33
Health centre	57	67	32	0	10	141
Clinic	49	63	35	8	21	57
PMH	80	5	0	0	100	20
Operating authority						
Public	54	71	30	1	17	218
Private religious	55	72	0	63	61	11
Other private	82	5	1	1	97	21
Region						
Western	72	94	6	0	34	22
Central	47	91	19	0	16	13
Greater Accra	83	39	10	0	86	24
Volta	52	28	64	9	11	39
Eastern	58	55	40	3	28	30
Ashanti	66	93	0	1	36	36
Brong Ahafo	62	57	36	3	9	30
Northern	18	71	31	6	16	25
Upper East	66	69	29	3	9	10
Upper West	40	91	0	7	10	22
Total	56	65	26	4	26	251

Chapter 4

Table A-4.1 Availability of child health services at the facility

Among facilities offering curative care for children, growth monitoring services, or child immunization services, percentage providing the service 1-2 days per week or 5 or more days per week at the facility, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Curative care for children		Weighted number of facilities that provide service	Growth monitoring		Weighted number of facilities that provide service	Child immunization		Weighted number of facilities that provide service
	1-2 days per week	5+ days per week		1-2 days per week	5+ days per week		1-2 days per week	5+ days per week	
Type of facility									
Hospital	0	98	42	60	15	36	39	49	39
Health centre	1	99	164	69	4	136	63	15	135
Clinic	2	96	107	57	7	81	52	16	80
PMH	0	100	92	30	8	23	35	8	29
Operating authority									
Public	1	98	270	66	6	224	58	19	224
Private religious	0	100	38	48	13	28	40	30	28
Other private	1	99	96	32	8	25	35	9	31
Region									
Western	0	97	39	72	3	25	55	18	23
Central	0	100	30	78	9	19	35	59	20
Greater Accra	0	100	27	54	30	18	52	32	19
Volta	0	98	63	47	4	43	55	14	41
Eastern	4	96	49	60	7	38	56	16	38
Ashanti	0	99	67	25	8	39	25	22	43
Brong Ahafo	2	98	52	60	0	30	51	12	33
Northern	0	100	37	75	9	32	65	18	32
Upper East	0	100	18	84	2	13	73	13	13
Upper West	0	100	22	100	0	21	100	0	21
Total	1	98	404	61	7	277	54	19	283

Table A-4.2 Availability of child health services

Among all facilities offering sick-child (SC) services, percentage offering SC services 7 days per week, percentage offering child immunization (EPI) every day SC services are offered, and percentage where both SC and EPI services were being provided the day of the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:			Weighted number of facilities offering SC services
	SC services available 7 days per week	EPI services available every day SC services are offered	Both SC and EPI services provided on day of survey	
Type of facility				
Hospital	75	36	57	42
Health centre	74	20	27	164
Clinic	71	16	19	107
PMH	84	4	6	92
Operating authority				
Public	75	20	28	270
Private religious	65	24	36	38
Other private	81	4	5	96
Region				
Western	89	14	21	39
Central	87	47	25	30
Greater Accra	83	17	23	27
Volta	65	11	26	63
Eastern	75	18	26	49
Ashanti	80	11	18	67
Brong Ahafo	76	14	24	52
Northern	73	12	22	37
Upper East	82	27	26	18
Total	75	17	23	404

Table A-4.3 Availability of child vaccines

Among facilities offering child immunization services and routinely storing vaccines, percentage with the indicated vaccine available on the day of the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with indicated vaccine available:								Weighted number of facilities offering child immunization services and storing vaccines
	BCG	Polio	HibHep ¹	Measles	All basic child vaccines ²	Yellow fever	DPT	All basic child vaccines ² and yellow fever	
Type of facility									
Hospital	95	90	91	92	84	57	0	56	35
Health centre	85	90	85	89	75	55	4	47	133
Clinic	77	86	77	86	70	40	3	35	52
PMH	16	30	31	31	8	15	0	8	14
Operating authority									
Public	84	90	85	89	75	53	3	46	194
Private religious	88	88	80	91	78	43	2	42	25
Other private	20	32	33	33	12	18	0	12	14
Region									
Western	63	70	70	70	63	60	0	53	20
Central	87	87	81	94	75	46	0	33	19
Greater Accra	56	73	70	70	56	59	0	52	15
Volta	73	87	79	84	61	36	4	27	35
Eastern	92	96	93	92	85	81	4	77	26
Ashanti	85	78	82	86	72	37	5	34	33
Brong Ahafo	85	85	85	85	74	48	4	44	33
Northern	84	91	86	91	82	31	0	31	25
Upper East	77	92	92	96	73	65	19	42	8
Upper West	93	100	72	93	72	62	0	53	
Total	81	86	81	86	71	50	3	43	233

¹ HibHep includes diphtheria, pertussis, polio, hepatitis B and haemophilus influenza type B

² BCG, polio, HibHep (or DTP), and measles all available

Table A-4.4 Specific equipment and supplies for vaccination services

Among facilities offering childhood vaccination services, percentage with specific equipment and supplies, infection prevention measures, and record keeping system components for quality services, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:							Weighted number of facilities offering child vaccination services
	Equipment and supplies			Infection prevention measures		Administrative practices		
	Blank immunization cards	Adequate supplies of syringes and needles ¹	Cold box with ice pack ²	Soap and water	Sharps box	Register or tally sheet ³	Monitoring of community coverage ⁴	
Type of facility								
Hospital	70	69	93	80	90	72	47	37
Health centre	75	64	98	71	90	89	57	132
Clinic	74	53	89	72	83	76	33	79
PMH	52	41	85	63	44	37	3	28
Operating authority								
Public	74	60	95	72	88	84	49	221
Private religious	70	68	92	79	83	70	40	27
Other private	53	43	85	63	46	38	4	29
Region								
Western	73	52	82	76	88	76	41	23
Central	39	94	100	88	100	94	45	20
Greater Accra	71	58	90	64	66	57	35	18
Volta	69	49	91	83	91	79	54	41
Eastern	81	47	97	65	70	83	44	34
Ashanti	71	64	91	65	74	62	25	43
Brong Ahafo	81	62	99	69	77	77	48	33
Northern	65	36	93	70	91	83	37	32
Upper East	62	82	91	69	82	78	60	13
Upper West	90	77	100	71	100	100	58	21
Total	71	59	93	72	83	78	43	277

¹ Disposable syringes and needles are universally utilized in Ghana.

² If a facility reported it purchased ice, this was accepted in place of the ice pack.

³ Register or tally sheets for recording immunizations provided

⁴ Either DPT dropout rate or measles coverage were documented.

Table A-4.5 Availability of specific equipment and supplies for quality assessments of the sick child

Among facilities that provide curative care for sick children (SC), percentage with indicated items to support quality of services, percentage with secondary qualified staff among interviewed providers, percentage with the indicated items to provide preventive services, and percentage with the indicated equipment to assess the sick child and provide care in the service delivery room, by type of facility and operating authority, Ghana SPA 2002

Items	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Support quality of care								
Soap and water	98	92	76	95	86	98	96	89
Child health cards	81	78	63	61	74	74	61	71
Treatment protocols/standards (any)	73	82	66	69	76	75	67	74
Visual aids for health education	16	35	29	16	32	19	15	27
All items to support quality of care ¹	12	27	14	8	21	15	8	18
Secondary qualified staff among interviewed providers of child health services	100	84	66	89	80	83	87	82
Items for preventive services								
Capacity to provide vaccinations ²	41	32	14	6	28	27	6	22
Infant weighing scale	27	44	51	60	44	43	60	48
Child weighing scale	46	61	65	48	61	55	49	58
Both scales	26	38	38	30	37	31	30	35
All preventive items ³	8	15	8	4	12	6	5	10
Equipment for assessment and care supplies								
Thermometer	72	84	77	97	80	76	96	84
Minute timer ⁴	76	79	72	90	75	80	90	79
Oral rehydration therapy (ORT) administration materials	14	53	45	54	47	27	53	47
All equipment for assessment and care ⁵	10	45	36	50	39	22	49	40
All equipment and supplies for quality, prevention, and for assessment and care ⁶	2	4	1	2	3	2	3	3
Weighted number of facilities offering SC services	42	164	107	92	270	38	96	404
¹ Soap, water, child health cards, treatment protocol/standards and visual aids for health education								
² Vaccines, equipment, immunization cards, and Infection prevention items all available. Register and monitoring of coverage were not considered essential to immunize sick children on the day of survey.								
³ Capacity to provide vaccinations, infant and child weighing scale								
⁴ This represents a minute timer that is facility equipment. In addition to this, many staff had personal watches with second hands that could be used to time for 1 minute.								
⁵ Thermometer, minute timer and ORT materials								
⁶ All items to support quality of care, all preventive items, and all equipment for assessment and care								

Table A-4.6 Availability of specific medicines for quality treatment of the sick child

Among facilities that provide curative care for sick children (SC), percentage where first-line, prereferral, and other nonessential medications are available, by type of facility and operating authority, Ghana SPA 2002

Medicines	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
First-line oral medicines								
Oral rehydration salts (ORS)	97	81	78	65	82	87	66	78
Antibiotic: Amoxicillin	93	70	69	64	71	86	63	71
Antibiotic: Co-trimoxazole	90	80	68	49	77	83	50	71
Anti-malarial: Chloroquine	96	90	92	71	91	92	72	87
All essential oral medicines ¹	90	68	70	48	71	76	48	66
Prereferral injectable medicines								
Antibiotic: Ampicillin	72	10	11	16	15	44	15	18
Antibiotic: Penicillin	99	82	71	73	79	96	72	79
Antibiotic: Gentamicin	95	24	25	44	30	61	43	36
Antibiotic: Ceftriaxone	28	1	1	1	3	12	2	4
Anti-malarial: Quinine	46	12	6	12	12	35	11	14
Intravenous solution with infusion set	99	87	65	88	80	92	86	83
All prereferral medicines ²	46	6	2	8	7	33	7	10
Other nonessential medicines								
Aspirin or paracetamol (antipyretic)	96	97	95	84	96	98	85	93
Vitamin A (any dose)	29	25	24	12	23	44	11	22
Iron tablet	87	74	66	73	71	88	74	73
Mebendazole (for deworming)	92	71	64	46	69	88	47	66
Antibiotic eye ointment	80	44	48	46	45	83	47	49
All other nonessential medicines	22	9	11	3	8	36	3	9
Weighted number of facilities offering SC services	42	164	107	92	270	38	96	404
¹ ORS, at least one antibiotic, and chloroquine								
² At least one first-line injectable antibiotic (ampicillin or penicillin), at least one second-line injectable antibiotic (ceftriaxone or gentamycin), quinine and intravenous solution (normal saline, Ringer's lactate, or dextrose and saline 0.9%) with infusion set								

Table A-4.7 Supportive management for child health service providers

Among interviewed child health service providers, percentage who were personally supervised during the past 6 months, percentage who received in-service training related to child health during the 12 months prior to the survey, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility, operating authority and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed child health service providers
	Who were personally supervised in the past 6 months	Who received in-service training in the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	46	32	15	35	464
Health centre	58	42	29	25	343
Clinic	56	41	28	24	243
PMH	41	28	15	24	88
Operating authority					
Public	55	37	23	30	855
Private religious	40	40	20	25	193
Other private	42	27	15	25	90
Region					
Western	33	38	20	32	120
Central	25	27	15	20	83
Greater Accra	69	24	14	34	165
Volta	53	34	21	32	143
Eastern	51	47	30	38	145
Ashanti	43	36	16	28	188
Brong Ahafo	57	53	33	18	131
Northern	63	32	27	27	91
Upper East	67	51	33	20	29
Upper West	71	32	18	25	43
Total	52	37	22	29	1,138

Table A-4.8 Supportive management: In-service training for child health service providers

Among interviewed child health service providers, percentage who received any child-health-related in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed child health service providers who received in-service training on specific topics														Weighted number of interviewed child health service providers
	EPI/cold chain		ARI treatment		Diarrhoea treatment		Malaria		Nutrition/micronutrient deficiencies		PMTCT ¹		IMCI		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility															
Hospital	14	18	3	13	7	24	15	22	5	14	15	22	4	4	464
Health centre	24	24	4	11	9	28	18	30	8	11	10	11	4	4	343
Clinic	22	14	5	7	14	18	22	24	7	8	11	10	2	2	243
PMH	7	20	3	9	12	18	12	19	4	3	16	7	4	3	88
Operating authority															
Public	20	20	3	11	9	24	16	26	6	11	12	16	4	3	855
Private religious	14	17	6	12	11	23	25	21	6	14	14	13	3	5	193
Other private	7	20	3	9	12	19	11	20	4	3	15	8	4	3	90
Region															
Western	20	19	1	7	3	24	12	25	7	10	7	12	6	1	120
Central	9	12	3	6	6	18	12	20	5	4	13	11	1	4	83
Greater Accra	6	12	2	9	7	16	10	20	2	8	17	29	3	4	165
Volta	20	27	5	12	9	27	9	30	5	11	13	17	1	6	143
Eastern	23	31	2	19	8	33	20	31	6	29	17	20	4	7	145
Ashanti	21	14	5	10	12	19	20	26	10	9	10	11	8	2	188
Brong Ahafo	27	15	9	6	18	20	34	16	12	2	16	7	4	1	131
Northern	12	31	1	11	4	28	17	22	3	16	6	11	3	5	91
Upper East	31	12	9	11	20	33	21	33	5	9	15	6	1	2	29
Upper West	16	22	2	19	7	25	21	29	2	8	3	2	1	1	43
Total	18	19	4	11	9	23	17	25	6	11	12	15	4	3	1,138

¹ PMTCT = Prevention of mother-to-child transmission

Table A-4.9 Out-of-pocket payments for sick child consultations

Among interviewed caretakers of sick children, percentage who reported that they are part of a prepayment plan and percentage who reported paying any out-of-pocket fees for services for the sick child on the day of the survey; among the caretakers who paid any fees for services for the sick child, median amount (cedis) paid on the day of the survey, by whether the client belongs to a prepay programme or not, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed caretakers of sick children who reported:		Weighted number of interviewed caretakers	Median out-of-pocket payment ¹ by caretakers who paid anything for child health services who:		Weighted number of interviewed caretakers providing valid responses for amount paid
	Belonging to a prepaid programme	Paying any out-of-pocket charges ¹ for this visit		Belong to prepaid programme	Do not belong to prepaid programme	
Type of facility						
Hospital	6	87	345	10,419	10,075	300
Health centre	7	63	571	2,581	8,010	362
Clinic	2	81	280	na	7,523	226
PMH	3	81	133	na	13,031	107
Operating authority						
Public	6	72	992	5,036	7,292	716
Private religious	4	84	201	10,500	12,014	168
Other private	3	81	137	na	13,008	111
Region						
Western	1	89	133	na	12,644	118
Central	11	59	156	10,542	8,093	92
Greater Accra	9	89	80	14,073	10,007	71
Volta	3	90	132	2,496	9,078	118
Eastern	2	82	201	10,100	10,770	164
Ashanti	3	87	184	na	11,003	160
Brong Ahafo	4	93	183	8,011	7,054	170
Northern	6	50	126	9,600	3,568	64
Upper East	10	41	78	na	2,094	32
Upper West	16	12	58	na	1,528	7
Total	5	75	1,330	9,046	9,006	995

¹ Includes any amount paid out-of-pocket, including fees for consultation, laboratory test, medicines, or other
na = Not applicable; none of the caretakers belonged to a prepaid programme

Table A-4.10 General assessments, examinations, and treatments for sick children

Percentage of observed children for whom the indicated assessment, examination, or intervention was a component of their consultation, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of observed children by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
History: Assessment of danger signs								
Inability to eat or drink anything	37	39	38	39	39	35	39	38
Vomiting everything	63	57	57	52	59	57	51	58
Convulsions	12	10	8	7	10	12	7	10
All danger signs	6	5	4	3	5	6	3	5
History: Assessment of symptoms								
Cough or difficult breathing	75	65	59	65	66	74	64	67
Diarrhoea	65	62	65	68	63	63	68	64
Fever	94	93	96	94	94	97	94	94
All major symptoms	53	42	45	49	45	51	49	46
Physical examination								
Counted respiratory rate per minute	27	18	7	8	17	24	8	17
Assessed dehydration	27	18	8	12	19	19	13	18
Measured temperature	78	76	82	80	77	86	80	78
Felt temperature	76	69	77	68	73	70	68	72
Any temperature	94	94	96	90	94	94	90	94
Assessed anaemia: Looked at palms	33	26	27	23	28	29	23	28
Assessed anaemia: Looked at eye conjunctiva or mucosa of mouth	70	64	62	58	64	70	58	65
Any anaemia	74	68	66	59	69	74	59	69
All physical checks ¹	8	5	2	2	5	8	2	5
Drinking/feeding practices during illness for children < 24 months (n = 879)								
Breastfeeding practices	45	45	46	47	46	43	47	45
Observed if child can drink or suck	2	11	15	20	10	4	21	10
Both assessments of drinking/feeding status	1	7	8	10	6	3	11	6
Essential advice								
Increase fluids	10	9	11	13	10	7	13	10
Continue/increase feeding	18	24	31	27	24	21	27	24
Symptoms for immediate return	9	8	9	7	8	11	8	8
All three essential messages	1	1	1	0	1	1	0	1
Preventive measures								
Child weighed	22	15	23	20	17	29	21	19
System weight	54	24	36	28	34	47	28	36
Any weight	60	32	41	39	41	52	40	43
Weight plotted	2	7	11	3	7	4	3	6
System plot weight	9	3	17	1	6	16	1	7
Any weight plotted	12	9	21	3	11	19	3	11
Normal feeding practices < 24 months assessed	36	43	34	41	40	33	40	39
Normal feeding practices > 24 months assessed	27	28	26	21	28	24	21	27
Any normal feeding practices assessed	31	38	31	34	35	30	34	34
Discussed child's weight or growth	10	9	14	11	10	14	11	10
Counselled caretaker about normal feeding	19	24	23	30	23	20	29	23
Immunization status assessed (<24 months)	44	52	62	36	52	54	37	51
Immunization status assessed (>24 months)	31	43	55	14	41	41	16	38
System assessed immunization status	33	33	37	20	31	47	20	32
Any immunization status assessed	50	57	67	36	55	66	37	55
Weighted number of observed children								
<24 months old	219	382	197	80	663	133	82	879
>24 months old	117	173	74	49	303	59	50	413
Weighted number of observed children ²	412	597	287	138	1,065	227	142	1,434

¹ Respiratory rate counted, either method for assessing presence of fever, either method for assessing presence of anaemia, and assessment for dehydration

² For 142 children, information on age was not available.

Table A-4.11 Caretaker report on topics discussed for the sick child

Percentage of interviewed caretakers of observed children who, when asked, reported that a provider discussed the indicated issues, percentage of interviewed caretakers who received all medicines prescribed, some medicines or prescriptions only, percentage who were told by provider how to give medication, who felt they know how to give the medication, the percentage who indicated the child was provided a dose of medicines at the facility and the percentage of children who were reported given vaccination, by facility type and operating authority, Ghana SPA 2002

Items	Percentage of interviewed caretakers by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Issues discussed								
Weight or nutritional status of child	11	8	9	6	8	12	6	9
General feeding practices	23	30	32	43	29	24	42	30
Give food and liquids during the illness	9	14	14	21	13	8	21	13
Was told what the illness was	23	25	28	22	24	27	21	24
Caretaker brought vaccination card	40	52	49	17	49	43	18	45
Weighted number of interviewed caretakers	345	571	280	133	992	201	137	1,330
Medicines								
Caretaker received all medicines prescribed	63	81	85	86	74	89	86	77
Caretaker received some medicines and has some prescriptions	21	16	11	9	18	8	8	15
Caretaker has only prescriptions	15	2	3	5	7	2	5	6
Caretaker was told how to give medicines at home	83	95	92	96	90	93	96	91
Caretaker feels comfortable in knowledge of how to provide medicines at home	80	90	93	92	88	89	92	88
Caretaker states the child was provided a dose of medicine at the facility	12	28	41	44	27	24	44	28
Weighted number of interviewed caretakers who received or were prescribed medicine	337	559	269	119	967	194	123	1,284
Immunization								
Reported child was given vaccination (<24 mo)	2	10	5	0	7	3	0	6
Weighted number of children < 24 months old	219	382	197	80	663	133	82	879
Weighted number of children ≥ 24 months old	117	173	74	49	303	59	50	413

Table A-4.12 Client feedback during exit interview for caretakers of observed children

Percentage of interviewed caretakers of observed children who said that they considered the specific items as big problems for them the day of the visit, by type of facility and operating authority, Ghana SPA 2002

Areas of complaint	Percentage of interviewed caretakers by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Behaviour/attitude of provider	3	1	1	1	2	0	1	1
Insufficient explanation about child's illness	4	5	3	2	5	1	2	4
Waiting time to see provider	17	7	9	3	10	14	3	10
Quality of examination and treatment	2	2	0	2	2	0	2	2
Availability of medicines or supplies	6	3	2	2	4	0	2	3
Hours facility is open	5	0	1	2	2	2	2	2
Cleanliness of facility	4	1	1	1	2	2	1	2
Lack of visual or auditory privacy	2	1	1	0	1	0	0	1
Weighted number of interviewed caretakers	345	571	280	133	992	201	137	1,330

Chapter 5

Table A-5.1 Availability of different methods of family planning

Percentage of facilities offering each of the indicated methods of family planning, percentage offering only sterilization, only the rhythm method, at least one temporary modern method, at least two temporary modern methods, and at least four temporary modern methods, by type of facility and operating authority, Ghana SPA 2002

Family planning methods	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Combined oral contraceptives	76	90	81	84	89	49	85	84
Progesterone-only oral pill	73	71	62	55	73	33	56	65
Progesterone-only injectable (2 or 3 monthly)	78	90	82	95	90	52	96	88
Combined injectable (1 monthly)	41	24	20	6	26	8	9	21
Implant	66	11	14	9	19	14	13	17
Intrauterine device	65	44	29	67	43	21	68	47
Male condom	78	87	73	82	85	45	83	81
Female condom	67	74	57	73	71	32	74	68
Spermicide	68	68	58	63	69	25	65	64
Diaphragm	5	0	1	2	1	0	2	1
Rhythm method	60	44	42	59	46	41	61	49
Male sterilization	21	0	1	0	3	2	0	2
Female sterilization	76	2	4	0	11	20	0	9
Emergency contraceptive pill	30	11	10	38	12	6	40	18
Only sterilization	6	0	1	0	0	6	0	1
Only the rhythm method	4	0	1	0	0	8	0	1
At least one temporary modern method ¹	78	92	83	97	92	52	97	89
At least two temporary modern methods	78	91	81	91	90	51	92	87
At least four temporary modern methods	73	70	62	74	72	27	75	69
Weighted number of facilities	43	166	125	95	288	39	100	428

¹ Temporary methods are: oral pill (combined or progesterone only), injection (every 2 or 3 months), implant, intrauterine device, condom (male or female), spermicide, diaphragm, or emergency contraceptive pill

Table A-5.2 Availability of different methods of family planning

Among facilities offering each of the indicated methods of family planning, percentage where the method was available on the day of survey, by type of facility and operating authority, Ghana SPA 2002

Family planning methods	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Combined oral contraceptives	66	80	62	64	75	42	66	70
Progesterone-only oral pill	57	61	37	41	56	26	39	49
Progesterone-only injectable (2 or 3 monthly)	69	88	72	90	85	42	90	82
Combined injectable (1 monthly)	35	19	16	6	21	8	7	17
Implant	45	7	11	7	13	12	10	12
Intrauterine device (IUD)	48	31	22	56	30	20	57	36
Male condom	63	71	52	69	66	34	71	64
Female condom	60	63	43	56	58	31	58	55
Spermicide	56	53	38	46	51	17	48	47
Emergency contraceptive pill	8	2	6	19	3	2	22	7
All offered methods were available	37	49	44	37	42	72	38	44
Weighted number of facilities	43	166	125	95	288	39	100	428

Table A-5.3 Availability of infrastructure, resources, and systems for quality family planning services

Percentage of facilities that offer temporary methods of family planning where there are items to support quality counselling (infrastructure to provide privacy, individual client cards, guidelines or protocols, and visual aids for health education), and items for quality physical examination (infection prevention items, visual privacy, an examination bed, an examination light, and a speculum), by type of facility and operating authority, Ghana SPA 2002

Items	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Items to support quality counselling								
Visual and auditory privacy (private room)	78	79	73	88	77	75	88	79
Visual privacy	8	79	82	93	81	83	94	84
No privacy	5	9	9	2	8	8	2	7
Individual client health cards	93	86	80	77	86	67	78	83
Written FP protocols or guidelines	85	68	64	83	70	43	84	72
Written STI protocols or guidelines	70	51	44	80	52	34	81	58
Visual aids for health education on FP	95	92	89	96	92	83	96	92
Visual aids for health education on STIs	60	45	41	70	44	47	71	51
Model for demonstrating use of condom	76	71	48	77	64	45	78	67
All items to support quality counselling ¹	67	49	42	60	49	31	62	51
All items to support quality counselling for FP and for STI services and education ²	37	24	15	48	22	14	49	29
Items to support quality physical examination								
Infection prevention								
Soap	88	87	83	92	86	84	92	87
Water	50	30	25	74	30	33	73	41
Single use towel	90	86	86	91	87	83	92	88
Clean gloves	76	63	60	86	62	70	86	69
Disinfecting solution	54	29	37	57	34	41	57	40
Sharps box	84	79	76	61	79	70	63	75
All items for infection prevention ³	32	10	16	33	13	28	33	19
Infrastructure for pelvic examination								
Visual and auditory privacy	93	90	88	92	90	86	93	91
Examination bed ⁴	84	82	67	93	78	64	93	81
Examination light ⁵	52	22	11	24	21	26	23	22
Vaginal speculum	74	44	32	66	43	35	67	48
All elements for pelvic examination ⁶	49	13	7	13	15	16	1	15
All items for infection prevention and pelvic examination	28	2	5	5	6	13	6	6
Weighted number of facilities offering family planning	36	153	105	92	264	25	97	386

¹ Visual and auditory privacy, individual client health cards, written protocols, and visual aids

² All items to support quality counselling, written sexually transmitted infection (STI) protocols or guidelines and visual aids for health education on STIs

³ Soap, water, clean gloves, disinfecting solution, and sharps box

⁴ Any bed where a woman can lie down flat

⁵ Examination light, flashlight, or other spotlight source

⁶ Visual and auditory privacy, examination bed, examination light, and vaginal speculum

Table A-5.4 Availability of medicines for treating sexually transmitted infections

Percentage of facilities that offer temporary methods of family planning where the indicated medicine is available for treating sexually transmitted infections, and percentage with at least one medicine for each of the STIs indicated, by type of facility and operating authority, Ghana SPA 2002

Medicines	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Nystatin suppository (candidiasis)	34	4	6	15	6	30	16	10
Metronidazole (trichomoniasis)	93	83	64	69	76	94	69	75
Ceftriaxone (gonorrhoea)	31	1	1	1	4	16	2	4
Ciprofloxin (gonorrhoea)	73	19	11	35	21	40	35	26
Doxycycline (chlamydia, syphilis)	68	14	9	19	17	36	19	19
Tetracycline (chlamydia, syphilis)	86	60	39	50	54	74	50	54
Erythromycin (chlamydia, syphilis)	55	8	4	7	10	35	7	11
Benzathine or procaine penicillin (syphilis)	97	68	58	70	66	91	68	68
At least one medicine for each STI ¹	75	15	10	29	19	42	29	23
Weighted number of facilities offering family planning	36	153	105	92	264	25	97	386

¹ At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis

Table A-5.5 Availability of equipment and infrastructure for providing specific methods of contraception

Among facilities where contraceptive methods containing estrogen are offered, facilities offering injectable methods, facilities offering intrauterine devices, and facilities offering implants; percentage of facilities having the required equipment and infrastructure to provide the method safely by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Methods containing estrogen			Injectable methods		IUD			Implant		
	Blood pressure apparatus ¹ (percentage)	Adult weight scale (percentage)	Weighted number of facilities	Sterile needle and syringe (percentage)	Weighted number of facilities	Equipment for IUD insertion ² (percentage)	Equipment and quality conditions for pelvic examination ³ (percentage)	Weighted number of facilities	Equipment for implant insertion ⁴ (percentage)	Equipment, infection prevention, and infrastructure ⁵ (percentage)	Weighted number of facilities
Type of facility											
Hospital	87	87	33	98	33	59	27	28	59	28	28
Health centre	80	91	148	95	150	56	3	73	47	6	19
Clinic	80	82	100	94	104	63	15	36	64	16	17
PMH	95	90	81	97	91	71	6	64	86	11	8
Operating authority											
Public	80	87	257	95	261	56	10	124	57	20	54
Private religious	95	88	19	98	21	75	31	8	41	0	6
Other private	95	91	87	97	96	72	7	69	84	13	13
Total	84	88	363	95	378	63	9	201	60	17	72

¹ Stethoscope and sphygmomanometer

² Clean gloves, iodine antiseptic, speculum, forceps for holding gauze to clean cervix, tenacula, and uterine sound (or IUD kit, which includes a tenacula and uterine sound)

³ Equipment for IUD insertion, all infection control items (soap, water, clean gloves, disinfecting solution, and sharps box) and visual privacy, an examination bed, and an examination light

⁴ Forceps for grasping implant, local anesthetic (Xylocaine), scalpel with blade, sterile needle and syringe, sterile gloves, and antiseptic for cleaning skin

⁵ Equipment for implant, all infection prevention items (soap, water, disinfecting solution, and sharps box) and visual privacy, examination bed, and examination light

Table A-5.6 Availability of all items for intrauterine device

Among facilities that offer the IUD, percentage that have each of the indicated supplies and pieces of equipment, by type of facility and operating authority, Ghana SPA 2002

Equipment and supplies	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Clean or sterile gloves	97	87	96	92	91	100	93	92
Antiseptic solution	70	60	67	77	61	87	79	68
Sponge holding forceps	93	90	90	91	90	92	91	91
Speculum	94	91	90	92	90	100	93	92
Tenacula	10	15	17	19	15	5	18	16
Uterine sound	12	14	17	17	15	5	17	15
IUD kit with tenacula and uterine sound	76	77	73	72	74	91	72	74
IUD	74	70	77	84	71	95	83	76
All items ¹	43	43	53	59	43	70	60	50
Weighted number of facilities offering IUD	28	73	36	64	124	8	69	201

¹ Clean or sterile gloves, antiseptic solution, sponge holding forceps, speculum, tenacula, uterine sound, or IUD kit with tenacula, uterine sound, and IUD

Table A-5.7 Availability of all items for implant

Among facilities that offer the implant method, percentage that have each of the indicated supplies and pieces of equipment by type of facility and operating authority, Ghana SPA 2002

Equipment and supplies	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Sterile gloves	88	80	84	86	82	100	89	84
Antiseptic solution	70	67	82	100	69	77	100	75
Local anesthetic	83	80	84	100	80	100	98	84
Sterile syringe and needle	88	81	93	100	85	100	100	89
Scalpel with blade	5	0	11	13	5	0	13	6
Forceps for grasping	8	7	11	13	9	0	13	9
Minor surgical kit with scalpel and grasping forceps	74	80	66	73	75	63	73	74
Implant	68	67	83	75	69	83	81	72
All items ¹	44	34	55	61	43	35	65	46
Weighted number of facilities offering implant	28	19	17	8	54	6	13	72

¹ Sterile gloves, antiseptic solution, local anesthetic, sterile syringe and needle, scalpel with blade, forceps for grasping, or minor surgical kit with scalpel, grasping forceps, and implant

Table A-5.8 Supportive management for providers of family planning services

Percentage of providers who were personally supervised in the 6 months preceding the survey, percentage who received in-service training related to family planning during the 12 months preceding the survey, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed family planning providers
	Who were personally supervised during the past 6 months	Who received in-service training during the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	57	57	33	35	244
Health centre	66	51	34	26	206
Clinic	64	43	29	30	126
PMH	42	48	25	21	89
Operating authority					
Public	62	52	33	30	517
Private religious	53	51	32	34	54
Other private	43	48	26	22	93
Region					
Western	51	74	47	15	62
Central	46	64	36	22	32
Greater Accra	67	58	40	25	64
Volta	51	29	17	43	88
Eastern	57	53	25	38	121
Ashanti	48	50	26	30	107
Brong Ahafo	72	44	32	21	68
Northern	72	40	31	41	67
Upper East	65	65	47	2	25
Upper West	79	72	56	16	31
Total	59	51	32	29	665

Table A-5.9 Supportive management: In-service training for family planning service providers

Among interviewed family planning service providers, percentage who received any family planning related in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed family planning service providers who received in-service training on specific topics												Weighted number of interviewed family planning service providers
	Emergency contraception		Other contraceptive technology		Minilap procedure		Infection prevention		Any counselling or treatment for STIs		Syndromic approach to STIs		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility													
Hospital	12	11	2	4	6	13	31	35	28	25	17	25	244
Health centre	9	10	1	6	1	5	23	30	15	20	11	18	206
Clinic	6	11	2	6	3	5	22	24	14	18	9	12	126
PMH	17	12	5	5	1	1	29	23	26	19	21	23	89
Operating authority													
Public	9	11	1	5	3	9	27	31	20	21	13	19	517
Private religious	11	7	3	3	7	4	17	32	26	26	14	23	54
Other private	18	14	5	6	1	2	29	24	26	21	20	24	93
Region													
Western	11	7	1	1	5	5	30	31	25	27	17	25	62
Central	7	23	6	20	7	16	24	36	21	20	10	26	32
Greater Accra	15	21	0	10	1	14	30	27	38	23	27	26	64
Volta	6	11	1	3	2	5	16	34	14	22	9	19	88
Eastern	9	10	0	1	6	5	30	37	19	26	12	29	121
Ashanti	13	8	1	6	5	15	31	28	11	23	7	18	107
Brong Ahafo	9	11	6	7	2	4	21	31	24	15	16	16	68
Northern	2	8	1	5	0	3	15	28	20	19	18	13	67
Upper East	20	12	1	3	0	4	40	10	20	5	13	7	25
Upper West	28	3	9	1	2	0	40	21	36	8	19	7	31
Total	10	11	2	5	3	7	26	30	21	21	14	20	665

Continued...

Table A-5.9—Continued

Background characteristics	Percentage of interviewed family planning service providers who received in-service training on specific topics										Weighted number of interviewed family planning service providers
	Counselling		Female condom		IUD		Norplant		Norigynom		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility											
Hospital	23	50	29	32	6	25	13	16	14	15	244
Health centre	27	34	32	16	5	19	4	3	14	7	206
Clinic	29	32	21	18	3	19	5	6	7	6	126
PMH	36	26	29	17	8	20	4	3	7	5	89
Operating authority											
Public	25	41	29	23	4	23	8	9	13	11	517
Private religious	35	34	27	21	6	8	8	7	10	2	54
Other private	35	28	29	17	9	20	4	5	7	5	93
Region											
Western	36	31	54	16	6	13	8	5	31	6	62
Central	27	41	50	10	12	23	9	15	19	10	32
Gt. Accra	12	52	32	28	5	47	14	7	25	17	64
Volta	17	41	14	14	3	16	3	5	3	5	88
Eastern	17	52	21	50	6	20	8	10	11	17	121
Ashanti	38	34	23	25	4	26	9	16	15	12	107
Brong Ahafo	27	30	22	10	5	18	5	5	2	4	68
Northern	26	47	19	15	2	20	2	5	0	4	67
Upper East	53	7	44	7	3	11	10	4	0	3	25
Upper West	51	6	58	1	13	13	15	7	8	3	31
Total	27	39	29	22	5	21	7	8	12	9	665

Table A-5.10 Out-of-pocket payments for family planning consultations

Among interviewed family planning clients, percentage who reported that they are part of a prepaid programme, and percentage who reported paying any out-of-pocket fees for services for the service on the day of the survey; among the family planning clients who paid any fees for services, median amount (cedis) paid on the day of the survey, by whether the client belongs to a pre-paid programme or not, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed family planning clients who reported:			Median out-of-pocket payment ¹ by family planning clients who paid for services on day of survey:		Weighted number of interviewed FP clients providing valid responses for amount paid
	Belonging to prepaid programme	Paying any out-of-pocket charges ¹ for this visit	Weighted number of interviewed FP clients	Belong to prepaid programme	Do not belong to prepaid programme	
Type of facility						
Hospital	2	93	139	509	2,063	130
Health centre	3	93	224	1,087	2,038	206
Clinic	1	93	186	na	2,050	173
PMH	2	88	53	na	4,075	46
Operating authority						
Public	2	93	465	1,521	2,042	431
Private religious	7	95	59	2,005	2,046	56
Other private	2	89	78	na	4,058	69
Region						
Western	5	94	41	na	3,066	39
Central	4	99	65	na	2,047	64
Greater Accra	7	92	80	1,550	2,093	74
Volta	1	93	121	na	1,579	111
Eastern	0	86	67	na	3,039	57
Ashanti	0	87	63	na	2,044	55
Brong Ahafo	1	97	67	na	2,055	65
Northern	3	93	47	na	2,049	44
Upper East	0	94	30	na	1,580	28
Upper West	0	90	21	na	2,015	19
Total	2	93	602	1,535	2,058	556

¹ Includes any amount paid out-of-pocket, including fees for consultation, laboratory test, medicines, or other
na = Not applicable; none of the clients belonged to a prepaid programme

Table A-5.11 Description of observed family planning clients														
Among observed family planning clients, percentage for whom this was the first visit for family planning at this facility, percentage for whom this was a follow-up visit, percentage of male clients, and percentage for whom each of the indicated methods was prescribed at the end of the visit, by type of facility, operating authority, and region, Ghana SPA 2002														
Background characteristics	Percentage of all clients:				Percentage of interviewed and observed family planning clients who left with the indicated method or were prescribed the indicated method:									Weighted number of observed and interviewed FP clients
	First-visit clients	Follow-up visit clients	Male clients	Weighted number of observed FP clients	Oral contraceptive (OC)	Injectable (3 monthly) (PIN)	Injectable (once monthly) (CIN)	Male condom	Female condom	Spermicide	IUD	Implant	Other ¹	
Type of facility														
Hospital	26	74	1	139	11	62	5	3	0	4	4	11	1	139
Health centre	23	77	0	229	18	73	2	1	2	2	2	2	0	224
Clinic	21	79	1	187	14	76	4	2	0	0	1	2	1	186
PMH	22	78	0	55	12	69	5	2	0	7	0	7	0	53
Operating authority														
Public	25	75	1	471	16	70	3	2	1	2	2	5	0	465
Private religious	11	89	0	59	6	80	9	0	0	0	0	2	2	59
Other private	23	77	0	80	12	69	4	3	0	4	2	6	1	78
Region														
Western	26	74	1	41	19	64	3	2	0	2	1	13	1	41
Central	8	92	0	65	4	79	10	0	0	2	2	2	1	65
Greater Accra	20	80	2	80	13	69	1	2	1	1	10	4	0	80
Volta	18	82	0	123	17	75	0	0	2	1	0	2	1	121
Eastern	35	65	0	67	15	59	7	0	0	3	0	15	1	67
Ashanti	22	78	0	65	9	70	14	8	0	8	1	0	0	63
Brong Ahafo	19	81	0	67	17	77	0	2	0	2	1	1	0	67
Northern	24	76	3	49	30	58	0	3	0	2	3	2	0	47
Upper East	59	41	0	33	13	81	0	2	2	0	0	6	0	30
Upper West	20	80	0	21	10	81	0	0	0	0	0	9	0	21
Total	23	77	0	611	15	71	4	2	1	2	2	5	0	602

¹ Includes male sterilization, diaphragm, rhythm, LAM, female sterilization, and emergency contraception

Table A-5.12 General assessments, examinations, and interventions for observed first-visit family planning clients

Percentage of observed first-visit family planning clients where the indicated assessment or examination was a component of their consultation, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Client history								
Age	87	72	74	71	77	80	73	76
Any history of pregnancy	88	72	81	70	79	86	74	78
Current pregnancy status	56	56	42	35	53	36	37	50
Desired timing for next child or desire for another child	75	63	67	61	69	69	56	67
Breastfeeding status	47	25	19	27	29	52	20	29
Regularity of menstrual cycle	86	78	87	62	82	86	73	81
All elements of reproductive history ¹	48	50	39	25	48	36	25	44
Client medical history								
Asked about smoking	28	37	53	8	42	17	12	37
Asked about symptoms of STIs	41	52	47	33	48	38	37	46
Asked about any chronic illnesses	73	63	65	25	68	56	34	63
All risk-history ²	19	32	31	8	30	12	12	27
Client examination								
Measure blood pressure	92	75	48	62	72	76	64	71
Measure weight	79	70	73	44	73	83	51	71
Counselling topics covered								
Partner attitude toward family planning	55	64	53	63	62	36	45	59
Partner status ³	47	46	53	35	50	36	31	47
Either partner question	39	44	46	27	46	24	19	42
Discussions related to STIs and condoms								
Risk of STIs	39	20	15	63	24	17	50	27
Use of condoms to prevent STIs	49	28	22	62	33	22	50	34
Use of condoms as dual method	45	29	25	54	33	22	43	34
Any discussion related to STIs ⁴	59	32	26	71	39	22	57	40
Individual client card reviewed during consultation	81	84	87	46	84	74	63	81
Individual client card written on after consultation	85	91	90	46	90	79	61	86
Visual aids used during consultation	72	67	72	82	71	46	77	71
Client assured of confidentiality	48	46	46	44	45	80	40	46
Weighted number of first-visit family planning clients	36	53	40	12	116	6	18	140
¹ Age, any history of pregnancy, current pregnancy status, desired timing for next child or desire for another child and regularity of menstrual cycle								
² Asked about smoking, symptoms of STIs and any chronic illness								
³ Asked about number of partners for client or client's partner or about partner's absence								
⁴ Risk of STIs discussed or use of condoms to prevent STIs or as dual method								

Table A-5.13 Conditions for counselling of observed family planning clients

Percentage of observed family planning clients who were counselled under the indicated conditions, by type of facility and operating authority, Ghana SPA 2002

Counselling conditions	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Visual and auditory privacy assured	79	86	90	86	85	89	90	86
Auditory privacy assured	84	87	92	86	86	96	89	88
Client assured of confidentiality	38	51	36	37	46	22	36	42
Client asked about concerns of methods discussed or currently used	79	78	77	71	75	93	75	77
All counselling conditions met ¹	30	40	25	33	34	16	32	32
Individual client card reviewed during consultation	89	90	94	74	91	92	80	90
Individual client card written on after consultation	93	90	95	80	92	96	83	91
Visual aids used during consultation	30	24	19	33	24	17	31	25
Return visit discussed	97	93	95	93	94	100	92	94
Weighted number of observed FP clients	139	229	187	55	471	59	80	611

¹ Visual and auditory privacy, confidentiality assured, and client was asked about concerns of methods discussed or currently used

Table A-5.14 Details on education provided and knowledge of clients regarding the method provided

Among clients who received condoms, spermicides, IUD, implants, or other methods the percentage who were observed being told critical information about the method, and percentage who knew the correct response to a critical question asked about using their method, percentage of clients not receiving pills, injections, condoms, spermicides, IUDs or implants who reported they were instructed by the provider on how to use the method, about side effects, what to do for problems, and when to return for follow up, Ghana SPA 2002

Consultation and knowledge components	Percentage of clients
Client received condom, and provider	
Shared critical information ¹	6
Asked about allergy to latex	6
Told client to use one time only	27
Talked about lubricant	6
Told client to use for backup	27
Talked about dual protection	21
Client received condom and knows critical information ²	51
Weighted number of clients receiving condom	14
Client received spermicide, and provider	
Told client about possible irritation	28
Told client to insert prior to each intercourse	89
Client received spermicide and knows when to insert	66
Weighted number of clients receiving spermicide	13
Client received IUD, and provider	
Told client to check string	80
Told client about possible heavy bleeding	69
Client received IUD and knows how to check IUD	75
Weighted number of clients receiving IUD	13
Client received implant, and provider	
Told implant is good for 5 years	86
Told client menstrual changes that might occur	67
Told client initial side effects that might occur	49
Client received implant and knows how long implant lasts	77
Weighted number of clients receiving implants	28
Client received other method, and client reported	
The provider explained how to use the method	85
The provider explained about possible side effects	73
The provider explained what to do for problems	69
The provider told about a follow up visit	86
Client received other method and knows critical information for their method ³	68
Weighted number of clients receiving other methods ⁴	66

¹ Told client to use a condom one time only and asked about allergy to latex

² Knows how many times to use a condom and for female condom knows what lubricant can be used

³ Knows how to use the method, about the possible side effects, and what to do for problems and or when the follow up visit should take place

⁴ Includes male and female sterilization, diaphragm, rhythm, LAM, and emergency contraceptive pill

Table A-5.15 Observed assessments of clients who received hormonal contraceptives

Percentage of observed and interviewed family planning clients who received an estrogen-based contraceptive and who had their blood pressure measured, their weight measured; percentage of observed and interviewed family planning clients who received an estrogen- or progesterone-based contraceptive where the indicated counselling item was observed being shared by the provider, or was reported by the client that they were told the information, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
ESTROGEN-BASED CONTRACEPTIVE								
Examination								
Blood pressure measured	100	76	91	100	85	100	100	88
Weight measured	82	96	91	87	90	95	91	91
Weighted number of observed and interviewed estrogen-based contraceptive family planning clients	19	36	27	8	72	6	11	89
ESTROGEN- OR PROGESTERONE-BASED CONTRACEPTIVE								
Provider was observed to explain the item to the client								
When to take	79	81	71	80	79	70	75	77
Menstrual changes	56	52	59	53	55	62	49	55
Side effects	35	28	24	35	30	19	32	29
What to do if client forgets	23	22	22	29	22	33	24	23
Provider mentioned follow up visit	97	94	97	93	95	100	95	96
Client reported that the provider shared he indicated information								
Provider explained how to use the method	69	77	77	66	74	81	70	74
Provider explained about possible side effects	65	71	66	80	70	50	75	69
Provider explained what to do for problems	66	72	59	75	68	54	73	67
Provider told about follow up visit	94	96	96	98	95	99	97	96
Client knows critical question that was asked	81	82	73	82	84	41	78	79
Weighted number of observed and interviewed oral or injectable contraceptives family planning clients	109	210	174	44	417	56	64	538

Table A-5.16 Client feedback on family planning services

Percentage of observed and interviewed family planning clients who said that they considered the specific item as major problems for them the day of the visit, by type of facility and operating authority, Ghana SPA 2002

Areas of complaint	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health Center	Clinic	PMH	Public	Private religious	Other private	
Inability to discuss concerns with provider	0	1	1	0	1	0	0	1
Not sufficient explanation about methods or problems	1	2	1	0	1	0	0	1
Poor quality of examination and treatment	0	1	1	0	1	0	0	1
Waiting time to see provider too long	2	3	2	2	3	1	4	3
Lack of availability of medicines or supplies	1	0	0	0	0	0	0	0
Opening hours of facility inconvenient	1	2	1	0	2	0	0	1
Lack of cleanliness of facility	0	1	3	0	2	0	0	1
Lack of visual privacy	0	1	0	0	0	0	0	0
Lack of auditory privacy	0	1	1	0	1	0	0	1
Staff treatment	0	1	2	0	1	0	0	1
Other issues	0	1	0	0	0	0	0	0
Weighted number of interviewed famioy planning clients	139	224	186	53	465	59	78	602

Table A-5.17 Attitudes of providers and clients to brand substitution for oral contraceptives

Among government facilities, the percentage where the providers believe clients have the mentioned attitude towards substitution of Lo-Femenal or Ovrette and the percentage of interviewed clients who indicated that the substitution of Lo-Femenal or Ovrette is or would be a major problem, slight problem, no problem or they are not sure, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Provider believes client's attitude toward substitution of Lo-Femenal or Ovrette with other brands is:				Weighted number of government facilities providing FP services	Client asked if substitution of Lo-Femenal or Ovrette with other brands of oral contraceptives is, or would be a problem:				Weighted number of clients who received oral contraceptives from government facilities
	Easily accepts	Has some problem	Strongly dislikes	Never has shortage		Yes, big problem	Yes, slight problem	No problem	Not sure	
Type of facility										
Hospital	44	34	7	13	28	0	14	69	18	11
Health centre	32	33	11	20	153	19	11	63	7	42
Clinic	35	25	7	18	77	24	17	59	0	17
Operating authority										
Public	34	31	9	19	258	17	13	63	7	70
Region										
Western	14	30	3	42	24	0	14	57	29	5
Central	55	9	0	36	13	82	0	18	0	3
Greater Accra	78	14	8	0	10	0	15	85	0	6
Volta	40	40	11	7	53	0	18	82	0	16
Eastern	16	41	16	19	31	16	10	74	0	8
Ashanti	44	22	15	11	35	0	21	64	15	7
Brong Ahafo	33	31	8	16	31	86	0	0	14	10
Northern	36	43	8	8	27	0	23	68	9	11
Upper East	12	17	0	42	17	0	0	100	0	3
Upper West	34	21	10	34	17	0	0	100	0	2
Total	34	31	9	19	258	17	13	63	7	70

Chapter 6

<u>Table A-6.1 Availability of antenatal care and tetanus vaccine services</u>				
Percentage of facilities offering antenatal care (ANC) 1-2 days per week or 5 or more days per week, and percentage of facilities where tetanus toxoid vaccine is provided every day ANC is offered, by type of facility, operating authority, and region, Ghana SPA 2002				
Background characteristics	Percentage of facilities offering ANC services for the indicated number of days per week:		Percentage offering tetanus toxoid every day ANC is offered	Weighted number of facilities offering ANC
	1-2 days	5+ days		
Type of facility				
Hospital	34	57	95	40
Health centre	1	79	87	149
Clinic	27	64	75	94
PMH	1	99	59	91
Operating authority				
Public	20	75	84	246
Private religions	50	44	83	35
Other private	2	98	60	94
Region				
Western	15	78	54	31
Central	2	94	84	28
Greater Accra	7	86	79	26
Volta	15	80	68	53
Eastern	15	85	87	48
Ashanti	18	79	79	68
Brong Ahafo	22	74	74	46
Northern	37	61	81	36
Upper East	30	52	92	16
Upper West	22	77	95	22
Total	18	78	78	375

Table A-6.2 Availability of specific equipment and supplies for quality assessment of the ANC client

Percentage of facilities that offer ANC services where there are items to support quality counselling (client health cards, treatment standards and protocols, visual aids for health education), items for infection prevention, infrastructure for physical examination, equipment for basic ANC examinations in or adjacent to the consultation or examination room, and percentage of facilities with basic ANC medications, by type of facility and operating authority, Ghana SPA 2002

Items	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Items to support quality counselling								
Individual client health cards	85	76	75	91	77	78	90	80
Written ANC protocols or guidelines	50	62	48	83	59	32	83	63
Visual aids for health education	62	54	47	71	53	52	71	57
All items to support quality counselling ¹	27	31	24	59	30	16	58	36
Items to support quality physical examination								
Infection prevention								
Soap	86	87	86	93	86	87	94	88
Water	84	87	87	91	86	87	91	88
Single use towels	43	29	27	79	30	28	78	42
Clean gloves	60	71	64	83	67	67	84	71
Disinfecting solution	31	30	34	55	32	27	54	37
Sharps box	52	65	65	60	64	56	61	63
All items for infection prevention ²	18	21	21	34	20	21	34	24
All infection prevention plus single use towel	16	10	14	27	11	18	27	16
Infrastructure for examination								
Visual and auditory privacy for examination	68	85	79	87	81	77	88	82
Visual privacy for examination	89	92	90	93	91	93	94	92
No privacy for examination	4	4	3	1	4	4	1	3
Examination bed ³	85	63	42	24	58	68	24	50
Examination light ⁴	21	22	7	8	17	19	8	15
All elements for physical examination ⁵	11	18	5	7	13	19	7	11
Equipment for ANC Assessment								
Blood pressure apparatus	95	86	87	97	86	93	97	90
Fetoscope (Pinard)	96	96	89	100	94	93	100	95
Basic ANC medicines								
Iron tablets ⁶	95	90	82	85	87	97	85	88
Folic acid tablets ⁶	94	77	75	80	77	94	80	79
Tetanus toxoid vaccine	92	87	54	45	77	76	45	69
All basic ANC equipment and medicines ⁷	81	53	41	40	51	66	40	50
Weighted number of facilities offering ANC	40	149	94	91	246	35	94	375

¹ Individual client health cards, written ANC protocols or guidelines, and visual aids for health education all available

² Soap, water, gloves, disinfecting solution for putting contaminated reusable items, and sharps box all available

³ May be any type of bed where woman can lie down flat

⁴ May be examination light, flashlight, or other spotlight source

⁵ Visual privacy, examination light, and bed

⁶ Iron and folic acid may be combined

⁷ Blood pressure apparatus, fetoscope, iron and folic acid, and tetanus toxoid all present

Table A-6.3 Availability of specific medicines and standards for ANC services

Percentage of facilities with indicated medicines for managing common complications during pregnancy, percentage that routinely provide the indicated medicine, test, or counselling as a component of ANC, and percentage with the indicated equipment related to PNC (thermometer and an infant scale), by type of facility and operating authority, Ghana SPA 2002

Components	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Medicines for managing common complications during pregnancy								
Antibiotic ¹	94	88	81	67	86	94	67	82
Metronidazole (trichomoniasis)	94	81	75	68	80	96	67	78
Mebendazole (antihelminth)	99	74	64	50	73	88	49	68
Antimalarial	99	90	87	72	90	95	72	86
Nystatin suppository (candidiasis)	39	4	6	15	6	35	15	11
Ceftriaxone (gonorrhoea)	29	1	1	1	4	12	1	4
Ciprofloxacin (gonorrhoea)	70	20	15	35	23	43	34	28
Doxycycline (chlamydia, syphilis)	70	14	10	19	18	39	19	20
Tetracycline (chlamydia, syphilis)	87	61	47	50	58	72	50	58
Erythromycin (chlamydia, syphilis)	59	8	5	7	11	39	7	12
Penicillin (syphilis)	99	82	70	73	78	94	73	79
All medicines for sexually transmitted infections ²	72	16	14	30	20	45	29	25
All basic ANC medications ³	26	1	3	8	3	20	8	6
Standards for routine ANC service								
Prescribe malaria prophylaxis	62	77	71	67	73	72	67	71
Prescribe STI treatment	18	36	34	79	32	34	80	44
Test blood for anaemia	98	60	52	84	60	77	84	68
Test urine for protein	97	56	69	82	65	72	82	70
Test urine for sugar	84	35	46	59	44	57	59	49
Test blood for syphilis	30	1	2	2	5	6	2	4
Voluntary counselling and testing HIV/AIDS	24	6	4	7	7	14	8	8
Counselling on family planning	73	73	66	71	72	59	72	71
Equipment related to postnatal care								
Thermometer	78	76	75	96	76	76	95	81
Infant scale	55	70	63	70	65	68	70	66
Weighted number of facilities offering ANC	40	149	94	91	246	35	94	375
¹ Amoxicillin or co-trimoxazole								
² At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis								
³ At least one antibiotic; at least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis; mebendazole, antimalarial; and nystatin suppository all present								

Table A-6.4 Supportive management for providers of ANC

Among interviewed providers of ANC services, percentage who were personally supervised during the past 6 months, percentage who received related in-service training during the past 12 months, percentage who were both supervised in the past 6 months and received in-service training in the past 12 months, and percentage whose most recent in-service training was 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed providers of ANC services
	Who were personally supervised during the past 6 months	Who received any in-service training during the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	46	43	24	44	334
Health centre	56	41	28	24	211
Clinic	60	36	22	25	144
PMH	45	46	26	17	88
Operating authority					
Public	54	42	27	33	559
Private religious	41	35	17	36	129
Other private	45	47	27	17	90
Region					
Western	34	43	24	34	77
Central	28	36	17	24	47
Greater Accra	57	41	31	36	106
Volta	47	30	17	42	107
Eastern	51	38	19	48	128
Ashanti	44	34	16	18	132
Brong Ahafo	68	52	35	14	76
Northern	65	47	34	45	57
Upper East	71	97	69	2	14
Upper West	74	64	43	17	34
Total	51	41	25	32	777

Table A-6.5 Supportive management: In-service training for ANC providers

Among interviewed ANC service providers, percentage who received in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristic	Percentage of interviewed ANC service providers who received in-service training on specific topics														Weighted number of interviewed ANC service providers
	ANC services		ANC counselling		Risk pregnancy		Lifesaving skills		Safe motherhood clinical skills		PMTCT		PNC		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility															
Hospital	6	24	9	25	8	19	7	15	11	26	17	19	8	17	334
Health centre	8	17	6	21	5	17	4	13	8	20	8	12	4	15	211
Clinic	9	13	5	16	4	10	3	9	8	10	13	11	5	10	144
PMH	22	16	21	17	21	10	13	9	20	13	15	6	22	11	88
Operating authority															
Public	7	20	8	24	6	18	5	16	10	22	12	14	6	17	559
Private religious	9	16	5	10	5	7	6	3	7	16	19	20	6	8	129
Other private	21	17	20	17	21	10	13	9	20	13	15	8	21	11	90
Region															
Western	5	14	5	14	3	7	2	5	3	16	6	19	3	13	77
Central	7	21	7	23	4	21	3	7	11	22	17	12	8	21	47
Greater Accra	9	32	13	29	12	27	8	28	18	32	22	20	10	26	106
Volta	7	21	6	20	7	17	4	11	7	15	14	18	8	17	107
Eastern	4	18	4	35	4	20	2	19	6	31	14	15	3	19	128
Ashanti	11	15	7	16	7	12	8	8	12	16	12	10	7	8	132
Brong Ahafo	14	10	13	11	10	6	8	5	12	11	19	9	10	9	76
Northern	12	16	8	24	5	14	4	16	10	19	8	15	10	6	57
Upper East	19	14	44	8	28	7	30	8	31	5	21	12	19	5	14
Upper West	16	24	15	9	22	9	17	9	20	9	3	3	22	5	34
Total	9	19	9	21	8	15	6	13	11	20	14	14	8	15	777

Continued...

Table A-6.5—Continued

Background characteristic	Percentage of interviewed ANC service providers who received in-service training on specific topics								Weighted number of interviewed ANC service providers
	Manual vacuum aspiration		Family planning		STI		Breastfeeding		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility									
Hospital	9	10	21	30	22	25	14	33	334
Health centre	4	12	31	22	14	17	11	21	211
Clinic	3	7	23	21	12	15	11	22	144
PMH	19	10	41	18	25	17	18	21	88
Operating authority									
Public	7	12	26	28	16	20	13	27	559
Private religious	4	3	17	16	22	23	10	27	129
Other private	19	10	42	19	25	18	17	22	90
Region									
Western	4	9	35	19	16	28	10	34	77
Central	3	13	29	22	14	16	9	27	47
Greater Accra	15	12	13	11	26	18	19	24	106
Volta	5	9	15	34	14	24	8	34	107
Eastern	3	11	24	44	15	23	15	37	128
Ashanti	6	9	25	15	10	17	14	15	132
Brong Ahafo	8	7	27	19	28	16	6	17	76
Northern	7	11	35	46	22	19	18	29	57
Upper East	19	7	92	3	32	8	42	14	14
Upper West	23	7	54	5	30	20	15	19	34
Total	8	10	27	25	18	20	13	26	777

Table A-6.6 Out-of-pocket payments for first-visit ANC clients

Among interviewed first-visit ANC clients, percentage who reported that they are part of a prepayment plan, and percentage who reported paying any out-of-pocket fees for ANC services on the day of the survey, among the clients who paid any fees for ANC services, median amount (cedis) paid for services on the day of the survey, by whether client belonged to prepay programme, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed first-visit ANC clients who reported:		Weighted number of interviewed first-visit ANC clients	Median out-of-pocket payment ¹ by first-visit ANC clients who paid anything for services:		Weighted number of first-visit ANC clients providing valid responses for amount paid
	Belonging to a prepaid programme	Paying any out-of-pocket charges ¹ for this visit		Belong to prepaid programme	Do not belong to prepaid programme	
Type of facility						
Hospital	8	93	211	497	10,030	206
Health centre	3	78	278	5,034	5,020	229
Clinic	0	75	162	na	7,029	125
PMH	2	93	91	na	15,010	88
Operating authority						
Public	4	81	555	2,018	6,518	472
Private religious	3	88	96	12,022	9,087	88
Other private	2	93	92	na	15,011	88
Region						
Western	2	94	68	1,093	11,040	64
Central	4	72	65	2,095	4,060	46
Greater Accra	8	100	45	16,018	15,590	45
Volta	2	81	107	5,073	9,068	85
Eastern	2	93	125	6,826	9,548	117
Ashanti	2	95	110	1,800	9,500	105
Brong Ahafo	3	81	93	na	5,047	72
Northern	0	80	111	na	3,073	89
Upper East	37	73	26	na	1,050	19
Upper West	14	20	33	na	589	7
Total	4	83	743	2,043	7,076	648

¹ Includes any amount paid out-of-pocket, including fees for consultation, laboratory test, medicines, or other
na = Not applicable; none of the clients belonged to a prepaid programme

Table A- 6.7 Characteristics of observed ANC

Percentage of observed ANC clients for whom this was their first ANC visit, percentage for whom this was a followup ANC visit, percentage who were estimated to be less than 5 months pregnant, at least 5 months pregnant, at least 8 months pregnant, and unknown, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of observed ANC clients								Weighted number of observed ANC clients
	First ANC visit for this pregnancy	Followup ANC visit	First pregnancy		Length of pregnancy (months)				
			Yes	No	<5 mo	≥5 mo	≥8 mo	Unknown	
Type of facility									
Hospital	49	51	26	74	19	78	33	3	476
Health centre	40	60	30	70	16	79	32	5	746
Clinic	46	54	27	73	20	75	29	5	376
PMH	39	61	20	80	17	79	38	4	248
Operating authority									
Public	43	57	28	72	17	78	31	5	1,395
Private religious	52	48	29	71	20	76	31	3	198
Other private	38	62	21	79	17	80	38	4	253
Region									
Western	43	57	20	80	14	76	27	10	161
Central	40	60	30	70	19	75	34	6	163
Greater Accra	35	65	30	70	15	83	38	1	131
Volta	46	54	32	68	18	81	38	0	240
Eastern	47	53	30	70	20	78	35	3	265
Ashanti	42	58	22	78	18	77	30	6	270
Brong Ahafo	43	57	29	71	17	77	32	6	218
Northern	48	52	26	74	20	78	27	2	236
Upper East	42	58	26	74	20	65	17	15	62
Upper West	35	65	20	80	12	86	38	3	100
Total	43	57	27	73	18	78	32	4	1,846

Table A-6.8 Assessment of client history

Percentage of all observed first-visit ANC clients for whom the indicated questions were components of their consultations and percentage of observed first-visit ANC clients with a prior pregnancy who were asked about specific complications of prior pregnancies, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of observed first-visit ANC clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Prior history and client characteristics								
Client's age	67	58	63	68	62	64	68	63
Date of last menstrual period	53	36	30	34	40	44	35	40
Any aspects related to prior pregnancy	71	66	64	69	69	62	69	68
Any aspects of complications during prior pregnancy (for women with prior pregnancy)	58	63	55	58	62	45	58	59
Medications client currently taking	19	8	12	20	12	14	21	14
All elements for client history ¹	11	2	4	5	6	2	5	5
Weighted number of first-visit ANC clients	233	296	171	96	597	103	97	797
Specific complications of prior pregnancies that were asked of all first-visit ANC clients with prior pregnancy								
Stillbirth	42	41	36	40	41	36	40	40
Infant mortality first week after birth	35	36	31	26	36	22	26	33
Severe bleeding during labour or postpartum	27	34	27	27	31	23	27	30
Assisted delivery	35	32	27	29	33	26	29	31
Weighted number of observed first-visit ANC clients with prior pregnancy	176	207	124	77	438	68	78	584

¹ Includes client age, date of last menstrual period, any aspects related to prior pregnancy, any aspects of complications during prior pregnancy (for women with prior pregnancy), and medications client is currently taking

Table A-6.9 General questions and examinations for assessment of current health status for observed ANC clients

Percentage of observed ANC clients for whom the indicated question and examination was a component of their consultation, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of observed ANC clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Client questioned regarding								
Occurrence of vaginal bleeding	31	29	29	25	31	21	25	29
Fetal movement (at least 5 months pregnant)	56	53	51	50	54	45	51	53
Any other problems	72	67	73	65	70	71	66	69
Physical examination								
Measured blood pressure	98	96	94	97	96	100	97	96
Palpated abdomen (at least 8 months pregnant)	97	98	98	96	98	98	96	97
Listened for fetal heart (at least 5 months pregnant)	88	92	82	83	89	88	83	88
Measured weight	97	97	95	95	96	99	95	96
Palpated or measured fundal height	94	96	92	93	94	93	93	94
All questions and examinations ¹	23	25	19	14	24	15	14	22
Provider used any visual aid	13	9	6	5	8	19	6	9
Weighted number of observed ANC clients at least 5 months pregnant	370	591	282	197	1,086	151	201	1,439
Weighted number of observed ANC clients at least 8 months pregnant	155	236	111	94	438	62	96	596
Weighted number of observed ANC clients	476	746	376	248	1,395	198	253	1,846

¹ Includes questions on occurrence of vaginal bleeding and fetal movement (if the woman is at least 5 months pregnant), measurement of the blood pressure, listening for fetal heart (if the woman is at least 5 months pregnant) and palpation of the abdomen (if the woman is at least 8 months pregnant)

Table A-6.10 Preventive and diagnostic interventions received by observed ANC clients

Percentage of observed ANC clients for whom the indicated intervention was a component of their consultation, by type of intervention, type of facility, and operating authority, Ghana SPA 2002

Intervention	Percentage of observed ANC clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Offered syphilis test								
First visit	5	0	1	0	2	2	0	2
Followup visit	0	1	0	0	1	0	0	0
Offered HIV/AIDS test or voluntary counselling and testing (VCT)								
First visit	4	5	4	5	4	5	5	4
Followup visit	5	4	1	3	4	4	3	3
Given or prescribed iron tablets								
First visit	80	83	86	77	81	90	77	82
Followup visit	75	80	87	73	79	87	74	79
Given or prescribed tetanus toxoid vaccine								
First visit	46	59	52	37	55	42	37	51
Followup visit	32	38	33	27	35	35	27	34
Given or prescribed antimalarial								
First visit	36	43	67	49	44	64	49	47
Followup visit	28	36	39	31	32	56	32	34
Weighted number of first-visit clients	233	296	171	96	597	103	97	797
Weighted number of followup clients	243	450	205	152	798	95	156	1,049
Weighted number of observed ANC clients	476	746	376	248	1,395	198	253	1,846

Table A-6.11 Observed content of ANC counselling for first-visit and follow-up clients

Percentage of first- and follow-up-visit ANC clients who were observed to receive counselling on topics related to nutrition during pregnancy, risk symptoms, the progress of their pregnancy, delivery plans, exclusive breastfeeding, and family planning after birth, and use of individual client cards, by type of facility and operating authority, Ghana SPA 2002

Counselling components	Percentage of first- and follow-up-visit ANC clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Content of ANC counselling for first-visit ANC clients								
Nutrition	58	47	48	59	49	63	60	52
Any risk symptoms for seeking help	28	26	29	26	26	35	25	27
Specific risk: vaginal bleeding	21	13	10	12	15	15	12	15
Specific risk: fever	18	12	14	16	13	24	16	15
Specific risk: shortness of breath, excessive tiredness	12	9	10	12	10	12	12	10
Specific risk: swollen hands or face	16	12	8	9	12	13	9	12
Specific Risk: headache or blurred vision	18	14	17	12	15	24	12	16
Progress of pregnancy	37	33	32	46	33	41	45	35
Delivery plans	40	31	31	35	33	41	36	34
Exclusive breastfeeding	28	19	15	16	20	28	16	20
Family planning after birth	22	20	14	18	21	11	18	19
Use of individual client card								
Card reviewed during consultation	98	95	96	93	96	95	93	96
Card written on during or after consultation	100	97	98	96	98	100	96	98
Weighted number of first-visit ANC clients	233	296	171	96	597	103	97	797
Content of ANC counselling for follow-up ANC client(s)								
Nutrition	55	46	40	53	45	64	53	48
Any risk symptoms for seeking help	36	22	16	26	22	44	25	25
Specific risk: vaginal bleeding	24	9	6	8	11	25	7	12
Specific risk: fever	16	6	7	13	7	24	12	9
Specific risk: shortness of breath, excessive tiredness	14	9	2	5	9	8	5	8
Specific risk: swollen hands or face	18	11	5	11	11	15	11	11
Specific Risk: headache or blurred vision	16	11	5	8	10	20	8	11
Progress of pregnancy	43	39	26	47	36	46	47	38
Delivery plans	44	34	24	40	33	44	40	35
Exclusive breastfeeding	27	18	4	6	16	20	7	15
Family planning after birth	20	11	5	14	13	7	14	12
Use of individual client card								
Card reviewed during consultation	98	99	93	96	98	99	97	97
Card written on during or after consultation	100	100	98	98	99	100	99	99
Weighted number of follow-up ANC client(s)	243	450	205	152	798	95	156	1,049

Table A-6.12 Observation of health education for iron tablets, antimalarials, and tetanus toxoid.

Percentage of observed ANC clients who received the indicated item (or received a prescription for the item) where the provider explained their purpose and where the provider explained how to take the medicine, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of ANC clients who received iron or folic acid, and provider explained:		Weighted number of observed ANC clients who received iron or folic acid	Percentage of ANC clients who received an antimalarial, and provider explained:		Weighted number of observed ANC clients who received an antimalarial	Percentage of ANC clients who received tetanus toxoid, and provider explained purpose		Weighted number of observed ANC clients who received tetanus toxoid
	Purpose	How to take		Purpose	How to take		Purpose	How to take	
Type of facility									
Hospital	35	52	367	37	62	151	24		185
Health centre	24	67	604	29	73	290	32		346
Clinic	19	64	326	16	64	195	16		156
PMH	43	84	185	54	88	93	46		76
Operating authority									
Public	23	62	1,117	25	69	512	25		608
Private religious	39	59	176	35	63	119	32		77
Other private	43	84	190	53	88	98	45		78
Region									
Western	29	79	80	33	96	37	25		35
Central	20	73	62	15	64	55	7		61
Greater Accra	29	58	115	57	79	44	29		58
Volta	48	68	218	53	71	150	51		113
Eastern	30	51	224	25	56	119	32		119
Ashanti	17	34	238	15	22	68	16		109
Brong Ahafo	33	83	193	38	89	118	23		69
Northern	18	89	219	9	98	89	29		129
Upper East	12	49	57	6	50	39	0		22
Upper West	22	72	77	26	100	12	36		48
Total	28	65	1,483	31	71	729	28		763

Table A-6.13 Health education during ANC visit

Percentage of observed and interviewed ANC clients who stated that provider had mentioned any warning signs for pregnancy, percentage who named any of the indicated symptoms as warning signs, percentage who indicated they were told to do the mentioned activity if they experienced any warning sign, and percentage who stated they discussed the named subject with the provider during the ANC visit, by type of facility and operating authority, Ghana SPA 2002

Components	Percentage of observed and interviewed clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Client said provider mentioned warning sign(s)	41	30	36	39	34	38	40	35
Warning signs patient mentioned								
Bleeding	30	16	16	25	20	23	25	21
Fever	14	8	9	15	9	20	15	11
Swollen face or hands	10	5	3	3	6	5	3	5
Tiredness or breathlessness	6	4	13	10	7	5	10	7
Headache or blurred vision	13	7	4	8	8	10	8	8
What client was told to do if warning sign occurs								
Seek care at facility	42	31	35	43	34	40	43	36
Decrease activity	2	1	1	1	1	1	1	1
Change diet	0	1	0	0	0	0	0	0
Subjects discussed								
Nutrition during pregnancy	64	54	58	63	56	69	63	59
Exclusive breast feeding	52	37	36	23	41	43	24	39
Delivery plans	39	36	33	34	36	36	34	36
Supplies to prepare for delivery	59	41	42	43	46	47	43	46
Weighted number of interviewed ANC clients	461	742	371	246	1,372	196	251	1,819

Table A-6.14 Client feedback on ANC services

Percentage of observed and interviewed ANC clients who said that they considered specific items as big problems for them the day of the visit, by type of facility and operating authority, Ghana SPA 2002

Areas of complaint	Percentage of observed and interviewed ANC clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Behaviour or attitude of provider	2	0	1	0	1	2	0	1
Inability to discuss concerns with provider	2	2	1	0	2	2	0	2
Not sufficient comment on progress of pregnancy	3	3	1	1	2	2	1	2
Poor quality of examination and treatment	1	1	0	0	1	0	0	0
Waiting time to see provider too long	14	5	10	3	8	15	3	8
Lack of availability of medicines or supplies	2	1	0	1	1	2	1	1
Opening hours of facility inconvenient	5	2	3	1	3	4	1	3
Lack of cleanliness of facility	5	2	3	1	3	3	1	3
Lack of privacy	2	1	4	0	2	3	0	2
Cost too high	0	0	0	0	0	0	0	0
Issues related to waiting area or order in which clients are called	1	0	0	0	0	2	0	0
Weighted number of interviewed ANC clients	461	742	371	246	1,372	196	251	1,819

Table A-6.15 Emergency maternity transportation systems

Percentage of facilities with emergency maternity transportation systems that have a dedicated vehicle, a vehicle at another facility or have other arrangements made, and the median transportation time (in minutes), by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities supporting emergency transportation that have:			Median transportation time to referral facility using most common mode of emergency transportation ⁴	Weighted number of facilities supporting emergency transportation
	Dedicated vehicle ¹	Vehicle at other facility ²	Other arrangement ³		
Type of facility					
Hospital	78	20	77	45	24
Health centre	38	15	73	46	31
Clinic	52	20	73	30	38
PMH	22	4	90	21	43
Operating authority					
Public	49	21	71	41	65
Private religious	66	10	79	46	26
Other private	22	5	90	21	45
Region					
Western	56	9	84	45	8
Central	46	0	100	20	7
Greater Accra	26	0	96	30	19
Volta	43	0	100	91	10
Eastern	72	6	56	16	13
Ashanti	42	14	71	30	35
Brong Ahafo	15	24	88	45	20
Northern	65	25	71	60	20
Upper East	46	45	37	11	3
Upper West	100	80	60	46	1
Total	44	14	79	31	137

Note: Emergency maternity transportation systems are any planned programme where facility takes some responsibility for ensuring client reaches referral location. Where client must find transport and must pay the total cost, the facilities do not have an emergency transportation system.

¹ Ambulance or other vehicle that stays at the facility

² Facility calls for dedicated vehicle from other facility to collect emergency patient.

³ Any other plan where the facility arranges for the emergency transport or contributes toward the cost of rental vehicles

⁴ Transportation time (in minutes) does not vary by season.

Table A-6.16 Availability of specific equipment and supplies for quality delivery services

Percentage of facilities that offer delivery services where there are infection prevention items, other items to support quality of services, and infrastructure for quality delivery, by type of facility and operating authority, Ghana SPA 2002

Items to support quality services	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Infection prevention								
Soap	100	88	92	92	90	98	92	91
Water	98	86	90	92	88	98	92	90
Single use towel	68	34	37	80	38	51	80	50
Clean gloves	98	86	79	92	84	93	92	87
Disinfecting solution	89	47	55	68	54	68	68	59
Sharps box	77	62	50	43	60	69	44	57
All items for infection prevention ¹	70	30	24	33	32	50	33	34
All items for infection prevention plus single-use towel	56	13	14	29	17	36	29	22
Other items to support quality of services								
Protocols for management of complications	77	56	30	71	53	42	71	57
Blank partograph	94	49	41	67	52	64	67	57
Delivery provider ² onsite 24 hours	90	43	32	64	44	65	64	52
Delivery provider on-call 24 hours	10	53	63	32	52	34	32	45
All other items to support quality ³	77	37	12	55	36	34	55	41
Infrastructure for delivery								
Visual and auditory privacy	82	92	87	87	90	81	87	89
Visual privacy	88	92	93	88	93	87	88	91
No privacy	4	2	1	2	2	2	2	2
Delivery bed ⁴	93	91	84	97	89	90	97	91
Examination light ⁵	66	21	18	58	26	38	57	35
All elements of infrastructure ⁶	53	20	17	51	24	25	51	31
Weighted number of facilities providing delivery services	41	146	78	92	228	35	93	357

¹ Soap, water, gloves, disinfecting solution for contaminated reusable items, and sharps box

² Any person with midwifery skills

³ Protocols, partograph, and delivery staff available 24 hours per day

⁴ Any type of bed where woman can lie down flat

⁵ Examination light, flashlight, or other spotlight source

⁶ Both visual and auditory privacy, examination bed, and examination light

Table A-6.17 Availability of specific equipment and supplies for quality delivery services

Percentage of facilities that offer delivery services where basic supplies for delivery services, basic medicines and supplies, and emergency medicines are available, by type of facility and operating authority, Ghana SPA 2002

Equipment and supplies	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Basic supplies for delivery								
Scissors or blade	95	90	91	96	90	94	95	92
Cord clamp or tie	96	92	89	96	91	96	95	93
Suction for newborn	94	84	73	88	80	97	88	84
Antibiotic eye ointment for newborn	48	20	18	20	18	58	20	23
Skin disinfectant for perineum	85	86	87	94	85	90	94	88
All basic supplies for delivery ¹	41	14	12	17	13	49	17	17
Basic treatment interventions for delivery								
Syringes and needles	96	92	89	96	91	96	95	93
Intravenous solution and infusion set ²	87	75	75	84	75	92	84	79
Oral antibiotic ³	94	87	89	66	88	96	67	83
Injectable oxytocic medication	98	92	86	93	90	99	93	92
Suture material	96	78	67	87	75	93	86	80
Needle holder	95	78	77	89	80	87	89	83
All basic treatment interventions ⁴	75	47	44	54	47	73	54	51
Emergency medicines (injectable)								
Valium	86	69	67	59	69	81	59	68
Magnesium sulfate	41	2	0	5	5	22	5	7
Ampicillin	74	11	11	16	17	47	16	20
Procaine penicillin	62	68	58	44	64	67	44	59
Gentamicin	93	26	31	44	34	63	44	39
Quinine	47	12	6	12	13	37	12	15
All emergency medicines ⁵	43	7	2	8	8	33	8	10
Weighted number of facilities	41	146	78	92	228	35	93	357
¹ Scissors or blade, cord clamp, suction bulb, antibiotic eye ointment for newborn, and skin disinfectant for perineum								
² Dextrose and normal saline, normal saline or Ringer's lactate								
³ Oral amoxicillin, ampicillin, or co-trimoxazole								
⁴ Syringes and needles, intravenous solution and infusion set, at least one oral antibiotic, injectable oxytocic, suture material, and needle holders								
⁵ Injectable: anticonvulsant (valium or magnesium sulfate), an antibiotic (penicillin and ampicillin or gentamicin), and quinine								

Table A- 6.18 Equipment and supplies for complications of labour and delivery

Percentage of facilities providing delivery services where the indicated equipment is available, and where all basic elements for caesarian section and blood transfusion services are available, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering delivery services that have:						Weighted number of facilities offering delivery services	
	Assisted labour		Removed retained products		Capacity to perform a manual removal of retained placenta	All basic elements for caesarian ¹		Blood transfusion services ²
	Forceps	Vacuum extractor	Vacuum aspirator	D&C kit				
Type of facility								
Hospital	16	70	33	13	99	91	96	41
Health centre	3	14	6	0	57	1	3	146
Clinic	0	9	4	0	54	6	9	78
PMH	0	30	15	0	71	1	1	92
Operating authority								
Public	4	19	9	2	59	12	15	228
Private religious	10	35	8	3	84	44	51	35
Other private	0	30	16	0	71	1	1	93
Region								
Western	10	41	4	4	84	15	21	32
Central	0	17	7	4	72	11	9	29
Greater Accra	2	24	6	2	40	12	12	25
Volta	8	20	8	4	39	12	14	46
Eastern	3	28	31	0	68	11	11	42
Ashanti	2	27	16	1	61	19	22	69
Brong Ahafo	3	17	10	0	77	7	9	48
Northern	2	25	3	0	83	11	17	34
Upper East	0	17	6	0	60	14	17	10
Upper West	0	7	0	0	66	8	8	22
Total	3	24	11	2	65	13	15	357

¹ Includes operating table, operating light, scrub area adjacent to operating room, and sterilized instruments prepared

² Blood transfusion with or without blood bank

Table A-6.19 Equipment for emergency care of the newborn			
Percentage of facilities providing delivery services where the indicated equipment is available, by type of facility, operating authority, and region, Ghana SPA 2002			
Background characteristics	Percentage of facilities with:		Weighted number of facilities offering delivery services
	Newborn respiratory support ¹	External heat source ²	
Type of facility			
Hospital	80	38	41
Health centre	36	5	146
Clinic	34	12	78
PMH	25	8	92
Operating authority			
Public	39	10	228
Private religious	67	27	35
Other private	25	8	93
Region			
Western	42	4	32
Central	51	26	29
Greater Accra	24	14	25
Volta	46	4	46
Eastern	40	8	42
Ashanti	44	8	69
Brong Ahafo	24	10	48
Northern	47	31	34
Upper East	43	14	10
Upper West	3	0	22
Total	38	11	357
¹ Resuscitator or ambu bag			
² Most often an incubator, although heat light would be sufficient			

Table A-6.20 Newborn care practices								
Percentage of facilities that report the indicated item is a routine component of newborn care, by type of facility and operating authority, Ghana SPA 2002								
Background characteristics	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Suction with catheter	38	22	17	15	21	35	16	21
Immediate bath-immersion in water	87	81	77	84	80	86	83	82
Weigh newborn	96	94	90	96	92	97	95	94
Infant scale available	98	89	74	82	85	91	82	85
Provide vitamin A to mother	12	12	9	14	11	10	14	12
Provide OPV to newborn	76	51	46	17	53	59	18	44
Provide BCG to newborn	73	39	35	7	43	51	7	34
Practice rooming-in ¹	98	90	91	91	92	93	90	91
Weighted number of facilities providing delivery services	41	146	78	92	228	35	93	357
¹ Newborn stays with mother								

Table A-6.21 Supportive management for providers of delivery services

Percentage of interviewed providers of delivery services who were personally supervised during the past 6 months, who received in-service training related to delivery services in the past 12 months, who were both supervised during the past 6 months and received in-service training during the past 12 months, and whose most recent in-service training was 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed delivery service providers
	Who were personally supervised in the past 6 months	Who received in-service training in the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	40	30	14	38	198
Health centre	51	25	17	33	159
Clinic	54	22	11	25	119
PMH	44	35	21	18	83
Operating authority					
Public	53	26	15	34	375
Private religious	27	27	10	30	100
Other private	44	34	21	18	84
Region					
Western	30	26	14	48	43
Central	23	18	5	29	38
Greater Accra	59	35	18	29	76
Volta	48	34	22	38	70
Eastern	42	17	6	54	64
Ashanti	39	23	10	19	133
Brong Ahafo	56	24	16	12	72
Northern	67	26	21	48	36
Upper East	63	79	55	3	7
Upper West	69	59	44	23	19
Total	47	28	15	31	559

Table A-6.22 Supportive management: In-service training for delivery service providers

Among interviewed delivery service providers, percentage who received in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed delivery service providers who received in-service training on specific topics																		Weighted number of interviewed providers
	Delivery care		Use of partograph		Lifesaving skills		Safe motherhood		Infection prevention		PMCT		Exclusive breastfeeding		Care of normal newborn		Neonatal resuscitation		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility																			
Hospital	10	23	17	24	12	22	16	32	9	21	11	24	12	42	9	20	10	22	198
Health centre	8	21	9	22	5	14	9	24	6	15	10	11	14	22	6	16	8	15	159
Clinic	5	11	6	14	2	7	7	13	2	9	6	9	10	22	6	6	6	7	119
PMH	19	17	21	12	16	10	22	14	14	10	17	6	17	22	16	11	18	12	83
Operating authority																			
Public	8	20	12	23	8	17	12	26	6	19	9	15	13	32	7	17	9	18	375
Private religious	6	16	10	12	7	10	9	18	7	3	11	19	8	25	7	7	6	7	100
Other private	19	18	21	12	16	11	22	14	14	10	17	7	17	23	16	12	18	12	84
Region																			
Western	5	18	2	24	4	11	5	18	4	10	10	16	20	36	3	10	2	14	43
Central	7	26	6	25	4	9	12	24	2	8	12	14	8	24	4	11	5	19	38
Greater Accra	12	21	21	22	17	24	18	34	7	33	10	16	18	34	14	18	14	17	76
Volta	12	22	19	27	7	13	11	23	8	12	16	22	8	43	9	19	11	19	70
Eastern	4	40	5	32	3	42	11	48	4	32	12	23	7	52	6	32	6	35	64
Ashanti	10	10	12	12	6	6	11	14	7	6	8	9	13	14	6	9	7	8	133
Brong Ahafo	9	10	12	8	9	4	13	9	8	5	12	5	6	17	10	7	12	6	72
Northern	6	21	8	29	8	18	9	29	2	20	6	22	14	32	11	16	7	17	36
Upper East	35	19	56	12	35	9	41	9	38	9	25	16	52	12	22	19	48	6	7
Upper West	23	8	30	10	33	10	35	17	29	15	6	5	27	24	19	8	23	8	19
Total	10	19	13	20	9	15	13	23	7	15	11	14	13	29	9	14	10	15	559

Chapter 7

Table A-7.1 Availability of infrastructure, resources, and systems for quality STI services

Percentage of facilities that offer sexually transmitted infection (STI) services where there are system components to support use of services (a written confidentiality policy, a system for partner followup), items to support quality counselling (infrastructure to provide privacy, diagnostic and treatment guidelines, visual aids for health education, and condoms), and items for quality physical examination (infection prevention items, privacy, an examination bed, and an examination light), by type of facility and operating authority, Ghana SPA 2002

Items	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Items to support utilization of STI services								
Written confidentiality policy	14	8	9	23	9	12	22	13
Active partner followup system	27	33	43	39	33	39	41	35
Passive partner followup system	69	62	56	59	63	58	58	61
No followup system for partners	4	6	2	1	5	3	1	4
Items to support quality counselling								
Visual and auditory privacy	86	88	78	87	85	82	88	86
Visual privacy only	97	94	92	90	94	95	91	93
No privacy	3	6	3	5	5	2	5	5
Any guidelines or protocols	62	67	63	92	65	57	92	72
National Reproductive Health Service protocols	21	43	39	82	40	17	82	49
Guidelines for syndromic diagnosis STIs	42	42	47	83	42	48	82	53
Any visual aids or educational materials	60	47	66	67	53	55	69	57
Educational materials specific for HIV/AIDS	49	36	33	33	36	44	36	37
Self-Directed Learning (SDL) models for HIV/AIDS/STIs	7	0	4	36	1	5	36	11
Stop AIDS Love Life poster	39	24	25	24	26	31	27	27
Model for teaching use of condom	31	48	39	82	43	31	83	52
Condoms at service delivery site	19	32	46	86	34	15	87	46
Condoms anywhere in facility	69	87	77	91	87	44	92	84
All items to support quality counselling ¹	13	17	26	67	17	15	69	31
Items to support quality physical examination								
Infection prevention								
Soap	100	94	91	95	93	100	95	94
Water	100	92	94	96	93	98	96	95
Single-use towels	34	22	32	85	26	29	83	41
Clean gloves	81	70	80	90	72	85	91	79
Disinfecting solution	22	23	44	62	27	27	61	36
Sharps box	26	57	68	61	54	46	63	55
All items for infection prevention ²	9	14	37	40	18	20	41	24
Infrastructure for examination								
Visual privacy for examination	92	90	91	93	89	95	94	91
Examination bed ³	93	84	84	91	85	88	91	87
Examination light ⁴	28	20	24	52	21	28	52	30
All elements for physical examination ⁵	4	4	8	24	4	5	24	9
Weighted number of facilities offering STI services	43	120	53	71	180	29	76	286

¹ Visual and auditory privacy, any guidelines or protocols, any visual aids or educational materials, and condoms

² Soap, water, gloves, disinfecting solution, and sharps box

³ Any type of bed where a woman can lie down flat

⁴ May be examination light, flashlight, or other spotlight source

⁵ All infection prevention items, visual privacy, examination bed, and examination light

Table A-7.2 Availability of specific equipment and supplies for good-quality assessment of the STI client

Percentage of facilities that offer STI services with specific items for making etiological diagnosis of STIs, with medicines for treating STIs available, by type of facility and operating authority, Ghana SPA 2002

Equipment, tests, and medicines	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Items for etiologic examination								
Vaginal speculum	44	24	45	77	29	47	77	44
Swab stick for specimen	22	2	5	10	6	8	10	8
Syphilis test capacity ¹	52	2	8	1	10	36	1	10
Gonorrhoea test capacity ²	86	5	9	1	18	52	1	17
Wet mount testing capacity ³	94	11	23	3	25	67	3	23
HIV/AIDS testing capacity ⁴	85	2	15	0	16	61	0	16
All four laboratory tests ⁵	44	0	5	0	6	34	0	7
Medicines for STIs								
Metronidazole (trichomoniasis)	94	81	79	72	81	99	71	80
Nystatin suppository	42	3	12	18	7	45	18	14
Ceftriaxone (gonorrhoea)	28	2	2	1	6	14	2	6
Ciprofloxacin (gonorrhoea)	71	25	26	41	31	54	40	36
Doxycycline (chlamydia, syphilis)	71	17	17	22	24	49	22	26
Tetracycline (chlamydia, syphilis)	87	64	52	54	64	78	54	63
Erythromycin (chlamydia, syphilis)	60	7	9	8	13	52	8	16
Penicillin, benzathine (syphilis)	63	70	56	47	67	59	46	61
Penicillin, procaine (syphilis)	95	66	77	66	73	92	63	72
All medicines for STIs ⁶	72	20	21	35	27	54	34	32
Weighted number of facilities offering STI services	43	120	53	71	180	29	76	286
¹ Either venereal disease research laboratory (VDRL) slide test and functioning microscope, or rapid plasma reagin (RPR) test kit ² Gram stain reagents and functioning microscope or culture capacity ³ Functioning microscope and glass slides ⁴ Enzyme-linked immunosorbent assay (ELISA), Western blot, rapid test, or HIV SPOT ⁵ Test for syphilis, gonorrhoea, HIV/AIDS, and wet mount ⁶ At least one medicine for treating trichomoniasis, gonorrhoea, chlamydia, and syphilis								

Table A-7.3 Usage and availability of diagnostic tests at facilities providing STI services

Among facilities providing STI services, percentage of facilities that conduct the indicated test, that send the specimen elsewhere for testing, that refer clients elsewhere for the test, where the test is not utilized, and percentage of facilities that conduct the test and where the test was available on the day of the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering test for:															Weighted number of facilities providing STI services
	Syphilis					Gonorrhoea					HIV/AIDS					
	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available ¹	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available ²	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available ³	
Type of facility																
Hospital	49	3	26	22	44	75	1	14	9	69	84	4	7	5	84	43
Health centre	1	1	33	64	1	5	1	37	57	2	2	1	27	69	2	120
Clinic	8	2	39	52	8	12	2	48	39	6	13	4	35	50	13	53
PMH	0	0	48	52	0	1	1	57	41	1	0	1	40	59	0	71
Operating authority																
Public	10	2	34	54	9	17	1	36	46	13	15	2	27	56	15	180
Private religious	28	3	23	46	28	49	0	21	30	40	59	3	14	25	59	29
Other private	0	0	48	52	0	1	1	58	39	1	0	2	40	58	0	76
Region																
Western	3	3	30	64	3	14	0	22	64	11	20	0	22	58	20	24
Central	9	0	10	81	9	16	0	30	54	11	11	0	26	63	11	24
Greater Accra	11	12	55	21	9	11	13	53	24	11	5	23	25	51	5	24
Volta	11	0	47	42	9	27	0	44	29	14	20	0	45	35	20	36
Eastern	12	0	75	13	12	13	0	71	15	13	14	2	6	78	14	38
Ashanti	11	0	35	54	9	18	0	45	37	15	27	0	32	41	27	48
Brong Ahafo	12	0	38	50	12	16	0	54	30	12	12	0	68	21	12	38
Northern	9	0	20	72	9	12	0	20	69	12	14	0	17	69	14	28
Upper East	4	0	0	96	4	17	0	0	83	13	17	0	0	83	17	7
Upper West	0	0	5	95	0	9	0	5	86	9	9	0	5	86	9	20
Total	9	1	37	53	8	16	1	41	42	13	16	2	29	53	16	286
¹ Either VDRL test and functioning microscope, or RPR test kit																
² Gram, stain reagents and functioning microscope or culture capacity																
³ ELISA, Western blot, rapid test, or HIV SPOT																

Table A-7.4 Usage and availability of diagnostic tests

Among facilities providing STI services, percentage of facilities that conduct the indicated test, that send the specimen elsewhere for testing, that refer clients elsewhere for the test, where the test is not utilized, and, percentage of facilities that conduct the test and where the test was available on the day of the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering test for:												Weighted number of facilities providing STI services
	Microscopic wet mount				Genital herpes				Chlamydia				
	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available ¹	Conduct test	Refer client for test	Test is not utilized	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	
Type of facility													
Hospital	70	0	12	16	67	19	16	65	39	0	22	38	43
Health centre	4	1	35	60	4	0	26	74	2	1	33	64	120
Clinic	7	0	42	51	7	2	20	78	3	2	41	56	53
PMH	0	1	48	51	0	0	24	76	0	1	46	53	71
Operating authority													
Public	15	0	34	50	14	2	24	74	7	1	34	58	180
Private religious	40	0	18	43	40	18	15	67	26	0	23	51	29
Other private	0	1	48	50	0	0	24	76	0	1	46	52	76
Region													
Western	9	0	22	67	9	3	25	72	6	0	22	70	24
Central	11	0	24	65	11	0	0	100	0	0	5	95	24
Greater Accra	16	7	35	42	16	2	0	98	2	14	45	42	24
Volta	13	0	49	39	11	4	53	43	9	0	50	40	36
Eastern	13	0	74	12	13	4	25	71	10	0	76	14	38
Ashanti	19	0	32	50	17	5	27	68	12	0	30	58	48
Brong Ahafo	13	0	46	41	13	2	34	65	7	0	48	45	38
Northern	12	0	20	69	12	6	17	77	8	0	20	72	28
Upper East	13	0	0	87	13	0	0	100	0	0	0	100	7
Upper West	9	0	5	86	9	0	5	95	3	0	5	92	20
Total	13	1	36	50	13	3	23	74	7	1	36	56	286

¹ Functioning microscope and glass slides

Table A-7.5 Out-of-pocket payments for first-visit STI clients

Among interviewed STI clients, percentage who reported that they are part of a prepayment plan and percentage who reported paying any out-of-pocket fees for STI services on the day of the survey; among the clients who paid any fees for STI services, median amount (Cedis) paid for services on the day of the survey, by whether client belonged to prepaid program, by type of facility and operating authority, Ghana SPA 2002

Background characteristics	Percentage of interviewed STI clients who reported:		Weighted number of interviewed STI clients	Median out-of-pocket payment ¹ by STI clients who paid anything for services day of survey:		Weighted number of interviewed STI clients providing valid responses for amount paid
	Belonging to a prepaid program	Paying any out-of-pocket charges ¹ for this visit		Belong to prepaid program	Do not belong to prepaid program	
Type of facility						
Hospital	16	88	32	18,085	25,080	29
Health centre	7	81	13	na	8,537	11
Clinic	0	80	13	na	10,077	11
PMH	56	100	2	na	0	2
Operating authority						
Public	11	81	41	17,786	10,094	33
Private religious	9	97	17	38,100	17,083	17
Other private	44	77	3	na	0	2
Region						
Western	52	52	1	na	0	1
Central	0	0	0	na	0	0
Greater Accra	38	15	4	na	0	1
Volta	0	86	11	na	27,223	10
Eastern	0	100	5	na	22,031	5
Ashanti	5	93	21	na	15,257	19
Brong Ahafo	25	96	12	38,014	8,532	12
Northern	25	75	4	na	35,050	3
Upper East	0	100	2	na	4,860	2
Upper west	0	0	0	na	0	0
Total	12	85	61	20,041	15,858	52

¹ Includes any amount paid out-of-pocket, such as fees for consultation, laboratory test, medicines, or other
na = Not applicable; none of the clients belonged to a prepaid programme

Table A-7.6 Supportive management for providers of STI services

Percentage of providers who were personally supervised in the past 6 months, percentage who received in-service training related to STI during the past 12 months, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of providers:				Weighted number of interviewed providers offering STI services
	Who were personally supervised in the past 6 months	Who received in-service training in the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
Type of facility					
Hospital	44	39	20	35	274
Health centre	65	31	23	24	132
Clinic	56	31	20	23	64
PMH	58	46	26	28	43
Operating authority					
Public	57	40	24	30	355
Private religious	34	23	10	31	112
Other private	59	45	26	31	46
Region					
Western	33	22	16	45	60
Central	52	40	25	27	23
Greater Accra	59	55	36	24	86
Volta	54	26	16	25	79
Eastern	47	49	17	40	76
Ashanti	42	26	8	44	47
Brong Ahafo	52	40	24	17	59
Northern	57	21	12	23	49
Upper East	86	38	35	38	8
Upper West	84	45	40	23	26
Total	52	37	21	30	513

Table A-7.7 Supportive management: In-service training for STI service providers

Among interviewed STI service providers, percentage who received in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed STI service providers who received in-service training on specific topics										Weighted number of interviewed STI service providers
	Counselling and prevention		Clinical diagnosis and treatment		Syndromic approach		Any course related to HIV/AIDS		Specific course related to PMTCT		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility											
Hospital	27	33	15	31	23	31	31	32	21	26	274
Health centre	19	24	14	26	19	24	20	16	14	12	132
Clinic	15	23	9	22	15	19	24	17	19	21	64
PMH	33	39	15	32	28	44	33	19	26	9	43
Operating authority											
Public	25	29	14	29	22	29	30	26	20	21	355
Private religious	18	27	13	25	16	23	18	21	15	21	112
Other private	30	42	14	34	27	45	32	22	24	13	46
Region											
Western	13	36	9	27	10	27	19	30	11	22	60
Central	27	29	19	33	23	28	34	17	27	19	23
Greater Accra	37	28	23	24	38	29	46	24	34	22	86
Volta	16	24	9	22	13	24	19	21	15	21	79
Eastern	24	48	7	54	19	48	38	39	25	32	76
Ashanti	20	38	12	34	16	42	19	31	16	29	47
Brong Ahafo	30	18	21	16	26	15	30	12	22	14	59
Northern	13	19	13	13	19	18	12	12	9	9	49
Upper East	18	28	18	29	25	31	8	37	3	12	8
Upper West	44	23	13	36	26	24	18	31	6	1	26
Total	24	30	14	29	21	29	27	25	19	21	513

PMTCT = Prevention of mother-to-child transmission

Table A-7.8 Observed consultation for STI clients

Among observed STI clients, percentage who were reassured about confidentiality and for whom the indicated information was asked during the consultation, by type of facility and operating authority, Ghana SPA 2002

Consultation components	Percentage of STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Health post	PMH	Public	Private religious	Other private	
Reassured about confidentiality	55	35	79	100	63	43	77	58
Client history elicited								
Client symptoms	95	100	76	100	90	96	89	92
How long symptoms have been present	91	100	76	100	89	92	89	90
History of recent sexual contacts	82	48	61	100	65	82	89	72
Symptoms in partner(s)	48	44	24	56	33	63	44	43
Relationship status ¹	57	67	45	100	52	67	89	58
All elements of client history ²	43	37	16	56	28	54	44	37
Weighted number of observed male STI clients	6	3	2	0	7	4	0	11
Weighted number of observed female STI clients	32	10	12	2	36	17	3	56
Weighted number of observed STI clients	38	13	14	2	43	21	3	68

¹ Monogamous, multiple partners, or non-monogamous partner

² Client symptoms, how long symptoms have been present, history of recent sexual contacts, symptoms in partner(s) and relationship status

Table A-7.9 Observed consultation for female STI clients

Among observed female STI clients who were examined, percentage for whom the indicated items were components of the physical examination and percentage which had a pelvic examination, by type of facility and operating authority, Ghana SPA 2002

Examination components	Percentage of STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Conditions during physical examination								
Visual privacy was assured	88	100	100	100	93	95	100	94
Auditory privacy was assured	92	61	100	100	87	100	100	92
Provider washed hands with soap before examination	63	100	40	100	51	69	100	60
Provider used single-use towel	32	61	12	100	25	30	100	31
Provider wore clean gloves	80	61	89	100	80	82	100	82
Genitals were fully exposed	83	61	56	100	61	87	100	72
Client was lying down	88	61	67	100	68	95	100	79
Labia were inspected	72	61	85	100	74	82	79	77
All elements of examination ¹	59	61	24	100	45	51	79	49
Female client had a pelvic examination	58	61	81	100	63	73	100	69
Weighted number of observed female clients	13	3	9	1	16	9	2	26

¹ Visual and auditory privacy was assured, provider washed hands with soap before examination, provider wore clean gloves, genitals were fully exposed, the client was lying down, and labia were inspected.

Table A-7.10 Observed pelvic examination for female STI clients

Among observed female STI clients who had pelvic examinations, percentage for whom the indicated items were components of the examination, by type of facility and operating authority, Ghana SPA 2002

Examination components	Percentage of observed female STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Provider treatment of client								
Visual privacy was assured	100	100	100	100	100	100	100	100
Auditory privacy was assured	100	100	100	100	100	100	100	100
Explained procedure before starting	100	100	100	100	100	100	100	100
Asked client to relax	66	0	19	100	24	59	100	43
Provider's infection prevention procedures								
Washed hands with soap before examination	79	100	25	100	54	57	100	60
Used single-use towel	46	100	5	100	33	29	100	38
Wore clean gloves	100	100	100	100	100	100	100	100
Washed hands after removing gloves	79	100	100	100	100	74	100	91
Wiped contaminated surfaces with disinfectant	53	100	5	100	39	26	100	40
Decontaminated materials	55	0	81	100	85	29	79	65
Procedures used								
Used speculum	53	100	95	100	100	43	79	78
Explained speculum procedure	32	0	95	100	85	17	79	61
Used sterilized or HLD instruments	55	0	95	100	85	46	79	71
Prepared all instruments before starting	55	0	95	100	85	46	79	71
Inspected cervix	32	0	81	100	85	0	79	55
Performed bimanual examination	23	100	0	100	33	0	79	26
All elements of examination ¹	23	0	0	100	17	0	79	17
Weighted number of observed pelvic examinations	8	2	8	1	10	6	2	18

¹ Used speculum, explained the speculum procedure, used sterilized or high-level disinfected (HLD) instruments, prepared all instruments before starting, inspected the cervix and performed a bimanual examination

Table A-7.11 Components of observed STI consultations

Among observed STI clients, percentage for whom the indicated items were components of the consultation, by type of facility and operating authority, Ghana SPA 2002

Item	Percentage of observed STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Diagnostic methods used								
Laboratory exam conducted or prescribed	58	69	51	0	57	62	11	57
Types of tests mentioned								
Blood test	12	12	23	0	10	23	0	14
Microscopic examination of specimen	31	47	51	0	34	48	11	37
Voluntary counselling and testing (VCT) and HIV/AIDS test	3	0	3	0	2	0	11	2
Consent sought for laboratory examinations	24	35	39	0	32	25	11	28
Any mention of diagnosis of likely STI	71	47	60	44	64	65	34	63
Client received prescription or medication	83	88	92	100	83	94	77	86
Client instructed about medications	67	54	81	100	62	80	77	69
Partner referral encouraged	54	33	23	100	38	53	89	45
Follow-up appointment discussed	81	54	70	100	65	94	77	74
Health education								
Visual aids used	5	0	0	0	4	0	0	3
Risk of HIV/AIDS mentioned	19	22	13	56	24	6	55	20
Discuss condoms for prevention	27	23	29	56	32	15	55	28
Instruct how to use condom	10	0	11	0	12	0	0	8
Demonstrate condom	5	0	22	0	12	0	0	8
Any discussion of condoms or HIV/AIDS	31	35	40	56	42	17	55	35
Wrote on client health card	96	100	97	100	97	100	89	97
Weighted number of observed STI consultations	38	13	14	2	43	21	3	68

Table A-7.12 Information from interviewed STI clients								
Among interviewed STI clients, percentage for whom the indicated items were components of the consultation, by type of facility and operating authority, Ghana SPA 2002								
Item	Percentage of interviewed STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Client reported								
Receiving medicine or prescription	92	88	91	100	90	97	77	92
Being told how to protect against STIs or HIV/AIDS	45	10	22	100	37	18	89	35
Being asked to have HIV/AIDS test	3	0	17	0	6	0	23	5
Having any laboratory test day of survey	52	23	46	0	41	51	11	42
Reason for laboratory test								
Infection or STI	20	12	19	0	16	21	11	17
HIV/AIDS	3	0	3	0	3	0	11	2
Other	2	0	8	0	2	6	0	3
Was not told or don't know	26	12	27	0	20	31	0	22
Weighted number of interviewed STI clients	32	13	13	2	41	17	3	61

Table A-7.13 Client knowledge about ways to protect against STIs or HIV/AIDS			
Among interviewed STI clients, percentage who mentioned specific ways to protect against STIs and HIV/AIDS, by sex, Ghana SPA 2002			
Ways to protect against STIs and HIV/AIDS	Percentage of interviewed STI clients		Total
	Male	Female	
Use condoms	58	50	51
Have only one partner	34	41	40
Weighted number of interviewed STI clients	11	51	61

Table A-7.14 Client experience and opinions about condom use			
Among interviewed STI clients percentage who used a condom before, percentage who agree that the issue mentioned is a major contributing factor for not using a condom, and of those, the percentage who discussed condom problems with health care worker, percentage who received a condom, and percentage who indicated that the health care worker talked about condoms on the day of survey, by sex, Ghana SPA 2002			
Experience and opinions	Percentage of interviewed STI clients		Total
	Male	Female	
Client has used condom before	48	46	46
Client agrees that item is a major contributing factor for not using a condom			
Embarrassing to purchase	27	32	31
Problem with disposal	7	7	7
Embarrassing to discuss with partner	21	7	10
Reduces own sexual satisfaction	7	7	7
Reduces partner's sexual satisfaction	0	15	13
Any other factor	41	45	44
Client discussed problems with condom with health care worker	0	23	19
Weighted number of interviewed STI clients who agree about problems with condoms	4	23	27
Client received condoms today	-	-	-
Health care worker talked about condoms today	17	21	20
Weighted number of interviewed STI clients	11	51	61

Table A-7.15 Client feedback on STI services								
Percentage of observed and interviewed STI clients who said that they considered specific items as major problems for them the day of the visit, by type of facility and operating authority, Ghana SPA 2002								
Areas of complaint	Percentage of observed and interviewed STI clients by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Inability to discuss concerns with provider	3	0	0	0	0	5	0	1
Insufficient explanation about the problem or treatment	8	23	0	0	12	5	0	9
Poor quality of examination and treatment	4	12	0	0	4	7	0	5
Waiting time too long	34	12	8	0	19	35	0	22
Opening hours of facility inconvenient	9	0	0	0	5	5	0	5
Lack of cleanliness	5	0	0	0	0	9	0	3
Lack of privacy	3	0	0	0	0	5	0	1
Total weighted number of interviewed STI clients	32	13	13	2	41	17	3	61

Table A-7.16 Services provided for HIV-positive clients

Among facilities providing any care for HIV-positive clients, percentage where the indicated service is provided on an inpatient basis, outpatient basis, both inpatient and outpatient basis, either inpatient or outpatient basis, percentage that refer clients for the service; and percentage where the facility does not routinely provide or refer the client for the service, by type of service, Ghana SPA 2002

Service	Percentage of facilities offering:				Client referred for service	Facility does not routinely provide service or refer for service
	Inpatient service only	Outpatient service only	Both inpatient and outpatient services	Either inpatient or outpatient services		
PMTCT	41	0	39	80	6	14
Tuberculosis diagnosis and treatment	34	0	47	81	19	0
Treatment opportunistic infections	35	1	53	89	7	4
Antiretroviral therapy	1	1	1	3	29	68
Home-based care	38	1	35	74	2	24
Palliative management for pain or debilitation	31	6	45	82	15	4
Counselling or training for home care	38	1	35	74	2	24
Psychosocial services	29	0	38	67	12	21
All non-acute care and support services ¹	0	0	0	48	0	52
All services available ²	0	0	0	2	0	98

¹ Includes home-based care, palliative management for pain or debilitation, counselling or training for home care, and psychosocial services

² Includes PMTCT, tuberculosis diagnosis and treatment, treatment of opportunistic infections, antiretroviral therapy (ART), home-based care, palliative management for pain or debilitation, counselling or training for home care, and psychosocial services

Table A-7.17 Availability of infrastructure, resources, and systems for quality HIV/AIDS services

Percentage of facilities that offer HIV services where there are system components (a written confidentiality policy, a system for partner followup) to support utilization of services, items to support quality counselling (infrastructure to provide privacy, diagnostic and treatment guidelines, visual aids for health education, and condoms) and items for infection prevention, by type of facility and operating authority, Ghana SPA 2002

Items	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Items to support utilization of STI services								
Written confidentiality policy	2	0	6	0	3	0	0	2
Informed consent protocol for HIV clients	7	0	9	0	5	5	0	4
Written protocols for referrals for HIV/AIDS	4	0	6	0	4	0	0	2
Active partner followup system	28	37	31	40	29	35	42	33
Passive partner followup system	69	63	64	60	69	61	58	65
No followup system for partners	3	0	4	0	2	4	0	2
Items to support quality counselling								
Visual and auditory privacy	79	28	37	23	51	65	22	47
Visual privacy only	86	28	43	23	52	80	22	51
No privacy	5	0	0	0	3	0	0	2
Any guidelines or protocols for HIV/AIDS	4	0	6	0	4	0	0	2
Any guidelines or protocols for STIs	50	20	30	17	36	41	15	32
National Reproductive Health Service protocols	21	16	10	17	20	11	15	17
Guidelines for syndromic diagnosis of STIs	47	20	30	17	34	41	15	31
Any visual aids or educational materials	93	28	46	28	56	83	26	55
Educational materials specific for HIV/AIDS	65	21	34	18	41	56	17	39
SDL models for STI/HIV/AIDS	9	0	0	4	4	3	4	4
Stop AIDS Love Life poster	43	13	11	0	25	32	1	21
Model for teaching use of condom	38	9	8	18	23	20	18	21
Condoms at service delivery site	30	8	8	23	21	10	21	19
Condoms anywhere in facility	72	100	64	90	92	40	91	81
All items to support quality counselling ¹	4	0	6	0	4	0	0	2
Infection prevention								
Soap	100	84	98	100	94	97	100	96
Water	100	80	95	90	92	94	91	92
Single-use towel	35	28	34	95	36	19	92	45
Clean gloves	84	71	86	86	76	89	88	81
All items for infection prevention ²	84	71	81	76	76	84	79	78
Weighted number of facilities offering HIV services	41	28	20	22	64	23	24	111

¹ Visual and auditory privacy, any guidelines or protocols for HIV/AIDS, any visual aids or educational materials, and condoms

² Soap, water, and gloves

Table A-7.18 Follow-up services for HIV/AIDS

Among facilities providing any HIV/AIDS services, percentage that had a referral form (or the facility is a referral facility), had a list of care and support services for referral, or had a partnership with People Living with HIV/AIDS (PLHA) group, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities with:			Weighted number of facilities providing any HIV/AIDS services
	Referral form or facility is a referral facility	List of care and support services for referral	Partnership with PLHA exists	
Type of facility				
Hospital	35	3	18	41
Health centre	11	10	5	28
Clinic	19	0	9	20
PMH	10	0	14	22
Operating authority				
Public	23	6	8	64
Private religious	26	3	25	23
Other private	11	0	13	24
Region				
Western	19	0	30	11
Central	7	0	7	8
Greater Accra	11	0	4	14
Volta	0	0	13	9
Eastern	45	14	10	13
Ashanti	26	0	15	24
Brong Ahafo	29	0	11	12
Northern	13	0	8	11
Upper East	33	0	33	1
Upper West	28	37	9	6
Total	21	4	12	111

Table A-7.19 Usage and availability of diagnostic tests at facilities providing HIV services

Among facilities providing HIV services, percentage of facilities that conduct the indicated test, that send the specimen elsewhere for testing, that refer clients elsewhere for the test, where the test is not utilized, and, percentage of facilities that conduct the test and where the test was available on the day of survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering test for:															Weighted number of facilities providing HIV services
	HIV/AIDS					Syphilis					Tuberculosis (sputum test)					
	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available	Conduct test	Send specimen elsewhere	Refer client for test	Test is not utilized	Conduct test and test is available	
Type of facility																
Hospital	86	4	6	4	86	51	3	26	20	46	94	0	3	3	89	41
Health centre	9	3	22	66	9	0	3	30	67	0	14	0	41	46	14	28
Clinic	33	11	34	26	33	20	4	30	46	20	37	4	28	32	35	20
PMH	0	5	63	33	0	0	0	54	46	0	0	0	71	29	0	22
Operating authority																
Public	42	5	18	36	42	26	3	28	43	23	51	0	24	25	48	64
Private religious	76	3	12	9	76	37	3	27	34	37	76	3	10	11	75	23
Other private	0	6	61	33	0	0	0	54	46	0	0	0	66	34	0	24
Region																
Western	43	0	13	44	43	6	7	44	43	6	56	0	13	31	56	11
Central	33	0	53	14	33	26	0	0	74	26	47	0	49	4	47	8
Greater Accra	8	33	36	28	8	19	15	60	6	15	19	0	48	32	19	14
Volta	79	0	10	10	79	43	0	17	40	36	79	0	10	10	66	9
Eastern	41	6	7	46	41	33	0	67	0	33	39	6	50	6	39	13
Ashanti	54	0	31	15	54	22	0	34	44	18	60	0	22	18	56	24
Brong Ahafo	36	0	52	12	36	26	0	19	55	26	36	0	50	15	36	12
Northern	34	0	12	54	34	21	0	12	67	21	34	0	10	56	34	11
Upper East	33	0	0	67	33	33	0	0	67	33	67	0	0	33	33	1
Upper West	28	0	16	56	28	0	0	16	84	0	28	0	16	56	28	6
Total	40	5	26	29	40	22	3	33	42	21	45	1	30	24	43	111

Table A-7.20 Availability of laboratory tests related to HIV/AIDS services

Among facilities providing HIV/AIDS services, percentage with the capacity to conduct specific HIV/AIDS tests, to do CD4 count, and to test for viral load, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of facilities offering:						Weighted number of facilities offering HIV/AIDS services
	Specific HIV/AIDS tests:				CD4 count	HIV viral load	
	Rapid test	ELISA	Western blot	HIV SPOT			
Type of facility							
Hospital	74	12	2	66	8	1	41
Health centre	4	0	4	9	0	0	28
Clinic	33	0	0	18	2	0	20
PMH	0	0	0	0	0	0	22
Operating authority							
Public	36	5	3	32	3	1	64
Private religious	66	7	0	56	8	0	23
Other private	0	0	0	0	0	0	24
Region							
Western	37	6	0	31	0	0	11
Central	47	0	0	12	0	0	8
Greater Accra	4	0	0	4	0	0	14
Volta	73	20	0	43	0	7	9
Eastern	28	8	0	44	0	0	13
Ashanti	43	0	9	37	9	0	24
Brong Ahafo	25	5	0	36	11	0	12
Northern	34	8	0	34	0	0	11
Upper East	33	0	0	33	0	0	1
Upper West	28	0	0	18	0	0	6
Total	34	5	2	30	3	1	111

Table A-7.21 Availability of tuberculosis services as routine component of HIV/AIDS services

Among facilities providing both services for HIV/AIDS and who indicate tuberculosis (TB) services are routine components of their HIV/AIDS services, percentage that have the capacity to test for TB, percentage that have the indicated medicines for treating TB, and percentage that have all medicines for providing the short course, standard treatment and second line treatment, and prophylactic treatment for TB, by type of facility and operating authority, Ghana SPA 2002

Test and medicines	Percentage of facilities by:							Total
	Type of facility				Operating authority			
	Hospital	Health centre	Clinic	PMH	Public	Private religious	Other private	
Ability to conduct sputum test for TB ¹	94	46	64	53	85	89	53	84
Availability of medicines for TB								
Isoniazid (INH)	72	45	6	0	59	66	0	57
Pyrazinamide	72	45	6	0	56	74	0	57
Rifampicin	63	45	6	0	49	64	0	50
Ethambutol	49	0	12	0	34	52	0	37
Red tablet (adult dose INH and thiacetazone)	63	18	6	0	49	58	0	48
Blue tablet (child dose INH and thiacetazone)	20	0	0	0	14	20	0	14
Streptomycin	73	45	6	28	60	69	28	60
All medicines for short course ²	13	0	0	0	5	20	0	9
All medicines for standard treatment ³	18	0	0	0	11	20	0	13
All medicines for second line treatment ⁴	8	0	0	0	3	12	0	6
INH alone (for prophylactic treatment)	72	45	6	0	59	66	0	57
Total weighted number of facilities providing HIV/AIDS services where TB is routine component of HIV services	36	4	5	4	30	16	4	50
¹ Slides and a microscope available								
² Streptomycin, pyrazinamide, isoniazid, rifampicin, red and blue tablet								
³ Streptomycin, red and blue tablet								
⁴ Streptomycin, pyrazinamide, isoniazid, rifampicin, ethambutol, red and blue tablet								

Table A-7.22 Supportive management for providers of HIV/AIDS services

Percentage of interviewed providers of HIV/AIDS services who provide the indicated services, who were personally supervised in the 6 months before the survey, percentage who received in-service training related to HIV/AIDS during the 12 months before the survey, percentage who received both personal supervision in the past 6 months and in-service training in the past 12 months, and percentage whose most recent in-service training was received 13-59 months preceding the survey, by type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed providers of HIV/AIDS services:								Weighted number of interviewed providers offering HIV/AIDS services
	Who provided:				Who were personally supervised in the past 6 months	Who received in-service training in the past 12 months	Who were personally supervised in the past 6 months and received in-service training in the past 12 months	Whose most recent in-service training was 13-59 months preceding the survey	
	Diagnosis	Medical care	ART	Counselling or support					
Type of facility									
Hospital	30	52	2	73	39	38	20	41	235
Health centre	38	71	0	72	57	38	19	39	13
Clinic	29	49	0	83	32	28	10	55	25
PMH	16	31	5	94	59	74	43	26	8
Operating authority									
Public	32	53	2	76	45	42	22	42	187
Private religious	26	54	1	68	25	27	10	42	85
Other private	15	30	5	91	64	69	42	31	9
Region									
Western	25	46	0	64	24	23	10	55	43
Central	54	62	0	57	49	38	19	42	8
Greater Accra	42	41	0	82	50	59	41	19	48
Volta	24	73	4	67	30	18	10	61	46
Eastern	28	49	8	68	37	40	7	49	44
Ashanti	41	79	0	84	40	31	12	53	34
Brong Ahafo	13	41	0	78	39	50	26	10	32
Northern	47	40	0	83	49	44	26	42	13
Upper East	0	45	0	100	45	73	45	27	1
Upper West	14	17	0	89	87	53	43	35	12
Total	30	52	2	74	40	38	19	42	281

Table A-7.23 Supportive management: In-service training for HIV/AIDS service providers

Among interviewed HIV/AIDS service providers, percentage who received in-service training in the past 12 months or 13-59 months preceding the survey, by specific topics, type of facility, operating authority, and region, Ghana SPA 2002

Background characteristics	Percentage of interviewed HIV/AIDS service providers who received in-service training on specific topics																		Weighted number of interviewed HIV/AIDS service providers
	Counselling and prevention of STIs		Clinical diagnosis and treatment of STIs		Syndromic approach for STIs		Counselling for prevention of HIV/AIDS		Specific course related to PMTCT		Counselling and social support for HIV/AIDS infected clients		Medical management for HIV/AIDS infected clients		ART		Tuberculosis		
	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	12 mo	13-59 mo	
Type of facility																			
Hospital	20	38	14	33	18	35	22	40	23	29	19	34	15	25	8	9	10	41	235
Health centre	21	34	26	36	26	32	28	20	28	11	28	17	15	16	11	0	4	46	13
Clinic	12	36	7	33	14	29	9	29	15	30	7	29	4	15	3	1	4	54	25
PMH	43	52	28	52	31	63	57	27	68	0	63	9	19	26	14	6	9	21	8
Operating authority																			
Public	20	39	14	34	19	36	24	43	24	31	21	35	16	22	10	10	10	44	187
Private religious	18	34	13	30	16	30	14	28	18	22	14	26	9	27	1	4	7	40	85
Other private	37	57	24	56	31	60	52	34	60	8	56	17	18	27	14	5	9	20	9
Region																			
Western	12	45	8	33	9	28	16	38	10	13	15	17	9	6	4	0	6	39	43
Central	13	41	11	38	11	38	8	31	24	23	13	18	0	26	8	12	19	48	8
Greater Accra	41	20	28	17	38	29	49	27	42	21	41	24	11	17	9	6	23	39	48
Volta	7	31	7	27	7	27	5	30	11	38	5	29	8	20	1	6	4	48	46
Eastern	2	60	2	61	3	59	10	73	20	49	8	64	32	38	32	3	5	41	44
Ashanti	24	46	17	43	16	42	21	37	23	38	20	34	10	35	0	19	6	43	34
Brong Ahafo	27	30	24	19	29	24	29	23	41	13	30	22	17	28	0	19	11	32	32
Northern	25	38	28	27	42	32	35	18	30	16	30	18	19	9	5	12	7	28	13
Upper East	18	55	45	27	45	27	18	82	27	27	27	55	27	27	0	0	0	55	1
Upper West	53	35	9	51	26	35	28	54	6	3	11	51	11	51	3	3	3	74	12
Total	20	38	14	34	18	35	22	38	24	27	20	32	14	24	8	8	9	42	281

2002 Ghana Service Provision Assessment Survey

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Dr. Isabella Sagoe-Moses	Analyst-Child Health Module
Dr. Agnes Dzokoto	Analyst-STI Module

Ghana Registered Midwives Association (GRMA)

Jane Okrah	Facilitator for Training
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Prosper Klu

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Opoku Boafo

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Richard K. Derby

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Moses Tetteh

Stephen Eshun

Ernest Annang

Geshon Nornyigbey

Jonathan Lawluvi

MEASURE Service Provision Assessment Reproductive and Child Health Service Delivery

PART 1: Facility Inventory Questionnaire

FACILITY IDENTIFICATION

Name of the facility _____ Facility Location _____ Region _____ District _____ Type of Health Facility: (11 = Teaching hospital; 12 = Regional/ District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 = Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____) Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____)	REGION CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DISTRICT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY TYPE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> OPERATING AUTHORITY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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GPS Reading: Latitude..... Longitude..... Altitude Waypoint	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">N/S</td> <td style="width: 15%; text-align: center;">Degrees</td> <td style="width: 15%; text-align: center;">Minutes</td> <td style="width: 15%; text-align: center;">Thousandths</td> </tr> <tr> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td style="text-align: center;">E/W</td> <td style="text-align: center;">Degrees</td> <td style="text-align: center;">Minutes</td> <td style="text-align: center;">Thousandths</td> </tr> <tr> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td colspan="4" style="text-align: center;">_____ Meters</td> </tr> </table>	N/S	Degrees	Minutes	Thousandths	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	E/W	Degrees	Minutes	Thousandths	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	_____ Meters			
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Date: _____ Name of the interviewer _____	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> INTERVIEWER CODE . <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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NUMBER OF QUESTIONNAIRES COMPLETED AT FACILITY: 1 Sick Child Observations 2 FP Observations 3 ANC Observations 4 STI Observation 5 Sick Child Exist Interviews 6 FP Exit Interviews 7 ANC Exit Interviews 8 STI Exist Interviews 9 Provider Interviews	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="width: 30%; text-align: center;">OBSERVATION</td> <td style="width: 30%; text-align: center;">EXIT</td> </tr> <tr> <td>CHILD</td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td>CHILD <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>FP</td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td>FP <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>ANC</td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td>ANC <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>STI</td> <td style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td>STI <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>PROVIDER INTERVIEWS</td> <td colspan="2" style="text-align: center;"><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> </tr> </table>		OBSERVATION	EXIT	CHILD	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	CHILD <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	FP	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	FP <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	ANC	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	ANC <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	STI	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	STI <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	PROVIDER INTERVIEWS	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
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PROVIDER INTERVIEWS	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>																		

1. General Information

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
100	<p>FOR OUTPATIENT SERVICES: FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. INTRODUCE YOURSELF AND EXPLAIN THE STUDY OBJECTIVES AS DESCRIBED IN THE TRAINING MANUAL. READ THE FOLLOWING:</p> <p>I am representing the Ministry of Health and the Ghana Statistical Service for this survey. We are collecting information that will help us to understand the health service situation for maternal, child, and reproductive health services. All information from this survey is confidential and is not identified with any facility name. 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. Can we begin now ?</p>	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">TIME</p> <p>YES <input type="checkbox"/> → <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> AM HOUR MINUTES PM</p> <p>NO <input type="checkbox"/> → REASON</p> <p style="text-align: center;">.....</p> </div>	
	SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT		
101	Routinely, how many days each week is the facility open for outpatient adult and/or child curative services?	NUMBER OF DAYS <input style="width: 30px; height: 20px;" type="text"/> DON'T KNOW8	
102	Is there a trained health provider present at the facility at all times (24 hours/day)	YES, TRAINED PROVIDER ALWAYS PRESENT1 NO,2	→104
103	Is there a trained health provider available on call at all times after hours? IF YES, ASK TO SEE DUTY SCHEDULE	YES, DUTY SCHEDULE SEEN 1 YES, NO DUTY SCHEDULE2 NO3	

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Now I have some questions about the staff **who provide OUTPATIENT services** . We want to know the highest technical qualification and the number of staff who are routinely assigned for outpatient services. This may include staff who provide both inpatient and outpatient services but **NOT** staff who function purely administratively and **NOT** staff who only serve in-patients.

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	PUB. HEALTH NURSE	<input type="text"/> <input type="text"/>
D) Professional Midwives	PROF. MIDWIFE	<input type="text"/> <input type="text"/>
E) Professional Nurses (INCLUDE NURSES WITH SPECIALITY TRAINING)	PROF. NURSE	<input type="text"/> <input type="text"/>
F) Midwives Assistants	MIDWIFE ASST	<input type="text"/> <input type="text"/>
G) Auxiliary Nurses	AUX. NURSES	<input type="text"/> <input type="text"/>
H) Pharmacists	PHARMACIST	<input type="text"/> <input type="text"/>
I) Dispensing Technicians	DISPENSING TECH	<input type="text"/> <input type="text"/>
J) Lab Technicians/technologists	LAB. TECH.	<input type="text"/> <input type="text"/>
K) Nutrition Technician Officers	NUT. TECH	<input type="text"/> <input type="text"/>
L) Ward Assistants	WARD ASST	<input type="text"/> <input type="text"/>
M) Environmental Health Officers	ENVIRONMENT HEALTH OFFICER	<input type="text"/> <input type="text"/>
M) Others: SPECIFY _____	OTHER	<input type="text"/> <input type="text"/>
M) SUM THE NUMBER OF STAFF REPORTED IN 104A-L AND CHECK: "You have told me that you have _____ (NUMBER OF STAFF) who provide outpatient services. Is this correct? IF NOT CORRECT, PROBE AND CHANGE 104A-M AS NECESSARY.	YES, NUMBER CORRECT..... 1 NO 2	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO						
105	Do have an estimate of the size of the catchment population that this facility serves, that is, the target population or total population living in the area served by this facility? IF YES, ASK "How many people is that?"	CATCHMENT POPULATION <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table> NO CATCHMENT AREA 999995 DON'T KNOW SIZE OF CATCHMENT POPULATION.....999998							
106	Does this facility routinely admit inpatients for treatment?	YES..... 1 NO 2	→108						
107	Does this facility have beds for overnight observation?	YES..... 1 NO 2							
108	Does this facility have a formal system for reviewing management or administrative issues?	YES..... 1 NO 2 DON'T KNOW..... 8	→112 →112						
109	How often do formal meetings to discuss the facility management/administrative issues take place?	MONTHLY 1 QUARTERLY 2 SEMI-ANNUALLY 3 OTHER 6							
110	Is an official record of meetings maintained? IF YES, ASK TO SEE SOME DOCUMENTATION (MINUTES/NOTES) FROM THE MOST RECENT MEETING	YES, DOCUMENT SEEN 1 YES, DOCUMENT NOT SEEN 2 NO DOCUMENTATION MAINTAINED..... 3							
111	Do community members <u>ROUTINELY</u> take part in any of the management or administrative meetings?	YES..... 1 NO 2 DON'T KNOW..... 8							
112	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED	SUGGESTION BOXA CLIENT SURVEY FORM.....B CLIENT INTERVIEW C OTHERW (SPECIFY) NO CLIENT FEEDBACK Y DON'T KNOW..... Z	→115 →115						
113	Do you have any system for collecting and reporting on client opinion? IF YES, ASK TO SEE A REPORT OR FORM WHERE DATA IS COMPILED.	YES, REPORT SEEN..... 1 YES, NO REPORT SEEN 2 NO 3							
114	In the past 3 months have any changes been made in the programme as a result of client opinion? IF YES, DESCRIBE THE CHANGES MADE.	YES, 1 (SPECIFY) NO 2 DON'T KNOW..... 8							

NO.	QUESTIONS	CODE CLASSIFICATION			GO TO
115	Does this facility monitor quality of care? This refers to a <u>ROUTINE</u> programme for quality assurance.	YES.....	1		
		NO	2		→118
		DON'T KNOW.....	8		→118
116	Are any of the following methods for quality assurance used? IF YES, ASK TO SEE SOME DOCUMENTATION (REPORT/ MINUTES/ ETC). FOR THE METHOD IMPLEMENTATION.				
	METHOD	METHOD USED : WAS FORM OR REPORT SEEN?		Not Applicable	Not Determined
		Observed	Reported Available		
	a) Supervisory checklist for health system components (e.g. service specific equipment, meds, and records)	1	2	3	8
	b) Supervisory checklist for health service provision (e.g. Observation Check list)	1	2	3	8
	c) System for identifying and addressing quality of care that is implemented by staff or specific service level (e.g. not carried out facility wide)?	1	2	3	8
	d) facility-wide review of mortality	1	2	3	8
	e) Periodic audit of medical records or service registers	1	2	3	8
	f) Quality Assurance or COPE committee/team?	1	2	3	8
	g) Regional/Dist. Health Management Teams?	1	2	3	8
	h) Other (SPECIFY)	1	2	3	8
117	Who is responsible for reviewing findings and taking action from quality activities? CIRCLE ALL THAT APPLY AND INDICATE IF THE PERSON(S) ARE POSTED INTERNAL (IN)TO THE FACILITY OR EXTERNAL (OUT) OR BOTH	Internal to facility	Outside Facility	Not Applicable	Don't Know
	A) Individual service provision staff	1	2	3	8
	B) Individual Supervisors	1	2	3	8
	C) Management Committee	1	2	3	8
	D) Special Quality Assurance committee or team	1	2	3	8
	E) Special Quality Assurance Staff	1	2	3	8
	F) District or Zonal Management Team	1	2	3	8
	W) Other	1	2	3	8
118	Does this facility routinely charge for the consultation for adult curative services?	YES	1		
		NO	2		
		DO'T KNOW	8		

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO																																
119	Does this facility participate in any formal plan which includes community/client financial support such as insurance, or other program where community OR other organization will provide payment for clients?	YES, ACCEPT INSURANCE 1 YES, OTHER _____ .. 2 (SPECIFY) NO 3 DON'T KNOW 8																																	
120	When was the last time a supervisor from OUTSIDE this facility came for a supervisory visit?	WITHIN PRIOR 6 MONTHS 1 MORE THAN 6 MONTHS AGO 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3	→ 121 → 121																																
121	Within the prior 6 months did a supervisor from outside the facility do any of the following activities? A) Check some registers or service related books? B) Discuss problems? C) Discuss policy/administrative issues? D) Discuss technical protocols, practices, or service delivery technical issues? E) Hold an official staff meeting? F) Observe individual staff providing services? G) Do anything else?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>CHECKED REGISTERS</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>DISCUSSED PROBLEMS</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>DISCUSSED POLICY ...</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>DISCUSSED TECHNICAL ISSUES ...</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>HELD STAFF MEETING</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>OBSERVE SERVICE PROVISION</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>OTHER _____</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table> (SPECIFY)		YES	NO	DK	CHECKED REGISTERS	1	2	8	DISCUSSED PROBLEMS	1	2	8	DISCUSSED POLICY ...	1	2	8	DISCUSSED TECHNICAL ISSUES ...	1	2	8	HELD STAFF MEETING	1	2	8	OBSERVE SERVICE PROVISION	1	2	8	OTHER _____	1	2	8	
	YES	NO	DK																																
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HELD STAFF MEETING	1	2	8																																
OBSERVE SERVICE PROVISION	1	2	8																																
OTHER _____	1	2	8																																
122	Is there a printed referral form which is sent with referrals from this facility? IF YES, ASK TO SEE THE FORM. (IF THE FACILITY IS THE REFERRAL FACILITY, THEN CIRCLE "5" FOR REFERRAL FACILITY.	YES, FORM SEEN 1 YES, FORM NOT SEEN 2 NO FORM, USE LETTERHEAD 3 NO 4 REFERRAL FACILITY 5 DON'T KNOW 8																																	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
123	INDICATE IF THIS FACILITY IS A GOVERNMENT HEALTH CENTER.	YES, GOV'T HC 1 NO 2	→124
123a	Since 1998, there has been a programme in Ghana called the CHPS program that encourages communities to support and assist nurses (or midwives) to live in the communities and provide health care at the ground level, rather than to have all nurses at the community or district headquarters. Is this going on in your sub-district?	YES, STARTED 1 BEGAN PLANNING, BUT NOT YET STARTED 2 NO 3 DON'T KNOW 8	→123h →123h →123h
123b	Is the entire population of the community served or only a portion?	ENTIRE (SUB) DISTRICT1 ONLY A PORTION2 DON'T KNOW8	
123c	How many nurses (and or midwives) have been posted to community-based positions in this sub-district?	NUMBER OF STAFF <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW998	
123d	Are there plans to post more nurses/midwives?	YES1 NO2 DON'T KNOW8	
123e	What level of CHPS implementation (SEE THE LIST OF 15 LEVELS ON NEXT PAGE) have you attained in your most advanced CHPS community area?	CHPS LEVEL <input type="text"/> <input type="text"/> DON'T KNOW98	
123f	Does this community have village level health committees/volunteers?	YES1 NO2 DON'T KNOW8	→123h →123h
123g	Do volunteers provide health services or assist CHO's in organizing the community?	YES1 NO2 DON'T KNOW8	
123h	Does this facility have a revolving drug fund?	YES 1 NO2 DON'T KNOW 8	→123k →123k
123i	Has the revolving drug fund seemed adequate to meet the local needs?	YES 1 NO2 DON'T KNOW 8	
123j	What is the source of the drugs? CIRCLE ALL SOURCES THAT ARE COMMONLY USED	REGIONAL HEALTH STOREA BUY THEMSELVES IN MARKET ..B OTHER (SPECIFY)..... C DON'T KNOWZ	
123k	Comment on any issues or problems with CHPS implementation in your area:		

COMMUNITY –BASED HEALTH PLANNING AND SERVICES (CHPS)

ACTIVITY SEQUENCE

STRATEGIC PLANNING

- STEP 1 Programme Planning: Situation Analysis and selection of communities
- STEP 2 Consult and sensitize health workers
- STEP 3 Dialogue with community leaders and DA

PROGRAMATIC PLANNING

- STEP 4 Community information durbar
- STEP 5 Selection and training of CHOs
- STEP 6 Select and orient community health committee
- STEP 7 Compile community profile

CHO PROGRAM IMPLEMENTATION

- STEP 8 Construct community health compound
- STEP 9 Mobilize logistics
- STEP 10 Launch CHP programme durbar

VOLUNTEER PROGRAMME IMPLEMENTATION

- STEP 11 Select community health volunteers
- STEP 12 Approval of community health volunteers durbar
- STEP 13 Training of community health volunteers
- STEP 14 Mobilisation of logistics
- STEP 15 Launch community health volunteer programme durbar

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
124	Does this facility ever have electricity?	YES 1 NO 2	→ 126
125	Is the electricity always available during times when the facility is providing services or is it sometimes interrupted? IF SOMETIMES INTERRUPTED: On how many days during the past week was the electricity not available for two (2) or more hours ?	ALWAYS AVAILABLE 0 # OF DAYS NOT <input type="text"/> AVAILABLE PAST WEEK	
126	What is the most commonly used source of water for the facility at this time of the year?	PIPED 1 PROTECTED WELL/BOREHOLE .. 2 UNPROTECTED WELL / BOREHOLE 3 RIVER/LAKE /POND 4 OTHER 96 (SPECIFY) NO WATER SOURCE 00	→ 129
127	Is this water source available on-site?	YES, ON-SITE 1 NO 2	
128	Does the normal source of water for this facility vary seasonally?	YES 1 NO 2 NO NORMAL SOURCE 3	
129	How is water made available for use in examination/consultation areas in the facility today ?	PIPED 1 BUCKET/BASIN 2 CONTAINER WITH VERONICA TAP 3 NO WATER PROVIDED IN SERVICE DELIVERY AREAS 4	
130	Is there a waiting area for clients, where they are protected from sun and rain?	YES 1 NO 2	
131	Is there a toilet (latrine) in functioning condition which is available for clients use?	YES, VERIFIED 1 YES, NOT VERIFIED 2 NO 3	
132	Does this facility have a working phone or short-wave radio?	YES, VERIFIED 1 YES, NOT VERIFIED 2 NO 3	→ 134
133	Is there a phone or short-wave radio within five minutes time from the facility that staff can use in an emergency? IF YES: Is that phone or short-wave radio available 24 hours a day?	YES, AVAILABLE 24 HOURS 1 YES, NOT AVAILABLE 24 HOURS 2 NO, NONE WITHIN 5 MINUTES 3	
134	Does this facility have a programme for routine preventive maintenance for major equipment i.e. such as a generator or sterilizing equipment? IF YES: Who is responsible for the maintenance?	YES, ON-SITE STAFF 1 YES, OUTSIDE SUPPORT 2 YES, BOTH 3 NO ROUTINE MAINTENANCE 4 DON'T KNOW 8	

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO		
135	What is the system for repairing or replacing small equipment (blood pressure cuffs, stethoscope, etc). (CIRCLE ALL THAT APPLY).	ON-SITE MAINTENANCEA PETTY CASH FOR REPLACING...B SEND ELSEWHERE FOR REPAIR C REPAIRMAN VISITS ON-CALL D OTHER _____W (SPECIFY) NO SYSTEM.....Y DON'T KNOW.....Z						
FOR EACH OF THE FOLLOWING ITEMS, CHECK WHETHER THE ITEM IS PRESENT AT THE FACILITY. IF YOU ARE NOT ABLE TO OBSERVE THE ITEM YOURSELF, ASK IF THE ITEM IS AVAILABLE. WHERE APPLICABLE, ASK IF THE ITEM IS IN WORKING ORDER OR NOT								
	ITEM	a) Is the item present?			b) Is the item in working order?			
	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined	
136	Generator	1	2	3 → 138	8 → 138	1	2	8
137	Fuel for generator	1	2	3	8			
138	AFTER DECONTAMINATING AND CLEANING , What is the method most commonly used for disinfecting syringes and needles?	AUTOCLAVEA DRY HEAT STERILIZATIONB STEAM STERILIZATION..... C BOILING ONLY D CHEMICAL ONLYE BOIL AND CHEMICALF OTHER _____W USE DISPOSABLES ONLYX						
139	AFTER DECONTAMINATING AND CLEANING , What is the most commonly used method for disinfecting other medical equipment (e.g., surgical instruments)? IF DIFFERENT METHODS USED FOR DIFFERENT TYPES OF EQUIPMENT, INDICATE THE DIFFERENT MOST COMMON METHODS.	AUTOCLAVEA DRY HEAT STERILIZATIONB STEAM STERILIZATION..... C BOILING ONLY D CHEMICAL ONLYE BOIL AND CHEMICALF OTHER _____W NONEY						

GO TO WHERE EQUIPMENT IS STERILIZED. FIND THE PERSON RESPONSIBLE FOR STERILIZATION/DISINFECTION OF EQUIPMENT. ASSESS AVAILABILITY OF ITEMS AND PROCEDURES UTILIZED AT THE FACILITY.

ITEM	a) Is the item present? Ask for all items				b) Item is in working order?			
	OBSERVED	REPORTED AVAILABLE	NOT AVAILABLE	NOT DETERMINED	YES	NO	NOT DETERMINED	
140	AUTOCLAVE (pressure; wet heat)	1	2	3→141	8→141	1	2	8
141	DRY HEAT STERILIZER	1	2	3→142	8→142	1	2	8
142	POT WITH COVER (FOR STEAM OR BOILING)	1	2	3	8			
143	HEAT SOURCE (Stove/Cooker)	1	2	3→144	8→144	1	2	8
144	AUTOMATIC TIMER	1	2	3→145	8→145	1	2	8
145	TST INDICATOR STRIPS (TAPE INDICATING STERILIZATION)	1	2	3	8			

FOR EACH OF THE FOLLOWING METHODS FOR STERILIZATION/DISINFECTION WHICH IS USED IN THE FACILITY, INDICATE THE DURATION OF TIME ITEMS ARE PROCESSED **AFTER** THE REQUIRED TEMPERATURE/PRESSURE/BOILING IS REACHED

146	METHOD FOR STERILIZING/DISINFECTING	NOT USED	MINUTES PROCESSED (DON'T KNOW=98)
	a) Autoclave:	95	MINUTES (UNWRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>
			MINUTES (WRAPPED) <input type="text"/> <input type="text"/> <input type="text"/>
	b) Dry Heat Sterilized	95	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> TEMPERATURE <input type="text"/> <input type="text"/> <input type="text"/>
	c) Boiling or Non-Pressurized Steam High Level Disinfection (Hld)	95	MINUTES <input type="text"/> <input type="text"/> <input type="text"/>
	d) Chemical Decontamination (Provide Name of Disinfecting Agent Used) If Chlorine bleach indicate Strength	95	MINUTES (SOAKING) <input type="text"/> <input type="text"/> <input type="text"/> SOLUTION : _____ STRENGTH: _____%
	e) Chemical High Level Disinfection (THIS WOULD BE THE FINAL STAGE OF DISINFECTION; THIS DOES NOT REFER TO DECONTAMINATION PRIOR TO BOILING OR STEAMING)	95	MINUTES (SOAKING) <input type="text"/> <input type="text"/> <input type="text"/> SOLUTION : _____ STRENGTH: _____%

NO.	QUESTIONS	CODE CLASSIFICATION				GO TO
		Observed	Reported Available	Not Available	Not Determined	
147	ASK TO SEE WHERE ITEMS ARE STORED AFTER PROCESSING, AND INDICATE WHICH OF THE CONDITIONS BELOW WERE OBSERVED OR REPORTED:					
	a) Wrapped in sterile cloth, sealed with TST tape.	1	2	3	8	
	b) Stored in sterile container with lid which clasps shut	1	2	3	8	
	c) On tray, covered with cloth	1	2	3	8	
	c) Sterilization date written on packet/container	1	2	3	8	
	d) Storage location dry, clean	1	2	3	8	
148a	How does this facility finally dispose of potentially contaminated waste and items which are not reused (e.g. bandages, syringes)? INDICATE WHICH METHOD USED FOR WET AND DRY WASTE. IF THE SAME METHOD, INDICATE THE SAME FOR EACH.	WET				DRY
		BURNED IN INCINERATOR 1				1
		BURNED IN OPEN PIT 2				2
		BURNED AND BURIED 3				3
		BURNED AND REMOVED TO OFFSITE DUMP 4				4
		THROW IN TRASH/OPEN PIT. 5				5
		THROW IN PIT LATRINE..... 6				6
		REMOVED AS IS				
		TO OFFSITE DUMP 7				7
		OTHER 8				8
148b	INTERVIEWER: ASK TO SEE PLACE USED FOR WASTE DISPOSAL TO DETERMINE IF WASTE IS VISIBLE OR NOT.	WASTE VISIBLE 1				1
		NO WASTE VISIBLE 2				2
		WASTE SITE NOT INSPECTED 3				3
149a	How does this facility finally dispose of needles and other sharps?	BURNED IN INCINERATOR 1				
		BURNED IN OPEN PIT 2				
		BURNED AND BURIED 3				
		BRNED AND REMOVED TO OFFSITE DUMP 4				
		THROW IN TRASH/OPEN PIT. 5				
		THROW IN PIT LATRINE..... 6				
		REMOVED AS IS				
		TO OFFSITE DUMP 7				
		OTHER 8				
149b	INTERVIEWER: ASK TO SEE PLACE USED FOR DISPOSAL OF SHARPS OBJECTS TO DETERMINE IF WASTE IS VISIBLE OR NOT.	WASTE VISIBLE 1				
		NO WASTE VISIBLE 2				
		WASTE SITE NOT INSPECTED 3				
150	ASSESS GENERAL CLEANLINESS OF FACILITY: ■A FACILITY IS CLEAN IF THE FLOORS ARE SWEEPED, COUNTERS/TABLES ARE WIPED AND FREE FROM OBVIOUS DIRT OR WASTE. ■A FACILITY IS NOT CLEAN IF THERE IS OBVIOUS DIRT/WASTE/BROKEN OBJECTS ON FLOORS OR COUNTERS	FACILITY CLEAN 1				
		FACILITY NOT CLEAN 2				

5. STI AND /HIV/AIDS Services					
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
500	Does this facility offer any services related to diagnosis, treatment or supportive services for STIs, or HIV/AIDS?	YES	1		→600
		NO.....	2		
501	<p>FIND THE MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF STI/HIV/AIDS SERVICES. IF DIFFERENT FROM INDIVIDUAL(S) RESPONDING TO THE PREVIOUS SECTIONS INTRODUCE YOURSELF AS IN SECTION 1. IF THE PERSON IS THE SAME, CONTINUE WITH 502.</p> <p>GREET THE RESPONDENT, INTRODUCE YOURSELF, GIVE OBJECTIVES OF STUDY AND ASSURE CONFIDENTIALITY.</p>				
	<p>SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>		<p>YES <input type="checkbox"/> → <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> AM PM</p> <p>HOUR MINUTE</p> <p>NO <input type="checkbox"/> → REASON</p> <p>.....</p> <p>.....</p>		
502	First I want to ask specifically about services for STIs. Does this facility offer STI services?	YES.....	1		→517
		NO.....	2		
503	Are STI services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC			1
		GENERAL OUTPATIENT			2
503a	How many days per week are STI services available in either the special or general clinic?	# DAYS	<input type="text"/>		
503b	Does this facility routinely charge for STI consultation services?	YES.....	1		
		NO.....	2		
		DON'T KNOW.....	8		
504	How are diagnoses of STIs made in this facility? (CIRCLE ALL METHODS USED)	SYMPTOMATIC.....			A
		ETIOLOGIC			B
		CLINICAL.....			C
505	Does this facility have protocols on the following: IF YES, ASK TO SEE A COPY.	Observed	Reported Available	Not Available	Not Determined
	a) Confidentiality Protocol or Policy for STI clients.	1	2	3	8
	b) Informed consent protocol for STI testing?	1	2	3	8
506	Does the facility normally perform partner notification or follow-up? IF YES, Is this active, that is where the facility will contact the partner(s) or is it only passive, where the client is asked to inform the partner(s)?	YES, SOMETIMES ACTIVE			1
		YES, ONLY PASSIVE			2
		NO			3

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
507	Is there a register where STI consultation information is recorded? If yes, may I see it? (REQUIRED INFORMATION=NAME, AGE, SEX, DIAGNOSIS)	YES, REGISTER SEEN.....	1			→509
		YES, REGISTER NOT SEEN ...	2			→509
		NO REGISTER KEPT	3			
507a	Does the register indicate specific type of STI diagnosed?	YES.....	1			
		NO.....	2			
508	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS.....	1			
		> 7 DAYS	2			
509	How many clients received STI services during the calendar year 2001?	NUMBER OF STI CLIENTS		<input type="text"/>	<input type="text"/>	
		DON'T KNOW	998			
509a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA..		<input type="text"/>	<input type="text"/>	
509b	Do you submit an official report externally (usually to the MOH or a public health agency) which indicate the numbers and types of STIs diagnosed? IF YES, is the report generated from consultation records or from the laboratory?	YES, CONSULTATION.....	1			
		YES, LABORATORY	2			
		YES, BOTH.....	3			
		NO.....	4			
510	ASK TO SEE WHERE COUNSELING FOR CLIENTS WITH SUSPECTED STI'S IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM	1			
		ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER	2			
		ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER	3			
511	Are any of the following available, in the counseling or the examination room?	Observed	Reported Available	Not Available	Not Determined	
	VISUAL AIDS FOR TEACHING					
	a) About STIs	1	2	3	8	
	b) About HIV/AIDS	1	2	3	8	
	c) Flip Chart for STI/HIV	1	2	3	8	
	d) Audio-visual for teaching about STI and HIV/AIDs	1	2	3	8	
	e) Model for demonstrating use of condom	1	2	3	8	
	f) Stop AIDS Love Life Poster	1	2	3	8	
	INFORMATION BOOKLET/PAMPHLET FOR CLIENT TO TAKE HOME					
	g) On STI?	1	2	3	8	
	h) HIV Questions & Answers booklet	1	2	3	8	
	i) Other pamphlet on HIV/AIDS?	1	2	3	8	
	j) Condoms present in room?	1	2	3	8	
	SERVICE DELIVERY PROTOCOLS					
	k) "National Reproductive Health Service Protocols"	1	2	3	8	
	li) Clinical guidelines for diagnosing and treating STI?	1	2	3	8	
	m) Guidelines for using syndromic approach for diagnosing and treating STI's	1	2	3	8	
	n) Guidelines for diagnosing HIV/AIDS?	1	2	3	8	

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
511 (cont)	Are any of the following available, in the counseling or the examination room?	Observed	Reported Available	Not Available	Not Determined			
	o) Clinical guidelines for treating HIV/AIDS? (Anti-retroviral use and/or Opportunistic infections)	1	2	3	8			
	p) Self Directed Learning (SDL) models for STI/ HIV/ AIDS	1	2	3	8			
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR STIS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
512	If same examination room has already been observed for items in 513 and 514, indicate for which module the room was assessed:	FAMILY PLANNING..... 1 DELIVERY 2 ANTENATAL..... 3 NOT PREVIOUSLY SEEN				→515 →515 →515		
513	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3						
	ITEMS REQUIRED FOR STI EXAMINATION	(a) Is item present?				(b) Is item in working order?		
514	FACILITY AND EQUIPMENT	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	a) Spotlight source (flashlight or examination light accepted)	1	2	3→514b	8→514b	1	2	8
	b) Table and stool for gynecological exam	1	2	3→514c	8→514c	1	2	8
	c) Hand-washing items (soap and towel)	1	2	3	8			
	h) Single use towel (handwashing)	1	2	3	8			
	d) Water for handwashing	1	2	3	8			
	e) Clean gloves	1	2	3	8			
	f) Sharps container	1	2	3	8			
	g) Decontamination solution for clinical equipment	1	2	3	8			
515	OTHER EQUIPMENT							
	a) Speculum	1	2	3	8			
	b) Swab sticks	1	2	3	8			
516a	Does this facility have or advocate any special program related to STIs or HIV/AIDS that are targeted to adolescents?	YES 1 NO 2				→517		
516b	What special program related to STIs or HIV/AIDS do you have or promote for adolescents?	SDL/CPR/ARH INITIATIVE A YOUTH FRIENDLY CLINIC B YOUNG AND WISE C (specify)						

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO	
	Now I want to ask you specifically about any services related to HIV or AIDS					
517	Does this facility offer any services related to HIV/AIDS?	YES1 NO2			→536	
518	Does this facility offer voluntary counselling and testing (VCT) for HIV?	YES1 NO2			→524	
519	Are VCT services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC1 GENERAL OUTPATIENT.....2 OTHER6 (SPECIFY)				
520	When a VCT client is found to be positive, indicate how often clients are referred elsewhere or services are provided by the facility for the following::	REFERRED OR SERVICE IS PROVIDED			Don't Know	
		Always	Sometimes	Rarely or Never		
	a) Medical Follow-up	1	2	3		8
	b) Diagnosis for TB	1	2	3		8
	c) Home-based Care Services	1	2	3		8
	d) Counseling on Prevention of Mother to Child Transmission	1	2	3		8
	e) Family Planning Services	1	2	3		8
	f) PLHA (Persons Living with HIV?AIDS Support Group	1	2	3		8
	g) Other Social Services	1	2	3		8
521	Is there a register where VCT client information is recorded? If yes, may I see it	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN ...2 NO REGISTER KEPT3			→523 →523	
522	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS 1 > 7 DAYS2				
523	How many NEW clients received VCT services during the calendar year 2001.	NUMBER OF NEW VCT CLIENTS	<input type="text"/>	<input type="text"/>	→524	
523a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	DON'T KNOW998 MONTHS OF DATA ..	<input type="text"/>	<input type="text"/>		
524	Does this facility provide any diagnostic, follow-up, or treatment for HIV/AIDS, apart from VCT?	YES..... 1 NO.....2			→536	

525	FOR EACH OF THE FOLLOWING HIV/AIDS RELATED SERVICES, INDICATE IF THE FACILITY PROVIDES THE SERVICE, REFERS ELSEWHERE, OR DOES NOT PROVIDE THE SERVICE OR REFERRAL.						
		PROVIDE SERVICE FOR			Refer Elsewhere for service	Don't refer or provide service	DK
		Out Patient	In Patient	Both Out and in-Patient			
	a) Tuberculosis diagnose & treat	1	2	3	4	5	8
	b) Concurrent infections diag & tx	1	2	3	4	5	8
	c) Palliative management for pain or debilitation (end-stage)	1	2	3	4	5	8
	d) Family planning services	1	2	3	4	5	8
	e) Counseling on prevention of mother to child transmission	1	2	3	4	5	8
	f) Psycho-social services	1	2	3	4	5	8
	g) Counseling/training for home care	1	2	3	4	5	8
	h) Anti-retroviral Therapy	1	2	3	4→527	5→527	8→527
526	How many clients received anti-retroviral therapy during the calendar year 2001?	NO. CLIENTS W/ ANTIRET. TX			<input type="text"/>	<input type="text"/>	<input type="text"/>
		DON'T KNOW			998		→527
526a	IF DATA IS NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA			<input type="text"/>	<input type="text"/>	
527	ASK TO SEE WHERE CONSULTATION FOR HIV/AIDS CLIENTS IS PROVIDED. INDICATE THE SETTING FOR COUNSELING HIV/AIDS CLIENTS	PRIVATE ROOM1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER3 SAME ROOM AS STI CLIENTS...4					→529
528	Are any of the following available, in the counseling or the examination room?	Observed	Reported Available	Not Available	Not Determined		
	VISUAL AIDS FOR TEACHING						
	a) About STIs	1	2	3	8		
	b) About HIV/AIDS	1	2	3	8		
	c) Flip Chart for STI/HIV	1	2	3	8		
	d) Audio-visual for teaching about STI and HIV/AIDS	1	2	3	8		
	e) Model for demonstrating use of condom	1	2	3	8		
	f) Stop AIDS Love Life Poster	1	2	3	8		
	INFORMATION BOOKLET/PAMPHLET FOR CLIENT TO TAKE HOME						
	g) On STI?	1	2	3	8		
	h) HIV Questions & Answers booklet	1	2	3	8		
	i) Other pamphlet on HIV/AIDS?	1	2	3	8		
	j) Condoms present in room?	1	2	3	8		
	SERVICE DELIVERY PROTOCOLS						
	k) "National Reproductive Health Service Protocols"	1	2	3	8		

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
528 (cont)	Are any of the following available, in the counseling or the examination room?	Observed	Reported Available	Not Available	Not Determined	
	li) Clinical guidelines for diagnosing and treating STI?	1	2	3	8	
	m) Guidelines for using syndromic approach for diagnosing and treating STI's	1	2	3	8	
	n) Guidelines for diagnosing HIV/AIDS?	1	2	3	8	
	o) Clinical guidelines for treating HIV/AIDS? (Anti-retroviral use and/or Opportunistic infections)	1	2	3	8	
	p) Self Directed Learning (SDL) models for STI/ HIV/ AIDS	1	2	3	8	
	ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR HIV/AIDS CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.					
529	If same examination room has already been observed for items in 530 and 531, indicate for which module the room was assessed:	FAMILY PLANNING..... 1 DELIVERY 2 ANTENATAL..... 3 STI 4 NOT PREVIOUSLY SEEN..... 5				→532 →532 →532 →532
530	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3				
531	Are any of the following available, in the examination room or immediately adjacent?	Observed	Reported Available	Not Available	Not Determined	
	a) Hand-washing items (Soap, Towel)	1	2	3	8	
	d) Single use towel (handwashing)	1	2	3	8	
	b) Water for hand-washing	1	2	3	8	
	c) Clean gloves	1	2	3	8	
532	Does this facility have protocols on the following. FOR EACH ASK IF THE PROTOCOL EXISTS AND ASK TO SEE A COPY					
	a) Confidentiality protocol for HIV/AIDS Clients?	1	2	3	8	
	b) Informed consent protocol for HIV/AIDS Clients?	1	2	3	8	
	c) Written protocols for referrals for HIV/AIDS clients for care and support services?	1	2	3	8	
533	Is there a register where information for HIV/AIDS clients receiving treatment is recorded? IF YES, MAY I SEE IT?	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN ... 2 NO REGISTER KEPT 3				→535 →535
534	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS 1 > 7 DAYS 2				

NO.	QUESTIONS	CODING CLASSIFICATION				GO TO
535	How many clients (NEW AND OLD) received any HIV/AIDS services (EXCLUDING VCT IF VCT DATA KEPT SEPARATELY) during the calendar year 2001?	NUMBER OF HIV CLIENTS <input type="text"/> <input type="text"/> <input type="text"/>				→536
535a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	DON'T KNOW998 MONTHS OF DATA.. <input type="text"/> <input type="text"/>				
536	Does the facility have a mechanism to follow-up on referrals? IF YES, ASK TO SEE RECORD OR FORM RELATED TO FOLLOW-UP MECHANISM. IF NO REFERRALS ARE MADE BECAUSE THIS IS REFERRAL FACILITY, INDICATE "4".	YES, OBSERVED FORM 1 YES, NO FORM SEEN 2 NO..... 3 REFERRAL FACILITY 4 DON'T KNOW 8				
537	Does the facility have a list of care and support services to which clients can be referred? IF YES, ASK TO SEE LIST.	YES, LIST SEEN 1 YES, LIST NOT SEEN..... 2 NO..... 3 DON'T KNOW 8				
538	Does the facility have a formal partnership with a Persons Living with HIV/AIDS (PLHA) support group?	YES..... 1 NO..... 2 DON'T KNOW 8				
539	Does this facility have the capacity to run the following tests for STIs? IF NOT: Do you collect the specimen and send it elsewhere for the test or does the client have to go somewhere else for the test?(check section6 for equipment and supplies required for any test conducted in the facility)	Conduct test at facility	Collect specimen and send elsewhere for test	Send client elsewhere for test	Test not utilized by this facility	
	a) Syphilis?	1	2	3	8	
	b) Gonorrhoea?	1	2	3	8	
	c) Sputum test for Tuberculosis	1	2	3	8	
	d) HIV	1	2	3	8	
	e) CD4 Count? (HIV)	1	2	3	8	
	f) HIV Viral Load?	1	2	3	8	
	g) Genital Herpes	1	2	3	8	
	h) Candidiasis	1	2	3	8	
	k) Chlamydia	1	2	3	8	

VI LABORATORY DIAGNOSTICS

600	Are any of the laboratory tests related to STIs or HIV (Q539) or laboratory tests related to MCH (Q407) marked "1"? IF YES, GO TO WHERE LABORATORY TESTS ARE CONDUCTED AND ASK TO SEE THE RELEVANT EQUIPMENT AND SUPPLIES	YES, STIS AND MCH 1 YES, STIS ONLY 2 MCH ONLY-NO TESTS FOR STIS 3				→612		
	ITEMS REQUIRED FOR LABORATORY EXAMINATION	(a) Is item present?				(b) Is item in working order?		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
601	Microscope	1	2	3	8	1	2	8
602	Centrifuge	1	2	3	8	1	2	8
603	Slides and covers (malaria smears; gram stain)	1	2	3	8			
603a	Giamse stain	1	2	3	8			
603b	Leishman stain	1	2	3	8			
	TEST FOR HIV/AIDS							
604	RAPID TEST	1	2	3	8			
605	ELISA+SCANNER	1	2	3	8	1	2	8
606	Western Blott	1	2	3	8			
606a	HIV SPOT test							
607	CD4	1	2	3	8			
608	HIV VIRAL LOAD	1	2	3	8			
	TEST FOR STIS							
609	VDRL (Syphilis)	1	2	3	8			
609a	Carbon antigen	1	2	3	8			
610	Chocolate Agar (culture media)	1	2	3	8			
611	(STI and TB Sputum) GRAMSTAIN OR ZILNETHUIN STAIN	1	2	3	8			
611a	Crystal violet	1	2	3	8			
611b	Lugals iodine	1	2	3	8			
611c	Acetone	1	2	3	8			
611d	Neutran Red or Safranin	1	2	3	8			
	URINE TESTS							
612	Clinistix or albitix for Urine Protein (w/ valid expiry date)	1	2	3	8			
613	Other test for urine albumin _____ (specify)	1	2	3	8			
	TESTS FOR ANEMIA							
614	Hemoglobinometer/ Calorimeter	1	2	3	8	1	2	8
614a	Dapkins solution	1	2	3	8			
615	Capillary tubes (for hematocrit)	1	2	3	8			
616	Stericon strips or Tallquist test (w/ valid expiry date)	1	2	3	8			

SECTION 7. CONTRACEPTIVE SUPPLIES

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR CONTRACEPTIVE SUPPLIES AT THE FACILITY. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
700a	Is there an inventory for the contraceptive supplies? IF YES, ASK TO SEE IT. IF NO INVENTORY EXISTS, ALL RESPONSES FOR (a) BELOW ARE "8" OR "NOT DETERMINED".	YES, OBSERVED 1 YES, NOT SEEN 2 NO 3	

A CONTRACEPTIVE SUPPLIES

ASK TO SEE THE FOLLOWING CONTRACEPTIVE SUPPLIES. FOR ALL ITEMS CHECK IF THEY ARE ARRANGED BY EXPIRY DATE. FOR THE SPECIFIC ITEMS INDICATED, CHECK FOR EXPIRED ITEMS AND VERIFY INVENTORY AND STOCK MATCH. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

	CONTRACEPTIVE METHOD	(a)			(b)					
		Stock and Inventory match?			Observed and Expiry Date Checked			Report ed Availab le	Not Avail able	Not Dete rmin ed
		YES	NO	ND	At least one valid	All Valid	Some Valid; some expired			
701	Oral Pill w/ progesterone	1	2	8	1	2	3	4	5	8
702	Oral Pill (combined)				1			4	5	8
703	Injectable (monthly)				1			4	5	8
704	Injectable (2/3 monthly)	1	2	8	1	2	3	4	5	8
705	Norplant	1	2	8	1			4	5	8
706	Condom (male)	1	2	8	1	2	3	4	5	8
707	Condom (female)	1	2	8	1	2	3	4	5	8
708	Intrauterine device (IUD)				1			4	5	8
709	Vaginal Form Tablets	1	2	8	1	2	3	4	5	8
710	Emergency contraceptive pill				1			4	5	8

711a	Were the methods organized according to expiry date "first in first out" on the shelves? (VERIFY WHEN COMPLETING 701-710 FOR INDICATED METHODS)	YES, VERIFIED 1 NO 2 DON'T KNOW 8	
711b	Did the stock records indicate that First-expired-First –Out policy is observed? (VERIFY WHEN COMPLETING 701-710)	YES, VERIFIED 1 NO 2 DON'T KNOW 8	
711c	ARE CONTRACEPTIVE SUPPLIES STORED IN THE SAME LOCATION AS OTHER MEDICINES?	YES 1 NO 2	→715

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS:		
712	Are the methods <u>off the floor</u> and protected from water?	YES..... 1 NO.....2 DON'T KNOW..... 8	
713	Are the methods protected from the sun?	YES..... 1 NO.....2 DON'T KNOW..... 8	
714	Is the room clear of any evidence of pests (rats, bats, etc).	YES..... 1 NO.....2 DON'T KNOW..... 8	
715	Does this facility determine the quantity of each contraceptive required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS..... 1 NEED DETERMINED ELSEWHERE..... 2	→717
716	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY..... 2	→719 →719
717	How do you decide how much of each contraceptive method to order. CIRCLE ALL THAT APPLY. Do you: A) Order to bring the stock to a fixed level B) Order the same quantity each time regardless of how many of each method remains in stock? C) Order different amounts, based on calculations of prior utilization and expected future activity? D) Order depending on what you think is needed, without a specific method for calculating amounts. W) Other (SPECIFY) _____ Z) Don't knowABCDWZ	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
718	<p>How do you decide when to order contraceptives? CIRCLE ALL THAT APPLY. Do you:</p> <p>A) Place an order whenever stock levels fall to a pre-determined level?</p> <p>B) Have a fixed time when you are suppose to submit orders for contraceptive supplies? IF YES, INDICATE HOW OFTEN THE ORDER IS SUBMITTED.</p> <p>C) The facility can place an order whenever there is believed to be a need. It is not necessary to wait until the official time for ordering</p> <p>W) Other (SPECIFY) _____</p> <p>Z) Don't know</p>	<p>.....A</p> <p>.....B</p> <p>EVERY ___ MONTHS</p> <p>.....C</p> <p>.....W</p> <p>.....Z</p>	
719	<p>During the past 3 months, have you always, sometimes or almost never receive the quantity of each contraceptive supply that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	

SECTION VIII ESSENTIAL MEDICATIONS AND SUPPLIES FOR PROVIDING SERVICES FOR SICK CHILDREN, MATERNAL HEALTH, AND CLIENTS WITH SEXUALLY TRANSMITTED INFECTIONS

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR PHARMACEUTICAL SERVICES AT THE FACILITY. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
800a	Is there an inventory for the medications? IF YES, ASK TO SEE IT. IF NO INVENTORY EXISTS, ALL RESPONSES FOR (a) BELOW ARE "NOT DETERMINED" OR "8".	YES, OBSERVED YES, NOT SEEN..... NO.....	

MEDICATIONS: ASK TO SEE THE FOLLOWING MEDICATIONS. FOR ALL ITEMS CHECK IF THEY ARE ARRANGED BY EXPIRY DATE. FOR THE SPECIFIC ITEMS INDICATED, CHECK FOR EXPIRED ITEMS AND VERIFY INVENTORY AND STOCK MATCH. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

	MEDICATION	(a)			(b)			Reported Available	Not Available	Not Determined
		Stock and Inventory match?			Observed and Expiry Date Checked					
		YES	NO	ND	At least one valid	All Valid	Some Valid; some expired			
801	<i>Amoxicillin oral</i> ^{1,3}	1	2	8	1	2	3	4	5	8
802	Aspirin oral				1			4	5	8
803	Chloroquine oral ^{1,2}				1			4	5	8
804	<i>Ciprofloxin PO</i> ³	1	2	8	1	2	3	4	5	8
805	<i>Cotrimoxazole oral</i> ¹	1	2	8	1	2	3	4	5	8
805a	<i>Daraprim oral</i>				1			4	5	8
806	<i>Doxycycline PO</i> ³	1	2	8	1	2	3	4	5	8
807	Ergometrine oral ²				1			4	5	8
808	<i>Erythromycin oral</i> ^{1,3}	1	2	8	1	2	3	4	5	8
809	Ethambutol PO ⁴				1			4	5	8
808	Iron ²				1			4	5	8
809	Iron with Folic Acid ²				1			4	5	8
810	Isoniazid ⁴				1			4	5	8
811	Mebendazole oral ¹				1			4	5	8
812	<i>Metronidazole</i> ^{2,3} (FLAGYL)				1			4	5	8
813	Multivitamins ¹				1			4	5	8
814	<i>Naladixic acid oral</i> ¹	1	2	8	1	2	3	4	5	8
815	Paracetamol oral ¹				1			4	5	8
816	Pyrazinamide PO ⁴				1			4	5	8
817	Rifampicin ⁴				1			4	5	8
818	Sulphadoxine/pyrimethamine (FANSIDAR) ^{1,2}				1			4	5	8
819	Vitamin A high dose (200,000 iu) ^{1,2}				1			4	5	8

	MEDICATION	(a)			(b)					
		Stock and Inventory match?			Observed and Expiry Date Checked			Reported Available	Not Available	Not Determined
		YES	NO	ND	At least one valid	All Valid	Some Valid; some expired			
820	Vitamin A low dose ¹ (50,000-100,000iu)				1			4	5	8
821	Oral rehydration salts ¹				1			4	5	
OTHER MEDICATIONS										
822	Nystatin Vaginal Tablet ^{2,3}				1			4	5	8
EYE OINTMENT/DROPS										
823	Silver nitrate ¹				1			4	5	8
824	Tetracycline ointment ^{1,2}				1			4	5	8
INJECTABLE MEDICATIONS										
825	Ampicillin Inj. ²	1	2	8	1	2	3	4	5	8
826	Benzathine benzyl pen ^{2,3} Inj. (IM) or (Procaine pen IM)	1	2	8	1	2	3	4	5	8
827	Benzyl Penicillin Inj ¹ (IV)				1			4	5	8
828	Ceftriaxone Inj. ³				1			4	5	8
829	Diazepam Inj.				1			4	5	8
830	Ergometrine/oxytoxin injection ²				1			4	5	8
831	Gentamycin injection				1			4	5	8
832	Magnesium sulfate injection ²	1	2	8	1	2	3	4	5	8
833	Quinine injection ¹				1			4	5	8
834	Streptomycin Injection ⁴				1			4	5	8
835	Syntocinon Inj ²				1			4	5	8
836	Xylocaine or lidocaine 1% ⁵				1			4	5	8
RECOMMENDED ANTIRETROVIRAL										
850	AZT/Ziduvudine				1			4	5	8
851	Nevirapine				1			4	5	8
852	Other NNRTI				1			4	5	8
853	Protease Inhibitors				1			4	5	8
INTRAVENOUS SOLUTIONS										
875	Normal Saline ²				1			4	5	8
876	Dextrose and saline ²				1			4	5	8
877	Ringers Lactate ²	1	2	8	1			4	5	8

1) Child Health; 2) Maternal Health ; 3) Sexually Transmitted Infections 4) Tuberculosis;
5) Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
889a	Were the medicines organized according to expiry date "first in first out" on the shelves? (VERIFY WHEN COMPLETING 801-897 FOR INDICATED MEDICINES)	YES, VERIFIED 1 NO 2 DON'T KNOW 8	
889b	Did the stock records indicate that First-expired-First –Out (FEFO) is practiced? (VERIFY WHEN COMPLETING 801-897)	YES, VERIFIED 1 NO 2 DON'T KNOW 8	
OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE CORRECT RESPOSE FOR EACH OF THE FOLLOWING CONDITIONS:			
890	Are the medicines <u>off the floor</u> and protected from water/dampness?	YES1 NO2 DON'T KNOW8	
891	Are the medicines protected from the sun?	YES1 NO2 DON'T KNOW8	
892	Is the room clear of any evidence of pests?	YES1 NO2 DON'T KNOW8	
893	Does this facility determine the quantity of each medication required and order this quantity, or is the quantity that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS.....1 NEED DETERMINED ELSEWHERE2	→895
894	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL 1 STANDARD FIXED SUPPLY2	→897 →897
895	How do you decide how much of each medication to order. CIRCLE ALL THAT APPLY. Do you: A) Order to bring the stock to a fixed level B) Order the same quantity each time regardless of how many of each medication remains in stock? C) Order different amounts, based on calculations of prior utilization and expected future activity? D) Order depending on what you think is needed, without a specific method for calculating amounts. W) Other (SPECIFY) _____ Z) Don't knowABCDWZ	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
896	How do you decide when to order medications? CIRCLE ALL THAT APPLY. Do you: A) Place an order whenever stock levels fall to a pre-determined level? B) Have a fixed time when you are suppose to submit orders for medications? IF YES, INDICATE HOW OFTEN THE ORDER IS SUBMITTED. C) The facility can place an order whenever there is believed to be a need. It is not necessary to wait until the official time for ordering W) Other (SPECIFY) _____ Z) Don't knowA B EVERY ___ MONTHS C W Z	
897	During the past 3 months , have you always, sometimes or almost never receive the amount of each medication that you order (or that you are suppose to routinely receive)?	ALWAYS 1 SOMETIMES 2 ALMOST NEVER 3	

SECTION IX SUPPLIES

SUPPLIES MAY BE IN THE STOREROOM OR IN SERVICE DELIVERY AREAS

	SUPPLY ITEM	Observed	Reported	Not Available	Not Determined
901	Disinfectant for cleaning surfaces (bleach or other cleaning solution)	1	2	3	8
902	Sterile gloves	1	2	3	8
903	Clean gloves	1	2	3	8
904	Guaze or cotton roll	1	2	3	8
905	Swab containers with sterile swabs or sterile gauze	1	2	3	8
906	Skin antiseptic (iodine or chlorhexidine)	1	2	3	8
907	I.V. giving set	1	2	3	8
908	I.V. canulae	1	2	3	8
910	CHEST KIT for education, in storage closet and not in service area	1	2	3	8

**MEASURE Service Provision Study
Reproductive and Child Health Service Delivery**

PART 2: Facility Inventory Questionnaire

FACILITY IDENTIFICATION	
<p>Name of the facility _____</p> <p>Facility Location _____</p> <p>Region _____</p> <p>District _____</p> <p>Type of Health Facility: (11 = Teaching hospital; 12 = Regional/ District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 = Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____)</p> <p>Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____)</p>	<p>REGION CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>DISTRICT CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>FACILITY CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>FACILITY TYPE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>OPERATING AUTHORITY <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p>
<p>Date: _____</p> <p>Name of the interviewer _____</p>	<p>DAY <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>MONTH <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>YEAR <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p> <p>INTERVIEWER CODE . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></p>

2a. Immunization Services

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	Now I would like to find out information about immunization services provided to children or pregnant women by your facility? Are any immunization services provided either as outreach or at the facility. IF YES, ASK WHO RECEIVES IMMUNIZATIONS, AND CIRCLE THE LETTER FOR EACH CATEGORY	YES, CHILDREN ONLY..... 1 YES PREGNANT WOMEN ONLY 2 BOTH CHILDREN AND PREGNANT WOMEN..... 3 NO IMMUNIZATION SERVICES EVER PROVIDED 4	→219
201	Does this facility routinely store <u>any</u> vaccines or are all vaccines either picked up from another facility or delivered when providing services?	STORES SOME VACCINES 1 STORES NO VACCINES 2	→210
202	ASK TO GO WHERE VACCINES ARE STORED AND EXPLAIN. I want to find out about your system for keeping vaccines. What type of equipment do you use to store your vaccines?	REFRIGERATOR 1 COLD BOX 2	
203	INTERVIEWER: INDICATE THE TEMPERATURE INSIDE THE FRIDGE OR COLD BOX	TEMPERATURE <input type="text"/> <input type="text"/> ° CENTIGRADE <input type="text"/> <input type="text"/> NOT OBSERVED 88 NO THERMOMETER 99	→206 →206
204	Do you have a cold chain temperature monitoring chart? IF YES: may I see it?	YES, SEEN 1 YES, NOT SEEN 2 NO 3	→206 →206
205	INTERVIEWER: CHECK THAT THE TEMPERATURE RECORD IS UP COMPLETED FOR EACH OF THE LAST 30 DAYS.	YES, COMPLETED 1 NO, NOT COMPLETED..... 2	
206	Is there an inventory for the vaccines? IF YES, ASK TO SEE IT. (IF THERE IS NO INVENTORY ALL RESPONSES FOR (a) IN 206 ARE "8" FOR NOT DETERMINED.	YES, OBSERVED 1 YES, NOT SEEN 2 NO INVENTORY 3	

IMMUNIZATIONS

ASK TO SEE THE VACCINES. FOR ALL ITEMS CHECK FOR THE FOLLOWING:
 1) ARE THEY PRESENT? 2) ARE THEY ARRANGED IN THE FRIDGE/FREEZER BY EXPIRY DATE (First-In-First-Out); 3) ARE THERE ANY EXPIRED VACCINES; 4) DO THE NUMBER OF EACH VACCINE IN THE FRIDGE/FREEZER MATCH THE NUMBER INDICATED ON THE INVENTORY? IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. FOR EACH VACCINE CIRCLE THE APPROPRIATE CODE FOR PART (a) AND PART (b).

NO.	QUESTIONS	CODING CLASSIFICATION					GO TO		
207	VACCINE	(a)			(b)				
		Stock and Inventory match?			Observed and Expiry Date Checked		Reported Available	Not Available	Not Determined
		YES	NO	ND	All Valid	Some Valid; some expired	Not Observed		
	a) Tetanus Toxoid	1	2	8	2	3	4	5	8
	b) BCG and Dilutant	1	2	8	2	3	4	5	8
	c) Oral Polio (OPV)	1	2	8	2	3	4	5	8
	d) DPT	1	2	8	2	3	4	5	8
	e) Measles & Dilutant	1	2	8	2	3	4	5	8
	f) Yellow Fever	1	2	8	2	3	4	5	8
g) HibHep	1	2	8	2	3	4	5	8	
208	Were the vaccines organized according to expiry date "first in first out" in the fridge/cold box? (VERIFY WHEN COMPLETING 207)	YES, VERIFIED 1 NO 2 DON'T KNOW 8							
209	Did the stock records indicate that First-expired-First – Out (FEFO) is practiced when distributing vaccines? (VERIFY WHEN COMPLETING 207)	YES, VERIFIED 1 NO 2 DON'T KNOW 8							
210	Does this facility determine the quantity of vaccines required and order this quantity, or is the quantity that you receive determined elsewhere? (BOTH IS THE RESPONSE IF A MATERNITY CENTER KEEPS TETANUS TOXOID , BUT GOVT STAFF BRING CHILD IMMUNIZATIONS)	DETERMINES OWN NEED AND ORDERS 1 → 212 NEED DETERMINED ELSEWHERE 2 BOTH 3 → 212							
211	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL 1 → 214 STANDARD FIXED SUPPLY 2 → 214 DON'T KNOW 8 → 214							
212	How do you decide how much of each vaccine to order? CIRCLE ALL METHODS USED. Do you: A) Order to bring the stock to a fixed level? B) Order the same quantity each time regardless of how many of each vaccine remains in stock? C) Order different amounts, based on calculations of prior utilization and expected future activity? D) Order depending on what you think is needed, without a specific method for calculating amounts. W) Other (SPECIFY) _____ Z) Don't Know A B C D W Z							

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
213	<p>How do you decide when to order the vaccines? CIRCLE ALL THAT APPLY. Do you:</p> <p>A) Place an order whenever stock levels fall to a pre-determined level?</p> <p>B) Have a fixed time when you are suppose to submit vaccine orders? IF YES, INDICATE HOW OFTEN THE ORDER IS SUBMITTED.</p> <p>C) The facility can place an order whenever there is believed to be a need. It is not necessary to wait until the official time for ordering.</p> <p>W) Other (SPECIFY) _____</p> <p>Z) Don't Know</p>	<p>.....A</p> <p>.....B</p> <p>EVERY ___ MONTHS</p> <p>..... C</p> <p>.....W</p> <p>.....Z</p>	
214	<p>During the past 3 months, have you always, sometimes or almost never received the quantity of vaccines (s) that you order (or that you are supposed to routinely receive)?</p>	<p>ALWAYS 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	
215	<p>Do government staff come to provide any immunization services in this facility? If yes, do they provide immunizations for children, for pregnant women, or for both?</p>	<p>CHILDREN ONLY 1</p> <p>PREGNANT WOMEN ONLY 2</p> <p>BOTH CHILDREN AND PREGNANT WOMEN 3</p> <p>NO GOVT STAFF COME 4</p>	→217
216	<p>How frequently do the government staff come to provide vaccinations?</p>	<p>ONCE WEEKLY 1</p> <p>TWICE MONTHLY 2</p> <p>OTHER _____ 6</p> <p>(SPECIFY)</p>	
217	<p>How many vaccine carriers do you have available?</p>	<p>ONE 1</p> <p>TWO OR MORE 2</p> <p>NONE 3</p>	→219
218	<p>Are there ice packs for the vaccine carriers ? (4-5 ice packs are required per carrier=1 set)?</p>	<p>YES, ONE SET 1</p> <p>YES, TWO OR MORE SETS 2</p> <p>NONE, PURCHASE ICE 3</p> <p>NO 4</p>	

2b: Child Health Services					
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
219	Now, I would like to ask you specifically about child health services. For each of the following services please tell me if the service is offered by your facility, and if yes, how many days per week the service is provided AT THE FACILITY				
	CHILD HEALTH SERVICE	# Days per week service provided at facility	Service only provided as outreach	Service not offered	
	a) Consultation / curative services for the Sick Child?	# DAYS <input type="checkbox"/>	11	95	
	b) GROWTH MONITORING or growth promotion (where the HEALTHY CHILD routinely weighed and charted on growth chart?)	# DAYS <input type="checkbox"/>	11	95	
	c) Immunization services for children?	# DAYS <input type="checkbox"/>	11	95	
	CHECK 219C AND INDICATE IF CHILD IMMUNIZATIONS ARE PROVIDED AT THE FACILITY	YES	1		
		NO	2		→ 229
220	Does this facility provide outreach immunization services, i.e., visit communities to vaccinate children?	YES	1		
		NO	2		
221	Are immunization services being offered at the facility today?	YES	1		
		NO	2		
222	Do caretakers routinely pay anything toward immunization?	YES	1		
		NO	2		
		DON'T KNOW	8		
223	What type of injection equipment is used during routine immunization sessions at this facility?	SINGLE USE	1		
		STERILIZABLE	2		
		OTHER _____	6		
		(SPECIFY)			
	ASK TO GO TO WHERE CHILD IMMUNIZATIONS ARE PROVIDED AND EXPLAIN THAT YOU WANT TO ASK ABOUT AND THEN SEE SOME SUPPLIES USED FOR IMMUNIZATIONS. CHECK FOR EACH OF THE FOLLOWING ITEMS, TO SEE IF THEY ARE IN THE ROOM WHERE THE SERVICE IS BEING PROVIDED OR IN AN IMMEDIATELY ADJACENT ROOM.				
224	ITEMS REQUIRED FOR IMMUNIZATION SERVICES	Observed	Reported Available	Not Available	Not Determined
	a) Sharps box for needles	1	2	3	8
	b) 5 or more ½ or 1 ml syringes (w/ needles)	1	2	3	8
	c) 5 or more 3 ml syringes (w/ 19 gauge needles)	1	2	3	8
	d) Hand-washing items (soap, towel)?	1	2	3	8
	h) Single-use towels (handwash)	1	2	3	8
	e) Water for hand-washing?	1	2	3	8
	f) Blank, individual child immunization cards	1	2	3	8
	g) Immunization tally/register sheets	1	2	3	8

231	ITEMS REQUIRED FOR CONSULTATION SERVICES FOR SICK CHILDREN SUPPLIES	(a) Is item present?				(b) Is item in working order?		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Deter.
	a) Hand-washing Items (soap, towel)	1	2	3	8			
	i) Single use towels (handwash)	1	2	3	8			
	b) Water for hand-washing	1	2	3	8			
	c) Infant Scale	1	2	3→231d	8→231d	1	2	8
	d) Child Scale	1	2	3→231e	8→231e	1	2	8
	e) Thermometer	1	2	3→231f	8→231f	1	2	8
	f) Timer/Watch with second Hand	1	2	3→231g	8→231g	1	2	8
	g) Jar/Pitcher for ORS	1	2	3	8			
	h) Cup and spoon	1	2	3	8			
232	REFERENCES/ PROTOCOLS/ TEACHING MATERIALS							
	a) Standard Treatment Guidelines 2000	1	2	3	8			
	b) Other Medical references or protocols for treating childhood illness	1	2	3	8			
	c) IMCI CHART BOOKLET	1	2	3	8			
	d) CHEST KIT Information cards	1	2	3	8			
	e) Mother Counseling Cards	1	2	3	8			
	f) Other visual aids for teaching caretaker	1	2	3	8			
NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
233	Does this facility routinely charge for consultation services for the sick child?	YES 1 NO 2 DON'T KNOW..... 8						
234	Is there a ROUTINE system where sick children are measured/assessed <u>prior</u> to the consultation for the illness?	YES 1 NO 2 DON'T KNOW..... 8				→ 236 → 236		
235	IF YES, ASK TO SEE WHERE SICK CHILDREN ARE SEEN PRIOR TO THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.							
	PART OF ROUTINE SERVICES	Observed	Reported	Not Done Routinely	Don't Know			
	a) Take Weight	1	2	3	8			
	b) Plot weight on graph	1	2	3	8			
	c) Take temperature	1	2	3	8			
	d) Assess immunization status	1	2	3	8			
	d) Other (SPECIFY) _____	1	2	3	8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
236	Is there a ROUTINE system for providing the first dose of PRESCRIBED oral medication for the child by someone other than the health worker who examined the child? IF YES, ASK TO SEE WHERE THE FIRST DOSE IS PROVIDED.	YES, OBSERVED CHILD RECEIVING DOSE..... 1 YES, REPORTED, NOT SEEN 2 NO 3 DON'T KNOW 8	
237	Are immunizations offered in the facility on every day that sick child consultations are provided?	YES 1 NO 2 DON'T KNOW 8	
238	Is there a patient register where information on each child consultation is written? IF YES, ASK TO SEE REGISTER. (REQUIRED INFORMATION=NAME, AGE, DIAGNOSIS)	YES, REGISTER SEEN 1 YES, REGISTER NOT SEEN... 2 NO REGISTER KEPT 3	→240 →240
239	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS 1 > 7 DAYS..... 2	
240	How many children below 5 years received curative services during the calendar year 2001?	NUMBER OF UNDER 5 YEARS CHILDREN <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→241
240a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA <input type="text"/> <input type="text"/>	
241	Are individual child health cards /records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD	YES, OBSERVED CARD 1 YES, CARD NOT SEEN..... 2 NO INDIVIDUAL CARDS 3	

3. Family Planning Services

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																				
300	Does this facility offer family planning services?	YES..... 1 NO..... 2	→400																																																				
301	FIND THE MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF FAMILY PLANNING SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO EARLIER SECTIONS, INTRODUCE YOURSELF AS IN SECTION 1. IF THE PERSON IS THE SAME, CONTINUE WITH 302.																																																						
	GREET THE RESPONDENT, INTRODUCE YOURSELF, GIVE OBJECTIVES OF STUDY AND ASSURE CONFIDENTIALITY.																																																						
	SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT	YES <input type="checkbox"/> → <table style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2" style="text-align: center;">TIME</td> </tr> <tr> <td style="text-align: center;">□</td> <td style="text-align: center;">□</td> </tr> <tr> <td style="text-align: center;">HOUR</td> <td style="text-align: center;">MINUTES</td> </tr> </table> AM PM	TIME		□	□	HOUR	MINUTES																																															
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		NO <input type="checkbox"/> → REASON																																																					
302	How many days in a week are family planning services provided at the facility.	# DAYS <input type="checkbox"/>																																																					
303	Are family planning services being provided today?	YES..... 1 NO..... 2																																																					
304	Does this facility routinely charge for any family planning consultation services?	YES 1 NO 2 DON'T KNOW 8																																																					
305	Which of the following methods of contraception is provided at this facility?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Don't Know</th> </tr> </thead> <tbody> <tr><td>A) Combined Oral Pill.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>B) Progesterone Only Pill.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>C) IUD</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>D) 2-3 Monthly Injectable</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>E) 1 Monthly Injectalbe.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>F) NORPLANT</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>G) Male Condom.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>H) Female Condom.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>I) Spermicides</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>J) Diaphragm.....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>k) Emergency Contraceptive Pill</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>l) Counseling about Natural Family Planning</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		Yes	No	Don't Know	A) Combined Oral Pill.....	1	2	8	B) Progesterone Only Pill.....	1	2	8	C) IUD	1	2	8	D) 2-3 Monthly Injectable	1	2	8	E) 1 Monthly Injectalbe.....	1	2	8	F) NORPLANT	1	2	8	G) Male Condom.....	1	2	8	H) Female Condom.....	1	2	8	I) Spermicides	1	2	8	J) Diaphragm.....	1	2	8	k) Emergency Contraceptive Pill	1	2	8	l) Counseling about Natural Family Planning	1	2	8	
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306	Does this facility conduct the following procedures?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr><td>a) TUBECTOMY (Female Sterilization)</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>b) VASECTOMY (Male Sterilization)</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DK	a) TUBECTOMY (Female Sterilization)	1	2	8	b) VASECTOMY (Male Sterilization)	1	2	8																																									
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307	For family planning consultations is there a ROUTINE system for taking measurements prior to the consultation?	YES 1 NO 2 DON'T KNOW 8	→309 →309																																																				

NO	QUESTIONS	CODING CLASSIFICATION				GO TO
308	IF YES, ASK TO SEE WHERE FAMILY PLANNING CLIENTS ARE SEEN PRIOR TO THE CONSULTATION AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.					
	PART OF ROUTINE SERVICES	Observed	Reported	Not Done Routinely	Don't Know	
	a) Weight Taken	1	2	3	8	
	b) Blood Pressure Taken	1	2	3	8	
	c) Other (SPECIFY) _____	1	2	3	8	
309	ASK TO SEE WHERE COUNSELING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.		PRIVATE ROOM 1	ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER 2	ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER 3	
310	Are any of the following available, in the counseling or the examination room?	Observed	Reported Available	Not Available	Not Determined	
	VISUAL AIDS FOR TEACHING					
	a) Different family planning methods	1	2	3	8	
	b) About STIs	1	2	3	8	
	c) About HIV/AIDS	1	2	3	8	
	d) Model for demonstrating use of condom	1	2	3	8	
	e) Posters on family planning	1	2	3	8	
	f) "Essentials of Contraceptive Technology" poster? (ie. Side effect)	1	2	3	8	
	INFORMATION BOOKLET/PAMPHLET FOR CLIENT TO TAKE HOME					
	g) On family planning	1	2	3	8	
	h) On STIs	1	2	3	8	
	i) On HIV/AIDS	1	2	3	8	
	SERVICE DELIVERY PROTOCOLS					
	j) "National Reproductive Health Service Protocols"?	1	2	3	8	
	k) "The Essentials of Contraceptive Technology" book? (HATCHER)	1	2	3	8	
	l) Guidelines for Syndromic Approach for diagnosis and treatment of STIs	1	2	3	8	
	m) Reference materials for Clinical or Etiologic diagnosis of STIs	1	2	3	8	
	n) Other protocols for family planning	1	2	3	8	
311	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE REGISTER. (REQUIRED INFORMATION: NAME, METHOD, 1 ST OR FOLLOW-UP VISIT)		YES, REGISTER SEEN 1	YES, REGISTER NOT SEEN... 2	NO REGISTER KEPT 3	→ 313 → 313
312	How recent is the date of the most recent entry?		WITHIN THE PAST 7 DAYS 1	> 7 DAYS..... 2		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO					
313	How many NEW clients received family planning services during the calendar year 2001?	NUMBER OF FP CLIENTS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→314					
313a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF <input type="text"/> <input type="text"/>						
314	Are individual client cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD.	YES, OBSERVED CARD..... 1 YES, CARD NOT SEEN 2 NO INDIVIDUAL CARDS..... 3						
315	Does the family planning provider(s) routinely treat STIs or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIS 1 REFERS TO OTHER PROVIDER OR LOCATION 2 NO TREATMENT PROVIDED.. 3						
ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR FAMILY PLANNING CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.								
316	If same examination room has already been observed for items in 317 and 318, note for which module the room was assessed:	ANTENATAL 1 DELIVERY 2 STI..... 3 NOT PREVIOUSLY SEEN 4	→319 →319 →319					
317	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM..... 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER..... 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3						
ITEMS REQUIRED FOR FAMILY PLANNING SERVICES		(a) Is Item present?		(b) Is item in working order?				
318	FACILITY AND EQUIPMENT	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	a) Spotlight source (flashlight or examination light accepted) LANTERN NOT ACCEPTED	1	2	3→318b	8→318b	1	2	8
	b) Table and stool for gynecological exam	1	2	3→318c	8→318c	1	2	8
	c) Hand-washing items (soap and towel)	1	2	3	8			
	h) Single use towel (handwash)	1	2	3	8			
	d) Water for hand-washing	1	2	3	8			
	e) Clean gloves	1	2	3	8			
	f) Sharps container	1	2	3	8			
	g) Decontamination solution for clinical equipment	1	2	3	8			

SPECIFIC ITEMS FOR FAMILY PLANNING SERVICES		(a) Is item present?				(b) Is item in working order?		
NO	QUESTIONS	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
319	EQUIPMENT (may be in room where measure is taken)							
	a) Blood pressure gauge	1	2	3→319b	8→319b	1	2	8
	b) Stethoscope	1	2	3→319c	8→319c	1	2	8
	c) Weighing scale	1	2	3→319d	8→319d	1	2	8
	d) Sterile needle and syringe	1	2	3	8			
320	Does the facility offer the IUD or NORPLANT? IF YES, CHECK FOR AVAILABILITY OF EQUIPMENT			YES..... 1 NO..... 2				→326
321	EQUIPEMENT AND SUPPLIES FOR BOTH PROCEDURES	Observed	Reported Available	Not Available	Not Determined			
	a) Sterile gloves	1	2	3	8			
	b) Antiseptic solution (e.g.Iodine)	1	2	3	8			
322	Materials for IUD			IUD OFFERED..... 1 IUD NOT OFFERED..... 2				→324
323	MATERIALS FOR IUD	Observed	Reported Available	Not Available	Not Determined			
	a) Speculum	1	2	3	8			
	b) Sponge holding forceps	1	2	3	8			
	c) Sterile IUD kit which includes Tenacula and uterine sound	1→324	2→324	3	8			
	d) Tenacula	1	2	3	8			
	e) Uterine sound	1	2	3	8			
324	MATERIALS FOR NORPLANT			NORPLANT OFFERED..... 1 NORPLANT NOT OFFERED.... 2				→326
325	a) Local anesthetic (e.g. lidocaine)	1	2	3	8			
	b) Sterile syringe and needle	1	2	3	8			
	c) Minor surgical kit with scalpel, blade and some forceps for grasping implant	1→326	2→326	3	8			
	d) Scalpel with blade	1	2	3	8			
	e) Any forceps for grasping implant (artery forceps/ hemostat/ tweezer/mosquito forceps)	1	2	3	8			
326	When there is a shortage of Lo-Femal or Overette oral contraceptives, do you clients accept substitution?			YES, EASILY..... 1 YES, SOME PROBLEM..... 2 NO, STRONGLY DISLIKE..... 3 NEVER HAVE SHORTAGE..... 4 NOT GOVT FACILITY..... 7 DON'T KNOW..... 8				
327	Does this facility have or advocate any special programs related to family planning that are targeted to adolescents? IF YES ASK RESPONDENT TO DESCRIBE PROGRAMS.			YES..... 1 (DESCRIBE) NO..... 2				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
409	Does the ANC provider(s) routinely treat STIs or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIS 1 REFERS TO OTHER PROVIDER /LOCATION..... 2 NO TREATMENT PROVIDED.. 3	
410	Is there a register where client information from ANC visits is recorded? IF YES, ASK TO SEE REGISTER. IF DIFFERENT REGISTERS USED FOR FIRST AND FOLLOW-UP VISITS, CHECK INFORMATION FOR BOTH. (REQUIRED INFORMATION=NAME, AGE, PARITY,FIRST OR FOLLOW-UP VISIT)	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN ... 2 NO REGISTER KEPT 3	→412 →412
411	How recent is the date of the most recent entry for ANC?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS 2	
412	How many antenatal visits (both new and follow-up) place during the calendar year 2001?	NUMBER OF ANC VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→412b
412a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA <input type="text"/> <input type="text"/>	
412b	Is there a register where client information from POSTPARTUM visits is recorded? IF YES, ASK TO SEE REGISTER. (Required information: Name, days postpartum)	YES, REGISTER SEEN..... 1 YES, REGISTER NOT SEEN ... 2 NO REGISTER KEPT 3	→413 →413
412c	How recent is the date of the most recent entry for POSTPARTUM care?	WITHIN THE PAST 7 DAYS..... 1 > 7 DAYS 2	
412d	How many postpartum visits took place during the last four (4) complete quarters? (2001)	NUMBER OF PNC VISITS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	→413
412e	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA <input type="text"/> <input type="text"/>	
413	Do you have an estimate of the number of deliveries (births) in the facility's catchment area? (e.g. your target population).	NUMBER OF BIRTHS.... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998 NO CATCHMENT AREA 0000	→416 →416

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
414	What do you estimate is the annual antenatal coverage rate for this facility for the previous year?	ANC % COVERAGE <input type="text"/> <input type="text"/>	
		DON'T KNOW.....	98
415	RECORD THE SOURCE OF INFORMATION FOR % ANTENATAL COVERAGE ESTIMATES	WRITTEN REPORT WALL GRAPH OTHER (SPECIFY) NOT KNOWN	
416	Are individual ANC cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD?	YES, OBSERVED BLANK CARD..... 1 YES, NO BLANK CARD OBSERVED..... 2 NO INDIVIDUAL CARDS..... 3	

ASK TO SEE THE ROOM WHERE EXAMINATIONS FOR ANTENATAL OR POSTPARTUM CLIENTS ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE EXAMINATION IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.

417	If same examination room has already been observed for items in 418 and 419, indicate for which module the room was assessed:	FAMILY PLANNING DELIVERY STI..... NOT PREVIOUSLY SEEN.....	→420 →420 →420
418	DESCRIBE THE SETTING FOR THE EXAMINATION ROOM	PRIVATE ROOM..... ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER..... ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER	

ITEMS REQUIRED FOR ANTENATAL SERVICES	(a) Is item present				(b) Is item in working order?		
	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
419 FACILITY AND EQUIPMENT							
a) Spotlight source (flashlight or examination light accepted) LANTERN NOT ACCEPTED	1	2	3→419b	8→419b	1	2	8
b) Table and stool for gynecological exam	1	2	3→419c	8→419c	1	2	8
c) Hand-washing items (soap and towel)	1	2	3	8			
h) Single use towel (handwashing)	1	2	3	8			
d) Water for hand-washing	1	2	3	8			
e) Clean gloves	1	2	3	8			
f) Sharps container	1	2	3	8			
g) Decontamination solution for clinical equipment	1	2	3	8			

420	EQUIPMENT (may be in room where measure is taken)	Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	a) Blood pressure gauge	1	2	3→420b	8→420b	1	2	8
	b) Stethoscope	1	2	3→420c	8→420c	1	2	8
	c) Fetal Stethoscope	1	2	3→420d	8→420d	1	2	8
	d) Thermometer	1	2	3→420e	4→420e	1	2	8
	e) Infant scale	1	2	3→421	4→421	1	2	8
NO.	QUESTIONS	CODING CLASSIFICATION				GO TO		
421	PROTOCOLS/TEACHING MATERIALS	Observed	Reported Available	Not Available	Not Determined			
	a) "National Reproductive Health Policy and Standards"	1	2	3	8			
	b) "National Reproductive Health Service Protocols"	1	2	3	8			
	c) Other ANC guidelines/ protocols	1	2	3	8			
	d) Teaching aids/ANC	1	2	3	8			
	- Anatomical Model	1	2	3	8			
	- Fliers for client to take	1	2	3	8			
	- Flip Charts	1	2	3	8			
	- Audio Visual (Video)	1	2	3	8			
	- Posters	1	2	3	8			
	e) "CHEST" Teaching materials	1	2	3	8			
422	Does this facility have a formal relationship with traditional birth attendants in which training or other types of support are provided to the TBAs?	YES..... 1 NO..... 2				→424		
423	Is there any documentation available on the TBA program, (e.g. lists of affiliated TBAs or TBA training records, supervisory notes)?	YES, DOCUMENT SEEN..... 1 YES, DOCUMENT NOT SEEN 2 NO DOCUMENTATION 3						
424	What is the most common means by which women are transported from home to this facility for help during obstetric emergencies?	PEOPLE CARRY..... A ANIMAL DRAWN VEHICLE B MOTOR VEHICLE..... C BICYCLE D COMBINATION OF ABOVE..... E OTHER..... W DON'T KNOW Z						
425	Does this facility have a procedure for transporting women to another facility if necessary in an obstetric emergency? RECORD "NOT APPLICABLE" IF FACILITY IS THE REFERRAL FACILITY.	YES 1 NO 2 NOT APPLICABLE 9				→428 →430		

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																				
426	Circle for each of the following method most commonly used by this facility for emergency transportation: a) Emergency Vehicle onsite at Facility b) Multi-use Vehicle Available at Facility. May be used for emergencies c) Call other Facility to Send Emergency Vehicle d) Rental/Hire Vehicle arrangement when needed (With some financial support from facility)	AVAILABILITY <table border="1"> <thead> <tr> <th data-bbox="912 302 1000 365">24 Hours</th> <th data-bbox="1000 302 1263 365">Normal facility hours (<24 hours)</th> <th data-bbox="1263 302 1351 365">No set times</th> <th data-bbox="1351 302 1479 365">Not used</th> </tr> </thead> <tbody> <tr> <td data-bbox="912 365 1000 399">1</td> <td data-bbox="1000 365 1263 399">2</td> <td data-bbox="1263 365 1351 399">3</td> <td data-bbox="1351 365 1479 399">8</td> </tr> <tr> <td data-bbox="912 399 1000 432">1</td> <td data-bbox="1000 399 1263 432">2</td> <td data-bbox="1263 399 1351 432">3</td> <td data-bbox="1351 399 1479 432">8</td> </tr> <tr> <td data-bbox="912 432 1000 466">1</td> <td data-bbox="1000 432 1263 466">2</td> <td data-bbox="1263 432 1351 466">3</td> <td data-bbox="1351 432 1479 466">8</td> </tr> <tr> <td data-bbox="912 466 1000 499">1</td> <td data-bbox="1000 466 1263 499">2</td> <td data-bbox="1263 466 1351 499">3</td> <td data-bbox="1351 466 1479 499">8</td> </tr> </tbody> </table>	24 Hours	Normal facility hours (<24 hours)	No set times	Not used	1	2	3	8	1	2	3	8	1	2	3	8	1	2	3	8	
24 Hours	Normal facility hours (<24 hours)	No set times	Not used																				
1	2	3	8																				
1	2	3	8																				
1	2	3	8																				
1	2	3	8																				
427	Is the vehicle available and operational today? If yes, may I see the vehicle?	YES SEEN/FUNCTIONING 1 YES SEEN/ NOT FUNCTIONING..... 2 VEHICLE AWAY FOR EMERGENCY 3 NOT SEEN..... 4	→ 429 → 429 → 429 → 429																				
428	What is the most common means by which women are transported from this facility to the nearest referral facility to receive help during an obstetric emergency?	PEOPLE CARRY A ANIMAL DRAWN VEHICLE.... B MOTOR VEHICLE C COMBINATION OF ABOVE D OTHER W DON'T KNOW Z																					
429	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998																					
429a	Does this facility have or advocate any special programs related to family planning that are targeted to adolescents?	YES 1 NO 2	→ 430																				
429b	What special program related to maternal care do you have or promote for adolescents?	SDL/CPR/ARH INITIATIVE A YOUTH FRIENDLY CLINICS... B YOUNG AND WISE C OTHER W (specify)																					

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
437	RECORD THE SOURCE OF INFORMATION FOR DELIVERY COVERAGE ESTIMATE	WRITTEN REPORT A WALL GRAPH B OTHER W (SPECIFY) NOT KNOWN..... Z	
438	Do midwives routinely provide home-deliveries or attend home delivery emergencies as a part of the facility service?	YES, ROUTINELY 1 YES, EMERGENCY ONLY 2 NO..... 3	→441
439	Is there a home delivery bag?	YES..... 1 NO 2	→441
440	ASK TO SEE THE DELIVERY BAG AND INDICATE WHETHER THE ITEMS LISTED ARE PRESENT OR NOT.	<p style="text-align: center;">YES NO DK</p> SOAP 1 2 8 SCISSOR/BLADE 1 2 8 CLAMP/UMBILICAL TIE 1 2 8 ERGOMETRINE ORAL 1 2 8 ERGOMETRINE INJ W/ SYRINGE AND NEEDLE 1 2 8	

ASK TO SEE THE ROOM WHERE NORMAL DELIVERIES ARE CONDUCTED. FOR THE FOLLOWING ITEMS, CHECK TO SEE IF THE ITEM IS IN THE ROOM WHERE THE DELIVERY IS CONDUCTED OR IN AN IMMEDIATELY ADJACENT ROOM.

441	If same examination room has already been observed for items in 442 and 443, indicate for which module the room was assessed:	FAMILY PLANNING 1 ANTENATAL 2 STI..... 3 NOT PREVIOUSLY SEEN 4	→444 →444 →444
442	DESCRIBE THE SETTING FOR THE DELIVERY ROOM	PRIVATE ROOM..... 1 ROOM WITH OTHER PEOPLE W/ SEPARATING BARRIER..... 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3	

	ITEMS REQUIRED FOR DELIVERY SERVICES	(a) Is item Present?				(b) Is item in working order?		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
443	FACILITY AND EQUIPMENT							
	a) Spotlight source (flashlight or examination light accepted) LANTERN NOT ACCEPTABLE	1	2	3 →443b	8 →443b	1	2	8
	b) Table and stool for delivery	1	2	3 →443c	8 →443c	1	2	8
	c) Hand-washing items (soap and towel)	1	2	3	8			
	h) Single use towel (handwashing)	1	2	3	8			
	d) Water for hand-washing	1	2	3	8			
	e) Clean gloves	1	2	3	8			
	f) Sharps container	1	2	3	8			
	g) Decontamination solution for clinical equipment	1	2	3	8			

	ITEMS REQUIRED FOR DELIVERY SERVICES	(a) Is item Present?				(b) Is item in working order?		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	FACILITY AND EQUIPMENT							
444	OTHER EQUIPMENT/SUPPLIES							
	a)24-hour functioning light source?(Lantern acceptable)	1	2	3→444b	8→444b	1	2	8
	b) Skin antiseptic (e.g. chlorhexidine;savlon;detol)	1	2	3	8			
	c) IV infusion set	1	2	3	8			
	d) Intravenous:either Ringers lactate, D5NS, or NS infusion w/ valid expiry date	1	2	3	8			
	e) Injectable ergometrine w/ valid expiry date	1	2	3	8			
	f) Syringes and needles?	1	2	3	8			
	G) Suture material w/needle	1	2	3	8			
	H) Sterile scissors/blade	1	2	3	8			
	I) Needle Holder	1	2	3	8			
445	SUPPLIES FOR BABY							
	a) Bag and mask or tube and mask (baby) for resuscitation	1	2	3→445b	8→445b	1	2	8
	b) Resuscitation table for baby	1	2	3	8			
	c) Heat source	1	2	3→445d	8→445d	1	2	8
	d) Baby scale	1	2	3→445e	8→445e	1	2	8
	e) Mucous extractor/ suction machine	1	2	3→445f	8→445f	1	2	8
	f) Cord ties/cordclamps	1	2	3	8			
	g) Towel/blanket to wrap baby	1	2	3	8			
446	PROTOCOLS/EDUCATIONAL MATERIALS							
	a) National Reproductive Health Guidelines	1	2	3	8			
	b) Other references or guidelines for delivery care/emergency care?	1	2	3	8			
	c) Blank Partographs	1	2	3	8			
447	Is this facility able to perform manual removal of retain Placenta after delivery?	YES..... 1 NO..... 2						
448	Does this facility handle assisted deliveries, that is using forceps or ventous (vacuum extractor?)	YES1 NO2						→450

NO.	QUESTIONS	CODING CLASSIFICATION						GO TO
449	ITEMS REQUIRED FOR ASSISTED DELIVERIES	(a) Is item Present?				(b) Is item in working order?		
		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not Determined
	a) Forceps?	1	2	3→449b	8→449b	1	2	8
	b) Vacuum Extractor?	1	2	3→450	8→450	1	2	8
450	Is this facility able to perform vacuum aspiration for a woman with retained products of conception? IF YES, ASK TO SEE EQUIPMENT USED.	YES1 NO2				→452		
451		Observed	Reported Available	Not Available	Not Determined	Yes	No	Not determined
	a) Manual vacuum aspirator	1	2	3→451b	8→451b	1	2	8
	b) Other (specify) _____	1	2	3→452	8→452	1	2	8
452	Does this facility conduct blood transfusion? IF YES, IS THERE A BLOOD BANK OR ARE THERE TRANSFUSION SERVICES ONLY?	YES, BLOOD BANK 1 YES, TRANSFUSION, NO BLOOD BANK 2 NO BLOOD TRANSFUSION.... 3						
453	Does this facility <u>routinely</u> insert a catheter for suctioning out normal newborns, that is, those with no respiratory problem at birth?	YES 1 NO 2 DON'T KNOW 8						
454	Does this facility routinely weigh the newborn infants at birth?	YES 1 NO 2 DON'T KNOW 8						
455	Does this facility routinely bathe newborn infants within 6 hours of birth, by emersing in water?	YES 1 NO 2 DON'T KNOW 8						
456	Is rooming-in the normal practice in this facility?	YES 1 NO 2 DON'T KNOW 8						
457	Does this facility routinely provide OPV or BCG to the newborn prior to discharge?	YES OPV A NO OPV B YES BCG C NO BCG D DON'T KNOW X						
458	Does this facility routinely provide Vitamin A <u>to the mother</u> prior to discharge?	YES 1 NO 2 DON'T KNOW 8						
459	Does the facility have a system for routinely reviewing maternal or newborn deaths or "near miss deaths"?	YES, FOR MOTHERS 1 YES, FOR NEWBORNS 2 YES, FOR BOTH 3 NO DO NOT PARTICPATE 4						
460	Does this facility <u>ever</u> perform Caesarean Section?	YES 1 NO 2				→500		
	ASK TO SEE THE ROOM WHERE CAESAREAN SECTIONS ARE PERFORMED. CHECK WHETHER THE FOLLOWING	(a) Is the item present?				(b) Is the item in working Order?		

461	EQUIPMENT & SUPPLIES ARE AVAILABLE IN THE ROOM OR IN AN IMMEDIATELY ADJACENT ROOM							
	FACILITY AND EQUIPMENT	Observed	Reported Available	Not Available	Not determined	Yes	No	Not determined
	a) Operating table	1	2	3→461b	8→461b	1	2	8
	b) Operating light	1	2	3→461c	8→461c	1	2	8
	c) Scrub area adjacent to or in the operating room	1	2	3	8			
d) Sterilized instruments ready for use	1	2	3	8				
462	Does this facility have a health worker who can perform a caesarean section present in the facility or on call 24 hours a day (including weekends)	YES, PRESENT 1 YES, ON CALL..... 2 NO3						
463	How many caesarean sections were conducted at this facility during the calendar year 2001?	NO. CAESAREAN <input type="text"/> <input type="text"/> <input type="text"/>				DON'T KNOW998		
463a	IF DATA NOT FOR 12 MONTHS, INDICATE NUMBER OF MONTHS REPRESENTED	MONTHS OF DATA <input type="text"/> <input type="text"/>						
464	What is the date of the last caesarean section?	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/>				YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
		DON'T KNOW9998						
465	TIME COMPLETED	HOUR..... <input type="text"/> <input type="text"/>				MINUTES <input type="text"/> <input type="text"/>		

**MEASURE Service Provision Assessment
Reproductive and Child Health Service Delivery**

Provider Interview	
FACILITY IDENTIFICATION	
Name of the facility _____ Facility Location _____ Region _____ District _____ Type of Health Facility: (11= Teaching hospital; 12 = Regional/ District Hospital;13 = Polyclinic; 14 = Health Centre; 15 =Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____) Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG;32 = GRMA; 96 = Other _____)	REGION CODE <input type="text"/> <input type="text"/> DISTRICT CODE <input type="text"/> <input type="text"/> FACILITY CODE <input type="text"/> <input type="text"/> FACILITY TYPE <input type="text"/> <input type="text"/> OPERATING AUTHORITY <input type="text"/> <input type="text"/>
Provider Information	
Provider category: (1 = Medical Doctor; 2 =Medical Assistant; 3=Public Health Nurse; 4=Professional Midwife; 5= Professional Nurse; 6= Midwife Assistant; 7=Auxiliary nurse; 8=Pharmacist; 9=Dispensing Technician; 10=Laboratory Technician; 11=Nutrition Technician Officer; 96=other _____) Sex of Provider: (1=female; 2=male) Provider Code (Use same code for observation component)	PROVIDER CATEGORY <input type="text"/> <input type="text"/> SEX OF PROVIDER <input type="text"/> PROVIDER CODE <input type="text"/> <input type="text"/>
INFORMATION ABOUT INTERVIEW	
Date: _____ Name of the interviewer _____ Time interview started:	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> INTERVIEWER CODE.. <input type="text"/> <input type="text"/> HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>

Provider Interview

100 **OBSERVER:** INTRODUCE YOURSELF TO THE PROVIDER.

EXPLAIN THE STUDY OBJECTIVES AS DESCRIBED IN THE TRAINING MANUAL. READ THE FOLLOWING:
 I am representing the Ministry of Health and the Ghana Statistical Service for this survey. We are collecting information that will help us to understand the health service situation for maternal, child, and reproductive health services. One part of this is to know about the qualification and training of the people who provide health services. All information from this survey is confidential and will not be identified with any one provider or facility. Can I ask you a few questions now?

SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT	YES <input type="checkbox"/> →	TIME				AM
		[] []	[] []	HOUR	MINUTES	PM
	NO <input type="checkbox"/> →	REASON				
					

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
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1. Provider Training and Experience

101	In what year did you start working in this facility?	YEAR..... [] [] [] []	
102a	What is the highest level of school (NAME) attended? (BEFORE TECHNICAL TRAINING)	PRIMARY 1 MIDDLE/JSS 2 SECONDARY/SSS 3 VOC/TECH/COMMERCIAL..... 4 POST SECONDARY 5 TERTIARY 6	
102b	What is the highest grade (NAME) completed at that level? PLEASE RECORD ACTUAL GRADE IF 0-8; IF 9 OR MORE CODE 9	GRADE..... [] []	
103	What is your current technical qualification?	MEDICAL DOCTOR 1 MEDICAL ASST 2 PUBLIC HEALTH NURSE 3 PROFESSIONAL MIDWIFE 4 PROFESSIONAL NURSE 5 MIDWIFE ASSISTANT 6 AUXILIARY NURSE 7 PHARMACIST 8 DISPENSING TECHNICIAN 9 LAB TECHNICIAN 10 NUT. TECH. OFFICER 11 WARD ASSISTANT 12 OTHER 96	→201 →201
104	What year did you graduate with this qualification?	YEAR..... [] [] [] []	

105	How many years of study was required for this qualification (AFTER COMPLETING BASIC EDUCATION DESCRIBED IN Q102)? (If less than 1 year, write "00" in years and Indicate number of months).	YEARS <input type="text"/> <input type="text"/> MONTHS <input type="text"/> <input type="text"/>	→201
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2. Child Health Care

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																
201	Do you currently personally provide child health care services?	YES..... 1 NO 2	→301																																
202	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>																																	
203	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) EPI/cold chain? B) ARI treatment? C) Diarrhoea treatment? D) Malaria treatment? E) Nutrition/micro-nutrient deficiencies? F) Mother to child transmission of HIV/AIDS? W) Other _____? (SPECIFY)	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>YES PRIOR 12mo</th> <th>YES PRIOR 13-59mo</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>EPI/COLD CHAIN</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>ARI</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>DIARRHOEA</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>MALARIA</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>NUTRITION</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>MTC TRANSMISSION</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OTHER _____</td> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>		YES PRIOR 12mo	YES PRIOR 13-59mo	NO	EPI/COLD CHAIN	1	2	3	ARI	1	2	3	DIARRHOEA	1	2	3	MALARIA	1	2	3	NUTRITION	1	2	3	MTC TRANSMISSION	1	2	3	OTHER _____	1	2	3	
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OTHER _____	1	2	3																																

3. Family Planning

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																
301	Do you currently personally provide family planning services?	YES..... 1 NO 2	→401																																																
302	For how many years in total have you provided this service? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>																																																	
303	<p>ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?</p> <p>A) Family planning counseling? B) Training in Female Condom? C) Family Planning Training with emphasis on IUD? D) Norplant Insertion and Removal? E) Introduction of Norigynon injectable? F) Emergency Contraception ("morning after" pill)? G) Other contraceptive technology (CT)?</p> <p>H) STI Syndromic Management? I) Minilap Procedure J) Infection Prevention X) Other _____? (SPECIFY)</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES PRIOR 12mo</th> <th style="text-align: center;">YES PRIOR 13-59mo</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>FP COUNSELING ...</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>FEMALE CONDOM .</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>IUD.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>NORPLANT</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>NORIGYNON INJ</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>EMERGENCY CONTRA.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>OTHER CT_____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>STI SYNDROMIC</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>MINILAP</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>INFECTION PREV... </td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td>OTHER _____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </tbody> </table>		YES PRIOR 12mo	YES PRIOR 13-59mo	NO	FP COUNSELING ...	1	2	3	FEMALE CONDOM .	1	2	3	IUD.....	1	2	3	NORPLANT	1	2	3	NORIGYNON INJ	1	2	3	EMERGENCY CONTRA.....	1	2	3	OTHER CT_____	1	2	3	STI SYNDROMIC	1	2	3	MINILAP	1	2	3	INFECTION PREV...	1	2	3	OTHER _____	1	2	3	
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NORPLANT	1	2	3																																																
NORIGYNON INJ	1	2	3																																																
EMERGENCY CONTRA.....	1	2	3																																																
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MINILAP	1	2	3																																																
INFECTION PREV...	1	2	3																																																
OTHER _____	1	2	3																																																

4. Maternal Health

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO		
401	Do you currently personally provide antenatal care?	YES NO	→404		
402	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS ----- <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			

403	<p>ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?</p> <p>A) Antenatal Care</p> <p>B) Counseling/safe motherhood health education for maternity clients?</p> <p>C) Management of risk pregnancies</p> <p>D) Life Saving Skills?</p> <p>E) Safe Motherhood/Clinical Skills?</p> <p>F) Mother to child transmission of HIV/AIDS?</p> <p>G) Postnatal care</p> <p>H) Post Abortion Care/Manual Vacuum Aspiration (MVA)?</p> <p>I) Family Planning?</p> <p>J) Sexually transmitted infections?</p> <p>W) Other _____? (SPECIFY)</p>	<table border="0"> <thead> <tr> <th></th> <th>YES PRIOR 12mo</th> <th>YES PRIOR 13-59mo</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>ANTENATAL CARE</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>COUNSELING/ HEALTH EDUCATION</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>MGMT RISK PREGNANCIES</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>LIFE SAVING SKILLS</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>SAFE MOTHERHOOD</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>MTC TRANSMISSION</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>POSTNATAL CARE</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>POSTABORTION CARE</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>FAMILY PLANNING</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>STIS</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OTHER _____</td> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>		YES PRIOR 12mo	YES PRIOR 13-59mo	NO	ANTENATAL CARE	1	2	3	COUNSELING/ HEALTH EDUCATION	1	2	3	MGMT RISK PREGNANCIES	1	2	3	LIFE SAVING SKILLS	1	2	3	SAFE MOTHERHOOD	1	2	3	MTC TRANSMISSION	1	2	3	POSTNATAL CARE	1	2	3	POSTABORTION CARE	1	2	3	FAMILY PLANNING	1	2	3	STIS	1	2	3	OTHER _____	1	2	3
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STIS	1	2	3																																															
OTHER _____	1	2	3																																															
404	<p>Do you currently personally provide delivery care? By this, I mean conducting the actual delivery.</p>	<p>YES</p> <p>NO</p> <p style="text-align: right;">→410</p>																																																
405	<p>For how many years in total have you conducted deliveries? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".</p>	<p>YEARS <input type="text"/> <input type="text"/></p>																																																
406	<p>ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?</p> <p>A) Care during labor or delivery?</p> <p>B) Use of partograph?</p> <p>C) Life saving skills/emergency complications?</p> <p>C1) Safe Motherhood/Clinical Skills?</p> <p>D) Infection Prevention</p> <p>W) Other _____ (SPECIFY)?</p>	<table border="0"> <thead> <tr> <th></th> <th>YES PRIOR 12mo</th> <th>YES PRIOR 13-59mo</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>DELIVERY CARE ..</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>PARTOGRAPH USE</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>LIFE SAVING/ EMERGENCY</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>SAFE MOTHERHOOD</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>INFECTION PREV ..</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OTHER _____</td> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>		YES PRIOR 12mo	YES PRIOR 13-59mo	NO	DELIVERY CARE ..	1	2	3	PARTOGRAPH USE	1	2	3	LIFE SAVING/ EMERGENCY	1	2	3	SAFE MOTHERHOOD	1	2	3	INFECTION PREV ..	1	2	3	OTHER _____	1	2	3																				
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OTHER _____	1	2	3																																															
407	<p>Approximately how many deliveries have you assisted as the principal provider, in the last 6 months? (INCLUDE DELIVERIES CONDUCTED FOR PRIVATE PRACTICE AND FOR FACILITY)</p>	<p>TOTAL DELIVERIES <input type="text"/> <input type="text"/> <input type="text"/></p>																																																

408	When was the last time you used a partograph?	NEVER..... 0 IN PAST WEEK..... 1 IN PAST MONTH..... 2 IN PAST 6 MONTHS..... 3 6 MONTHS AGO OR LONGER 4 DON'T KNOW 8	
409	Do you currently personally provide PAC/MVA	YES.....1 NO.....2	

NEW BORN CARE

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																
410	Do you currently personally provide newborn care?	YES..... NO.....	→413																																
411	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS..... <input type="text"/> <input type="text"/>																																	
412	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months? A) Care of the normal newborn? B) Neonatal resuscitation? C) Mother to child transmission HIV/AIDS? D) Exclusive breast-feeding? W) Other _____? (SPECIFY)	<table border="0"> <tr> <td></td> <td>YES</td> <td>YES</td> <td>NO</td> </tr> <tr> <td></td> <td>PRIOR</td> <td>PRIOR</td> <td></td> </tr> <tr> <td></td> <td>12mo</td> <td>13-59mo</td> <td></td> </tr> <tr> <td>NORMAL NEWBORN</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>NEONATAL RESUSCIT</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>MTC TRANSMISSION</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>BREAST FEEDING.....</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OTHER _____</td> <td>1</td> <td>2</td> <td>3</td> </tr> </table>		YES	YES	NO		PRIOR	PRIOR			12mo	13-59mo		NORMAL NEWBORN	1	2	3	NEONATAL RESUSCIT	1	2	3	MTC TRANSMISSION	1	2	3	BREAST FEEDING.....	1	2	3	OTHER _____	1	2	3	
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OTHER _____	1	2	3																																

POST NATAL CARE

413	Do you currently personally provide post natal care?	YES 1 NO 2	→501
414	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS <input type="text"/> <input type="text"/>	

415	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?		YES PRIOR 12mo	YES PRIOR 13-59mo	NO
	A) Care of the normal newborn?	NORMAL NEWBORN	1	2	3
	B) Neonatal resuscitation?	NEONATAL RESUSCIT	1	2	3
	C) Mother to child transmission HIV/AIDS?	MTC TRANSMISSION	1	2	3
	D) Exclusive breast-feeding? W) Other _____? (SPECIFY)	BREAST FEEDING .. OTHER	1	2	3

SEXUALLY TRANSMITTED INFECTIONS

501	Do you currently personally provide care for clients with sexually transmitted infections? (STIs)?	YES	1	NO	2	→503
502	For how many years in total have you provided this services? (May be from another facility) IF LESS THAN ONE YEAR, RECORD "00".	YEARS	<input type="text"/>	<input type="text"/>		
503	Do you currently personally provide care for clients who are HIV/AIDS positive?	YES	1	NO	2	→506
504	Which type of care do you provide? CIRCLE ALL THAT APPLY	INITIAL DIAGNOSIS	A	MEDICAL MANAGEMENT OF CONCURRENT ILLNESS ..	B	ANTI-RETROVIRAL THERAPY
		COUNSELING/SOCIAL SUPPORT	D			
505	For how many years have you provided any services for HIV/AIDS clients? IF LESS THAN ONE YEAR, RECORD "00".	YEARS	<input type="text"/>	<input type="text"/>		
506	IS YES CIRCLED FOR EITHER Q501 OR Q503	YES	1	NO	2	→601
507	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Did you received training in (SUBJECT) as a part of the basic training for your current technical qualification (pre-service training)			YES	NO	DK
	a) How to counsel for prevention of STIs	STI COUNSELING	1	2	8	
	b) Clinical diagnosis and treatment of STIs	STI CLINICAL DX & TX.....	1	2	8	
	c) Syndromic diagnosis and treatment of STIs	STI SYNDROMIC DX & TX....	1	2	8	
	d) How to counsel for prevention of HIV/AIDS	PREVENTION OF HIV/AIDS..	1	2	8	
	e) Counseling and social support needs for HIV/AIDS infected clients?	COUNSEL/SUPPORT HIV/AIDS	1	2	8	
	f) Medical management of HIV/AIDS	MEDICAL MGMT HIV/AIDS...	1	2	8	

	7 Anti-retroviral therapy for HIV/AIDS?	ANTI-RETROVIRAL TX	1	2	8	
	8 Diagnosis and treatment of TB?	TB DX AND TX.....	1	2	8	
508	ASK THE FOLLOWING QUESTION FOR EACH SPECIFIC SUBJECT: Have you received any in-service training in the last five years in (SUBJECT)? IF YES, Did you receive this training in the last 12 months?			YES PRIOR 12mo	YES PRIOR 13-59mo	NO
	a) Counseling for prevention of STIs?	STI COUNSELING/ PREVENTION	1	2	3	
	b) Clinical diagnosis and treatment of STIs?	CLINICAL DX & TX ..	1	2	3	
	c) Syndromic diagnosis and treatment of STIs?	SYNDROMIC DX & TX	1	2	3	
	d) Counseling for prevention of HIV/AIDS?	PREVENTION HIV/AIDS	1	2	3	
	e) Mother to Child transmission?	MOTHER TO CHILD TRANSMISSION	1	2	3	
	f) Counseling/social support for HIV/AIDS infected clients?	COUNSEL/SUPPORT HIV/AIDS	1	2	3	
	g) Medical management of HIV/AIDS infected clients?	MEDICAL MGMT HIV/AIDS	1	2	3	
	h) Anti-retroviral therapy for HIV/AIDS infected clients?	ANTI-RETROVIRAL TX.....	1	2	3	
	i) Diagnosis and treatment of Tuberculosis	TUBERCULOSIS	1	2	3	
	w) Other_____? (SPECIFY)	OTHER.....	1	2	3	

6. Supervision

NO	QUESTIONS	CODING CLASSIFICATION	GO TO																												
601	In the last six months have you had a supervisor speak with you about your work or observe your work?	YES..... 1 NO..... 2	→701																												
602	How many times in the last six months has your work been supervised?	NO OF TIMES..... <input type="text"/> <input type="text"/>																													
603	What did your supervisor do the last time he/she supervised you? A) Check your records/reports B) Observe your work C) Provide feedback on your performance? D) Provide updates on administrative or technical issues related to your work? E) Discuss problems you have encountered? W) Anything else _____? (SPECIFY)	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>CHECK RECORD.....</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OBSERVE</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>FEEDBACK.....</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>UPDATES</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>DISCUSS</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>OTHER.....</td> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>		YES	NO	DK	CHECK RECORD.....	1	2	3	OBSERVE	1	2	3	FEEDBACK.....	1	2	3	UPDATES	1	2	3	DISCUSS	1	2	3	OTHER.....	1	2	3	
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7. Provider opinion

701	What are the three most important issues which you feel need to be addressed for you to improve your work? PROBE: Any other issues you think are more important than these?	MORE STAFFA TREAT STAFF BETTER.....B PAY BETTER..... C MORE TRAINING D MORE FEEDBACK ON STAFF PERFORMANCE.....E MORE/BETTER EQUIPEMENT OR SUPPLIESF EMERGENCY TRANSPORT FOR PATIENTS..... G BETTER PHYSICAL ENVIRONMENT H BETTER SECURITY..... I OTHER.....W	
702	RECORD TIME INTERVIEW ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>	
703	INTERVIEWER COMMENTS		

**MEASURE Service Provision Assessment
Reproductive And Child Health Service Delivery**

Observation of Sick Child Consultation

FACILITY IDENTIFICATION

<p>Name of the facility _____</p> <p>Facility Location _____</p> <p>Region _____</p> <p>District _____</p> <p>Type of Health Facility : (11 = Teaching hospital; 12 = Regional/District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 = Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____)</p> <p>Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____)</p>	<p>REGION CODE <input type="text"/> <input type="text"/></p> <p>DISTRICT CODE <input type="text"/> <input type="text"/></p> <p>FACILITY CODE <input type="text"/> <input type="text"/></p> <p>FACILITY TYPE <input type="text"/> <input type="text"/></p> <p>OPERATING AUTHORITY <input type="text"/> <input type="text"/></p>
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Provider Information

<p>Provider category: (1 = Medical Doctor; 2 = Medical Assistant; 3 = Public Health Nurse; 4 = Professional Midwife; 5 = Professional Nurse; 6 = Midwife Assistant; 7 = Auxiliary nurse; 8 = Pharmacist; 9 = Dispensing Technician; 10 = Laboratory Technician; 11 = Nutrition Technician Officer; 96 = other _____)</p> <p>Sex of Provider: (1 = female; 2 = male)</p> <p>Code for Provider should be the same as that used for the Provider Interview</p>	<p>CATEGORY <input type="text"/> <input type="text"/></p> <p>SEX OF PROVIDER <input type="text"/></p> <p>PROVIDER CODE <input type="text"/> <input type="text"/></p>
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<p>Date: _____</p> <p>Name of the interviewer _____</p> <p>Time observation started:</p> <p>Client Code</p>	<p>DAY <input type="text"/> <input type="text"/></p> <p>MONTH <input type="text"/> <input type="text"/></p> <p>YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>INTERVIEWER CODE.. <input type="text"/> <input type="text"/></p> <p>HOUR <input type="text"/> <input type="text"/></p> <p>MINUTES <input type="text"/> <input type="text"/></p> <p>CLIENT CODE. <input type="text"/> <input type="text"/></p>
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Observation of Sick Child Consultation

100a	<p>INTERVIEWER: PRIOR TO THE OBSERVATION, MEET WITH THE PROVIDER AND EXPLAIN THE SURVEY. THEN INTRODUCE YOURSELF TO THE PROVIDER AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the child health services provided in Ghana. As one part of this assessment I would like to sit in the room while you see the sick child and see how the consultation goes. We want to see the types of sicknesses and the types of care that are provided. Is it ok with you if I watch when you see the child? Please tell me if this is ok or not. IF PROVIDER GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".</p>																												
	<p>_____ SIGNATURE OF INTERVIEWER INDICATES PROVIDER AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>																												
100b	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CARETAKER AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the child health services provided in Ghana. As one part of this assessment I would like to sit in the room while you see the (NURSE/DOCTOR) and see how the consultation goes. We want to see the types of sicknesses and the types of care that are provided. Is it ok with you if I watch when you see the (NURSE/DOCTOR)? Please tell me if this is ok or not. IF CARETAKER GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".</p>																												
	<p>_____ SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>	<p style="text-align: center;">TIME</p> <p>YES <input type="checkbox"/> → <table style="display: inline-table; border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: none; padding: 0 5px;">→</td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td colspan="2"></td><td style="text-align: center;">HOUR</td><td colspan="2"></td><td style="text-align: center;">MINUTES</td><td colspan="2"></td><td style="text-align: center;">AM</td><td colspan="2"></td><td style="text-align: center;">PM</td><td colspan="2"></td></tr></table></p> <p>NO <input type="checkbox"/> → REASON</p> <p>.....</p>		→		→		→		→		→		→				HOUR			MINUTES			AM			PM		
	→		→		→		→		→		→																		
		HOUR			MINUTES			AM			PM																		
100c	SEX OF CHILD	<p>MALE 1</p> <p>FEMALE 2</p>																											
100d	Visit type (THIS REFERS TO THIS SICKNESS)	<p>FIRST VISIT 1</p> <p>FOLLOW-UP 2</p>																											

1. Provider Interaction with Child and Caretaker

NO.	QUESTIONS	CODING CLASSIFICATION		GO TO
		YES	NO	
101	DOES THE PROVIDER ASK ABOUT OR THE CARETAKER MENTION IF THE CHILD HAS ANY OF THE FOLLOWING MAJOR SYMPTOMS ?			DON'T KNOW
	A) Cough or Difficulty breathing	1	2	8
	B) Diarrhea?	1	2	8
	C) Fever/Body hotness?	1	2	8
102	DOES THE PROVIDER ASK ABOUT OR THE CARETAKER MENTION ANY OF THE FOLLOWING PROBLEMS ?			DON'T KNOW
	A) If the child is unable to drink or breastfeed at all?	1	2	8
	B) If the child vomits everything?	1	2	8
	C) If the child has had convulsions with this sickness?	1	2	8
103	DOES THE PROVIDER PERFORM ANY OF THE FOLLOWING PHYSICAL EXAMINATIONS ?	YES	NO	DON'T KNOW
	A) Take temperature using a thermometer?	1	2	8
	B) Feel the child for fever or body hotness?	1	2	8
	C) Count respirations (breaths per minute?)	1	2	8
	D) Check skin turgor for dehydration? (Pinch abdominal skin?)	1	2	8
	E) Check for pallor by looking at palms?	1	2	8
	F) Check for pallor by looking at conjunctiva or mouth?	1	2	8
	G) Weigh the child/ Check weight of child?	1	2	8
	H) IF YES: Plot weight on a growth chart?	1	2	8
104	DOES THE PROVIDER ASK ABOUT OR PERFORM OTHER ASSESSMENTS OF THE CHILD'S HEALTH?	YES	NO	DON'T KNOW
	A) Offer the child something to drink or put the child to the breast? (TO VERIFY IF THE CHILD CAN DRINK OR NOT)	1	2	8
	B) Ask about normal feeding or breastfeeding practices, that is, when the child is not ill?	1	2	8
	C) Ask about feeding or breastfeeding practices for the child during this illness?	1	2	8
	D) Mention the child's weight or growth to the caretaker, or discuss the growth chart with the caretaker?	1	2	8
	E) Look at the immunization card or ask the mother about the child's vaccination history?	1	2	8
	F) Look at the child's health card either before the consultation or while collecting information from the caretaker? (THIS MAY BE THE VACCINATION CARD OR ANOTHER HEALTH CARD)	1	2	8

NO.	QUESTIONS	CODING CLASSIFICATION			
		YES	NO	DON'T KNOW	N A
105	Does the Provider provide any of the following advice when counseling the caretaker?				
	a) Provide general information about feeding or breast-feeding the child even when not sick?	1	2	8	
	b) Give extra fluids to the child during this sickness? (ONLY PRESCRIBING ORS IS NOT SUFFICIENT)	1	2	8	
	c) Continue feeding the child during this sickness?	1	2	8	
	d) Tell the caretaker what illness(es) the child has?	1	2	8	
	e) Describe signs or symptoms in the child for which the caretaker should bring the child back to the facility?	1	2	8	
106	a) Was the child referred to another health worker or for a laboratory test? IF YES	1	2	8	
	G) Did the Health worker explain why the referral was made?	1	2	8	9
107	Were medications prescribed or provided during the consultation? IF YES: DID THE PROVIDER:	1	2 →108	8 →108	
	A) Explain how to administer oral treatment(s)?	1	2	8	9
	B) Give the first dose of the oral treatment?	1	2	8	9
108	Did the Provider use any visual aids when providing health education or counseling the caretaker about the child?	1	2	8	
109	Did the Provider write on the child health card?	YES..... 1 NO..... 2 NO CHILD HEALTH CARD USED 3 DON'T KNOW 8			
110	OUTCOME OF CONSULTATION	CHILD SENT HOME 1 CHILD REFERRED (TO LAB OR OTHER PROVIDER) AT SAME FACILITY 2 CHILD ADMITTED TO SAME FACILITY 3 CHILD REFERRED TO OTHER FACILITY 4 CHILD NOT PRESENT..... 5 DON'T KNOW 8			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
202a	<p>Did the child have any diarrhea or dehydration? IF YES, ASK:</p> <p>What was your diagnosis [classification] for the child with regards to DIARRHOEA?</p> <p>CIRCLE ALL APPLICABLE. IF THE CHILD DID NOT HAVE ANY DIARRHOEA ACCORDING TO THE PROVIDER'S CLASSIFICATION, CIRCLE CODE "Y".</p>	<p>SEVERE PERSISTENT DIARRHEA A PERSISTENT DIARRHEA..... B DYSENTERY C OTHER _____ W (SPECIFY)</p> <p>YES DIARRHOEA, DON'T KNOW HOW TO CLASSIFY X</p> <p>NO DIARRHEA OR DEHYDRATION ... Y DON'T KNOW ABOUT DIARRHEA..... Z</p>	<p>→203</p>
202b	<p>Did the child have any dehydration?</p> <p>How did you (Provider) classify the child with regard to DEHYDRATION?</p> <p>CIRCLE ALL APPLICABLE. IF THE CHILD DID NOT HAVE ANY DEHYDRATION ACCORDING TO THE PROVIDER'S CLASSIFICATION, CIRCLE CODE "Y".</p>	<p>SEVERE DEHYDRATION A SOME DEHYDRATION B</p> <p>OTHER _____ W (SPECIFY)</p> <p>YES DEHYDRATION, DON'T KNOW HOW TO CLASSIFY X</p> <p>NO DEHYDRATION Y</p> <p>DON'T KNOW ABOUT DEHYDRATION..... Z</p>	
202c	<p>What did you (Provider) administer or prescribe for the child's DIARRHOEA/ DEHYDRATION?</p> <p>CIRCLE ALL APPLICABLE.</p>	<p>IMMEDIATE REFERRAL..... A ANTIBIOTIC INJECTION B ANTIBIOTIC TABLETS/SYRUP C</p> <p>PLAN A (ORT HOME) D PLAN B (4 HOURS IN CLINIC) E PLAN C (IV FLUIDS/REFERRAL) F</p> <p>FEEDING/BREAST FEEDING ADVICE..... G</p> <p>OTHER _____ W (SPECIFY)</p> <p>NO TREATMENT OR REFERRAL Y I</p>	<p>→203</p>

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
203a	<p>Did the child have a fever? IF YES, ASK:</p> <p>“What was your diagnosis [classification] for the child with regard to FEVER?</p> <p>CIRCLE ALL APPLICABLE.</p> <p>IF THE CHILD DID NOT HAVE FEVER ACCORDING TO THE PROVIDER’S CLASSIFICATION, CIRCLE CODE “Y”.</p>	<p>VERY SEVERE FEBRILE DISEASEA MALARIAB PROBABLE MALARIA.....C FEVER, MALARIA UNLIKELY.....D FEVER, NO MALARIA.....E</p> <p>SEVERE/COMPLICATED MEASLES ..F MEASLESG OTHER_____W (SPECIFY)</p> <p>YES FEVER BUT DON'T KNOW HOW TO CLASSIFY.....X NO FEVER.....Y DON'T KNOW ABOUT FEVERZ</p>	<p>→204</p>
203b	<p>What did you (Provider) administer or prescribe for the child's FEVER?</p> <p>CIRCLE ALL APPLICABLE.</p>	<p>IMMEDIATE REFERRAL.....A ANTIBIOTIC INJECTIONB ANTIBIOTIC TABLETS/SYRUPC VITAMIN A CAPSULED</p> <p>ANTIMALARIAL INJECTION.....E ANTIMALARIAL TABLETS/SYRUP.....F</p> <p>PARACETAMOL/ASPIRING</p> <p>OTHER INJECTION_____W (SPECIFY)</p> <p>OTHER _____X (SPECIFY)</p> <p>NO TREATMENT OR REFERRAL.....Y DON'T KNOWZ</p>	<p>→204</p>
204	<p>Did you (Provider) give or refer the child for, an immunization?</p>	<p>PROVIDER GAVE1 PROVIDER REFERRED2 NOT DUE FOR IMMUNIZATION.....3 NO IMMUNIZATION ACTIVITY4 NO DID NOT CHECK5</p>	
205	<p>RECORD TIME INTERVIEW WITH PROVIDER ENDED.</p>	<p>HOUR <input type="text"/> <input type="text"/></p> <p>MINUTES <input type="text"/> <input type="text"/></p>	
206	OBSERVER COMMENT		

**MEASURE Service Provision Assessment
Reproductive and Child Health Delivery Service**

EXIT INTERVIEW FOR CARETAKER OF SICK CHILD

FACILITY IDENTIFICATION

Name of the facility _____

Facility Location _____

Region _____

District _____

Type of Health Facility : (11= Teaching hospital; 12 Regional/
District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 =Health
Post; 16 = Private Maternity; 17 = Clinic; 96 = Other
_____)

Operating Authority:

11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim;
31 = PPAG;32 = GRMA; 96 = Other _____)

REGION CODE

DISTRICT CODE

FACILITY CODE

FACILITY TYPE

OPERATING AUTHORITY

INFORMATION ABOUT INTERVIEW

Date: _____

DAY

MONTH

YEAR

Name of the interviewer _____

INTERVIEWER
CODE

Time interview started:

HOUR

MINUTES

Client Code

CLIENT CODE

SEX OF CARETAKER
(1=MALE; 2=FEMALE)

SEX OF
CARETAKER

EXIT INTERVIEW FOR CARETAKER OF SICK CHILD

NO	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CARETAKER AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____. As my colleagues explained, I am working with the Ministry of Health and the Ghana Statistical Service to look at the care for sick children that is provided in Ghana. As another part of this assessment I would like to ask you a few questions about your visit to the facility today. This will help us to better understand the issues discussed and your thoughts about the care provided to [the sick child]. Please tell me if this is ok or not. IF CLIENT GIVES PERMISSION, THEN STATE "If there are any questions you don't want to answer 's please let me know". Can I begin?</p>		
	<p>SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>	<p>YES <input type="checkbox"/> →</p> <p style="text-align: center;">TIME</p> <p style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> AM HOUR MINUTES PM </p> <p>NO <input type="checkbox"/> → REASON</p> <p>.....</p>	
101	What is the name of the sick child?	NAME _____	
102	In what month and year was (NAME) born?	MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW MONTH98 YEAR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DON'T KNOW YEAR.....9998	→102a
102a	How old is {NAME} in [COMPLETED] months?	AGE IN MONTHS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→102a
103	Can you tell me if you brought (NAME) to the facility today because he had any of the following problems either today or at home? A) Cough or difficult breathing? B) Diarrhoea? C) Fever or body hotness?	YES NO COUGH/DIFFICULT BREATHING.....1 2 DIARRHOEA.....1 2 FEVER/BODY HOTNESS1 2	
104	For what other reason(s) or other problems did you bring {NAME} to this health facility today? (CIRCLE ALL ITEMS MENTIONED.) PROBE: Anything else?	EYE PROBLEMS A SORE SKIN B INJURY..... C OTHER_____ D (SPECIFY)	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
105	Has (NAME) been brought to this facility before for this same episode of sickness?	YES 1 NO 2 DON'T KNOW 8	→107 →107
106	If Yes, How long ago was this?	WITHIN THE PAST WEEK..... 1 WITHIN THE PAST MONTH 2 MORE THAN ONE MONTH AGO..... 3 DON'T KNOW 8	
107	How many days ago did the illness for which you brought (NAME) here begin? RECORD 00 IF LESS THAN ONE DAY	DAYS AGO..... <input type="text"/> <input type="text"/> DON'T KNOW 98	
108	Did the Provider tell you what illness (NAME) has?	YES 1 NO 2 DON'T KNOW 8	
109	What will you do if (NAME) does not get completely better or becomes worse?	RETURN TO FACILITY 1 GO TO OTHER FACILITY 2 GO TO OTHER HEALTH WORKER/HEALER/ OR PHARMACY 3 WAIT 4 DON'T KNOW 8	
110	Did the Provider tell you anything about bringing (NAME) back to the health facility?	YES 1 NO 2 CHILD ADMITTED 3 DON'T KNOW 8	→112 →112 →112
111	What did the provider tell you about bringing (NAME) back? IF NECESSARY, PROBE "Were there any signs or symptoms for which you were told to bring (NAME) back? CIRCLE THE SYMPTOM LISTED IF THE CARETAKER INDICATES THAT THE CHILD SHOULD BE BROUGHT BACK IF THE SYMPTOM DOES NOT GO AWAY OR BECOMES WORSE.	FEVER A FAST/DIFF BREATHING B BLOODY DIARRHOEA C VOMITING EVERYTHING D POOR/NOT DRINKING E BECOMES WORSE F COME BACK FOR MORE MEDICATIONS..... G OTHER W OTHER X DON'T KNOW Z	
112	Did the Provider give or prescribe any medicines for (NAME)?	YES,GAVE MEDS 1 YES, GAVE PRESCRIPTION .. 2 GAVE MEDS AND PRESCRIPTION..... 3 NO 4	→117

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO															
113	ASK TO SEE ALL MEDICATIONS WHICH WERE RECEIVED AND ANY PRESCRIPTIONS WHICH HAVE NOT YET BEEN SUPPLIED. CIRCLE THE RESPONSE DESCRIBING THE MEDICATIONS/PRESCRIPTIONS SEEN.	HAS ALL MEDS 1 HAS SOME MEDS, SOME SUPPLIED PRESCRIPTIONS . 2 NO MEDICATIONS SEEN, HAS PRESCRIPTIONS ONLY 3																
114	Did a Provider at the facility explain to you how to give those medicines to (NAME) at home?	YES 1 NO2 DON'T KNOW8																
115a	Now I would like you to explain to me how you will give these medicines to (NAME). Do you feel comfortable that you know how much of each medication to give (NAME)?	YES1 NO2 NOT SURE8	→116 →116															
115b	ASK THE CARETAKER ABOUT EACH MEDICINE THAT WAS PRESCRIBED OR RECEIVED: How many spoonful of _____ will you give this child for a day and for how many days?																	
	(i) CHLOROQUINE	Teaspoonful/5ml Tablespoonful/15 ml Tablets Others	<table border="1"> <thead> <tr> <th>Dosage each time</th> <th>No. of Times each day</th> <th>No. of DAYS</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </tbody> </table>	Dosage each time	No. of Times each day	No. of DAYS												
Dosage each time	No. of Times each day	No. of DAYS																
	(ii) PARACETAMOL	Teaspoonful/5ml Tablespoonful/15ml Tablets Others	<table border="1"> <thead> <tr> <th>Dosage each time</th> <th>No. of Times each day</th> <th>No. of DAYS</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </tbody> </table>	Dosage each time	No. of Times each day	No. of DAYS												
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	(iii) SEPTRIN	Teaspoonful/5ml Tablespoonful/15ml Tablets Others	<table border="1"> <thead> <tr> <th>Dosage each time</th> <th>No. of Times each day</th> <th>No. of DAYS</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </tbody> </table>	Dosage each time	No. of Times each day	No. of DAYS												
Dosage each time	No. of Times each day	No. of DAYS																

	(iv) AMOXICILLIN		Dosage each time	No. of Times each day	No. of DAYS
		Teaspoonful/5ml	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Tablespoonful/15ml	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Tablets	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>	<input type="text"/>

	(v) OTHER MEDICINES	NAME	DOSAGE EACH TIME	NO. TIMES EACH DAY	NO. DAYS
		_____	_____	_____	_____
		_____	_____	_____	_____
		_____	_____	_____	_____
		_____	_____	_____	_____

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
116	Was (NAME) given a dose of any of these medications here at the facility already?	YES 1 NO2 DON'T KNOW8	
117	Now I want to ask you some questions about (NAME). When (NAME) is not sick, what types of food or fluid does s/he normally take?	ONLY BREASTMILK1 BREASTMILK AND LIQUIDS...2 BREASTMILK AND OTHER FOODS AND LIQUIDS.....3 NO BREASTMILK4 DON'T KNOW8	
118	Did a Provider ask you about the types of foods and amounts that you normally feed (NAME) when not sick?	YES 1 NO2 DON'T KNOW8	
119	Did anyone at the health facility weigh (NAME) today?	YES 1 NO2 DON'T KNOW8	
120	Did any Provider talk to you about (NAME'S) weight and how s/he is growing?	YES1 NO2 DON'T KNOW8	
121	Since becoming ill, has the way that (NAME) eats/drinks changed from normal? IF YES, CLARIFY IF THE CHILD IS TAKING MORE OR LESS THAN NORMAL	MORE THAN NORMAL.....1 SAME AS NORMAL2 LESS THAN NORMAL3 NOT EATING/DRINKING4 DON'T KNOW8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
122	What did the Provider tell you about feeding (NAME) during this illness?	GIVE LESS THAN USUAL 1 GIVE SAME AS USUAL2 GIVE MORE THAN USUAL3 GIVE NOTHING/NOT FEED ...4 DIDN'T DISCUSS6 DON'T KNOW8	
123	What did the Provider tell you about giving fluids (or breast milk, if breast fed) to (NAME) during this illness?	GIVE LESS THAN USUAL 1 GIVE SAME AS USUAL2 GIVE MORE THAN USUAL3 GIVE NOTHING/NOT FEED ...4 DIDN'T DISCUSS6 DON'T KNOW8	
124	INTERVIEWER: CHECK 102A. CHILD <input type="checkbox"/> LESS THAN 24 MONTHS OLD ↓	CHILD <input type="checkbox"/> → →	→201
125	Was (NAME) given a vaccination today?	YES 1 NO2 DON'T KNOW8	
126	Do you have (NAME)'S vaccination card with you?	YES 1 NO2	→201
127	INTERVIEWER: POLITELY ASK TO SEE THE CHILD'S VACCINATION CARD. INDICATE WHETHER THE RECORD SHOWS THAT THE CHILD HAS BEEN VACCINATED TODAY.	YES 1 NO2	

INTERVIEWER: CHECK THE HEALTH CARD AND RECORD IN COLUMN 1 WHETHER THE CHILD HAS EVER RECEIVED ANY OF THE FOLLOWING VACCINATION. ALSO CHECK THE DATE THAT EACH VACCINATIONS WAS GIVEN AND RECORD THE DATE IN COLUMN 2. IF NO DATE IS RECORDED ON THE CARD, ENTER "66" FOR THE DAY AND MONTH AND "6666" FOR THE YEAR.

	CHILD EVER RECEIVED VACCINATION	DATE			
		DAY	MONTH	YEAR	
POLIO-0	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
BCG	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
POLIO-1	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
POLIO-2	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
POLIO-3	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT-1	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT-2	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT-3	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT/HEPB/ HIB-1	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT/HEPB/ HIB-2	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
DPT/HEPB/ HIB-3	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
MEASLES	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
YELLOW FEVER	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	
OTHER	YES..... 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	NO/NO RECORD 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Section 2. Caretaker Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the child health services.		
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw (NAME) for the consultation?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY 000 DON'T KNOW 998	
	Now I am going to ask about some issues that some clients say are problems with different health facilities. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems.		
202	Were any of the following big problems? Small problems? Or not problems at all?	BIG SMALL NO DK	
	A) Time you waited?	WAIT 1 2 3 8	
	B) Ability to discuss problems or concerns about your child's health with the health worker?	DISCUSS PROBLEMS 1 2 3 8	
	C) Amount of explanation about the problem or treatment?	EXPLAIN PROBLEM/TX .. 1 2 3 8	
	D) Quality of the examination and treatment provided?	QUALITY EXAM/ TREATMENT ... 1 2 3 8	
	E) Privacy from others seeing exam?	VISUAL PRIVACY 1 2 3 8	
	F) Privacy from others hearing discussion?	AUDITORY PRIVACY 1 2 3 8	
	G) Availability of medicines at the facility?	AVAILABLE MEDICINES 1 2 3 8	
	H) The hours services are provided?	HOURS SERVICE 1 2 3 8	
	I) Cleanliness of facility?	FACILITY CLEANLINESS 1 2 3 8	
	J) How staff treated you?	HOW TREATED1 2 3 8	
	K) Any problem today which I did not mention?	_____1 2 3 8 (SPECIFY)	

203	Are you a part of any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility?	YES..... 1 NO2 DON'T KNOW.....8	
204	What is the total amount which you paid for all services for [child] today? Laboratory Test Medicines/method Consultation/Others	TOTAL AMOUNTS FOR: LAB <input type="text"/> <input type="text"/> MEDI- CINES <input type="text"/> <input type="text"/> OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TOTAL <input type="text"/> <input type="text"/> AMOUNT PAID NO MONEY 0000000 DON'T KNOW 9999998	
205	Have you ever visited this facility before?(either as a patient or visiting or accompanying a patient?)	YES 1 NO 2	
Section 3. Personal Characteristics of Caretaker			
301	What is your relationship to {NAME}?	MOTHER 1 FATHER 2 SIBLING 3 GRANDPARENT 4 AUNT/UNCLE 5 OTHER: 6 (SPECIFY)	
302	How old were you at your last birthday?	AGE IN YEARS ... <input type="text"/> <input type="text"/> DON'T KNOW 98	
303	Have you ever attended school?	YES 1 NO 2	→ 306
304	What is the highest level of school you attended?	PRIMARY 1 MIDDLE/JSS 2 SECONDARY/SSS 3 VOC/TECH/COMMERCIAL 4 POST SECONDARY 5 TERTIARY 6	
305	What is the highest grade (NAME) completed at that level? PLEASE RECORD ACTUAL GRADE IF 0-8; IF 9 OR MORE CODE 9	GRADE <input type="text"/> <input type="text"/>	
306	TIME INTERVIEW ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	

307	INTERVIEWER COMMENTS
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MEASURE Service Provision Assessment Reproductive and Child Health Service Delivery

Family Planning Client Observation	
FACILITY IDENTIFICATION	
<p>Name of the facility _____</p> <p>Facility Location _____</p> <p>Region _____</p> <p>District _____</p> <p>Type of Health Facility : (11 = Teaching hospital; 12 = Regional/ District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 = Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____)</p> <p>Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____)</p>	<p>REGION CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>DISTRICT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>FACILITY TYPE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>OPERATING AUTHORITY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>
Provider Information	
<p>Provider category: (1 = Medical Doctor; 2 =Medical Assistant; 3=Public Health Nurse; 4=Professional Nurse; 5=Professional Midwife; 6= Midwife Assistant; 7=Auxiliary nurse; 8=Pharmacist; 9=Dispensing Technician; 10=Laboratory Technician; 11=Nutrician Technican Officer; 96=other _____)</p> <p>Sex of Provider: (1=female; 2=male)</p> <p>Provider Code(Same as given in HW interview)</p>	<p>PROVIDER CATEGORY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>SEX OF PROVIDER <input style="width: 20px; height: 20px;" type="text"/></p> <p>PROVIDER CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>
<p>Date: _____</p> <p>Name of the interviewer _____</p> <p>Time observation started:</p> <p>Family Planning Client Code</p>	<p>DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>INTERVIEWER CODE.. <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>MINUTES <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>FP CLIENT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>

1. Client Counselling

NO.	QUESTIONS	CODING CLASSIFICATION		
	OBSERVER: PLEASE COMPLETE THE FOLLOWING ITEMS FOR ALL CLIENTS.			
101	INDICATE WHETHER THE CLIENT HAD ANY PREVIOUS CONTACT WITH A PROVIDER AT THIS FAMILY PLANNING CLINIC.	YES	1	
		NO	2	
		NOT DETERMINED	8	
	CLIENT INFORMATION AND HISTORY: INDICATE BELOW WHETHER THE PROVIDER ASKED ABOUT /CLIENT OFFERED INFORMATION FOR EACH OF THE FOLLOWING ITEMS:			
102	REPRODUCTIVE HISTORY	YES	NO	DON'T KNOW
	a) AGE of client?	1	2	8
	b) Number of LIVING CHILDREN?	1	2	8
	c) LAST DELIVERY DATE/Age of youngest child?	1	2	8
	d) HISTORY OF COMPLICATIONS with pregnancy?	1	2	8
	e) CURRENT PREGNANCY STATUS?	1	2	8
	f) DESIRE for more CHILDREN?	1	2	8
	g) Desired TIMING for birth of NEXT CHILD?	1	2	8
	h) Breast feeding status?	1	2	8
	i) Regularity of menstrual cycle?	1	2	8
103	HEALTH/PHYSICAL EXAM	YES	NO	DK
	a) Take Blood pressure?	1	2	8
	b) Take weight?	1	2	8
	c) Ask about smoking?	1	2	8
	d) Ask about symptoms of STIs (e.g. abnormal discharge)?	1	2	8
	e) Ask about any chronic illnesses (heart disease, diabetes, hypertension, liver /jaundice problem; breast cancer)?	1	2	8
104	DID THE PROVIDER :	YES	NO	DK
	a) Ensure VISUAL PRIVACY?	1	2	8
	b) Ensure AUDITORY PRIVACY?	1	2	8
	c) Assure CLIENT of CONFIDENTIALITY?	1	2	8
	d) Ask about questions or CONCERNS WITH METHODS discussed or with currently used method?	1	2	8
	DISCUSS ISSUES RELATED TO SEXUAL PARTNERS AND METHOD CHOICE:	YES	NO	DK
	e) PARTNER attitude toward family planning ?	1	2	8
	f) PARTNER STATUS: (Number of partners for client or client's partner; Partner absence)?	1	2	8
	g) Discuss RISK OF STIS?	1	2	8
	h) Discuss use of CONDOMS TO PREVENT STIs?	1	2	8
	i) Discuss using CONDOMS AS DUAL METHOD for preventing STIs and pregnancy?	1	2	8

105	INDICATE WHICH METHOD(S) WERE PRESCRIBED ON THIS VISIT. IF CONDOM WAS PRESCRIBED WITH ANOTHER METHOD, CIRCLE BOTH METHODS.		ORAL PILL A CONDOM B IUD C SPERMICIDE D DIAPHRAGM..... E INJECTABLE F NORPLANT IMPLANT G NATURAL METHODS (RHYTHM)..... H BREASTFEEDING/LAM..... I VASECTOMY J FEMALE STERILIZATION K EMERGENCY CONTRACEPTION L OTHER..... W NO METHOD..... Y		
FOR THE METHOD(S) IN QUESTION 105 INDICATE IF THE RELEVANT INFORMATION WAS ASSESSED/DISCUSSED. COMPLETE ONLY FOR METHODS CIRCLED IN 105					
106	METHOD	INFORMATION	YES	NO	DK
	PILLS INJECTIONS	a) When to take (PILL DAILY; INJECTION EITHER EVERY 1 OR 3 MONTHS;	1	2	8
		b) Changes which may occur with menstruation (decrease; spotting)	1	2	8
		c) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1	2	8
		d) What to do if forget pill/do not get injection on time.	1	2	8
	NORPLANT	e) Good for 5 years	1	2	8
		f) Changes which may occur with menstruation (decrease; spotting)	1	2	8
		g) Initial side-effects which may occur (nausea; weight gain, breast tenderness)	1	2	8
	EMERGENCY CONTRACEPTION	h) If vomit within 2 hours need another dose	1	2	8
		i) If next period unusually light or not within 4 weeks, return for pregnancy check	1	2	8
	IUD	j) Check string	1	2	8
		k) May have HEAVY BLEEDING/SPOTTING	1	2	8
	STERILIZATION	l) Permanent: -will not impregnate/become pregnant again	1	2	8
		m) May be slight discomfort at incision site	1	2	8
		n) Male must use condom/other method first 20 ejaculations/ 3 months	1	2	8
	CONDOMS	o) Any allergy to latex?	1	2	8
		p) Use only one time	1	2	8
		q) Can use lubricant (male-water soluble only; female any lubricant)	1	2	8
		r) Use as back-up if you fear other method failure	1	2	8
		s) Dual Protection	1	2	8

	METHOD	INFORMATION	YES	NO	DK	
	SPERMICIDE	s) May cause irritation	1	2	8	
		t) Insert before each occurrence of intercourse	1	2	8	
	RHYTHM/ PERIODIC ABSTINENCE	u) How to identify fertile period	1	2	8	
		v) Should not have intercourse during fertile period without alternate method (condom/spermicide)	1	2	8	
	LACTATIONAL AMMENORRHEA	w) Slight risk of pregnancy at time shortly before restarting menstruation	1	2	8	
		x) Most effective with exclusive breast-feeding	1	2	8	
		y) Not effective after menstruation begins again	1	2	8	
		z) Not effective after baby is 6months	1	2	8	
107	Did the provider refer to/look at the individual client record either prior to or during the consultation?	YES 1 NO 2 DON'T KNOW 8				
108	Were any visual aids or models used for health education or counseling about different methods?	YES 1 NO 2 DON'T KNOW 8				
109	DID THE PROVIDER DISCUSS A RETURN VISIT?	YES 1 NO 2 DON'T KNOW 8				

PELVIC EXAM

206	DID THE PROVIDER:		YES	NO	N A
	1) ENSURE CLIENT HAS VISUAL PRIVACY?	VISUAL PRIVACY	1	2	
	2) ENSURE CLIENT HAS AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2	
	3) EXPLAIN PROCEDURE PRIOR TO BEGINNING PROCEDURE>	EXPLAIN PROCEDURE	1	2	
	4) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS.....	1	2	
	5) WASH HIS/HER HANDS BEFORE THE EXAM USING SOAP?	WASHED HANDS	1	2	
	5a) USE SINGLE-USE TOWEL FOR HANDWASHING/DRYING?	SINGLE USE TOWEL	1	2	
	5) USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ?	DISINFECTED INSTRUMENTS.....	1	2	
	6) PUT ON NEW OR HIGH LEVEL DISINFECTED GLOVES <u>BEFORE</u> EXAM?	PUT ON GLOVES.....	1	2	
	7) ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES?	ASK CLIENT TO RELAX MUSCLES.....	1	2	
	8) INSPECT THE EXTERNAL GENITALIA?	INSPECT GENITALIA	1	2	
	9) (IF USED) EXPLAIN SPECULUM PROCEDURE?	EXPLAIN SPECULUM.....	1	2	8
	10) INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM)	INSPECT CERVIX.....	1	2	
	11) PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM	1	2	
	12) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER.....	1	2	
	13) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA	1	2	
	14) PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE BLEACH SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE GLOVES/INSTRUMENTS ...	1	2	

→301

IUD INSERTION AND REMOVAL

207a	INDICATE PROCEDURE CONDUCTED	IUD INSERTION 1 IUD REMOVAL 2			
207b	DID THE PROVIDER:		YES	NO	N A
1)	ENSURE CLIENT HAD VISUAL PRIVACY?	VISUAL PRIVACY	1	2	
2)	ENSURE CLIENT HAD AUDITORY PRIVACY	AUDITORY PRIVACY	1	2	
3)	(NEW CLIENT) RECONFIRM THE METHOD CHOICE?	RECONFIRM CHOICE	1	2	8
4)	EXPLAIN PROCEDURE PRIOR TO BEGINNING	EXPLAIN PROCEDURE	1	2	
5)	USE STERILIZED/HIGH-LEVEL DISINFECTED INSTRUMENTS?	STERILE INSTRUMENTS...	1	2	
6)	WASH HANDS WITH SOAP <u>BEFORE</u> PUTTING ON GLOVES?	WASH HANDS BEFORE.....	1	2	
6a)	USE SINGLE-USE TOWEL FOR HANDWASHING/DRYING?	SINGLE USE TOWEL	1	2	
7)	GLOVE HANDS (STERILE GLOVES)?	GLOVE HANDS.....	1	2	
8)	SPECULUM EXAM FOR RTI/STIS <u>BEFORE</u> BIMANUAL EXAM?	SPECULUM EXAM.....	1	2	8
9)	CONDUCT BIMANUAL PELVIC EXAM? (ONE HAND INSIDE VAGINA OTHER PALPATE UTERUS THROUGH ABDOMEN)	BIMANUAL EXAM	1	2	8
10)	VISUALIZE CERVIX DURING CLEANING? (SHINE LIGHT IN INSERTED SPECULUM)	VISUALIZE CERVIX.....	1	2	
11)	USE TENACULUM?	USE TENACULUM.....	1	2	8
12)	SOUND THE UTERUS <u>BEFORE</u> IUD INSERTION?	SOUND UTERUS	1	2	8
13)	USE THE NO-TOUCH TECHNIQUE FOR INSERTING THE IUD?	NO-TOUCH TECHNIQUE.....	1	2	8
14)	WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER.....	1	2	
15)	ASK CLIENT TO WAIT/REST FOR 15 MINUTES AFTER INSERTION?	ASK CLIENT TO WAIT	1	2	
16)	WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA	1	2	
17)	PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE/ BLEACH SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE INSTRUMENTS/GLOVES ...	1	2	

→ 301

INJECTABLE

208	WHEN GIVING THE INJECTABLE , DID THE PROVIDER::		YES	NO	N A
1)	(NEW CLIENT) RECONFIRM METHOD CHOICE?	RECONFIRM CHOICE	1	2	8
2)	(NEW CLIENT) VERIFY CLIENT NOT PREGNANT?	NOT PREGNANT	1	2	8
3)	(CONTINUING CLIENT) CHECK CLIENT CARD TO ENSURE GIVING INJECTION AT CORRECT TIME?	CORRECT TIME	1	2	8
4)	WASH HANDS WITH SOAP <u>BEFORE</u> INJECTION?	WASH HANDS	1	2	
4a)	USE SINGLE-USE TOWEL FOR HANDWASHING/DRYING?	SINGLE USE TOWEL	1	2	
5)	(IF REUSABLE) USE NEWLY STERILIZED NEEDLE AND SYRINGE?	STERILE SYRINGE AND NEEDLE	1	2	8
6)	REMOVE NEEDLE FROM MULTIPLE DOSE VIAL EACH TIME	REMOVE NEEDLE	1	2	8
7)	STIR/MIX BOTTLE <u>BEFORE</u> DRAWING DOSE? (DEPO)	STIR BOTTLE.....	1	2	8
8)	CLEAN AND AIR-DRY INJECTION SITE <u>BEFORE</u> INJECTION?	CLEAN AND AIR DRY SITE	1	2	
9)	DRAW BACK PLUNGER <u>BEFORE</u> INJECTION?	DRAW BACK PLUNGER.....	1	2	
10)	ALLOW DOSE TO SELF-DISPERSE INSTEAD OF MASSAGING?	NO MASSAGE	1	2	
11)	DISPOSE OF SHARPS IN PUNCTURE RESISTANT CONTAINERS?	DISPOSE OF SHARPS	1	2	8

→301

NORPLANT

209	When inserting the Norplant, did the provider		YES	NO
	1) VERIFY CLIENT NOT PREGNANT	NOT PREGNANT		
	2) ENSURE CLIENT HAS VISUAL PRIVACY?	VISUAL PRIVACY	1	2
	3) ENSURE CLIENT HAS AUDITORY PRIVACY?	AUDITORY PRIVACY	1	2
	4) EXPLAIN PROCEDURE PRIOR TO BEGINNING	EXPLAIN PROCEDURE	1	2
	5) PREPARE ALL INSTRUMENTS <u>BEFORE</u> EXAM?	PREPARED INSTRUMENTS.....	1	2
	6) USE STERILIZED INSTRUMENTS ?	STERILIZED INSTRUMENTS	1	2
	7) WASH HIS/HER HANDS WITH SOAP BEFORE THE EXAM?	WASHED HANDS	1	2
	7a) USE SINGLE-USE TOWEL FOR HANDWASHING/DRYING?	SINGLE USE TOWEL	1	2
	8) PUT ON STERILE GLOVES AND MAINTAIN STERILITY DURING INSERTION	GLOVES AND STERILITY	1	2
	9) CLEAN SKIN WHERE INCISION WILL BE MADE WITH ANTISEPTIC	ANTISEPTIC	1	2
	10) ALLOW TIME FOR LOCAL ANESTHETIC TO TAKE EFFECT PRIOR TO MAKING INCISION	TIME FOR ANESTHETIC TO WORK	1	2
	11) PROVIDE WOMAN WITH CARD STATING THE DATE NORPLANT WAS INSERTED AND THE DATE WHEN 5 YEARS OF IMPLANT IS COMPLETED	PROVIDE CARD	1	2
	12) EXPLAIN CARE OF INCISION AREA INCLUDING WHEN PLASTER CAN BE REMOVED	EXPLAIN INCISION CARE	1	2
	13) DISCUSS RETURN VISIT TO REMOVE PLASTER	RETURN VISIT	1	2
	14) DISPOSE OF SHARPS IN PUNCTURE RESISTANT CONTAINERS?	DISPOSE OF SHARPS	1	2
	15) WASH HANDS <u>AFTER</u> REMOVING GLOVES?	WASH HANDS AFTER	1	2
	16) WIPE CONTAMINATED SURFACES WITH DISINFECTANT?	DISINFECT AREA.....	1	2
	17) PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE/BLEACH SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE?	DECONTAMINATE	1	2

→301

3. Client's Family Planning Status

NO	QUESTIONS	CODING CLASSIFICATION
301	INDICATE CLIENT'S FAMILY PLANNING STATUS AT THE BEGINNING OF THE CONSULTATION.	CURRENT USER 1 NONUSER, USED IN PAST 2 →304 NONUSER, NO PAST USE 3 →306 NOT DETERMINED..... 8 →306
302	INDICATE PRINCIPAL REASON FOR VISIT.	RESUPPLY/ROUTINE FOLLOWUP1 DISCUSS PROBLEM WITH METHOD 2
303	INDICATE OUTCOME OF VISIT.	CONTINUED WITH CURRENT METHOD..... 1 →307 SWITCHED METHOD 2 →307 DECIDED TO STOP USING FAMILY PLANNING..... 3 →307
304	INDICATE OUTCOME OF VISIT.	RESTARTED PRIOR METHOD 1 ADOPTED DIFFERENT METHOD . 2 →307 RECEIVED INFORMATION/ COUNSELING ONLY 3 →307 NOT DETERMINED..... 8 →307
305	INDICATE TIMING OF CLIENT'S MOST RECENT USE OF CONTRACEPTION.	WITHIN PAST 6 MONTHS 1 →307 SIX MONTHS OR MORE AGO 2 →307 NOT DETERMINED..... 8 →307
306	INDICATE OUTCOME OF VISIT.	RECEIVED/PREScribed METHOD..... 1 DID NOT RECEIVE METHOD..... 2
307	DID THE PROVIDER WRITE IN AN INDIVIDUAL CLIENT RECORD OR CARD AFTER THE CONSULTATION?	YES.....1 NO.....2 DON'T KNOW8
308	TIME OBSERVATION ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>
309	Observer Comment:	

**MEASURE Service Provision Assessment
Reproductive and Child Health Service Delivery**

Family Planning Exit Interview

FACILITY IDENTIFICATION

Name of the facility _____

Facility Location _____

Region _____

District _____

Type of Health Facility: (11 = Teaching hospital; 12 = Regional/
District Hospital; 13 Polyclinic; 14 = Health Centre; 15 = Health
Post; 16 = Private Maternity; 17 = Clinic; 96 = Other
_____)

Operating Authority:
11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim;
31 = PPAG; 32 = GRMA; 96 = Other _____)

REGION CODE

DISTRICT CODE

FACILITY CODE

FACILITY TYPE

OPERATING AUTHORITY

INFORMATION ABOUT INTERVIEW

Date: _____

DAY

MONTH

YEAR

Name of the interviewer _____

INTERVIEWER CODE..

Time interview started:

HOUR.....

MINUTES.....

FP CLIENT CODE.....

FP Client Code

CODE.....

Exit Interview for Family Planning Clients

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____. As my colleagues explained, I am working with the Ministry of Health and the Ghana Statistical Service to look at the family planning services that are provided in Ghana. As another part of this assessment I would like to ask you a few questions about your visit to the facility today. This will help us to better understand the issues discussed and your thoughts about the services. Please tell me if this is ok or not. IF CLIENT GIVES PERMISSION, THEN STATE "If there are any questions you don't want to answer 's please let me know". Can I begin?</p>	<p style="text-align: center;">TIME</p> <p>YES <input type="checkbox"/> → <input type="text"/> <input type="text"/> AM HOUR MINUTES PM</p> <p>NO <input type="checkbox"/> → REASON</p> <p>.....</p>	
	<p>SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>		
101	<p>Were you doing anything to prevent pregnancy when you came today?</p>	<p>YES 1 NO 2</p>	<p>→ 103</p>
102	<p>Have you used a family planning method or taken any steps to prevent pregnancy at any time in the past six months?</p>	<p>YES 1 NO 2</p>	<p>→ 109</p>
103	<p>What method(s) were you using until today's visit?</p> <p>IF CONDOM AND ANOTHER METHOD CIRCLE BOTH.</p>	<p>COMBINED PILL A PROGESTIN-ONLY PILL..... B PILL (TYPE UNSPECIFIED).... C MALE CONDOM D FEMALE CONDOM..... E IUD F SPERMICIDE G DIAPHRAGM H INJECTABLE DEPO I INJECTABLE NORIGYNON J NORPLANT IMPLANT K NATURAL METHODS (RHYTHM) L BREASTFEEDING/LAM..... M VASECTOMY N FEMALE STERILIZATION O EMERGENCY CONTRACEPTION P OTHER _____ W</p>	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
104	Did the Provider ask if you were having (had had) a problem with the method?	YES 1 NO 2 DON'T KNOW 8	
105	Have you been having (did you have) a problem with the method?	YES 1 NO 2 DON'T KNOW 8	→107 →107
106	Did the Provider suggest what action(s) you should take to resolve the problem?	YES 1 NO 2 DON'T KNOW 8	
107	What was the outcome of this visit, i.e., did you decide to continue (restart) the same method or to switch methods?	CONTINUE WITH/RESTART SAME METHOD..... 1 SWITCH METHOD..... 2 STOP/NOT RESTART USING . 3	
108	Had you thought about switching methods, and which method to switch to before you came today?	YES 1 NO 2	→110 →112
109	Had you thought about what method you wanted to use to before you came today?	YES 1 NO 2	→112
110	What method was that? IF CONDOM AND OTHER METHOD, CIRCLE BOTH.	COMBINED PILL..... A PROGESTIN-ONLY PILL..... B PILL (TYPE UNSPECIFIED) C MALE CONDOM D FEMALE CONDOM..... E IUD F SPERMICIDE G DIAPHRAGM..... H INJECTABLE DEPO I INJECTABLE NORIGYNON J NORPLANT IMPLANT K NATURAL METHODS (RHYTHM)..... L BREASTFEEDING/LAM..... M VASECTOMY N FEMALE STERILIZATION O EMERGENCY CONTRACEPTION P OTHER _____ __W	
111	Did the Provider talk about the method(s) IN 110?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																												
112	<p>What (other) methods did the Provider talk with you about?</p> <p>CIRCLE ALL METHODS MENTIONED</p>	COMBINED PILL.....A PROGESTIN-ONLY PILL.....B PILL (TYPE UNSPECIFIED)....C MALE CONDOMD FEMALE CONDOM.....E IUD.....F SPERMICIDE.....G DIAPHRAGM.....H INJECTABLE DEPOI INJECTABLE NORIGYNONJ NORPLANT IMPLANTK NATURAL METHODS (RHYTHM).....L BREASTFEEDING/LAM.....M VASECTOMYN FEMALE STERILIZATIONO EMERGENCY CONTRACEPTIONP OTHER..... _____W																																																													
113	<p>What method did you receive or were you given a prescription or referral for?</p> <p>CIRCLE ALL METHODS CLIENT HAS RECEIVED (REC) OR HAS PRESCRIPTION OR REFERRAL (PRES) FOR. IF THE CLIENT IS CONTINUING WITH PRIOR METHOD AND DID NOT RECEIVE ANY METHOD, PRESCRIPTION OR REFERRAL THIS VISIT, CIRCLE "X".</p>	<table border="0"> <tr> <td></td> <td style="text-align: right;">REC</td> <td style="text-align: right;">PRES</td> </tr> <tr> <td>COMBINED PILL.....</td> <td style="text-align: right;">A</td> <td style="text-align: right;">A</td> </tr> <tr> <td>PROGESTIN-ONLY PILL.....</td> <td style="text-align: right;">B</td> <td style="text-align: right;">B</td> </tr> <tr> <td>PILL (TYPE UNSPECIFIED)....</td> <td style="text-align: right;">C</td> <td style="text-align: right;">C</td> </tr> <tr> <td>MALE CONDOM</td> <td style="text-align: right;">D</td> <td style="text-align: right;">D</td> </tr> <tr> <td>FEMALE CONDOM.....</td> <td style="text-align: right;">E</td> <td style="text-align: right;">E</td> </tr> <tr> <td>IUD.....</td> <td style="text-align: right;">F</td> <td style="text-align: right;">F</td> </tr> <tr> <td>SPERMICIDE.....</td> <td style="text-align: right;">G</td> <td style="text-align: right;">G</td> </tr> <tr> <td>DIAPHRAGM.....</td> <td style="text-align: right;">H</td> <td style="text-align: right;">H</td> </tr> <tr> <td>INJECTABLE DEPO</td> <td style="text-align: right;">I</td> <td style="text-align: right;">I</td> </tr> <tr> <td>INJECTABLE NORIGYNON</td> <td style="text-align: right;">J</td> <td style="text-align: right;">J</td> </tr> <tr> <td>NORPLANT IMPLANT</td> <td style="text-align: right;">K</td> <td style="text-align: right;">K</td> </tr> <tr> <td>NATURAL METHODS (RHYTHM)</td> <td style="text-align: right;">L</td> <td style="text-align: right;">L</td> </tr> <tr> <td>BREASTFEEDING/LAM.....</td> <td style="text-align: right;">M</td> <td style="text-align: right;">M</td> </tr> <tr> <td>VASECTOMY</td> <td style="text-align: right;">N</td> <td style="text-align: right;">N</td> </tr> <tr> <td>FEMALE STERILIZATION</td> <td style="text-align: right;">O</td> <td style="text-align: right;">O</td> </tr> <tr> <td>EMERGENCY CONTRACEPTION</td> <td style="text-align: right;">P</td> <td style="text-align: right;">P</td> </tr> <tr> <td>NO METHOD REC OR PREC, CONTINUING W/ METHOD IN QUESTION 103.....</td> <td style="text-align: right;">X</td> <td style="text-align: right;">X</td> </tr> <tr> <td>OTHER.....</td> <td style="text-align: right;">W</td> <td style="text-align: right;">W</td> </tr> <tr> <td colspan="3" style="text-align: center;">(SPECIFY)</td> </tr> </table>		REC	PRES	COMBINED PILL.....	A	A	PROGESTIN-ONLY PILL.....	B	B	PILL (TYPE UNSPECIFIED)....	C	C	MALE CONDOM	D	D	FEMALE CONDOM.....	E	E	IUD.....	F	F	SPERMICIDE.....	G	G	DIAPHRAGM.....	H	H	INJECTABLE DEPO	I	I	INJECTABLE NORIGYNON	J	J	NORPLANT IMPLANT	K	K	NATURAL METHODS (RHYTHM)	L	L	BREASTFEEDING/LAM.....	M	M	VASECTOMY	N	N	FEMALE STERILIZATION	O	O	EMERGENCY CONTRACEPTION	P	P	NO METHOD REC OR PREC, CONTINUING W/ METHOD IN QUESTION 103.....	X	X	OTHER.....	W	W	(SPECIFY)			
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OTHER.....	W	W																																																													
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NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																				
114	Does your method provide any protection against STIs and AIDS?	YES 1 NO 2 DON'T KNOW 8																					
115	During your consultation, did the provider: A) Explain how to use the method? B) Talk about possible side effects? C) Tell you what to do if you have any problems? D) Tell you when to return for follow-up?	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td>DK</td> </tr> <tr> <td>HOW TO USE</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>TALK ABOUT SIDE EFFECTS</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>TELL WHAT TO DO ABOUT PROBLEMS</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>TELL WHEN TO RETURN</td> <td>1</td> <td>2</td> <td>8</td> </tr> </table>		YES	NO	DK	HOW TO USE	1	2	8	TALK ABOUT SIDE EFFECTS	1	2	8	TELL WHAT TO DO ABOUT PROBLEMS	1	2	8	TELL WHEN TO RETURN	1	2	8	
	YES	NO	DK																				
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TELL WHAT TO DO ABOUT PROBLEMS	1	2	8																				
TELL WHEN TO RETURN	1	2	8																				
116	MARK BELOW THE METHOD THAT IS CIRCLED IN 113. AFTER ASKING THE CLIENT THE RELEVANT QUESTION																						
	A. Pill	How often do you take the pill?	TAKE A PILL ONCE A DAY ... 1 OTHER 2 DON'T KNOW 8																				
	B. IUD	What should you do to make sure that your IUD is in place?	CHECK STRINGS 1 OTHER 2 DON'T KNOW 8																				
	C. Injectable (e.g., Depo Provera)	How long does the Depo Provera injection provide protection against pregnancy?	3 MONTHS 1 OTHER 2 DON'T KNOW 8																				
	D. Injectable (Norigynon)	How long does the Norigynon injection provide protection against pregnancy?	1 MONTHS 1 OTHER 2 DON'T KNOW 8																				
	E. NORPLANT	How long does NORPLANT provide protection against pregnancy?	5 YEARS 1 OTHER 2 DON'T KNOW 8																				
	F. Female Sterilization	Once you have been sterilized, could you ever become pregnant again?	NO 1 OTHER 2 DON'T KNOW 8																				
	G. Male Sterilization	Once you have been sterilized, (and after the first three months), can you make a woman pregnant again?	NO 1 OTHER 2 DON'T KNOW 8																				
	H Condom (both male and female)	How many times can you use a condom?	ONCE PER ROUND 1 OTHER 2 DON'T KNOW 8																				

	I. Condom (female)	What type of lubricant can you use with the female condom?	ANY OIL OR LUBRICANT..... 1 OTHER 2 DON'T KNOW 8	
	J. Spermicide	Approximately how long before intercourse should you insert the vaginal tablet?	BETWEEN 15 MINUTES AND 1 HOUR 1 OTHER 2 DON'T KNOW 8	
	K. Periodic Abstinence/Rhythm	How do you recognize the days on which you should <u>not</u> have sexual intercourse?	BODY TEMPERATURE RISES1 MUCUS IN VAGINA 2 DAYS 12-16 OF THE MENSTRUAL CYCLE 3 OTHER 4 DON'T KNOW 8	
	L. LAM	Can you use this method if your menstrual period has returned?	YES 1 NO 2 DON'T KNOW 8	
	M. Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	AT LEAST SIX HOURS (BUT NO LONGER THAN 24 HOURS) 1 OTHER 2 DON'T KNOW 8	
117	IS CLIENT AN ORAL CONTRACEPTIVE USER?		YES 1 NO 2	→201
118	If your oral contraceptive pill [SHOW A LO-FEMAL OR OVERETTE PILL] were not in stock, and we provided another pill with exactly the same function [SHOW MICROGYNON OR MICRONOR] would you see this as a problem or would this bother you? IF YES, CLARIFY IF IT WOULD BE A BIG OR A SMALL PROBLEM		YES, BIG PROBLEM 1 YES, SLIGHT PROBLEM..... 2 NO PROBLEM 3 UNSURE 8	

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
	Now I are going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the family planning health services.		
201	How long did you wait between the time you first arrived at this facility and the time a Provider saw you for the consultation?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY 000 DON'T KNOW 998	

Now I am going to ask about some issues that some clients say are problems with different health facilities. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems.		BIG	SMALL	NO	DK
202	Were any of the following big problems? Small problems? Or not problems at all?				
	A) Time you waited?	WAIT1	2	3	8
	B) Ability to discuss problems or concerns about your health with the health worker?	DISCUSS PROBLEMS1	2	3	8
	C) Amount of explanation about the problem or treatment?	EXPLAIN PROBLEM/TX...1	2	3	8
	D) Quality of the examination and treatment provided?	QUALITY EXAM/ TREATMENT1	2	3	8
	E) Privacy from others seeing exam?	VISUAL PRIVACY1	2	3	8
	F) Privacy from others hearing discussion?	AUDITORY PRIVACY1	2	3	8
	G) Availability of medicines at the facility?	AVAILABLE MEDICINES1	2	3	8
	H) The hours services are provided?	HOURS SERVICE1	2	3	8
	I) Cleanliness of facility?	FACILITY CLEANLINESS .1	2	3	8
	J) How staff treated you?	HOW TREATED1	2	3	8
	K) Any problem today which I did not mention?	_____1	2	3	8
		(SPECIFY)			

203	Are you a part of any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility?	YES 1 NO 2 DON'T KNOW..... 8
204	What is the total amount which you paid for all services for family planning services today? Laboratory Test Medicines/method Consultation/Others	TOTAL AMOUNTS FOR: LAB <input type="text"/> <input type="text"/> MEDI- CINES <input type="text"/> <input type="text"/> OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TOTAL AMOUNT <input type="text"/> <input type="text"/> PAID NO MONEY 0000000 DON'T KNOW 9999998
205	Have you ever visited this facility before?(either as a patient or visiting or accompanying a patient?)	YES 1 NO 2
Section 3. Personal Characteristics of Client		
302	How old were you at your last birthday?	AGE IN YEARS... <input type="text"/> <input type="text"/> DON'T KNOW 98
303	Have you ever attended school?	YES 1 NO 2 → 306
304	What is the highest level of school you attended?	PRIMARY 1 MIDDLE/JSS 2 SECONDARY/SSS 3 VOC/TECH/COMMERCIAL 4 POST SECONDARY 5 TERTIARY 6
305	What is the highest grade (NAME) completed at that level? PLEASE RECORD ACTUAL GRADE IF 0-8; IF 9 OR MORE CODE 9	GRADE <input type="text"/> <input type="text"/>
306	TIME INTERVIEW ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>

**MEASURE Service Provision Assessment
Reproductive and Child Health Service Delivery**

Antenatal Care Observation	
FACILITY IDENTIFICATION	
Name of the facility _____ Facility Location _____ Region _____ District _____ Type of Health Facility: (11 = Teaching hospital; 12 = Regional/District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 = Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____) Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____)	REGION CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DISTRICT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY TYPE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> OPERATING AUTHORITY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Provider Information	
Provider category: (1 = Medical Doctor; 2 =Medical Assistant; 3=Public Health Nurse; 4=Professional Midwife; 5= Professional Nurse; 6= Midwife Assistant; 7=Auxiliary nurse; 8=Pharmacist; 9=Dispensing Technician; 10=Laboratory Technician; 11=Nutrition Technician Officer; 96=other _____) Sex of Provider: (1=female; 2=male) Code for Provider should be the same as that used for the Provider Interview	CATEGORY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> SEX OF PROVIDER <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> PROVIDER CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
INFORMATION ABOUT INTERVIEW	
Date: _____ Name of the interviewer _____ Time observation started: ANC Client Code	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> INTERVIEWER CODE.. <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> CLIENT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

Antenatal Care Consultation Observation

100 INTERVIEWER: PRIOR TO THE OBSERVATION, MEET WITH THE PROVIDER AND EXPLAIN THE SURVEY. THEN INTRODUCE YOURSELF TO THE PROVIDER AND EXPLAIN THE FOLLOWING:
 Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the antenatal care services provided in Ghana. As one part of this assessment I would like to sit in the room while consult with the antenatal care client to know more about the types of issues discussed and the types of care that are provided. Is it ok with you if I sit in the room and observe when you see the client? Please tell me if this is ok or not. IF PROVIDER GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".

 SIGNATURE OF INTERVIEWER INDICATES PROVIDER AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT

100a INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT AND EXPLAIN THE FOLLOWING:
 Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the antenatal care services provided in Ghana. As one part of this assessment I would like to sit in the room while you see the (NURSE/DOCTOR. We want to know more about the types of issues discussed and the types of care that are provided. Is it ok with you if I sit in the room and observe when you see the (NURSE/DOCTOR)? Please tell me if this is ok or not. IF CLIENT GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".

SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT	YES	<input type="checkbox"/>	→	TIME				AM PM
				<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
				HOUR		MINUTES		
	NO	<input type="checkbox"/>	→	REASON				
							

No	QUESTIONS	CODING CLASSIFICATION			GO TO
		YES	NO	DK	
101	INDICATE WHETHER THIS IS THE CLIENT'S FIRST VISIT FOR ANTENATAL CARE <u>AT THIS FACILITY</u> FOR THIS PREGNANCY. IF THE PROVIDER DOES NOT ASK ABOUT/THE CLIENT DOES NOT PROVIDE THE INFORMATION, RECORD 8 (NOT KNOWN).				
		1	2	8	
102	DOES THE PROVIDER ASK OR THE CLIENT PROVIDE THE FOLLOWING INFORMATION:				
	CLIENT HISTORY	YES	NO	DK	
	a) Client AGE?	1	2	8	
	b) Date of LAST MENSTRUAL PERIOD?	1	2	8	
	c) Number of PRIOR PREGNANCIES?	1	2	8	
	PRIOR PREGNANCY HISTORY				
	d) Any PRIOR STILL BIRTH(S)?	1	2	8	
	e) Any INFANT(S) DIED in the first week?	1	2	8	
	f) Any HEAVY BLEEDING During or after delivery with a PRIOR PREGNANCY?	1	2	8	
	g) Any PREVIOUS ASSISTED DELIVERY?(Caesarean-section, ventouse (vacuum extractor) or forceps)	1	2	8	
103	SYMPTOMS OF THIS PREGNANCY	YES	NO	DK	
	a) Any BLEEDING during this pregnancy	1	2	8	
	b) MEDICATIONS woman is currently taking?	1	2	8	
	c) If the woman has FELT THE BABY MOVE?	1	2	8	
	d) If there are any OTHER SYMPTOMS OR PROBLEMS the woman thinks might be related to this pregnancy?	1	2	8	
104	DOES THE PROVIDER PERFORM ANY OF THE FOLLOWING EXAMINATIONS?	YES	NO	DK	
	a) Take the client's blood pressure?	1	2	8	
	b) Take WEIGHT of client?	1	2	8	
	c) Measure HEIGHT of client?	1	2	8	
	d) Palpate abdomen for fetal presentation?	1	2	8	
	e) Palpate or measure for fundal height	1	2	8	
	f) Listen to the client's abdomen to hear fetal heartbeat?	1	2	8	
	g) Perform or refer for a syphilis test?	1	2	8	
	h) Screen (for STI/HIV) and/or offer voluntary counseling and testing (VCT)	1	2	8	
	i) Look at client's health card either before beginning the consultation or while collecting information or examining the client?	1	2	8	

No	QUESTIONS	CODING CLASSIFICATION			
105	DOES THE PROVIDER PROVIDE ANY OF THE FOLLOWING TREATMENTS OR COUNSELING?				
	TREATMENTS	YES	NO	DON'T KNOW	
	a) Prescribe or give iron pills and/or folic acid?	1	2→106	8→106	
	b) Explain the purpose of iron/folic?	1	2	8	
106	a) Prescribe or give tetanus toxoid (TT) injection?	1	2→107	8→107	
	b) Explain the purpose of TT injection?	1	2	8	
	c) Explain how to take iron/folic pills?	1	2	8	
107	a) Prescribe or give anti-malarial prophylaxis?	1	2→108	8→108	
	b) Explain the purpose of the preventive treatment with malaria medications?	1	2	8	
	c) Explain how to take the anti-malarial medications?	1	2	8	
108	ADVICE OR COUNSEL ABOUT PREGNANCY				
	a) Quality and quantity of food to eat during pregnancy?	1	2	8	
	b) Mention the following signs and symptoms as risk factors for which the woman should return to the facility?				
	1) Vaginal bleeding?	1	2	8	
	2) Fever?	1	2	8	
	3) Excessive tiredness and breathlessness?	1	2	8	
	4) Swollen hands and face?	1	2	8	
	5) Severe Headache/Blurred Vision	1	2	8	
6) Others?	1	2	8		
c) Inform the client about the progress of the pregnancy?	1	2	8		
109	DOES THE PROVIDER PROVIDE ADVISE/COUNSEL ABOUT DELIVERY OR INFANT CARE?	YES	NO	DK	NA
	a) Ask the client where she will deliver?	1	2	8	
	b) Counsel the client to use a skilled health worker during delivery?	1	2	8	9
	c) Discuss with client about items to have on hand at home, for delivery?	1	2	8	
110	Advise exclusive breastfeeding for up to 6 months?	1	2	8	
111	Discuss birth control/ family planning, for after delivery?	1	2	8	
112	Ask if the client has any questions and encourage questions?	1	2	8	
113	Use any visual aids during consultation?	1	2	8	
114	Did the Provider write on the woman's health card?	YES..... 1 NO..... 2 NO HEALTH CARD USED 3 DON'T KNOW 8			
115	HOW MANY WEEKS PREGNANT IS THE CLIENT?	WEEK OF PREGNANCY <input type="text"/> <input type="text"/> DON'T KNOW 98			

No	QUESTIONS	CODING CLASSIFICATION
116	INDICATE IF THIS IS THE FIRST PREGNANCY FOR THE CLIENT.	YES, FIRST PREGNANCY 1 NO, HAD PRIOR PREGNANCY 2 DON'T KNOW 8
117	OUTCOME OF CONSULTATION	CLIENT SENT HOME 1 CLIENT REFERRED (TO LAB OR OTHER PROVIDER) AT SAME FACILITY 2 CLIENT ADMITTED TO SAME FACILITY 3 CLIENT REFERRED TO OTHER FACILITY 4 DON'T KNOW 8
118	RECORD TIME CONSULTATION ENDED	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>
119	OBSERVER COMMENTS:	

**MEASURE Service Provision Assessment
Reproductive and Child Health Service Delivery**

Exit Interview for Antenatal Care Clients	
FACILITY IDENTIFICATION	
Name of the facility _____ Facility Location _____ Region _____ District _____ Type of Health Facility: (11 = Teaching hospital; 12 = Regional/ District Hospital; 13 = Polyclinic; 14 = Health Centre; 15 =Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other _____) Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32= GRMA; 96 = Other _____)	REGION CODE <input type="text"/> <input type="text"/> DISTRICT CODE <input type="text"/> <input type="text"/> FACILITY CODE <input type="text"/> <input type="text"/> FACILITY TYPE <input type="text"/> <input type="text"/> OPERATING AUTHORITY <input type="text"/> <input type="text"/>
INFORMATION ABOUT INTERVIEW	
Date: _____ Name of the interviewer _____ Time observation started: ANC Client Code	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> INTERVIEWER CODE.. <input type="text"/> <input type="text"/> HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/> CLIENT CODE <input type="text"/> <input type="text"/>

Exit Interview for Antenatal Care Clients

Section 1. Visit Information

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____. As my colleagues explained, I am working with the Ministry of Health and the Ghana Statistical Service to look at the antenatal care services that are provided in Ghana. As another part of this assessment I would like to ask you a few questions about your visit to the facility today. This will help us to better understand the issues discussed and your thoughts about the services. Please tell me if this is ok or not. IF CLIENT GIVES PERMISSION, THEN STATE "If there are any questions you don't want to answer 's please let me know". Can I begin?</p>	<p style="text-align: center;">TIME</p> <p>YES <input type="checkbox"/> → <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> AM HOUR MINUTES PM</p> <p>NO <input type="checkbox"/> → REASON</p>	
	<p>SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>		
101	How many weeks pregnant are you?	<p>WEEKS <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/></p> <p>DON'T KNOW 98</p>	
101a	Is this your first pregnancy?	<p>YES..... 1</p> <p>NO..... 2</p>	
102	Is this your first antenatal visit at this facility for this pregnancy?	<p>YES..... 1</p> <p>NO..... 2</p>	
103	During this, or previous visits, did the Provider give or prescribe for you iron pills/folic acid? SHOW THE PILL.	<p>YES, THIS VISIT..... A</p> <p>YES, PREVIOUS VISIT B</p> <p>NO..... Y</p> <p>DON'T KNOW..... Z</p>	<p>→106</p> <p>→106</p>
104	During this or previous visits, has a Provider explained how to take the Iron pills?	<p>YES, THIS VISIT..... A</p> <p>YES, PREVIOUS VISIT B</p> <p>NO..... Y</p> <p>DON'T KNOW..... Z</p>	
105	ASK TO SEE THE IRON PILLS	<p>SAW DRUGS..... 1</p> <p>SAW PRESCRIPTION..... 2</p> <p>NO DRUG OR PRESCRIPTION3</p>	
106	During this or previous visits, has a Provider given or prescribed for you either of these medicines? SHOW TABLETS OF CHLOROQUINE OR DARAPRIM (DEPENDING ON WHAT THE FACILITY USES)	<p>YES, CHLOROQUINE THIS VISIT..... A</p> <p>YES, DARAPRIM THIS VISIT . B</p> <p>YES, CHLOROQUINE PREVIOUS VISIT..... C</p> <p>YES, DARAPRIM PREVIOUS VISIT D</p> <p>NO..... Y</p> <p>DON'T KNOW Z</p>	<p>→109</p> <p>→109</p>

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	Did a Provider explain how to take the antimalaria drugs either this visit, a previous visit, or both?	YES, THIS VISITA YES, PREVIOUS VISITB NOY DON'T KNOW.....Z	
108	ASK TO SEE THE ANTIMALARIA DRUGS	SAW DRUGS..... 1 SAW PRESCRIPTION..... 2 NO DRUG OR PRESCRIPTION3	
109	During this or previous visits has a Provider talked with you about any warning signs or symptoms for problems with the pregnancy?	YES, THIS VISITA YES, PREVIOUS VISITB NOY DON'T KNOW.....Z	→112 →112
110	What warning signs or symptoms have been mentioned? (CIRCLE ALL THOSE MENTIONED.) PROBE: Anything else?	BLEEDING.....A FEVER.....B SWOLLEN FACE/HANDC TIREDNESS/BREATHLESSNESSD HEADACHE/BLURRED VISIONE OTHER _____X (SPECIFY)	
111	What did the Provider advise you to do if you experienced any of the warning signs? RECORD ALL MENTIONED.	SEEK CARE AT THE FACILITYA DECREASE ACTIVITYB CHANGE DIETC OTHER _____X (SPECIFY)	
112	During this or previous visits has a Provider talked to you about what to eat during your pregnancy?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOWZ	
113	During this or previous visits has a Provider given you advice on the importance of exclusive breastfeeding, i.e. about giving your baby nothing apart from breast milk?	YES, THIS VISIT A YES, PREVIOUS VISIT B NO Y DON'T KNOWZ	→115 →115
114	For how many months, did the Provider recommend that you breastfeed exclusively?	MONTHS <input type="text"/> <input type="text"/> DON'T KNOW 98	
115	During this or previous visits, did the Provider talk to you about where you plan to deliver?	YES 1 NO 2 DON'T KNOW 8	
116	Have you decided where you will have your delivery? IF YES, PROBE FOR WHETHER THE PLAN IS TO DELIVER IN A FACILITY OR AT HOME.	AT THIS HEALTH FACILITY.. 1 AT OTHER HEALTH FACILITY2 IN A PRIVATE HOME 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
117	During this or previous visits has a Provider discussed supplies you should have at home or other preparations you should make for the delivery?	YES 1 NO 2	→201
118	ASK CLIENT TO MENTION SOME OF THE SUPPLIES OR PREPARATIONS FOR DELIVERY WHICH HAVE BEEN MENTIONED . CIRCLE ALL THAT APPLY. PROBE: Are there any other items? Anything else you have been advised to prepare before delivery?	SOAP A STERILE BLADE..... B SCISSOR C TIES FOR UMBILICAL CORDD MACKINTOSH/PLASTIC COVER..... E PLAN FOR TRANSPORTATION TO FACILITY..... F OTHER..... X (SPECIFY)	

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GOTO
201	Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the antenatal health services. How long did you wait between the time you first arrived at this facility and the time you saw a Provider for the consultation?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> SAW PROVIDER IMMEDIATELY 000 DON'T KNOW 998	

Now I am going to ask about some issues that some clients say are problems with different health facilities. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems.		BIG	SMALL	NO	DK
202	Were any of the following big problems? Small problems? Or not problems at all?				
	A) Time you waited?	WAIT1	2	3	8
	B) Ability to discuss problems or concerns about your health with the health worker?	DISCUSS PROBLEMS1	2	3	8
	C) Amount of explanation about the problem or treatment?	EXPLAIN PROBLEM/TX...1	2	3	8
	D) Quality of the examination and treatment provided?	QUALITY EXAM/ TREATMENT1	2	3	8
	E) Privacy from others seeing exam?	VISUAL PRIVACY1	2	3	8
	F) Privacy from others hearing discussion?	AUDITORY PRIVACY1	2	3	8
	G) Availability of medicines at the facility?	AVAILABLE MEDICINES1	2	3	8
	H) The hours services are provided?	HOURS SERVICE1	2	3	8
	I) Cleanliness of facility?	FACILITY CLEANLINESS .1	2	3	8
	J) How staff treated you?	HOW TREATED1	2	3	8
	K) Any problem today which I did not mention?	_____1	2	3	8
		(SPECIFY)			

203	Are you a part of any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility?	YES 1 NO 2 DON'T KNOW 8
204	What is the total amount which you paid for all services for antenatal care today? Laboratory Test Medicines/method Consultation/Others	TOTAL AMOUNTS FOR: LAB <input type="text"/> <input type="text"/> MEDI- CINES <input type="text"/> <input type="text"/> OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TOTAL AMOUNT <input type="text"/> <input type="text"/> PAID NO MONEY 0000000 DON'T KNOW 9999998
205	Have you ever visited this facility before?(either as a patient or visiting or accompanying a patient?)	YES1 NO2

Section 3. Personal Characteristics of Client

302	How old were you at your last birthday?	AGE IN YEARS... <input type="text"/> <input type="text"/> DON'T KNOW 98
303	Have you ever attended school?	YES 1 NO 2 → 306
304	What is the highest level of school you attended?	PRIMARY1 MIDDLE/JSS2 SECONDARY/SSS3 VOC/TECH/COMMERCIAL4 POST SECONDARY5 TERTIARY6
305	What is the highest grade (NAME) completed at that level? PLEASE RECORD ACTUAL GRADE IF 0-8; IF 9 OR MORE CODE 9	GRADE <input type="text"/> <input type="text"/>
306	TIME INTERVIEW ENDED.	HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>

**MEASURE Service Provision Assessment
Reproductive And Child Health Service Delivery**

Observation of STI CLIENT Consultation

FACILITY IDENTIFICATION

Name of the facility _____

Facility Location _____

Region _____

District _____

Type of Health Facility : (11 = Teaching hospital; 12 = Regional/
District Hospital; 13 = Polyclinic; 14 = Health Centre;
15 =Health Post; 16 = Private Maternity; 17 = Clinic; 96 = Other
_____)

Operating Authority: 11= Government; 21 = Catholic; 22 =
Protestant; 23 = Muslim; 31 = PPAG;32 = GRMA;
96 = Other _____)

REGION CODE

DISTRICT CODE

FACILITY CODE

FACILITY TYPE

OPERATING AUTHORITY

Provider Information

Provider category: (1 = Medical Doctor;
2 =Medical Assistant; 3=Public Health Nurse;
4=Professional Midwife; 5= Professional Nurse; 6=
Midwife Assistant; 7=Auxiliary nurse;
8=Pharmacist; 9=Dispensing Technician;
10=Laboratory Technician; 11=Nutrition Technician
Officer; 96=other _____)

Sex of Provider: (1=female; 2=male)
Code for Provider should be the same as that used
for the Provider Interview

CATEGORY

SEX OF
PROVIDER.....

PROVIDER
CODE

INFORMATION ABOUT INTERVIEW

Date: _____

DAY

MONTH

YEAR

Name of the interviewer _____

INTERVIEWER CODE..

Time observation started:

HOUR

MINUTES.....

STI CLIENT CODE

CLIENT CODE.....

STI Client Consultation Observation

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																				
100	<p>INTERVIEWER: PRIOR TO THE OBSERVATION, MEET WITH THE PROVIDER AND EXPLAIN THE SURVEY. THEN INTRODUCE YOURSELF TO THE PROVIDER AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the reproductive health services provided in Ghana. As one part of this assessment I would like to sit in the room while consult with the client who has symptoms for STIs to know more about the types of issues discussed and the types of care that are provided. Is it ok with you if I sit in the room and observe when you see the client? Please tell me if this is ok or not. IF PROVIDER GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".</p>																						
	<p>_____ SIGNATURE OF INTERVIEWER INDICATES PROVIDER AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>																						
100	<p>INTERVIEWER: INTRODUCE YOURSELF TO THE CLIENT AND EXPLAIN THE FOLLOWING:</p> <p>Hello, my name is _____, and I am working with the Ministry of Health and the Ghana Statistical Service to look at the health services provided in Ghana. As one part of this assessment I would like to sit in the room while you see the (NURSE/DOCTOR. We want to know more about the types of issues discussed and the types of care that are provided. Is it ok with you if I sit in the room and observe when you see the (NURSE/DOCTOR)? Please tell me if this is ok or not. IF CLIENT GIVES PERMISSION, THEN STATE "If there's any time that you would prefer I leave, please let me know".</p>																						
	<p>_____ SIGNATURE OF INTERVIEWER INDICATES PARTICIPANT AGREEMENT TO PARTICIPATE AND THAT THE TIME IS CONVENIENT</p>	<p>YES <input type="checkbox"/> →</p> <p style="text-align: center;">TIME</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 20px; vertical-align: middle;">→</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 20px; vertical-align: middle;">→</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 20px; vertical-align: middle;">→</td> <td style="text-align: right;">AM PM</td> </tr> <tr> <td colspan="2" style="text-align: center;">HOUR</td> <td></td> <td colspan="2" style="text-align: center;">MINUTES</td> <td></td> <td colspan="4"></td> </tr> </table> <p>NO <input type="checkbox"/> → REASON</p> <p style="text-align: center;">.....</p>			→			→			→	AM PM	HOUR			MINUTES							
		→			→			→	AM PM														
HOUR			MINUTES																				

NO.	QUESTIONS	CODING CLASSIFICATION			GOTO
		YES	NO	DON'T KNOW	
101	Did the Provider advise the client that any information shared between the provider and the client is confidential?	1	2	8	
102	DID THE PROVIDER ASK ABOUT, OR DID THE CLIENT PROVIDE ANY OF THE FOLLOWING INFORMATION?				
	CLIENT HISTORY				
	a) SYMPTOMS the client is having?	1	2	8	
	b) HOW LONG the client has had the present SYMPTOMS?	1	2	8	
	c) The client's history of RECENT SEXUAL CONTACTS?	1	2	8	
	d) SYMPTOMS IN SEXUAL PARTNER(S)?	1	2	8	
	e) The RELATIONSHIP STATUS (monogomous; multiple partners; non-monogamous partner)	1	2	8	
103	Were the External; Genitalia examined?	YES..... 1 NO..... 2 NOT OBSERVED 8			→105 →105
104	IF YES: DID THE PROVIDER:		YES	NO	NA
	a) Ensure client visual privacy?	VISUAL PRIVACY	1	2	
	b) Esure client auditory privacy?	AUDITORY PRIVACY			
	c) Wash his/her hands with soap before the exam?	WASH HANDS.....	1	2	
	i) Use single use towel for handwashing?	SINGLE USE TOWEL	1	2	
	d) Wear clean gloves?	WEAR GLOVES	1	2	
	e) Wre genitals fully exposed?	GENITALS FULLY EXPOSED.....	1	2	
	FOR FEMALE CLIENT:				
	f) Was female client lying down during exam?	CLIENT LYING DOWN	1	2	9
	g) Were labia separated and inspected to inspect for lesions or discharge?	LABIA SEPARATED AND INSPECTED.....	1	2	9
	FOR MALE CLIENT NOT CIRCUMCISED:		YES	NO	NA
	h) Was foreskin retracted to inspect for lesions or discharge?	FORESKIN RETRACTED	1	2	8

105	IF CLIENT IS FEMALE: INDICATE WHETHER PROVIDER CONDUCTED A PELVIC EXAM.	YES.....	1	→107
		NO.....	2	
		MALE CLIENT	3	

106 PELVIC EXAM

DID THE PROVIDER:		YES	NO	NA
1)	ENSURE CLIENT HAS VISUAL PRIVACY? VISUAL PRIVACY.....	1	2	
2)	ENSURE CLIENT HAS AUDITORY PRIVACY? AUDITORY PRIVACY	1	2	
3)	EXPLAIN PROCEDURE BEFORE BEGINNING? EXPLAIN PROCEDURE	1	2	
4)	PREPARE ALL INSTRUMENTS BEFORE EXAM? PREPARED INSTRUMENTS	1	2	
5)	WASH HIS/HER HANDS WITH SOAP BEFORE EXAM? WASHED HANDS	1	2	
5a)	USE SINGLE USE TOWEL (HANDWASH) SINGLE USE TOWEL	1	2	
6)	USE STERILIZED OR HIGH-LEVEL DISINFECTED INSTRUMENTS ? DISINFECTED INSTRUMENTS	1	2	
7)	PUT ON NEW OR DISINFECTED GLOVES BEFORE EXAM? PUT ON GLOVES	1	2	
8)	ASK THE CLIENT TO TAKE SLOW, DEEP BREATHS, AND RELAX ALL MUSCLES? ASK CLIENT TO RELAX MUSCLES	1	2	
9)	INSPECT THE EXTERNAL GENITALIA? INSPECT GENITALIA	1	2	
10)	(IF USED) EXPLAIN SPECULUM PROCEDURE? EXPLAIN SPECULUM	1	2	9
11)	INSPECT THE CERVIX AND VAGINAL MUCOSA? (AIM LIGHT INSIDE INSERTED SPECULUM) INSPECT CERVIX	1	2	
12)	PERFORM BIMANUAL EXAM (ONE HAND INSIDE VAGINA, OTHER PALPATING UTERUS THROUGH ABDOMEN) BIMANUAL EXAM.....	1	2	
13)	WASH HANDS <u>AFTER</u> REMOVING GLOVES? WASH HANDS AFTER ...	1	2	
14)	WIPE CONTAMINATED SURFACES WITH DISINFECTANT? DISINFECT AREA.....	1	2	
15)	PLACE REUSABLE GLOVES AND INSTRUMENTS IN A CHLORINE BLEACH SOLUTION IMMEDIATELY AFTER COMPLETING PROCEDURE? DECONTAMINATE GLOVES/INSTRUMENT S.....	1	2	

107	Was a specimen taken or a laboratory examination ordered for the client?	YES1 NO2 DON'T KNOW8	➔110 ➔110																												
108	IF YES, WERE ANY OF THE FOLLOWING TYPES OF TESTS MENTIONED?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>1) BLOOD TEST</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>2) MICROSCOPIC EXAMINATION OF SPECIMEN OF VAGINAL OR URETHRAL DISCHARGE?</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>3) HIV/AIDS TEST WITH COUNSELLING</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>4) HIV/AIDS TEST WITHOUT COUNSELLING</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	1) BLOOD TEST	1	2	8	2) MICROSCOPIC EXAMINATION OF SPECIMEN OF VAGINAL OR URETHRAL DISCHARGE?	1	2	8	3) HIV/AIDS TEST WITH COUNSELLING	1	2	8	4) HIV/AIDS TEST WITHOUT COUNSELLING	1	2	8									
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109	Did the provider at any time ask for the client's agreement or permission for ordering or taking a specimen to check for infection or specifically mention a STI (e.g. syphilis or HIV/AIDS)?	YES1 NO2 DON'T KNOW8																													
110	Did the provider discuss the diagnosis with the client?	YES1 NO2																													
111	Did the provider give the client a prescription or medications?	YES1 NO2	➔113																												
112	Did the provider instruct the client on the importance of completing the full course of treatment?	YES1 NO2																													
113	Was the client encouraged to refer his/her partner(s) for treatment?	YES1 NO2																													
114	Did the provider give a follow-up date to return for re-examination?	YES1 NO2																													
115	Were any visual aids used for client education about STIs or HIV/AIDS?	YES1 NO2																													
116	Was the risk of HIV/AIDS mentioned?	YES1 NO2																													
117	Did the provider:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) Talk about the role of condoms in prevention of STIs and HIV/AIDS transmission?</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) Instruct the client on how to use Condom?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c) Demonstrate how to put on condom?</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) Offer condoms to the client?</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	a) Talk about the role of condoms in prevention of STIs and HIV/AIDS transmission?	1	2	8	b) Instruct the client on how to use Condom?				c) Demonstrate how to put on condom?	1	2	8	d) Offer condoms to the client?					1	2	8		1	2	8	
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118	Did the provider write on the client health card during or at the end of the consultation?	YES 1 NO 2 DON'T KNOW 8					
119	RECORD TIME OBSERVATION ENDED.	HOUR..... MINUTES	<table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>				
120	OBSERVER COMMENTS						

**MEASURE Service Provision Assessment
Reproductive and Child Health Service Delivery**

EXIT INTERVIEW FOR STI CLIENTS	
FACILITY IDENTIFICATION	
Name of the facility _____ Facility Location _____ Region _____ District _____ Type of Health Facility: (1 = Teaching hospital; 2 = Regional/ District Hospital; 3 = Polyclinic; 4 = Health Centre; 5 = Health Post; 6 = Private Maternity; 7 = Clinic; 8 = Other _____) Operating Authority: 11= Government; 21 = Catholic; 22 = Protestant; 23 = Muslim; 31 = PPAG; 32 = GRMA; 96 = Other _____	REGION CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> DISTRICT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> FACILITY TYPE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> OPERATING AUTHORITY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
INFORMATION ABOUT INTERVIEW	
Date: _____ Name of the interviewer _____ SEX OF INTERVIEWER (1-MALE; 2=FEMALE) Time interview started: STI Client Code	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> INTERVIEWER CODE.. <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> SEX OF INTERVIEWER <input style="width: 20px; height: 20px;" type="text"/> HOUR..... <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> CLIENT CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
107	Did the health worker offer you or ask you to have an HIV/AIDS test?	YES..... 1 NO 2 DON'T KNOW..... 8	
108	Have you ever used condoms before?	YES NO.....	
109	I want to ask you about your opinion about some of the reasons people may <u>not</u> using a condom. As I mention each item, please tell me if you think that it might be, or has been, a reason you might not use condoms. Tell me if you think it has been or could be a big problem, a small problem or not a problem for you to use condoms. Many people say: 1) It is embarrassing to purchase/obtain condoms? 2) Disposal of the condom is a problem 3) It is embarrassing to discuss use of condom with partner? 4) The condom reduces your own sexual satisfaction? 5) The condom reduces partner's sexual satisfaction?	<p style="text-align: right;">BIG SMALL NO DK</p> <p>EMBARASSING TO OBTAIN 1 2 3 8</p> <p>PROBLEM WITH DISPOSAL 1 2 3 8</p> <p>EMBARRASSING TO DISCUSS 1 2 3 8</p> <p>REDUCES OWN..... 1 2 3 8</p> <p>REDUCES PARTNER'S 1 2 3 8</p>	
110	Did you discuss any of the issues related to using condoms that were mentioned above with the health worker?	YES 1 NO 2	
111	Did the health worker talk to you about condoms today?	YES 1 NO 2	
112	Were you given any condoms today?	YES 1 NO 2	
113	Did you receive a blood test or did anyone take a specimen for laboratory examination today?	YES 1 NO 2	→201
114	Did the health worker explain to you what the laboratory test was for? IF YES, WHAT WAS THE TEST FOR?	YES, INFECTION/STI A YES, HIV/AIDS..... B YES, OTHER..... W NO Y DON'T KNOW Z	

Section 2. Client Satisfaction

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO																																																												
201	<p>Now I am going to ask you some questions about the services today. I would like to have your honest opinion about the things that we will talk about. This will help us to improve the health services.</p> <p>How long did you wait between the time you first arrived at this facility and the time a health worker saw you for the consultation?</p>	<p>MINUTES <input type="text"/> <input type="text"/> <input type="text"/></p> <p>SAW PROVIDER IMMEDIATELY 000 DON'T KNOW 998</p>																																																													
<p>Now I am going to ask about some issues that some clients say are problems with different health facilities. As I mention each one, please tell me if any of these were problems for you today, and if so, if they were big or small problems.</p>																																																															
202	<p>Were any of the following big problems? Small problems? Or not problems at all?</p> <p>A) Time you waited?</p> <p>B) Ability to discuss problems or concerns about your health with the health worker?</p> <p>C) Amount of explanation about the problem or treatment?</p> <p>D) Quality of the examination and treatment provided?</p> <p>E) Privacy from others seeing exam?</p> <p>F) Privacy from others hearing discussion?</p> <p>G) Availability of medicines at the facility?</p> <p>H) The hours services are provided?</p> <p>I) Cleanliness of facility?</p> <p>J) How staff treated you?</p> <p>K) Any problem today which I did not mention?</p>	<table border="1"> <thead> <tr> <th></th> <th align="center">BIG</th> <th align="center">SMALL</th> <th align="center">NO</th> <th align="center">DK</th> </tr> </thead> <tbody> <tr> <td>WAIT</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>DISCUSS PROBLEMS</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>EXPLAIN PROBLEM/TX ..</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>QUALITY EXAM/TREATMENT ...</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>VISUAL PRIVACY.....</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>AUDITORY PRIVACY.....</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>AVAILABLE MEDICINES</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>HOURS SERVICE.....</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>FACILITY CLEANLINESS.</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>HOW TREATED</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> <tr> <td>_____</td> <td align="center">1</td> <td align="center">2</td> <td align="center">3</td> <td align="center">8</td> </tr> </tbody> </table> <p>(SPECIFY)</p>		BIG	SMALL	NO	DK	WAIT	1	2	3	8	DISCUSS PROBLEMS	1	2	3	8	EXPLAIN PROBLEM/TX ..	1	2	3	8	QUALITY EXAM/TREATMENT ...	1	2	3	8	VISUAL PRIVACY.....	1	2	3	8	AUDITORY PRIVACY.....	1	2	3	8	AVAILABLE MEDICINES	1	2	3	8	HOURS SERVICE.....	1	2	3	8	FACILITY CLEANLINESS.	1	2	3	8	HOW TREATED	1	2	3	8	_____	1	2	3	8	
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203	Are you a part of any pre-pay plan such as insurance, or other program or an institutional arrangement that provides some of the payment for services at this facility?	YES 1 NO 2 DON'T KNOW 8
204	What is the total amount which you paid for all services for health services today? Laboratory Test Medicines/method Consultation/Others	TOTAL AMOUNTS FOR: LAB <input type="text"/> <input type="text"/> MEDI- CINES <input type="text"/> <input type="text"/> OTHER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TOTAL AMOUNT <input type="text"/> <input type="text"/> PAID NO MONEY 0000000 DON'T KNOW 9999998
205	Have you ever visited this facility before?(either as a patient or visiting or accompanying a patient?)	YES 1 NO 2
Section 3. Personal Characteristics of Client		
302	How old were you at your last birthday?	AGE IN YEARS ... <input type="text"/> <input type="text"/> DON'T KNOW 98
303	Have you ever attended school?	YES 1 NO 2 → 306
304	What is the highest level of school you attended?	PRIMARY 1 MIDDLE/JSS 2 SECONDARY/SSS 3 VOC/TECH/COMMERCIAL 4 POST SECONDARY 5 TERTIARY 6
305	What is the highest grade (NAME) completed at that level? PLEASE RECORD ACTUAL GRADE IF 0-8; IF 9 OR MORE CODE 9	GRADE <input type="text"/> <input type="text"/>
306	TIME INTERVIEW ENDED.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>