

Integration of Family Planning into Other Health Services in Ghana

Performance Needs Assessment at Four Facilities in the Ashanti and Eastern Regions

MIDTERM
REPORT



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Report on the Mid-term Assessment at Four Facilities in the Ashanti and Eastern Regions



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Preface

In Ghana, most public district- or higher-level hospitals have a family planning (FP) unit to which clients are referred for services. On the contrary, FP services are limited at lower levels. Clients presenting to health facilities for non-FP purposes are not routinely screened and counseled for FP needs. The Ghana Health Services is cognizant of these deficiencies and is willing to address them. One of the envisaged strategies to addressing the problem is the integration of FP services into other services.

This report presents data on the mid-term assessment of the integration process at four facilities in the Ashanti and Eastern Regions. It follows an earlier report on Performance Needs Assessment (PNA) on the integration of FP. The issues addressed in this current report include: Background characteristics of clients and providers; feasibility of integrating FP services, acceptability of integrated FP services to providers and clients, and effect of FP integration on service utilization. Specifically, attitude and support of stakeholders including policy makers, program managers, providers, other facility staff, and clients, capacity of institutions to provide FP services; staff training and ability to provide FP services, service statistics, supervision and monitoring of service delivery, institutional setup of service delivery, commodities supply and logistics, and quality of care are examined.

Acknowledgments

The members of the assessment team would like to express sincere gratitude to those whose dedication has made the assessment possible. We acknowledge regional health directors Dr. Aron Offei (Ashanti) and Dr. Erasmus Agongo (Eastern) for their vocal and visible support during the project. We thank the management and administrative staff of Dodowa Health Center for their support during the pretest phase of the study instruments. The study sites (Maternal and Child Health Hospital, Kumasi; Government Hospital, Obuasi; Regional Hospital, Koforidua; and Tetteh Quarshie Memorial Hospital, Mampong) facilitated immensely toward our entry; they also gave us a resounding support throughout the data collection period.

We are also grateful to those individuals who were involved in the training and pretest of field instruments, data management, data analysis, and all the stages of the report writing. Finally, special thanks are extended to all the clients, providers and unit heads who consented to participate in this study.

This report was written by Dr. Amos Laar, School of Public Health, University of Ghana, Legon.

List of Abbreviations/Acronyms

ANC	Antenatal Care
CAC	Comprehensive Abortion Care
CWC	Child Welfare Clinic
CYP	Couple Years of Protection
DDHS	District Director of Health Service
DHS	Demographic and Health Survey
FP	Family Planning
FHD	Family Health Division
GHS	Ghana Health Service
IEC	Information, Education, and Communication
IUD	Intrauterine Device
MCHH	Maternal and Child Health Hospital
MDG	Millennium Development Goal
MOH	Ministry of Health
OPD	Outpatient Department
PAC	Post Abortion Care
PMTCT/VCT	Prevention of Mother-to-Child Transmission of HIV/Voluntary Counseling and Testing
PNA	Performance Needs Assessment
PNC	Postnatal Care
R3M	Reducing Maternal Morbidity and Mortality Program
RDDHS	Regional Deputy Director of Health Service
STI	Sexually Transmitted Infection
TQMH	Tetteh Quarshie Memorial Hospital

Executive Summary

Ghana has one of the highest maternal mortality ratios in the world. A recent national survey (GSS et al., 2009a) revealed that about 451 women per 100,000 live births die due to pregnancy, unsafe abortion, or complications of labor in Ghana. According to a related survey - the 2008 Ghana Demographic Health Survey (DHS) (GSS et al., 2009b), the total fertility rate in Ghana is 4.0, whereas rate of modern contraceptive use is quite low at 17% among married women. The report indicates that 14% of all births in Ghana are unwanted, 37% are unplanned, and 23% are mistimed. This is true despite the fact that knowledge of FP is virtually universal, with 98% of all women and 99% of all men aged 15–49 knowing at least one modern method of contraception. Mistimed, unplanned, and unwanted pregnancy all greatly contribute to the risk of death posed by unsafe abortion, which often stems from limited access to and use of FP services.

From May 2010 to March 2011, the Reducing Maternal Morbidity and Mortality (R3M) Program worked with the Ghana Health Service (GHS) to conduct a Performance Needs Assessment (PNA) on family planning (FP) integration in four facilities in two of the country's regions. The purpose of this endeavor was ultimately to pilot a project in which interventions that would improve clients' access to FP at these facilities could be developed and implemented, based on a sound assessment of the current and desired FP service provision levels, importantly from the viewpoint of facility staff themselves, while taking into account client preferences. This culminated in a baseline survey and the roll out of interventions in some health facilities in the Eastern and Ashanti regions of Ghana.

This current survey involved visitation of four of these health facilities, conduction of 36 departmental inventories, interaction with 149 providers and 637 clients. A total of 124 provider-client encounters were also observed. The assessments were conducted in November 2011. This exercise, focused on eight core units: (1) antenatal (ANC); (2) maternity; (3) postnatal (PNC); (4) child welfare clinic (CWC); (5) pediatric; (6) prevention of mother-to-child transmission of HIV/voluntary counseling and testing (PMTCT/VCT); (7) outpatient department (OPD); and (8) family planning (FP).

This midterm survey sought to assess the status of the integration process of FP services into other reproductive health services in four Ghanaian health facilities. This will enable the Population Council and other stakeholders glean relevant and useful information regarding the course of their intervention, which seeks to facilitate the above integration process. The key points that emerge from this midterm assessment are compared to those of the baseline and are summarized below under eight thematic areas:

Reproductive history, family planning use, and reproductive intentions

The clients sampled at baseline and at midterm were comparable in many respects. For instance, the two cohorts had on average, two children; and fifteen percent of them were childless. At midterm, 29% of them had one child, 22% had two, and 17% had four or more children at the time of survey. These compare favorably with the baseline findings where the statistics were respectively 29%, 22% and 19%.

Of those with at least one child, a little over a quarter (25.4%) would like to limit childbirth while close to three-quarters (71.4%) would like to space their births. About one-in-ten (12.1%) of those who wanted to space their births would wait at least a year. Most (82.2%) wanted to wait at least two years to have the next child. Relatively few clients (2%) did not know their fertility intentions for the future. Similarly, at baseline, about 95% wanted to space or limit childbearing: almost a quarter stated that they wanted to limit childbirth while 71% wanted to space their births. Of those who wanted to space, three out of every four clients wanted to wait at least a year to have the next child.

Even though the overwhelming majority of the clients at midterm (97% of the 637 clients), wanted to space or limit births only about 1 in 5 (23.1%) were currently using any FP method, compared to about 1 in four at baseline. Injectables were almost 5 times as common as male condoms, or oral pills, and 10 times as common as natural FP. Long-term methods, including intrauterine devices, sterilization and vasectomy, were not popular to the clients. These data at midterm illustrate an insignificant reduction of the very high-unmet need for family planning (in terms of both spacing and limiting births) with reference to the baseline.

Interaction with Provider on FP

At midterm, 45% of clients reported that, that providers talked to them about FP during their current visit compared to 25% during the baseline. While a little over 1% of clients reported receiving information, education, and communication (IEC) materials on FP during the baseline, more than 6% received IEC materials during the midterm survey. A comparable proportion of clients at baseline and at midterm – about 7 in 10 of the clients who reported that their providers did not talk to them about FP, said they would have liked the provider to have spoken to them about FP.

Captured through the exit interviews at midterm, clients who received FP information stated in a multiple option response that the provider had talked about types of FP methods (38%), how to use methods (30.8%). Eight percent of the clients were given a referral for FP, all of them verbally (53 out of 53 referrals). Most of the clients (41/53) said they would honor the referral. About 3% of the few who would not honor the referral cited reasons including ‘afraid of spouse’, not enough time amongst others.

Related statistics from the provider-client observation at midterm do not compare favorably with those of the client exit interview. In particular the mode of the referrals of clients by providers to other units for FP services. Such referrals though overwhelmingly verbal (about 95%) at baseline, and 66.7% at midterm, was not 100% as captured by the exit interview.. A few of the providers (6.7%) used GHS referral letter), and referral cards (26.7%) during the midterm survey.

Family Planning Provision

Data from both the midterm and the baseline surveys confirm that acceptability of the range of FP services was not limited to just clients. During the midterm survey, almost 3 out of every 4 providers reportedly gave FP information (73.2%), FP referral (63.1%), and/or FP counseling (66.4%) compared to 50%, 42%, and 42% respectively during the baseline. Of those who reportedly provided information/methods to clients, 31% said they identified reproductive goals of client during the process, 67% provided information about different contraceptive methods, 55% discussed client’s contraceptive preferences, or helped client select a suitable method. About one-third explained to clients how to use the selected method. About 10% of the providers offer other services. These include correct misconceptions, discuss challenges, follow up visits, importance of FP to mother and child, refer to FP unit, allay fears.

When these providers were asked about the main steps to be taken in counseling clients on FP, steps correctly named included the following: identify reproductive goals of client (46 mentions); provide information about different contraceptive methods (100 mentions); discuss the client contraceptive preference (82 mentions); help client select a suitable method (81 mentions); and explain to client how to use selected method (54 mentions). There were significant improvements from the baseline where these statistics were 43, 21, 27, 31, and 45 respectively.

Of those who were providing FP information at midterm, a substantial proportion of providers reported that they currently provide FP information to their female (90%) and male (75%) clients, compared to 88% and 72% during the baseline. Of the remaining providers who were not currently providing FP information, 9 out the 15 providers said they would want to include FP in their activities.

When asked whether they were willing to provide a range of FP services in the future, the majority of providers wanted to provide FP information (95%) compared to 97% (at baseline), FP counseling and referral (93.3%) compared to 94%(at baseline). Compared to 11 (8%) during the baseline, 14 (9.4%) providers reported no difficulties in providing FP services.

Some of the difficulties in providing FP noted by providers at baseline included lack of qualified personnel, lack of supplies and stock outs of commodities, a lack of equipment, and a lack of IEC materials. For those who reported encountering difficulties in providing FP services at midterm survey, the common reasons had to do with inappropriate facilities/layout, lack of equipment, lack of qualified personnel, and lack of supplies. Almost one out of every five providers did not feel sufficiently trained.

With the exception of male condoms and Levonorgestrel intrauterine devices, the availability of contraceptives in the sampled units seemed to have been better at baseline. None of the units had Levonorgestrel intrauterine devices at the time of the surveys. Two units had spermicides at baseline, and only one unit at midterm. In context, IUS has not been introduced to all facilities of the GHS. Just a few sites in the Greater Accra and Ashanti regions have been exposed to this in a pilot. The GHS does not also provide spermicides in its supply chain. Facilities that have spermicides procure that on their own from the private sector.

Job Expectations

Both in the first and second wave of assessments, the majority of providers (96% and 92%) respectively reported having a job description; about three-quarters of them in written form. Close to 80% (107 of the 137 providers) who had a job description at midterm indicated that their job description included FP; a change from the 62% recorded at baseline.

During the midterm survey, guidelines recommending that FP services be offered to clients were available in about 80% of the 36 units sampled compared to 50% of the 32 units sampled during the baseline survey. The FP Protocol and/or the Global Handbook was available in 25/36 units (69.4%) compared to 31% during the baseline. At baseline providers were often (65%) not aware that there were written guidelines on FP services, during the midterm survey, a comparable proportion (63.8%) knew.

Performance Feedback

About two-third (66.7%) of the 36 units sampled at midterm had a method for monitoring quality of care. Of those who had this monitoring mechanism, some monitored quality of care through review meetings (8/24 units), client feedback (13/24 units), supervision of staff (16/24 units). Three units mentioned monitoring of waiting time as a means of monitoring quality of care. Regarding supervision, about 75% of the providers said that a supervisor spoke with them or had observed their work in the past six months. For those who had been spoken to by a supervisor in the past six months, 26%, 6% and 7% said this occurred on one, two, three and six occasions, respectively. At baseline, these statistics were 34%, 16% and 19% respectively.

At baseline the majority of the providers indicated that supervisors did the following during their visit: checked their records (76%), observed their work (82%), provided feedback on their performance (76%), and discussed problems they had encountered (79%). Over three-fifths (64%) stated that supervisors provided updates on administrative or technical issues related to their work, whereas only 32% said that supervisors discussed FP and gave feedback specifically on FP performance. These indicators improved after the intervention as observed at midterm. At midterm, close to 90% (87.2%), of the providers indicated that their supervisors had checked their records, observed their work (87.2%), provided feedback on their performance (74.5%). About sixty percent of the providers indicated that their supervisors provided updates on administrative or technical issues related to their work.

Regularity of monthly review meetings that include FP was assessed both at baseline and at midterm. At baseline, seven units (22%) indicated ever holding such meetings, 9 units (28%) held it quarterly and 1 unit held it annually. Fifteen units (47%) never held a review meeting that included FP. In comparison, only 2.8% of the 36 units sampled during the midterm survey indicated never holding such meetings. A little over eight percent held it annually, about a third held in quarterly, and 42% monthly. Refreshingly, two of the 36 units sampled during the midterm survey indicated holding such meetings more than once in a month.

When asked at baseline and at midterm surveys, an overwhelming majority of the clients said they were satisfied with services received at the facility during that visit. The clients articulated at midterm that they were particularly satisfied with respect to their ability to discuss their problems or concerns with the providers (97.3%), with the explanation the providers gave them about their problem or treatment (96.7%), with the quality of examination or treatment provided (97.3%), and with the cleanliness of this facility (97.0%). As such, most (94%) of them would strongly recommend the facilities they were currently visiting to a friend. With respect to the strength of recommendation, there was an increment of seven percentage points with respect to what was recorded at baseline. The most common reasons for lack of satisfaction at baseline were inadequate explanation by providers and not being able to discuss a problem with the provider.

Motivation

About the same proportion of unit heads at baseline and at midterm indicated that their staff are recognized for good performance in carrying out regular duties (close to 70% and 63.9) respectively. Further, five unit heads (19%) at baseline indicated that staff receive recognition for performance specifically directed at integrating FP into the unit. During the midterm survey 10 unit heads (28%) disclosed that their staff receive such recognition. At baseline two individuals had been awarded in the past six months for their efforts in FP compared to five at midterm.

Over three-quarters (77%) of providers at baseline and 84% at midterm indicated that there is recognition for good work. About the same proportion of providers had received verbal or written recognition in the last six months preceding these surveys – 61% at baseline and 66.4% at midterm.

Knowledge and skills

In comparison with the baseline where about half of the providers reportedly gave FP information (50%), FP referral (42%), and/or FP counseling (42%), an overwhelming majority of the providers during the midterm gave FP information 141 (94.6%), referral or counseling 139 (93.3%). FP methods, specifically short term methods were offered by 115 (77.2%). A little over half 85 (57.0) offered long term methods during the midterm survey compared to one-fifth (19%) at baseline.

Both at baseline and at midterm, providers' opinions on the ideal interval between pregnancies were sought. Thirteen percent of them at baseline said any period/interval of less than two years was optimal, 16% thought that an optimal interval was three to five years, and 71% specified two to three years. At midterm, these statistics were 2.7%, 8.7%, and 87.2% respectively.

Infrastructure, supplies and equipment

In twenty three of the 32 units sampled at baseline, examination rooms were private compared to 13 of 36 units during midterm assessment. However, there were two units which had no visual or audio barriers, seven (19.4%) had examination rooms with other people or had such rooms with no visual or audio barrier. One unit had a counseling room with neither visual nor audio barriers both at baseline and at midterm.

Conditions in the facilities were generally conducive for providers in terms of infrastructure, with for example all/almost all units sampled at baseline and at midterm having piped running water/veronica buckets, electricity, clean facilities, and waiting areas for clients that were protected from the sun and rain. Working latrines/toilet for clients were available in 78% of the 36 units sampled during the midterm assessments, and there were enough chairs or benches in the waiting area for 64% of the units.

At baseline visual aids for teaching about different FP methods were available in 9 out of the 32 units compared 16 out of the 36 units at midterm. At midterm, counseling flipcharts were available in 23 out of 36 units compared to eight of 32 units at baseline. Both at baseline and at midterm, only six units had models for demonstrating female condom use. Information booklets or leaflets on FP for clients were available in 10 at baseline and 21 units at midterm

Background

Under the leadership of the Ministry of Health (MOH)/Ghana Health Service (GHS), a consortium of five agencies¹ with specialized but complementary skills and experience initiated the R3M Program in September 2006. The program aims to provide financial and technical resources that will enable the Ghanaian government significantly expand women's access to modern family planning (FP) and comprehensive abortion care (CAC), thereby reducing unwanted fertility and the severe complications and deaths caused by unsafe abortions. The GHS indicated interest in having the R3M Program provide technical assistance in revitalizing the country's FP program. The integration of FP services into other services was identified as promising and as feasible and desired by many providers and clients, given the reproductive health context.

The GHS's unflinching support to the initiative may have been informed by the very high rates of unwanted fertility and unsafe abortion, as well as relatively low use of modern contraception in the country. It is widely accepted that a combination of the above factors contribute significantly to the high levels of maternal morbidity and mortality found in Ghana. The number of maternal deaths increased from 957 to 995 between 2006 and 2007, and maternal mortality ratio went up from 187.2/100,000 to 229.9/100,000 live births over this period (Ghana Statistical Service [GSS], Ghana Health Service [GHS] and ICF Macro 2009). Most of these deaths were related to unsafe abortion. Recent Ghana DHS data (2008) indicate that only 17% of married women of reproductive age use modern contraceptives, while 14% of all births in Ghana are unwanted, 37% are unplanned and 23% are mistimed, despite the fact that knowledge of family planning (FP) is virtually universal, with 98% of all women and 99% of all men age 15-49 knowing at least one modern method (GSS, GHS & Macro International 2009). Mistimed, unplanned, and unwanted fertility which all greatly contribute to the risk of death posed by unsafe abortion, arise from limited access to and use of FP services.

In Ghana, most hospitals and clinics have a FP unit where clients are referred to for services. However clients presenting to health facilities for non-FP purposes are not routinely screened and counseled for FP need. Generally, providers tend to be focused on their own service delivery area and a client's specific reasons for the particular visit. For example, post abortion care (PAC) clients and post natal care (PNC) clients often are not told when they are likely to become fertile again, or about FP methods they might use to prevent another unwanted pregnancy or abortion. A similar situation exists with antenatal care (ANC) and clients with HIV and/or sexually transmitted infections (STIs) who are often not told about the dual protection afforded by condom use or otherwise counseled for additional FP methods that may be suitable.

Further, each type of service or unit has its own training curricula, staffing patterns, information systems, supervisory tools and a top-down management approach (CATALYST Consortium, 2003). Generally vertical service delivery has the advantage of being focused on one specific activity and maximum utilization of resources to achieve specific outcomes.

In FP and reproductive health (RH) more broadly, integration often provides broader cultural acceptability of services: use of FP services when presented as an RH service component is improved; there is usually greater access to medical personnel trained in delivering comprehensive services; improved service delivery efficiency often occurs; costs can be reduced for clients and the service delivery system; the capacity of health care providers to make a more comprehensive assessment of women's reproductive health needs is increased; and ultimately, improved health outcomes for clients can be achieved (CATALYST Consortium, 2003).

Integration is an approach that uses a client visit as an opportunity to address other health and social needs beyond those that prompted the current health visit. This tactic combines services at one site and/or enhances linkages between additional health service delivery points. In addition to benefiting the client's overall health and well-being, integration may also have programmatic and cost benefits when multiple services are provided during one visit or at one facility (EngenderHealth [EH] 2007). In the health sector, integration has been defined as "offering two or more services at the same facility during the same operating hours, with the

¹ The five R3M consortium partners are: EngenderHealth, Ipas, Marie Stopes International, Population Council, and Willows Foundation

provider of one service actively encouraging clients to consider using other services during the same visit in order to make those services more convenient and efficient” (USAID 2003).

In practice integrated services are usually offered within the same facility, but when they are not, strong referral systems are crucial to ensure that clients receive high quality comprehensive services. The evaluation component of the study assesses the integration of FP services into other reproductive health (RH) services in the public sector. It has following specific aims and objectives.

Specific aims

The overall goal of the entire project is to increase access to FP services in Ghana. However, the research component led by PC is currently assessing the integration of FP services into other reproductive health service in the public sector in Ghana. In line with the baseline survey, this round of survey (the midterm survey) assessed the following in four selected facilities:

1. Feasibility of integrating FP services,
2. Acceptability of integrated FP services to providers and clients, and
3. Effect of FP integration on service utilization.

The specific components included:

- attitude and support of stakeholders including program managers, providers, other facility staff, and clients
- capacity of institutions to provide FP services
- staff training and ability to provide FP services
- supervision and monitoring of service delivery
- institutional setup of service delivery
- commodities supply and logistics
- quality of care

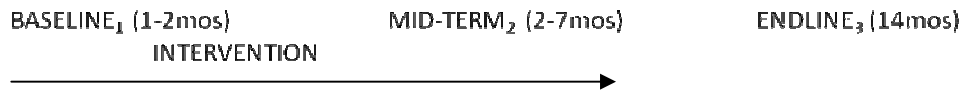
The baseline data or the performance needs assessment, and overall timelines have been detailed elsewhere (Population Council et al., 2011; unpublished PNA/Baseline Survey Report).

Methodology

As a generally accepted practice, the assessment team conducted the midterm evaluation using the same methodology as well as indicators of the baseline survey. This was done to ensure the comparability of findings. This section summarizes the data collection and analysis procedures that were adopted.

Study Design

Overall, a pre-test-post-test design was adopted, with a baseline assessment conducted just before the intervention is implemented. Other measurements were done during and after the intervention. This is illustrated as follows:




Setting

The assessment took place at four health facilities in two regions -Ashanti and Eastern regions of Ghana. These project sites which included rural and urban facilities were selected conveniently during the baseline survey. These are Kumasi MCH, Obuasi, Koforidua and Tetteh Quarshie Memorial Hospitals. With the exception of Koforidua, these are all district hospitals. The particular hospital units included were: ANC clinics, PNC clinics, FP clinics, pediatric units, and PMTCT units. Below is a map of Ghana showing the towns where these facilities are located.

Map of Ghana



Source: Magellan Geographix., <http://www.maps.com>

 Study instruments were tested in this town/Dodowa.

Evaluation methodology

The assessment of integration of services included both process and outcome evaluations. As in the baseline, the Assessing Integration Methodology (AIM) developed by PC was adopted. This methodology allows for “determining the feasibility of various [integration] combinations, assessing and monitoring the quality of service received, and evaluating their effect on utilization” (Rivero-Fuentes et al. 2008). AIM involves collection of data by a research team during one- to several-day facility visits. In this particular round of survey, the visits entailed five main components: inventory of services, equipment and supplies; examination of service statistics for the previous 12 months; interviews of providers; observations of provider-client interactions; and interviews with clients.

Evaluation Tools

Existing AIM tools, instructions, protocols, and consent forms which were reviewed and adapted during the baseline survey was also used during the midterm assessment. The tools included:

Facility (Unit) Inventory

A facility inventory that includes a section on service statistics, facility inventory of services, infrastructure, equipment and supplies: This tool allows for an assessment of the readiness of a facility to provide services, and will provide information on: Availability of particular services, Organization of services within the facility, management, supervision and record keeping procedures, availability of functional or unexpired FP equipment, supplies, materials and commodities

Provider-client Observations

This made use of an observation guide for recording provider-client interactions: This tool assesses quality of service. It is an itemized checklist which will be filled in by a nonparticipant observer who has some clinical training. The checklist covers items that ought to be addressed during a consultation, according to current service delivery guidelines. The following measures were put in place to ensure the reliability of the data collected by this instrument.

- There was a need for interviewers with clinical training (e.g. senior-level nursing staff) for the inventories and provider-client observations.
- *Interrater reliability* is a concern when more than one observer is used. We did not test interrater reliability; however, a careful decision was made during the development of the observation guide, to ensure that it was objective and not subjective in nature, decreasing the likelihood of inter-observer disagreement.
- The *Hawthorne effect* is the presence of an observer during the consultation, which may influence the way a provider interacts with a client or vice versa. To minimize this as much as possible, the observer emphasized to both client and provider that she was not a staff member, nor was she there to interrupt or provide clinical input. The interviewer sat out of direct line of sight of both provider and client, and recorded information as inconspicuously as was possible.

Client Exit Interviews

An exit interview with the client was conducted using this tool. This was a standardized questionnaire for exit interviews with clients: This tool elicits information on the perceptions of clients on services received, as well as their knowledge, attitudes and intentions as related to FP. Again a number of measures were instituted to ensure the validity of the data collected by using this tool. These include:

- To minimize *recall bias*, most clients were interviewed immediately after being seen. However, it is possible that some clients nevertheless would not have remembered all that was discussed

- during the consultation. Where data available in different instruments overlapped, comparisons (e.g. between observation and client interviews) were generally congruent.
- With *courtesy bias*, clients may be reluctant to express dissatisfaction with services. In some cases, even though clients had said they had waited too long or that they felt they had not been treated well by staff, they still reported being satisfied with services. This may have been what clients thought interviewers wanted to hear. Or, it may have reflected client expectations for care. A key part of the training of data collectors was on the need for unbiased and impartial voice, facial and body expressions when administering interviews.
 - For *sampling*, it would be beneficial to prepare a schedule of unit visits and determine on what days particular services are available, especially because there was considerable overlap between units, with the same clinical sites providing multiple unit services such as antenatal, postnatal, and PMTCT, but on different days. Other units were open on only one particular day of the week. Efforts were made to obtain the schedules for all units at each facility, but some volume problems still occurred. Schedules of visits should be more certain before the data teams arrive at the facilities.
 - Because there were different client loads for different units, sample weights may have been useful. However, the data presented have not been weighted.
 - Regarding *selection bias*, we obtained or observed only the experiences of those clients, providers and unit heads that came for service during typical working hours (8:00 A.M.–5:00 P.M.). We did not cover those clients who did not receive services or providers who attended late evening or weekend hours. Clients who were unable to take time away from work during the day, or those who did not want to come to the facility during daylight hours were therefore excluded. Selection also was an issue for the provider interviews. Some providers were on leave. For example, one of the only two FP providers at one of the facilities was away during the study, leaving only the other provider to participate.

Provider Interview Tool

Research assistants used this tool to interact with providers on the subject matter of FP integration into other health services. This tool was used specifically to collect information on the knowledge, attitudes and practices of providers in relation to FP services, as well as training. Providers from FP units as well as other units/departments were interviewed.

Interviewers/Data collectors

Four senior-level, clinically trained nurses who were familiar with standards of clinical care conducted interviews using the first two instruments. Eight experienced interviewers who did not necessarily have clinical or medical backgrounds but who had extensive experience in interviewing for surveys conducted interviews using the last two instruments. In some facilities, it was necessary to call on the senior nurses to help reach sample targets by carrying out some provider interviews.

For the first instrument, a senior nurse obtained consent from the unit head to obtain information on the unit's readiness for providing FP services. The inventory required collection of data through questions to the unit head, observation and recording of the presence or absence of infrastructure and materials, and an examination of service statistics.

For the second instrument, the senior data collector obtained consent from both the provider and client to be present during individual consultation. She used the observation guide to record mainly yes-or-no answers to a series of actions reflective of certain aspects of quality of care (questions that the provider should ask, points of information that should be covered, etc.) with respect to FP.

Following a consultation, or as a client left the facility after his or her visit, another interviewer would approach the client to ask if the interviewer could ask him or her about the visit and satisfaction with the services received. The interviewer explained to the client that the interviewer was not hospital staff that the client's answers would remain confidential, that the client was able to refuse participation at any point before or during the interview, and that the client's answers would not affect the care he or she was likely to receive in the future. If the interviewer obtained consent, the interviewer then proceeded to ask the client a series of questions (which usually took about 15 minutes).

Table 3.1 shows the instruments used and the sample sizes achieved for each. The instruments used in all four facilities were identical, although questionnaires for the exit interviews (and some provider interviews) were verbally translated into local languages in each hospital.

Training of Data Collectors

Data collection staff (comprising both men and women) underwent a three-day training session (November 7–9, 201) on the instruments and methodology that included a pilot test of the instruments at Government Hospital, Dodowa (Greater Accra region). Dodowa was not one of the study sites. There were minor revisions of the instruments following the debriefing session.

Table 3.1: PNA study instruments and sample sizes

Instrument	Sample size targeted	Sample size achieved	% Target achieved
Facility (unit) inventory Applied once per unit; gathered information on infrastructure, technical, administrative, resource and other capacities; also included service statistics over the past year, six months, three months and one month	32	36	113%
Provider-client observation guide Assessed the interaction between provider and client, mainly focusing on FP	128	124	97%
Client exit interview Assessed clients' experiences during the visit, especially with respect to FP, but also client satisfaction	640	637	99%
Provider interview Assessed nature of FP involvement, interest, training, supervision, and motivation	128	149	116%

Sampling procedures

The data collection at the four facilities took place from November 14 to 19, 2011.

The types of facilities included regional and district hospitals, but their differences should not affect the research results. These facilities formed a convenience sample and were selected to represent different levels of the health system with high enough patient volumes for the study. These facilities were located in four districts receiving support from the R3M Project.

Entry to the various facilities was made possible by the medical superintendents and matrons. All providers who were available during the study period were interviewed. Clients were selected at random from all eight core units [(1) antenatal (ANC); (2) maternity; (3) postnatal (PNC); (4) child welfare clinic (CWC); (5) pediatric; (6) prevention of mother-to-child transmission of HIV/voluntary counseling and testing (PMTCT/VCT); (7) outpatient department (OPD); and (8) family planning (FP)] where available, as well as other units such as medical wards and surgical wards. To qualify for the study, clients had to have directly received care (except in the case of the pediatric ward, where mothers of clients were eligible for interview) and had to be between 15 and 49 years of age (women) or 15 to 59 years (men).

Across the four facilities, the sample size achieved included 36 unit inventories, 124 provider-client observations, 637 client exit interviews, and 149 provider interviews. Most client exit interviews and some provider interviews were conducted in local languages. All data were entered using EpiData, exported into PASW Statistics, Release Version 18.0.0, and analyzed.

General Results

Client Perspective

Background Characteristics of Clients

During the midterm assessment, a total of 637 clients participated in the exit interviews compared to 712 clients in the baseline. As in the baseline, clients selected from the ward units were interviewed after the discharge encounter (last encounter prior to departure) with the provider. We show in Table 4.1 that 85 (13.3%) of the clients were sampled from the OPD unit, while 48 (7.5%) were sampled from the FP unit. Antenatal and postnatal clients accounted for 19% and 10% of the sample, respectively. It is worthy of note that 93% of the clients were female. This statistic was 91% during the baseline survey. As in the baseline, the majority of clients (82%) were either married or cohabiting.

The median age of the clients interviewed was 29 years (range: 15 – 58); 6.8% of the sample were teenagers, and about 9% were aged 40 years or older. About 9% of clients had no formal schooling, while 19.5% had primary education. Most (67.2%) had secondary or higher education.

Table 4.1 Distribution of clients sampled by unit

Health unit	Baseline		Midterm		Percent change
	Frequency	Percent	Frequency	Percent	
ANC	102	14.3	118	18.5	4.2
Maternity	58	8.1	61	9.6	1.5
PNC	63	8.8	62	9.7	0.9
CWC	90	12.6	78	12.2	-0.4
Pediatric	83	11.7	77	12.1	0.4
PMTCT/VCT	91	12.8	65	10.2	-2.6
OPD	128	18.0	85	13.3	-4.7
FP	80	11.2	48	7.5	-3.7
Other	17	2.4	43	6.8	4.4
Total	712	100.0	637	100.0	-

Reproductive History, Family Planning Use, and Reproductive Intentions

As in the baseline, the clients sampled for the midterm assessment had on average, two children, although 95 (15%) were childless. Twenty nine percent had one child, 22% had two, and 17% had four or more children at the time of survey. These compare favorably with the baseline findings where the statistics were respectively 29%, 22% and 19%.

Of those with at least one child, a little over a quarter (25.4%) would like to limit childbirth while close to three-quarters (71.4%) would like to space their births. Of those who wanted to space, 12.1% wanted to wait at least a year to have the next child. Most (82.2%) wanted to wait at least two years to have the next child. Relatively few clients (2%) did not know their fertility intentions for the future. Interestingly, one female client noted that her future fertility intentions were dependent on the almighty God.

Even though the overwhelming majority (97% of the 637 clients), wanted to space or limit births only about 1 in 5 (23.1%) were currently using any FP method. Injectables were almost 5 times as common as male condoms, or oral pills, and 10 times as common as natural FP. Long-term methods, including intrauterine devices, sterilization and vasectomy, were not popular to the clients. Details of these and comparisons with the baseline data are given in Table 4.2 below.

Table 4.2: Percentage distribution of clients by FP method currently being used

FP method	Baseline		Midterm		% change
	Frequency	Percent	Frequency	Percent	
Oral pills	24	12.4	17	12.4	0
Injectables	85	44.0	70	51.1	7.1
Implants	13	6.7	16	11.7	5
IUD/IUS	3	1.6	3	2.2	0.6
Male condoms	18	9.3	17	12.4	3.1
Female condoms	3	1.6	3	2.2	0.6
Female sterilization	8	4.1	4	2.9	-1.2
Fertility awareness/natural FP	30	15.5	7	5.1	-10.4
LAM	6	3.1	-	-	-
Other	3	1.6	-	-	-
Total	193†	100.0	137‡	100.0	0.0

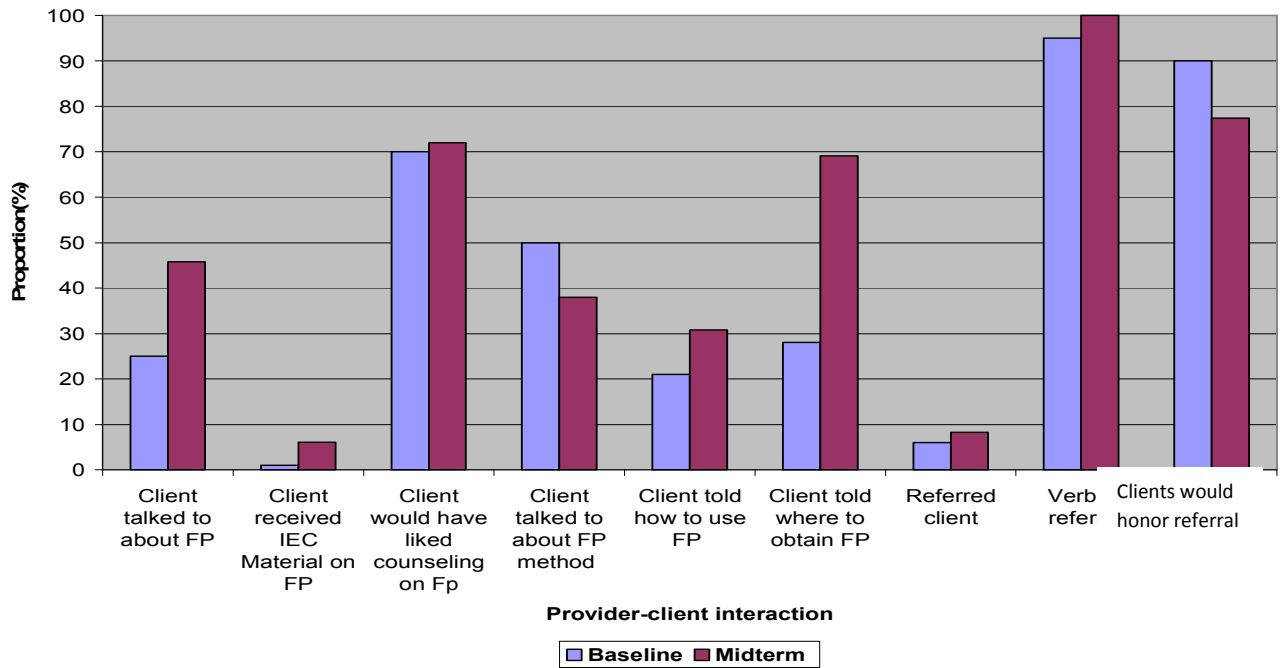
Interaction with Provider on FP

Forty-five percent of clients reported that, that providers talked to them about FP during their current visit compared to 25% during the baseline. While a little over 1% of clients reported receiving information, education, and communication (IEC) materials on FP during the baseline, more than 6% received IEC materials during the midterm survey. Also at midterm, 72% of the clients who reported that their providers did not talk to them about FP said they would have liked the provider to have spoken to them about FP. Those who received FP information stated in a multiple option response that the provider had talked about types of FP methods (38%), how to use methods (30.8%). Eight percent of the clients indicated during the exit interview that they were given a referral for FP, all of them verbally (53 out of 53 referrals). Most of the clients (41/53) said they would honor the referral. About 3% of the few who would not honor the referral cited reasons including ‘afraid of spouse’, not enough time amongst others. These are compared with the data from the baseline survey in Figure 4.1 below. These, however, do not compare favorably with related statistics from the provider-client observation at midterm. In particular the mode of the referrals of clients by providers to other units for FP services. Such referrals though overwhelmingly verbal (about 95%) at baseline, and 66.7% at midterm, was not 100% as reported by the clients during the exit interview. A few of the providers (6.7%) used GHS referral letter, and referral cards (26.7%) during the midterm survey.

† 519 not applicable

‡ 500 not applicable

Figure 4.1: Provider-Client interaction on FP (baseline and midterm compared)



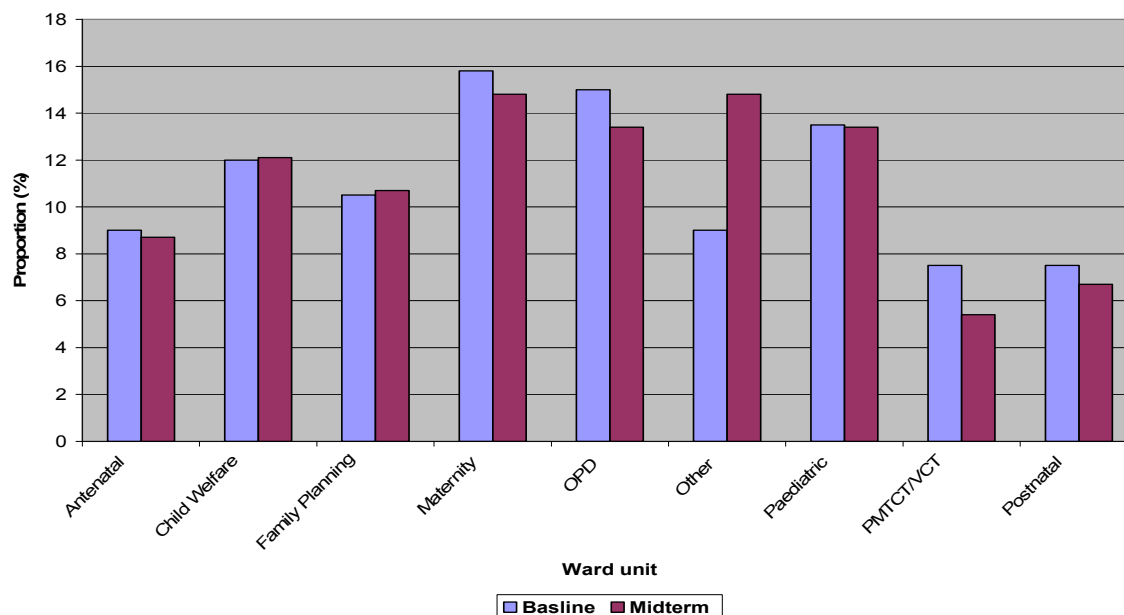
Provider Perspective

Background and Qualifications

About fifty percent of all the 149 providers interviewed were from the Ashanti region. The majority of them (90.6%) were female. However, when characterized by professional qualification, midwives constituted about 28%, state registered nurses 20%, and community health nurses 20%. Others included field technicians, general nurses, health extension workers, health information officers, national service personnel, ophthalmic nurses, nutritionists, principal ward assistants, and psychiatric nurses.

The mean age of providers was 39 years, and 66% of them were 40 years or younger. The distribution of staff sampled across the units is shown in Figure 4.2. About 30% of providers were from ANC, PNC, or maternity departments; 13% were from OPD units; and 11% were from FP units.

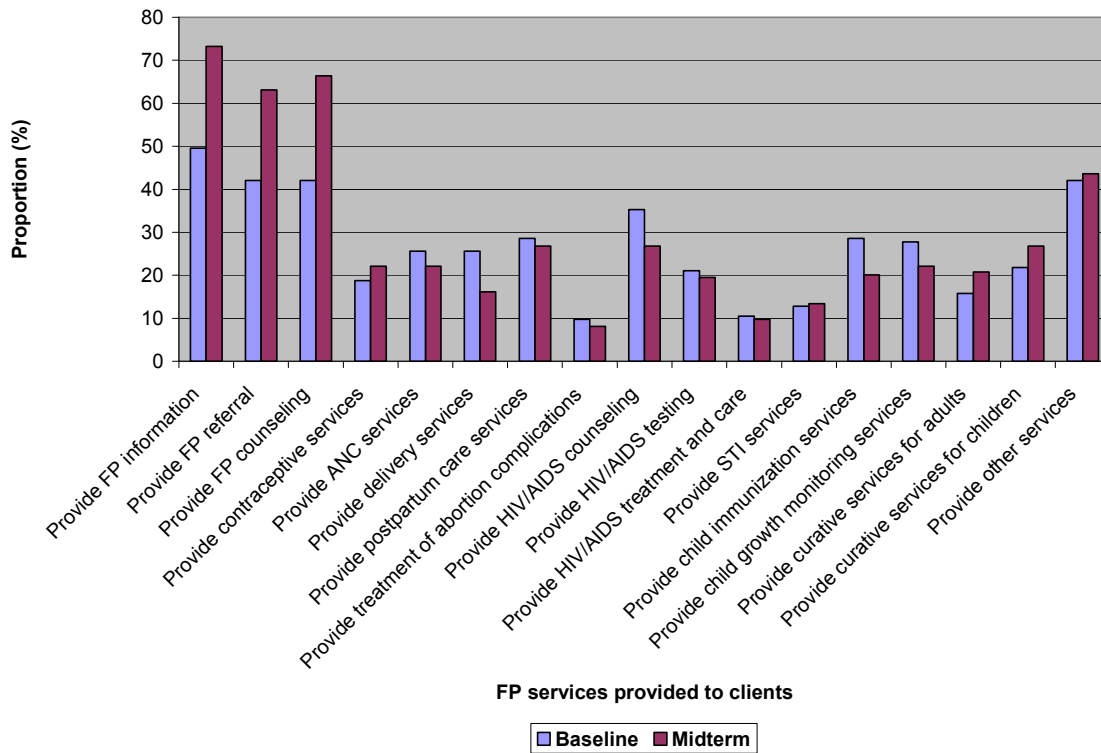
Figure 4.2: Distribution of service providers by specific type of unit (baseline and midterm compared)



Family Planning Provision

Figure 4.3 illustrates the mix of FP services providers offered to clients during the baseline and the midterm surveys. At midterm, almost 3 out of every 4 providers reportedly gave FP information (73.2%), FP referral (63.1%), and/or FP counseling (66.4%) compared to 50%, 42%, and 42% respectively during the baseline. Of those who reportedly provided information/methods to clients, 31% said they identified reproductive goals of client during the process, 67% provided information about different contraceptive methods, 55% discussed client’s contraceptive preferences, or helped client select a suitable method. About one-third explained to clients how to use the selected method. About 10% of the providers offer other services. These include correct misconceptions, discuss challenges, follow up visits, importance of FP to mother and child, refer to FP unit, allay fears. Some of the providers (4.0%) noted that they do not provide counseling to clients.

Figure 4.3: Mix of FP services providers offer to clients



When these providers were asked about the main steps to be taken in counseling clients on FP, steps correctly named included the following: identify reproductive goals of client (46 mentions); provide information about different contraceptive methods (100 mentions); discuss the client contraceptive preference (82 mentions); help client select a suitable method (81 mentions); and explain to client how to use selected method (54 mentions). There were significant improvements compared to the baseline where these statistics were 43, 21, 27, 31, and 45 respectively.

Of those who were providing FP information, a substantial proportion of providers reported that they currently provided FP information to their female (90%) and male (75%) clients, compared to 88% and 72% during the baseline. Of the remaining providers who were not currently providing FP information, 9 out of the 15 providers said they would want to include FP in their activities.

Regardless of current practice, however, when asked whether they were willing to provide a range of FP services in the future, the majority of providers wanted to provide FP information (95% baseline), FP counseling and referral (93.3%; 94% baseline), short-term FP methods (77.2%; 84% baseline), and long-term methods (55.0; 71% baseline). Compared to 11 (8%) during the baseline, 14 (9.4%) providers reported no difficulties in providing FP services; these were from maternity (2), postnatal (2), child welfare (1), pediatric (1), FP (3), OPD (4), and PMTCT/VCT (1). For those who reported encountering difficulties in providing FP services, the common reasons had to do with inappropriate facilities/layout. Lack of equipment, lack of qualified personnel, and lack of supplies were major challenges. Almost one out of every five providers did not feel sufficiently trained (Table 4.3).

Table 4.3 Difficulties providers face in providing FP services

Baseline (Clients; n =128)		Midterm (Clients; n =149)	
Difficulties in providing FP services			
	Percent	Percent	Percent change
Lack of supplies	36.1	22.8	-13.3
Lack of qualified personnel	45.1	22.8	-22.3
Lack of equipment	35.3	26.2	-9.1
Failure in equipment	7.5	6.7	-0.8
Inappropriate facilities/layout	27.1	34.9	7.8
Lack of furniture	14.3	7.4	-6.9
Lack of IEC materials	33.1	7.4	-25.7
Do not feel sufficiently trained	21.8	17.4	-4.4
Not enough time to counsel/provide service	18.8	20.8	2
No difficulties	8.3	9.4	1.1
Other	21.8	35.6	13.8

Performance Factor Results

Job Expectations

In this second wave of data collection, the majority 137/149 (92%) of providers reported having a job description. About three-quarters 99/137(72.3%) of them were in written form. Over fifty percent (107 of the 137 providers) who had a job description indicated that their job description included FP, whereas 22% of them had job description that did not include FP.

Both rounds of assessments collected data on the availability of written guidelines on FP. At baseline, 28 of 32 (87.5%) sampled units had written guidelines and 28 (77.8%) of the 36 units sampled during the midterm survey also had. Sixteen of the 32 units (57%) sampled during the baseline had guidelines recommending that FP services be offered to clients. This statistic jumped to 80% (24 of the 30 units with guidelines) during the midterm survey. The FP Protocol and/or the Global Handbook was available in 25/36 units (69.4%) compared to 31% during the baseline. At baseline providers were often (65%) not aware that there were written guidelines on FP services. During the midterm survey, the majority 95 of the 149 (63.8%) knew.

Performance Feedback

About two-third (66.7%) of the 36 units had a method for monitoring quality of care. Of those who had this monitoring mechanism, some monitored quality of care through review meetings (8/24 units), client feedback (13/24 units), supervision of staff (16/24 units). Three units mentioned monitoring of waiting time as a means of monitoring quality of care.

Regarding supervision, about 75% of the providers said that a supervisor spoke with them or had observed their work in the past six months; For those who had been spoken to by a supervisor in the past six months, 26% 6% and 7% said this occurred on two, three and six occasions, respectively. At baseline, these statistics were 34%, 16% and 19% respectively.

At baseline, the majority of the providers indicated that supervisors did the following during their visit: checked their records (76%), observed their work (82%), provided feedback on their performance (76%), and discussed problems they had encountered (79%). Over three-fifths (64%) stated that supervisors provided updates on administrative or technical issues related to their work, whereas only 32% said that supervisors discussed FP and gave feedback specifically on FP performance. These indicators improved after the intervention as observed at midterm. Close to 90% (87.2%), of the providers indicated that their supervisors had checked their records observed their work (87.2%), provided feedback on their performance (74.5%). About sixty percent of the providers indicated that their supervisors provided updates on administrative or technical issues related to their work. Others also noted that their supervisors discussed problems they have encountered, discussed their performance in FP and gave feedback specifically on their FP performance.

At baseline, regularity of monthly review meetings that include FP was assessed. Seven units (22%) indicated ever holding such meetings, 9 units (28%) held it quarterly and 1 unit held it annually. Fifteen units (47%) never held a review meeting that included FP. In comparison, only 2.8% of the 36 units sampled during the midterm survey indicated never holding such meetings. A little over eight percent held it annually, about a third held in quarterly, and 42% monthly. Refreshingly, two of the 36 units sampled during the midterm survey indicated holding such meetings more than once in a month.

In terms of management reports, more than forty percent of the units (44.4%) did not include issues on FP in their monthly reports. Fifty percent of the 35 units reported on FP. Only one unit had no monthly report. In terms of a mechanism for client feedback, 21 of the units had systems of determining clients' opinions. Among these 21 units, 16 (66.7%) indicated that there had been some changes in the units in the last six months as a result of clients' opinions. This particular statistic was 8 units (44%) at baseline.

From the perspective of the client, more than 90% of them were satisfied with services received at the facility during that visit. They were satisfied with respect to their ability to discuss their problems or concerns with the providers (97.3%), with the explanation the providers gave them about their problem or treatment (96.7%), with the quality of examination or treatment provided (97.3%), and with the cleanliness of this facility (97.0%). Ninety four percent of clients said they would strongly recommend the facility to a friend, and 5.3% would recommend the facility, but not strongly.

Motivation

About the same proportion of unit heads at baseline and at midterm indicated that their staff are recognized for good performance in carrying out regular duties (close to 70% and 63.9) respectively. Further, five unit heads (19%) at baseline indicated that staff receive recognition for performance specifically toward integration of FP into the unit compared to 10 unit heads (28) at midterm. At baseline two individuals had been awarded in the past six months for their efforts in FP compared to 5 at midterm

Over three-quarters (77%) of providers at baseline and 84% at midterm indicated that there is recognition for good work. About the same proportion of providers had received verbal or written recognition in the last six months preceding the baseline and midterm surveys – 61% at baseline and 66.4% at midterm. At baseline, more than half (52%) of providers mentioned that there are negative consequences for bad work, and 8% said that they did not know what happens when a provider performs poorly. At midterm, these statistics were 75.2%, and 40%

Knowledge and Skills

In comparison with the baseline where about half of the providers reportedly gave FP information (50%), FP referral (42%), and/or FP counseling (42%), an overwhelming majority of the providers during the midterm gave FP information 141 (94.6%), referral or counseling 139 (93.3%). FP

methods, specifically short-term methods were offered by 115 (77.2%). A little over half 85 (57.0) offered long-term methods during the midterm survey compared to one-fifth (19%) at baseline.

Both at baseline and at midterm, providers' opinions on the ideal interval between pregnancies were sought. Thirteen percent of them at baseline said any period/interval of less than two years was optimal, 16% thought that an optimal interval was three to five years, and 71% specified two to three years. At midterm, these statistics were 2.7%, 8.7%, and 87.2% respectively.

Providers' knowledge on FP guidelines was also sought. At baseline, a little over half (56%) of them said they knew the content of the FP guidelines very well, 41% had fair knowledge about them, and the remainder did not know the guidelines. At the time of the midterm survey, providers' knowledge on the content of the guidelines had improved. Close to sixty percent (58%) knew the content very well, 40% knew it fairly well and only 3 of the 95 providers did not know the guidelines.

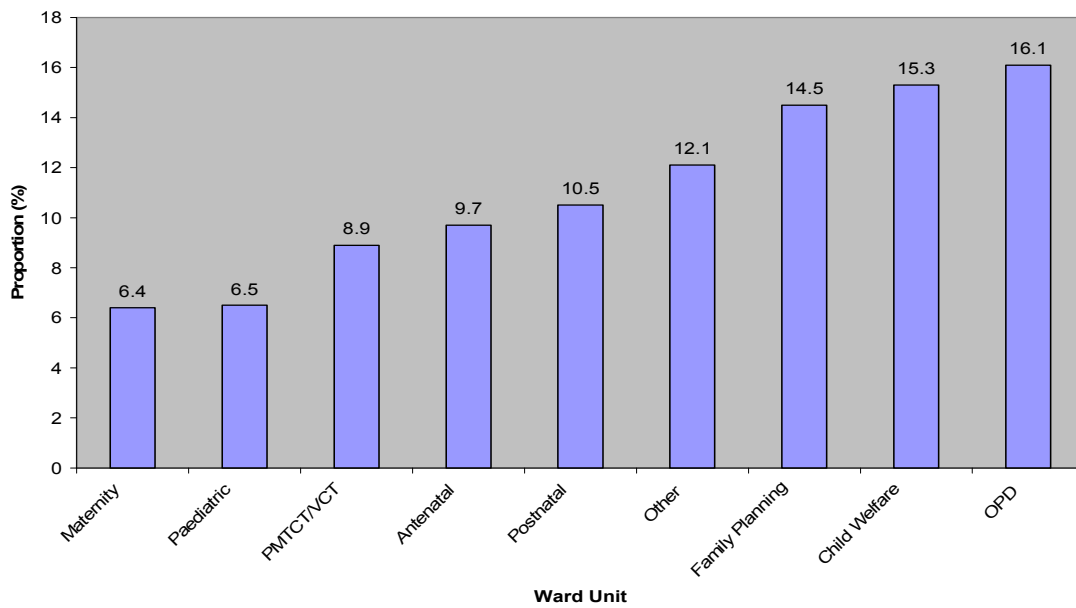
Presented in Table 4.4, are the results of providers' appraisal of their own knowledge of and comfort with specific contraceptive methods. Most providers were knowledgeable enough to counsel clients on natural FP or fertility awareness (48.3% compared to 66% at baseline) and on lactational amenorrhea method (58.4% compared to 77% at baseline). Most providers could counsel on short-term methods; however, a substantial proportion of providers were unable to actually provide them. Just as was observed at baseline, a few providers reported that they did not know short-term methods such as pills (2.0%), spermicides (1.3%), female condoms (2.0%) and male condoms (0.7%).

Table 4.4: Providers' knowledge of different family planning methods

	%											
	Oral pills	Injectables	Implants	IUD/IUS	Male condoms	Female condoms	Spermicides	Female sterilization	Vasectomy	Natural FP	LAM	Other
Don't know it	2.0	4.0	8.1	5.4	.7	2.0	1.3	8.1	8.1	4.7	3.4	4.0
Know little about it	13.4	12.8	20.1	18.1	4.0	8.1	16.8	20.8	20.1	14.8	10.1	2.0
Know well to counsel and provide it	38.3	35.6	14.8	12.8	48.3	41.6	18.8	3.4	2.7	48.3	58.4	.7
Know well to counsel but not provide it	46.3	47.7	57.0	63.8	47.0	48.3	19.5	67.8	69.1	32.2	28.2	.7
Summation	100	100	100	100	100	100	56.4	100	100	100	100	

One hundred twenty three 123 provider-client interactions were observed at baseline in all four facilities in the two study regions. Most of the observations were done at the OPD (17%), FP (16%), ANC (16%), and PMTCT/VCT units (13%). The distribution of the observations done during the midterm survey by ward unit is presented in Figure 4.4 below.

Figure 4.4: Distribution of observation done by ward unit (midterm)



At baseline 32% of the provider-client interactions that were observed involved new clients compared to 63/124 (50.8%) at midterm. The basic FP questions that were expected to be asked by providers to introduce the subject of FP were not asked by most providers both at baseline and at midterm (see Figure 4.5). The methods that the providers discussed with these new clients during the midterm survey are presented in Figure 4.6.

Figure 4.5: Basic introductory FP questions providers asked clients (baseline and midterm compared)

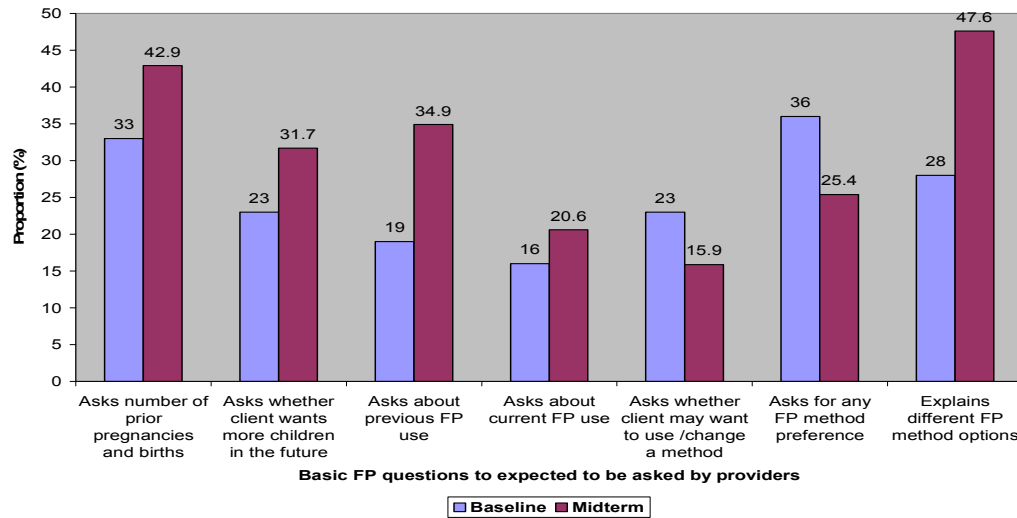


Figure 4.6: Comparison of methods discussed with new clients as recorded by provider-client observation (midterm)

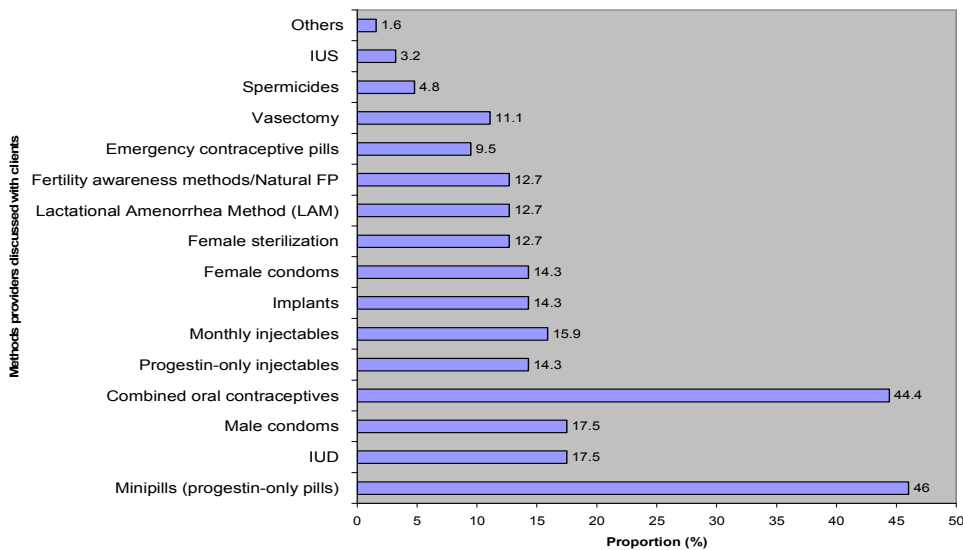
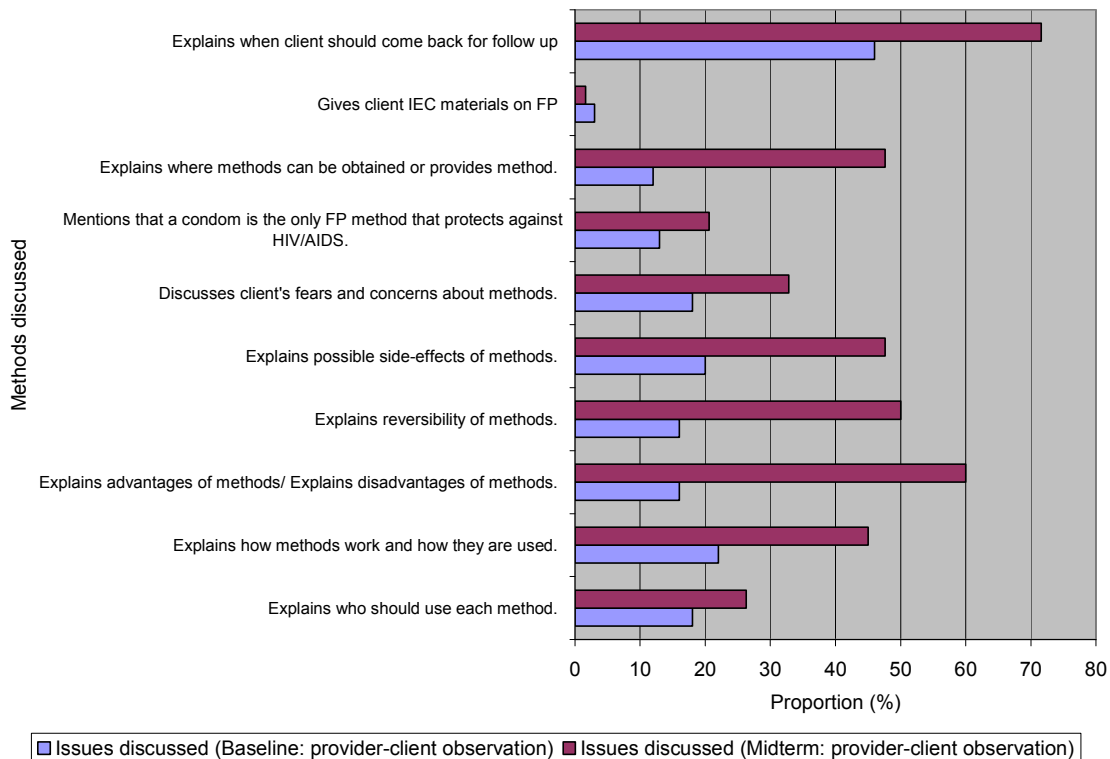


Figure 4.7 compares the FP-related issues providers discussed (provider-client observation) to what the clients reported during the exit interviews. It is elemental that telling clients about types of FP methods without explaining who can use what method, carefully explaining the advantages and disadvantages of a method, as well as side effects of a method can be counterproductive. It was observed at baseline that about 18% of the providers explained to clients who should use a particular method, 22% explained how a method works and how it is used, and 16% explained the advantages and disadvantages of the methods to clients. At midterm these statistics had increased to 27% 45% and 60% respectively.

In addition, 16% of providers at baseline explained the reversibility of the methods to clients, and one fifth explained the possible side effects of a method to clients compared to 50% and 48% respectively

at midterm. Eighteen percent satisfactorily discussed with clients their fears about the methods. About 33% did that at midterm (Figure 4.8).

Figure 4.7: Comparison of FP-related issues providers discussed with clients as documented during provider-client observation (baseline and midterm compared)



Both at baseline and midterm, less than one-fifth (baseline - 16%; midterm – 16.2%) of providers referred clients to other units for FP services. Such referrals were overwhelmingly verbal (about 95% at baseline and 66.7% at midterm).

A few of the providers (6.7%) used GHS referral letter), and referral cards (26.7%) during the midterm survey.

Infrastructure, Supplies and Equipment

In twenty three of the 32 units sampled at baseline, examination rooms were private compared to 13 of 36 units during midterm assessment. However, there were two units which had no visual or audio barriers, seven (19.4%) had examination rooms with other people or had such rooms with no visual or audio barrier. One unit had a counseling room with neither visual nor audio barriers both at baseline and at midterm.

Just as was observed at baseline, all 36 units sampled for the midterm assessment had electricity and clean facilities. However, at midterm, piped running water/veronica buckets and waiting areas for clients that were protected from the sun and rain were available in 97% of the units compared to 100% at baseline. Working latrines/toilet for clients were available in 78% of the 36 units sampled, and there were enough chairs or benches in the waiting area for 64% of the units. Thirty-one units

had hand-washing items such as soap and clean towels. However, only six units had a nail brush for hand washing.

At baseline visual aids for teaching about different FP methods were available in 9 out of the 32 units compared 16 out of the 36 units at midterm. At midterm, counseling flipcharts were available 23 out of 36 units compared to eight of 32 units at baseline. Both at baseline and at midterm, only six units had models for demonstrating female condom use. Information booklets or leaflets on FP for clients were available in 10 at baseline and 21 units at midterm

With the exception of male condoms and Levonorgestrel intrauterine devices, the availability of contraceptives in the sampled units seem to have been better at baseline (Table 4.5). None of the units had Levonorgestrel intrauterine devices at the time of the surveys. Two units had spermicides at baseline, and only one unit at midterm.

Table 4.5 Availability of contraceptives in units (baseline and midterm compared)

Indicator	Baseline		Midterm		Per cent difference
	Number of units with commodity	Percent	Number of units with commodity	Percent	
Combined oral contraceptive	6	18.8	6	16.7	-2.1
Progestin-only pills	7	21.9	5	13.9	-8
Emergency contraceptive pills	5	15.6	4	11.1	-4.5
Progestin-only injectables	8	25.0	5	13.9	-11.1
Monthly injectables	6	18.8	6	16.7	-2.1
Implants	6	18.8	2	5.6	-13.2
Copper-bearing intrauterine devices	5	15.6	5	13.9	-1.7
Levonorgestrel intrauterine devices	0	0.0	0	0.0	0
Male condoms	10	31.3	12	33.3	2
Female condoms	8	25.0	6	16.7	-8.3
Spermicides	2	6.3	1	2.8	-3.5

Actual Performance

This section focuses on the specific results relating to the desired performance statements that stakeholders developed prior to the baseline survey. It compares the various performance indicators measured at midterm to those at baseline.

Performance Indicators

As was done at baseline, the computation of the various indicators followed the same procedures.

1. For statement 1(a), we used data from the provider interviews to calculate what percentage routinely gave FP information to clients.
2. For statement 1(b), information from the question to providers, on whether they provided basic FP information and referrals in their interactions with their male clients was used in the calculation.
3. For statement 2(a), information from the provider interviews was used to calculate the number of paramedics who stated that they had basic information on FP; this was divided by the total number of paramedics sampled. Basic information was defined as knowing enough to counsel clients about the range of FP methods providers were asked about.
4. For statement 3(a), data from the facility (unit) inventory were used to calculate the percentage of units having required FP commodities, logistics, and equipment.
5. For statement 4(a), information from the facility (unit) inventory was used to determine the proportion of units that receive monitoring and feedback on various activities, including FP, at least quarterly.
6. For statement 5(a), information from the provider interviews was used to determine the number of staff in a particular unit who had been recognized for FP work within the past six months.
7. For statement 5(b), information from the facility (unit) inventory was used to calculate the percentage of staff whose performance in FP was reviewed regularly; the definition of regularly was at least every six months.

8. For statement 6(a), facility (unit) inventory data were used to determine the percentage of unit heads who said they sent reports which included FP, at least monthly.
9. For statement 7(a), facility inventory data were used to calculate the percentage of nurses (midwives, public health nurses, senior registered nurses, community health nurses, and enrolled nurses) providing FP services, relative to the total number of nurses.
10. For statement 7(b), the facility inventory completed with the unit head was used to provide data on the percentage of providers dispensing condoms.

Overall Targets for Desired Performance

Table 4.6 shows the overall actual performance relative to the desired performance across all sampled facilities. This is the “average” performance, taking all facilities together.

Table 4.6 Overall Actual Performance (across all four facilities; baseline and midterm compared)

Theme	Desired performance statement	Indicator	Desired performance	Actual performance		
				Baseline	Midterm	
1. Providing information to clients	1(a) All staff (both FP and non-FP providers) provide FP information to clients who visit the facility	% of health workers providing FP information	100.0%	50% (provider report) 70% (inventory)	73.2 (109/149) 75% (27/36)	
		% of health workers having basic knowledge on FP methods:			38.5% (57/149)	
		– oral contraceptives		79%	35.6% (53/149)	
		– injectables	100.0%	75%	14.8% (22/149)	
		– implants	100.0%	62%	12.8% (19/149)	
		– intrauterine devices	100.0%	63%	48.3% (72/149)	
		– male condoms	100.0%	84%	41.6% (62/149)	
		– female condoms	100.0%	83%	19.5% (29/149)	
		– tubal ligation (female)	100.0%	60%	3.5% (5/149)	
		– vasectomy (male sterilization)	100.0%	56%	2.7% (4/149)	
		– natural FP	100.0%	66%	48.3% (72/149)	
		– lactational amenorrhea method	100.0%	77%	58.4% (87/149)	
						0.7% (1/149)
						1.6% (1/63)
			% of patients or visitors in the reproductive age group provided with FP educational materials	100.0%	3% (observation) 1% (client report)	6.1 (39/637)

Theme	Desired performance statement	Indicator	Desired performance	Actual performance	
				Baseline	Midterm
	(1b) All service providers educate men on the importance of FP	% of providers giving education to men on importance of FP	100.0%	5% (client report) 73% (provider report)	- 80.6% (112/139)
2. Referral of clients by paramedics	2(a) 60% of paramedics able to provide basic information and referral on FP services	% of paramedics referring clients for FP	60.0%	17%(provider report) 16% (inventory)	63.9% (93/149) -
		% of paramedics having basic knowledge on FP methods:			
		– oral contraceptives	60.0%	83% (provider report)	38.3% (57/149)
		– injectables	60.0%	67%	35.6% (53/149)
		– implants	60.0%	67 %	14.8% (22/149)
		– intrauterine devices	60.0%		12.8% (19/149)
				50%	
		– male condoms	60.0%	83%	48.3% (72/149)
		– female condoms	60.0%	83%	41.6% (62/149)
		– tubal ligation (female)	60.0%		19.5% (29/149)
		– vasectomy (male sterilization)	60.0%	50%	
				33%	3.4% (5/149)
		– natural FP	60.0%	50%	2.7% (4/149)
		– lactational amenorrhea method	60.0%	50%	48.3% (72/149)
			58.4% (87/149)		

Theme	Desired performance statement	Indicator	Desired performance	Actual performance	
				Baseline	Midterm
3. Logistics and commodities	3(a) All required FP commodities, logistics, and equipment available at all times	% of units reporting availability of commodities			
		– oral contraceptives	100.0%	22% (inventory)	16.7% (6/36)
		– injectables	100.0%	22%	16.7(6/36)
		– IUD kit	100.0%		22.2% (8/36)
		– implants	100.0%	16%	5.7% (2/36)
		– implant removal/insertion kit	100.0%	16%	19.4% (7/36)
		– intrauterine devices (copper)	100.0%	0%	13.9% (5/36)
		– intrauterine devices (levo)	100.0%	31%	
			100.0%	16%	44.4% (16/36)
		– male condoms	100.0%	6%	33.3% (12/36)
		– female condoms			16.7% (6/36)
		– mini-lap kit	100.0%	10%	
			100.0%	19%	5.6% (2/36)
		– uterine model	100.0%	32%	
		– model for female condom	100.0%	25%	8.3% (8/36)
		– model for male condom	100.0%	28%	16.7 (6/36)
			100.0%	32%	75% (27/36)
		– flipchart			
		– poster	100.0%	31%	63.9% (23/36)
		– IEC/booklet for patients			25% (9/36)
	100.0%	31%	58.3% (21/36)		
– FP protocol/global	100.0%	44%			
	100.0%	81%			

Theme	Desired performance statement	Indicator	Desired performance	Actual performance	
				Baseline	Midterm
		handbook	100.0%	71%	69.4% (25/36)
		– spot light source			36.1% (13/36)
		– gynec. examination couch			50% (18/36)
		– adult weighing scale			63.9% (23/36)
		– blood pressure gauge			61.1% (22/36)
4. Supervision and feedback	4(a) All units receive monitoring, technical, and support visits and feedback on various activities including FP at review meetings	% of units holding at least quarterly review meetings on various activities including FP	100.0%	50% (inventory)	80.6% (29/36)
5. Motivation	5(a) Staff motivated for providing FP services	% of staff awarded for good performance in FP in the past six months	n/a	19% (inventory)	66.4% (99/149)
	5(b) Performance of all providers are reviewed regularly	% of staff performance reviewed regularly	100.0%	85% (provider report)	75.2 (112/149)
6. Reporting	6(a) Unit heads are able to submit monthly reports on FP services	% of unit heads submitting monthly reports on FP	100.0%	34% (inventory)	50% (18/36)

Theme	Desired performance statement	Indicator	Desired performance	Actual performance		
				Baseline	Midterm	
7. Service provision	7(a) All identified units in the facility give quality FP care	% of units having systems (client satisfaction surveys, suggestion boxes) for determining clients' opinions about the health facility or services	100.0%	56% (inventory)	58.3% (21/36)	
	7(b) All nurses (midwives, PHNs, CHNs, ENs) provide FP services	% of nurses providing FP services				
		– FP information	100.0%	54% (provider report)	73.3%	
– FP referral		100.0%	50%	63.1%		
– FP counseling		100.0%	51%	66.4%		
– FP method		100.0%	23%	22.1		
– FP information		100.0%	92% (inventory)	97.2%		
– FP referral		100.0%	98%	97.2%		
– FP counseling		100.0%	58%	77.8%		
– FP method		100.0%	36%/31% (condom/ other)	33.3%		
7(c) All staff provide condoms	% of staff providing condoms	100.0%	23% (inventory)	48.3% (72/149 male condoms) 41.6 (62/149 female condoms)		

Conclusions

This midterm survey sought to assess the status of the integration process of FP services into other reproductive health services in four Ghanaian health facilities. The key points that emerge from this midterm assessment are compared to those of the baseline and are summarized below:

Reproductive history, family planning use, and reproductive intentions

A little over a quarter (25.4%) of clients with at least one child would like to limit childbirth while close to three-quarters (71.4%) would like to space their births. Similarly, at baseline, about 95% wanted to space or limit childbearing. Even though the overwhelming majority of the clients at midterm (97% of the 637 clients), wanted to space or limit births only about 1 in 5 (23.1%) were currently using any FP method, compared to about 1 in four at baseline. These data at midterm illustrate an insignificant reduction of the very high-unmet need for family planning (in terms of both spacing and limiting births) with reference to the baseline.

Interaction with provider on family planning

At midterm, 45% of clients reported that their providers talked to them about FP during their current visit compared to 25% during the baseline. While a little over 1% of clients reported receiving IEC materials on FP during the baseline, about 6% received IEC materials during the midterm survey. A comparable proportion of clients at baseline and at midterm – about 7 in 10 of the clients who reported that their providers did not talk to them about FP, said they would have liked the provider to have spoken to them about FP. The unmet need for FP information identified during the baseline seemed to have been unaffected by the current interventions being rolled out in the sampled facilities. Many more clients during the midterm as were at baseline in need of counseling and IEC materials on FP are not receiving them.

Family Planning Provision

Providers' knowledge on the main steps to be taken in counseling clients on FP were assessed both at baseline and at midterm. The steps correctly named included the following: identify reproductive goals of client (46 mentions); provide information about different contraceptive methods (100 mentions); discuss the client contraceptive preference (82 mentions); help client select a suitable method (81 mentions); and explain to client how to use selected method (54 mentions). There were significant improvements from the baseline where these statistics were 43, 21, 27, 31, and 45 respectively.

Regardless of the current practices, when asked whether they were willing to provide a range of FP services in the future, the majority of providers wanted to provide FP information (95%) compared to 97% (at baseline), FP counseling and referral (93.3%) compared to 94% (at baseline). Even though the data from both the midterm and the baseline surveys confirm that acceptability of the range of FP services was high for both providers and clients, there were nevertheless difficulties. Only 11 (8%) providers at baseline, and 14 (9.4%) at midterm reported having no difficulties providing FP services. Some of them noted by providers at baseline and during the midterm assessment included inappropriate facilities/layout, lack of equipment, lack of qualified personnel, and lack of supplies and IEC materials.

Job Expectations

The majority of providers (96% at midterm and 92% at baseline) reported having job descriptions; about three-quarters of them in written form. Close to 80% (107 of the 137 providers) who had a job description at midterm indicated that their job description included FP; a change from the 62% recorded at baseline. During the midterm survey, guidelines recommending that FP services be offered to clients were available in about 80% of the 36 units sampled compared to 50% of the 32 units sampled during the baseline. For instance, the FP Protocol and/or the Global Handbook was available in 25/36 units (69.4%) compared to 31% during the baseline.

Performance feedback

About two-third (66.7%) of the 36 units sampled at midterm had a method for monitoring quality of care. Of those who had this monitoring mechanism, some monitored quality of care through review meetings (8/24 units), client feedback (13/24 units), supervision of staff (16/24 units). Three units mentioned monitoring of waiting time as a means of monitoring quality of care.

Regularity of monthly review meetings that include FP was assessed both at baseline and at midterm. At baseline, seven units (22%) indicated ever holding such meetings, 9 units (28%) held it quarterly and 1 unit held it annually. Fifteen units (47%) never held a review meeting that included FP. In comparison, only 2.8% of the 36 units sampled during the midterm survey indicated never holding such meetings.

When asked at baseline and at midterm surveys, more than 90% of the clients said they were satisfied with services received at the facility during that visit. They clients articulated at midterm that they were particularly satisfied with respect to their ability to discuss their problems or concerns with the providers (97.3%), with the explanation the providers gave them about their problem or treatment (96.7%), with the quality of examination or treatment provided (97.3%), and with the cleanliness of this facility (97.0%). As such, most (94%) of them would strongly recommend the facilities they were currently visiting to a friend. With respect to the strength of recommendation, there was an increment of seven percentage point with respect to what was recorded at baseline.

Motivation

About the same proportion of unit heads at baseline and at midterm indicated that their staff are recognized for good performance in carrying out regular duties (close to 70% and 63.9) respectively. Further, five unit heads (19%) at baseline indicated that staff receive recognition for performance specifically directed at integrating FP into the unit. During the midterm survey 10 unit heads (28%) disclosed that their staff receive such recognition. At baseline two individuals had been awarded in the past six months for their efforts in FP compared to five at midterm. Thus, recognition of staff for good performance in carrying out both their regular and FP-related duties is not widespread.

Knowledge and skills

Generally, the providers were quite knowledgeable and skilled to deliver FP-related services. With reference to the baseline, we observed a sharp improvement in the provision of some of these services at midterm. About half of the providers reportedly gave FP information (50%), FP referral (42%), and/or FP counseling (42%) at baseline, compared to an overwhelming majority providing these services at midterm: Ninety five percent of the providers gave FP information, referral or counseling 139 (93.3%), FP methods, specifically short term methods were offered by 115 (77.2%). A little over half 85 (57.0) offered long term methods during the midterm survey compared to one-fifth (19%) at baseline.

Infrastructure, supplies and equipment

In twenty three of the 32 units sampled at baseline, examination rooms were private compared to 13 of 36 units during midterm assessment. However, there were two units which had no visual or audio barriers, seven (19.4%) had examination rooms with other people or had such rooms with no visual or audio barrier. One unit had a counseling room with neither visual nor audio barriers both at baseline and at midterm. Some of these facilities may not be conducive for clients as far as privacy and confidentiality are concerned.

On the contrary, conditions in the facilities were generally conducive for providers in terms of infrastructure, with for example all/almost all units sampled at baseline and at midterm having piped running water/veronica buckets, electricity, clean facilities, and waiting areas for clients that were protected from the sun and rain.

With respect to supplies and materials for technical service provision, the improvements in their quantities after the baseline are slight. At baseline visual aids for teaching about different FP methods were available in 9 out of the 32 units compared 16 out of the 36 units at midterm. At midterm, counseling flipcharts were available 23 out of 36 units compared to eight of 32 units at baseline. Both at baseline and at midterm, only six units had models for demonstrating female condom use. Information booklets or leaflets on FP for clients were available in 10 at baseline and 21 units at midterm

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Appendices

Appendix 1

A1.1 Actual Performance for MCHH, Kumasi

Theme	Desired Performance Statement	Indicator	Desired Performance	BASELINE	MIDTERM
				Actual Performance	
(1) Providing information to clients	1(a) All staff (both FP and non FP providers) provide FP information to clients who visit the facility	% of health workers providing FP information	100.0% 100.0%	36.7% (provider report)	86.1% 100.0%
		% of health workers having basic knowledge on FP methods: -oral contraceptives -injectables -implants -intrauterine devices -male condoms -female condoms -tubal ligation (female) -vasectomy (male sterilization) -natural family planning -lactational amenorrhea method	100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0%	72.0% (inventory) 53.3% (provider report)	30.6% 27.8% 11.1% 27.8% 2.8% 8.0% 33.3% 41.7%
	% of patients or visitors in the reproductive age group provided with FP educational materials			9.5% (observation) 1.6% (client report)	9.2% 7.3%
	(1b) All service providers educate men on the importance of FP	% of providers giving education to men on importance of FP	100.0% 100.0%	0.0% (client report) 80.0% (provider report)	0.0% (client report) 69.4% (provider report)
(2) Referral of clients by paramedics	2(a) 60% of paramedics are able to provide basic information and referral on FP services	% of paramedics referring clients for FP % of paramedics having basic knowledge on FP methods: -oral contraceptives -injectables -implants -intrauterine devices -male condoms -female condoms -tubal ligation (female) -vasectomy (male sterilization) -natural family planning -lactational amenorrhea method	60.0% 6.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0%	50.0% (provider report) 50.0% (inventory) 100% (provider report) 100% 100% 100% 100% 100% 100% 50.0% 50.0% 50.0%	100.0% (only 1 person) 100% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person) 100.0% (only 1 person)

(7)Service provision	7(a)All identified units in the facility give quality FP care	% of units having systems (client satisfaction surveys, suggestion boxes) for determining clients' opinions about the health facility or services	100.0%	14.3% (inventory)	100.0%
	7(b)All nurses (Midwives, PHNs, CHNs, ENs), provide FP services	% of nurses providing FP services		40.9% (provider report)	86.1%
		-FP information	100.0%	27.3%	75.0%
-FP referral		100.0%	31.8%	77.8%	
-FP counseling		100.0%	18.2%	19.4%	
-FP method		100.0%	98.0% (inventory)		
	<i>-FP information</i>	<i>100.0%</i>	<i>98.0%</i>	77.8%	
	<i>- FP referral</i>	<i>100.0%</i>	<i>46.9%</i>	100.0%	
	<i>-FP counseling</i>	<i>100.0%</i>	<i>44.9%</i>	77.8%	
	<i>-FP method</i>	<i>100.0%</i>	<i>/40.8%</i> (condom/ other)	22.2%	
	7(c)All staff provide condoms	% of staff providing condoms	100.0%	24.7% (inventory)	27.8%

A 1.2. Actual Performance for Government Hospital, Obuasi

Theme	Desired Performance Statement	Indicator	Desired Performance	BASELINE	MIDTERM
				Actual Performance	
(1)Providing information to clients	1(a) All staff (both FP and non FP providers) provide FP information to clients who visit the facility	% of health workers providing FP information	100.0% 100.0%	96.7% (provider report) 74.6% (inventory)	74.4% 65.0%
		% of health workers having basic knowledge on FP methods:			
-oral contraceptives		100.0%	86.7% (provider report)	41.0%	
-injectables		100.0%	83.3%	30.8%	
-implants		100.0%	66.7%	7.7%	
-intrauterine devices		100.0%	70.0%	5.1%	
-male condoms		100.0%	90.0%	43.0%	
-female condoms		100.0%	90.0%	38.5%	
-tubal ligation (female)		100.0%	63.3%	20.5%	
-vasectomy (male sterilization)		100.0%	60.0%	2.6%	
-natural family planning		100.0%	53.3%	2.6%	
-lactational amenorrhoea method		100.0%	80.0%	38.5%	
% of patients or visitors in the reproductive age group provided with FP educational materials			0.0% (observation) 0.53% (client report)	0.0% 1.3%	
(1b)All service providers educate men on the importance of FP		% of providers giving education to men on importance of FP	100.0% 100.0%	11.8% (client report) 66.7% (provider report)	13.3% 76.9%
(2)Referral of clients by paramedics		2(a)60% of paramedics are able to provide basic information and referral on FP services	% of paramedics referring clients for FP	60.0% 6.0%	No paramedics interviewed
	% of paramedics having basic knowledge on FP methods:				
	-oral contraceptives		60.0%		100.0% (only 1 person)
	-injectables		60.0%		0.0%(only 1 person)
	-implants		60.0%		0.0%(only 1 person)
	-intrauterine devices		60.0%		0.0%(only 1 person)
	-male condoms		60.0%		100.0%(only 1 person)
	-female condoms		60.0%		100.0%(only 1 person)
	-tubal ligation (female)		60.0%		0.0%(only 1 person)
	-vasectomy (male sterilization)		60.0%		0.0%(only 1 person)
	-natural family planning		60.0%		0.0%(only 1 person)

		-lactational amenorrhea method			
(3) Logistics and commodities	3(a) All required FP commodities, logistics and equipment available at all times	% of units reporting availability of commodities			
		-oral contraceptives	100.0%	12.5% (inventory)	9.1%
		-injectables	100.0%	25.0%	9.1%
		-IUD kit	100.0%	12.5%	9.1%
		-implants	100.0%	25.0%	0.0%
		-implant removal/insertion kit	100.0%	12.5%	9.1%
		-intrauterine devices (copper)	100.0%	12.5%	9.1%
		-intrauterine devices (levo)	100.0%	0.0%	0.0%
		-male condoms	100.0%	25.0%	9.1%
		-female condoms	100.0%	12.5%	9.1%
		-minilap kit	100.0%	0.0%	9.1%
		-uterine model	100.0%	0.0%	0.0%
		-model for female condom	100.0%	12.5%	18.2%
		-model for male condom	100.0%	37.5%	54.5%
		-flipchart	100.0%	25.0%	45.5%
		-poster	100.0%	0.0%	18.2%
		-IEC/booklet for patients	100.0%	12.5%	54.5%
		-FP protocol/global handbook	100.0%	25.0%	63.6%
		-spot light source	100.0%	12.5%	18.2%
		-gynec. examination couch	100.0%	50.0%	18.2%
		-adult weighing scale	100.0%	62.5%	18.2%
		-blood pressure gauge	100.0%	37.5%	18.2%
(4) Supervision and Feedback	4(a) All units receive monitoring, technical, support visits and feedback on various activities including FP at review meetings	% of units holding at least quarterly review meetings on various activities including FP	100.0%	50.0% (inventory)	90.0%
(5) Motivation	5(a) Staff motivated for providing FP services	Percent of staff awarded for good performance in FP in the past six months	n/a	20.0% (inventory)	0.0%
	5(b) Performance of all providers are reviewed regularly	% of staff performance reviewed at least quarterly	100.0%	53.3% (provider report)	62.8%
(6) Reporting	6(a) Unit heads are able to submit monthly reports on FP services	% of unit heads submitting monthly reports on FP	100.0%	25.0% (inventory)	45.5%
(7) Service provision	7(a) All identified units in the facility give quality FP care	% of units having systems (client satisfaction surveys,	100.0%	50.0% (inventory)	18.2%

		suggestion boxes) for determining clients' opinions about the health facility or services			
	7(b)All nurses (Midwives, PHNs, CHNs, ENs), provide FP services	% of nurses providing FP services -FP information 100.0% -FP referral 100.0% -FP counseling 100.0% -FP method 100.0% <i>-FP information 100.0%</i> <i>- FP referral 100.0%</i> <i>-FP counseling 100.0%</i> <i>-FP method 100.0%</i>	100.0% 100.0% 100.0% 100.0% <i>100.0%</i> <i>100.0%</i> <i>100.0%</i> <i>100.0%</i>	95.7% (provider report) 95.7% 69.6% 43.5% <i>90.9%</i> <i>(inventory)</i> <i>90.0%</i> <i>90.9%</i> <i>48.5%</i> <i>/42.4%</i> <i>(condom/ other)</i>	74.4% 69.2% 69.2% 17.9% 100.0% 100.0% 72.7% 90.9%
	7(c)All staff provide condoms	% of staff providing condoms	100.0%	36.5% (inventory) 43.0%	

A 1.3. Actual Performance for Regional Hospital, Koforidua

Theme	Desired Performance Statement	Indicator	Desired Performance	BASELINE		MIDTERM	
				Actual Performance		Actual Performance	
(1) Providing information to clients	1(a) All staff (both FP and non FP providers) provide FP information to clients who visit the facility	% of health workers providing FP information	100.0% 100.0%	32.3% (provider report) 64.8% (inventory)	46.7%	100.0%	42.2%
		% of health workers having basic knowledge on FP methods:	100.0% 100.0%		15.6%	17.8%	53.3%
-oral contraceptives		100.0%		80.6%	51.1%		
-injectables		100.0%		(provider report)	20.0%		
-implants		100.0%		(report)	6.7%		
-intrauterine devices		100.0%		71.0%	2.2%		
-male condoms		100.0%		54.8%	55.6%		
-female condoms		100.0%		61.3%	64.4%		
-tubal ligation (female)		100.0%		87.1%			
-vasectomy (male sterilization)		100.0%		87.1%			
-natural family planning		100.0%		64.5%			
-lactational amenorrhea method		100.0%		64.5%			
			% of patients or visitors in the reproductive age group provided with FP educational materials		71.0% 83.9%	0.0% (observation)	42.3%
	1(b) All service providers educate men on the importance of FP	% of providers giving education to men on importance of FP	100.0% 100.0%	0.0% (client report) 61.5% (provider report)	0.0%	68.9%	
(2) Referral of clients by paramedics	2(a) 60% of paramedics are able to provide basic information and referral on FP services	% of paramedics referring clients for FP	60.0% 6.0%	0.0% (only 1 paramedic interviewed) 33.3% (inventory)	100.0% (only 2 persons)		
		% of paramedics having basic knowledge on FP methods:					
		-oral contraceptives	60.0%		100.0%	50% (only 2 persons)	
		-injectables	60.0%		0.0%	50% (only 2 persons)	
		-implants	60.0%		0.0%	0% (only 2 persons)	
		-intrauterine devices	60.0%		0.0%	0% (only 2 persons)	
		-male condoms	60.0%		100.0%	100% (only 2 persons)	
		-female condoms	60.0%		100.0%	100% (only 2 persons)	
		-tubal ligation (female)	60.0%		100.0%	0% (only 2 persons)	
		-vasectomy (male sterilization)	60.0%		0.0%	0% (only 2 persons)	
		-natural family planning	60.0%		0.0%	0% (only 2 persons)	
		-lactational amenorrhea method	60.0%		100.0%	100% (only 2 persons)	
		(3) Logistics and commodities	3(a) All required FP commodities, logistics and equipment available at all times	% of units reporting availability of commodities			
-oral contraceptives	100.0%				25.0%	25.0%	
-injectables	100.0%				(inventory)	25.0%	
-IUD kit	100.0%				25.0%	25.0%	
-implants	100.0%				12.5%	25.0%	

		-implant removal/insertion kit	100.0%	12.5%	25.0%
		-intrauterine devices (copper)	100.0%	12.5%	25.0%
		-intrauterine devices (levo)	100.0%	0.0%	0.0%
		-male condoms	100.0%	37.5%	62.5%
		-female condoms	100.0%	37.5%	37.5%
		-minilap kit		12.5%	12.5%
		-uterine model	100.0%	12.5%	25.0%
		-model for female condom	100.0%	12.5%	25.0%
		-model for male condom	100.0%	37.5%	75.0%
		-flipchart	100.0%	25.0%	87.5%
		-poster	100.0%	25.0%	75.0%
		-IEC/booklet for patients	100.0%	62.5%	37.5%
		-FP protocol/global handbook	100.0%	62.5%	87.5%
		-spot light source	100.0%	50.0%	62.5%
		-gynec. examination couch	100.0%	62.5%	87.5%
		-adult weighing scale	100.0%	87.5%	100.0%
		-blood pressure gauge	100.0%	75.0%	100.0%
(4)Supervision and Feedback	4(a)All units receive monitoring, technical, support visits and feedback on various activities including FP at review meetings	% of units holding at least quarterly review meetings on various activities including FP	100.0%	37.5% (inventory)	88.9%
(5)Motivation	5(a)Staff motivated for providing FP services	Percent of staff awarded for good performance in FP in the past six months	n/a	0.0% (inventory)	0.0%
	5(b) Performance of all providers are reviewed regularly	% of staff performance reviewed at least quarterly	100.0%	84.0% (provider report)	100.0%
(6)Reporting	6(a)Unit heads are able to submit monthly reports on FP services	% of unit heads submitting monthly reports on FP	100.0%	37.5% (inventory)	75.0%
(7)Service provision	7(a)All identified units in the facility give quality FP care	% of units having systems (client satisfaction surveys, suggestion boxes) for determining clients' opinions about the health facility or services	100.0%	87.5% (inventory)	87.5%
	7(b)All nurses (Midwives, PHNs, CHNs, ENs), provide FP services	% of nurses providing FP services -FP information -FP referral	100.0% 100.0%	39.1% (provider report) 34.8%	46.7% 31.1%

		-FP counseling	100.0%	78.3%	60.0%
		-FP method	100.0%	26.1%	26.7%
		-FP information	100.0%	85.7%	37.5%
		- FP referral	100.0%	(inventory)	25.0%
		-FP counseling	100.0%	100%	50.0%
		-FP method	100.0%	72.5%	25.0%
				17.6% / 9.9%	
				(condom/ other)	
	7(c)All staff provide condoms	% of staff providing condoms	100.0%	10.6%	53.3%
				(inventory)	

A 1.4. Actual Performance for Tetteh Quarshie Memorial Hospital, Mampong

Theme	Desired Performance Statement	Indicator	Desired Performance	BASELINE	MIDTERM
				Actual Performance	
(1) Providing information to clients	1(a) All staff (both FP and non FP providers) provide FP information to clients who visit the facility	% of health workers providing FP information	100.0% 100.0%	38.1% (provider report) 76.9% (inventory)	96.6% 80.0%
		% of health workers having basic knowledge on FP methods: -oral contraceptives -injectables -implants -intrauterine devices -male condoms -female condoms -tubal ligation (female) -vasectomy (male sterilization) -natural family planning -lactational amenorrhea method	100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0%	90.5% (provider report) 88.1% 78.6% 73.8% 95.2% 90.5% 71.4% 83.3% 85.7% 83.3%	37.9% 44.8% 27.6% 17.2% 72.4% 48.3% 37.9% 3.45 6.9% 69.0% 86.2%
	% of patients or visitors in the reproductive age group provided with FP educational materials		100.0% 100.0%	5.4% (observation) 1.2% (client report)	0.0% 0.7%
	(1b) All service providers educate men on the importance of FP	% of providers giving education to men on importance of FP	100.0% 100.0%	0.0% (client report) 79.5% (provider report)	0.0% 89.7%
(2) Referral of clients by paramedics	2(a) 60% of paramedics are able to provide basic information and referral on FP services	% of paramedics referring clients for FP % of paramedics having basic knowledge on FP methods: -oral contraceptives -injectables -implants -intrauterine devices -male condoms -female condoms -tubal ligation (female) -vasectomy (male sterilization) -natural family planning	60.0% 6.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0% 60.0%	0.0% (provider report) 0.0% (inventory) 66.7% 66.7% 66.7% 33.3% 66.7% 66.7% 33.3% 33.3% 66.7% 33.3%	100.0% (only 1 person) 100.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person) 0.0% (only 1 person)

		-lactational amenorrhea method			
(3) Logistics and commodities	3(a) All required FP commodities, logistics and equipment available at all times	% of units reporting availability of commodities			
		-oral contraceptives	100.0%	22.2% (inventory)	14.3%
		-injectables	100.0%	22.2%	37.5%
		-IUD kit	100.0%	22.2%	0.0%
		-implants	100.0%	22.2%	37.5%
		-implant removal/insertion kit	100.0%	22.2%	0.0%
		-intrauterine devices (copper)	100.0%	22.2%	0.0%
		-intrauterine devices (levo)	100.0%	0.0%	
		-male condoms	100.0%	33.3%	50.0%
		-female condoms	100.0%	22.2%	0.0%
		-minilap kit	100.0%	0.0%	0.0%
		-uterine model	100.0%	22.2%	0.0%
		-model for female condom	100.0%	22.2%	28.6%
		-model for male condom	100.0%	33.3%	85.7%
		-flipchart	100.0%	22.2%	71.4%
		-poster	100.0%	44.4%	14.3%
		-IEC/booklet for patients	100.0%	22.2%	42.9%
		-FP protocol/global handbook	100.0%	22.2%	62.5%
		-spot light source	100.0%	22.2%	50.0%
		-gynec. examination couch	100.0%	44.4%	75.0%
		-adult weighing scale	100.0%	100.0%	100.0%
		-blood pressure gauge	100.0%	100.0%	100.0%
(4) Supervision and Feedback	4(a) All units receive monitoring, technical, support visits and feedback on various activities including FP at review meetings	% of units holding at least quarterly review meetings on various activities including FP	100.0%	66.7% (inventory)	100.0%
(5) Motivation	5(a) Staff motivated for providing FP services	Percent of staff awarded for good performance in FP in the past six months	n/a	0.0% (inventory)	0.0%
	5(b) Performance of all providers are reviewed regularly	% of staff performance reviewed at least quarterly	100.0%	76.2% (provider report)	87.5%
(6) Reporting	6(a) Unit heads are able to submit monthly reports on FP services	% of unit heads submitting monthly reports on FP	100.0%	33.3% (inventory)	62.5%
(7) Service provision	7(a) All identified units in the facility give quality FP care	% of units having systems (client satisfaction surveys, suggestion boxes) for determining clients'	100.0%	66.7% (inventory)	37.5%

		opinions about the health facility or services			
	7(b)All nurses (Midwives, PHNs, CHNs, ENs), provide FP services	% of nurses providing FP services -FP information -FP referral -FP counseling -FP method -FP information -FP referral -FP counseling -FP method	100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0%	41.4% (provider report) 41.4% 27.6% 20.7% 100% (inventory) 100% 13.6% 52.3% / 56.8% (condom/ other)	96.6% 89.7% 58.6% 24.1% 100.0% 100.0% 75.0% 57.1%
	7(c)All staff provide condoms	% of staff providing condoms	100.0%	31.9% (inventory) 50.0%	