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**REPORT OF SECOND SITUATION ANALYSIS STUDY
OF FAMILY PLANNING SERVICES IN GHANA**

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PREFACE

Reliable, valid and current information on family planning services, their access and utilisation are crucial for understanding the factors which influence reproductive health and child spacing as well as fertility levels in a country. It is in line with this observation that the Government of Ghana, USAID and the Population Council once again combined efforts and resources to initiate the second Situation Analysis Study of family planning service delivery points in Ghana.

Like the earlier one, the second Situation Analysis Study focuses on the facilities and the staff who provide family planning services and examines the background of the clients seeking these services. The study methodology was designed to help provide insight into the workings of a family planning delivery system through interaction, observation and interviewing, in order to determine

- a) whether the family planning systems are available for the provision of the needed services,
- b) whether the needed services are being provided at all, if available, and
- c) whether the quality of the services is adequate.

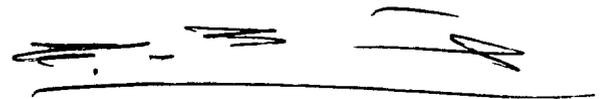
It should be recalled that when the first National Population Policy was formulated in 1969, it was expected that the nation's population growth rate of 2.4 per cent at the time would gradually decline till the year 2000, through a lowering of fertility. With this goal in mind, the Government set up the National Family Planning Secretariat to coordinate efforts in the provision of family planning services. Fifteen years after launching the policy, however, the observed growth rate of the population (in 1984) had risen to 2.6 per cent per annum. In 1994, the Government of Ghana launched a revised version of the policy, which expects the population growth rate to reduce to 1.5 per cent by the year 2020.

The level of fertility in Ghana has remained high for a long time, although in recent years, evidence of a decline has been recorded in the Demographic and Health Surveys. The current total fertility rate stands at 5.5 and the revised Population Policy envisages that this will reduce to 5 by the year 2000 and continue to decline thereafter. To achieve such a lowering of fertility, at a time when traditional methods of birth postponement and spacing are on the decline, will entail increasing the prevalence of modern contraceptive usage to much appreciable levels.

In fact, modern contraception is increasingly required to fill the gap created by the reduction of traditional methods of birth control. The decline of long periods of exclusive breastfeeding, as well as the erosion of post-partum sexual abstinence taboos and the consequent shortening of the nonsusceptible period following birth, means that adequate use of modern contraceptives is vital, not only to prevent fertility from rising still further, but also to promote needed child spacing, survival and development as well as the health and well-being of mothers and children.

Situation Analysis Studies have typically been aimed at the systematic examination of the Family Planning programmes to gauge the strengths and weaknesses of the system with special attention to availability, functioning and quality of the services. In view of emerging trends, the methodology is now expanded to include more information encompassing STDs/HIV/AIDS, availability of laboratory tests, counselling on sexual behaviour and other reproductive health areas.

This repeat study does not only allow the examination of the current status of programmes but also permit the study of change over time in the whole programme and within the subsystem under investigation. Furthermore, it provides an insight to several aspects of reproductive health programmes and related client behaviour. Additionally, it facilitates the evaluation of the new guidelines on Family Planning developed on the basis of the 1993 Situation Analysis Study and the consequent strengthening of the guidelines. Thus, the second Situation Analysis Study in Ghana is expected to improve efficiency and effectiveness of the entire family planning system and ensure optimal utilisation of the family planning facilities in the country. The report makes many specific recommendations for further interventions which, if fully implemented, will improve the welfare of the Ghanaian family.



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ACKNOWLEDGMENTS

Ghana is one of only four African countries that have successfully undertaken a second round of the study of family planning service delivery points, using the situation analysis methodology developed by the Population Council's Africa Operations Research and Technical Assistance (OR/TA) project staff. Ghana however remains the only country to have done this within a space of three years. Even though the number of facilities canvassed in the second round was scaled down from that of the first round for budgetary considerations, the number is larger than what has been studied anywhere in Africa under the programme.

None of these would have been easy to achieve without the financial, technical and moral support of some institutions and individuals. The Ghana Statistical Service wishes to express profound gratitude to the Government of Ghana and USAID for the needed financial support. We wish also to record the enthusiastic support of Dr Pamela Wolf (a collaborator in the first round of the study), the then Chief of the Population, Health and Nutrition Department of USAID (Accra), in pushing for the early conduct of the second round of the study.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
AVSC	Association of Voluntary Surgical Contraception
BCG	Anti Tuberculosis Vaccine(Developed by Baccile Calmett Guerin)
CBD	Community Based Distributors (of Family Planning Information and Services)
CHAG	Christian Health Association of Ghana
COC	Combined Oral Contraceptives
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
FP	Family Planning
GHANAPA	Ghana Population and Aids Project
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
HRDD	Human Resource Development Division
HRU	Health Research Unit
IEC	Information, Education and Communication
IUD	Intra Uterine Device
LAM	Lactational Amenorrhoea Method
MCH	Maternal And Child Health
MOH	Ministry of Health
ML/LA	Minilap/Laparoscopy
NGO	Non-Governmental Organisation
NPC	National Population Council
POLIO	Poliomyelitis
POP	Progestin Only Pill
PPAG	Planned Parenthood Association of Ghana
SDP	Service Delivery Point
STD	Sexually Transmitted Disease

I FAMILY PLANNING SERVICE DELIVERY

1.1 INTRODUCTION

Acceptance and practice of family planning have increased tremendously over the last decade. Within the same period, fertility has also declined considerably. In spite of these gains, family planning continues to be relevant to the national population policy and national aspirations. More than a quarter of a century after the Government issued its policy on population (March 1969), the country's rate of population growth remains unacceptably high and this continues to be an impediment to the national effort at sustainable development and the eradication of widespread poverty. Not only has the 1969 long-term objective of reducing population growth (from the 1960-1970 intercensal rate of 2.4 per cent) to 1.7 by year 2000 not been achieved, it has actually increased (through 2.6 per cent in the 1970-1984 intercensal period) to an estimated 3.0 per cent in the post-1984 period. This puts Ghana among the world's fastest population growing countries.

One of the reasons for Ghana's high population growth rate is the fact that fertility, defined as the average number of children for the Ghanaian woman, has remained high over the years, irrespective of how it is measured. For instance, the total fertility rate (a measure of period fertility), which is the average number of children a Ghanaian woman would have if she experienced the specific schedules for the various reproductive age groups, declined from 6.7 in 1980 to 6.4 in 1988 and to 5.5 in 1993, but this is still very high compared to rates of less than 2 for most developed countries. If we look at completed family size (a measure of cohort fertility), the picture is even less encouraging. In 1960, the cohort of women aged 45-49, who were expected to have completed childbearing, each had an average of 5.9 children. This figure increased through 6.4 in 1971 and 6.7 in 1980 to 7.3 in 1988 before declining to 6.6 in 1993.

The high fertility has persisted because of two main factors: marriage and the practice of contraception. Marriage in Ghana is contracted at a very early age. With a median age at first marriage of 18.1 years, it means half of all first marriages occurred at ages below 18. Another feature of marriage is that it is nearly universal, about 30 per cent of females aged 15-19 have been married, over 80 per cent of women aged 20-24 have married and by age 30, about 99 per cent of women have been married at least once. Marriage is also fairly stable. In the 1979/1980 Ghana Fertility Survey, for instance, 89.7 per cent of all ever married women were still married, while 72.7 per cent of the women were still in their first marriage. Of those whose first marriage had been dissolved, 71.5 per cent had remarried. The fact that childbearing occurs largely within marriage means that the near universality of marriage and the long period spent in marriage significantly contribute to high fertility in Ghana.

Probably more important as a factor of Ghana's high fertility level is the practice of contraception, particularly among women in sexual unions. Knowledge of modern contraceptive methods, including how they are used and their possible side effects, as well as how and where to obtain them is fairly widespread. Nine out of every ten

(90.7%) married women know of at least one modern contraceptive method while seven out of ten (73.5%) know where to obtain one. Moreover, two out of five (39.3%) of all married women (ie 69.8% of the 56.3% of married women who desired to have more children) say they would like to postpone childbearing for at least two years. In spite of these revealing numbers, only one out of ten married women in 1993 used a modern contraceptive method, up from one in every twenty in 1988.

Obviously, something other than lack of knowledge or unavailability of modern contraceptive methods should explain the low rate of prevalence in Ghana. Quality of service could influence method use, but it would appear that much more needs to be done to convince couples that it is in their best interest to limit the number of their children. The Minister of Finance, in the Preface to the revised National Population Policy of 1994, makes the profound statement that the Policy represents "the collective will of the people and the expression of their determination and commitment to the principle that a well-managed population resource is a fundamental requirement for sustainable development", because "the main tenets, principles, strategies and programmes enunciated in the document emerged through debates, discussions and consultations with a wide spectrum of institutions and individual Ghanaians from every part of the country" (Government of Ghana, 1994).

If this, indeed, is the situation on the ground, then the objectives and targets set in the revised Policy stand a good chance of being achieved. The objectives include

- ensuring systematic integration of population issues in all aspects of development planning and activity at all levels of the administrative structure,
- promoting awareness and understanding of population issues and the implications of rapid population growth,
- providing education on the value of a small family size,
- ensuring accessibility to, and affordability of, family planning services for all interested persons

To help achieve these specific short-term fertility objectives, the Policy includes the following fertility targets

- to reduce the present annual population growth rate of 3.0 per cent to 1.5 per cent by the year 2020,
- to reduce the total fertility rate from the 1993 level of 5.5 to 5.0 by year 2000, to 4.0 by 2010 and to 3.0 by year 2020,
- to increase modern contraceptive prevalence rate from 10 per cent to 15 per cent by year 2000, to 28 per cent by 2010 and to 50 per cent by the year 2020,
- to reduce the proportion of women who marry before age 18 by 50 per cent by year 2000 and by 80 per cent by the year 2020,
- to reduce the proportion of women below 20 years and above 34 years having births by 50 per cent by year 2010 and by 80 per cent by the year 2020,
- to achieve minimum birth spacing of at least 2 years for all births by the year 2020,
- to make family planning services available, accessible and affordable to at least half of all adults in need of such service by the year 2020

These targets were set after the Ghana Demographic and Health Survey (DHS) and the Situation Analysis Study of 1993. It will be interesting to see if the current situation analysis of family planning service gives an indication of the extent to which these targets are achievable.

1.2 STUDY RATIONALE AND OBJECTIVES

The Situation Analysis methodology was developed by the Population Council's Africa Operations Research and Technical Assistance Project to examine the supply side of family planning service delivery, i.e. the way family planning services are organized, delivered and perceived by clients at the service delivery point (clinic level). By examining these issues, programme managers hope to understand and improve on weaknesses in the system, with resulting increase in quality of care and concomitant increase in utilization of services. A situation analysis study was conducted in Ghana in 1993 in 399 service delivery points (SDPs), including Planned Parenthood Association of Ghana (PPAG, an NGO) clinics, private maternities, public hospitals and clinics (Statistical Service, 1994). The Ghana study was the tenth in the series of such studies in sub-Saharan Africa.

The 1993 Situation Analysis Study helped to identify some of the problems existing in family planning service delivery facilities which are likely to discourage people from using them. Some of the key findings from the study relate to accessibility, infrastructure, logistics, supervision and personal biases of providers.

The accessibility of service delivery points (SDPs), to a large extent, determines the ease with which potential clients can locate and use the family planning services. The Study indicates that almost a quarter of the SDPs had no visible family planning signs and about 40 per cent opened their facilities later than the official opening time. On the issue of infrastructure, less than half of the facilities had access to pipeborne water (42%) and electricity (47%) while about 20 per cent did not have a separate room or area for examination. The supply of IEC materials was also quite inadequate. For example, over three-quarters of the facilities had no promotional materials while samples of contraceptives were absent in 20 per cent of them.

Despite the fact that most of the SDPs were offering a range of contraceptive methods (five on average), quite a sizeable number of them lacked the basic essential equipment for delivering family planning services such as sterilizers, uterine sounds, tenacula, gloves, examination tables and blood pressure apparatus, among others. Regular supervision of providers helps to put them in check and also assists in bridging a possible communication gap between them and their supervisors. The results of the 1993 Situation Analysis Study suggest that almost a quarter of the SDPs (24%) had received no family planning supervisory visit within the six months prior to the study. Relatively more disturbing is the fact that about a fifth (18%) of them had never received a supervisory visit.

In order to provide effective counselling, a provider is expected to elicit certain basic information from the client. These include the client's reproductive goals, concerns about methods, method preference and breastfeeding status. In more than 50 per

cent of the cases, however, neither did the provider nor the client initiate discussion on the reproductive goals of the client. Furthermore, only 41 per cent of clients who indicated a method preference received the method of their choice.

Observations made during the consultation period also indicate that the lack of specific service delivery guidelines at the time of the Study made room for individual provider biases in terms of the age of the client, parity, breastfeeding status, marital status and spousal consent. Of these, the issue of marriage was the most significant. About 40 per cent of providers would not give IUD and injectable to unmarried clients while over a quarter would not provide the pill.

An enquiry into the background of the providers showed that less than 60 per cent of them were professional health personnel (i.e. doctors and nurses) and these were mostly located in the urban areas. The rural SDPs were mainly managed by auxiliary nurses and extension workers. Over 90 per cent of these staff reported that they had received both theoretical and practical on-the-job training, but how well designed these types of training are is not clear.

Since 1993, when the DHS and the Situation Analysis Study were conducted, USAID/Ghana has developed a new population and AIDS programme (GHANAPA Project) which will continue through the year 2000. In the process of this project design, many analytic questions were raised concerning AIDS/STDS, pricing of family planning services, in-depth questions (and studies) about service provider practices, to name a few. It was also observed that much of the information obtained from the Situation Analysis Study was used by programme managers of the various implementing agencies (MOH, Ghana Registered Midwives' Association and PPAG) to design their programmes for the coming years or to readjust their emphases in accordance with specific findings from the study. The results from the Situation Analysis Study have also assisted in the development of new guidelines for service providers.

To function effectively and efficiently, it is essential that family planning and health service delivery structures operate in an optimal way. It is important, therefore, for the programme implementing agencies to gain as much knowledge and information as possible about their facilities, their clients, and the clients' perception of the services they receive. A second situation analysis study after three years was considered essential in evaluating these services.

Situation analysis studies have traditionally been systematic examinations of the strengths and weaknesses of family planning programmes, with particular attention to availability, functioning and quality of these services. Along with the worldwide expansion of the reproductive health paradigm, however, the Situation Analysis methodology has been expanded to include substantially more information on STD/HIV/AIDS, availability of laboratory tests, counselling on sexual behaviour and other important areas. A repeat study was not only going to permit us to examine the status of programmes at a point in time, but would also allow the study of change over time in the whole programme as well as within the subsystems under

investigation. In addition, it was going to provide the first look at several aspects of reproductive health programmes and related client behaviour.

As mentioned earlier, new guidelines for the delivery of family planning services have been developed since the 1993 Situation Analysis Study. It was felt that it would be of interest to the Ministry of Health to evaluate the adherence of providers to these new guidelines on the basis of the 1996 study. A second study was also to offer opportunity to investigate issues relating to long-term methods, pricing of family planning services and AIDS/STDs programme.

The ultimate objective of the 1996 Study, like the earlier one, was to generate data to assist the strategic planning of family planning service delivery. Towards this end, the immediate and specific objectives of the 1996 Study were:

- i To describe the status, availability and quality of family planning services provided in Ghana in terms of method choice, provider-client interactions, provider training/competence, and the constellation of services available
- ii To document changes that have taken place in these services since the 1993 Situation analysis Study as a way of monitoring progress
- iii To provide baseline data for evaluating the new guidelines on family planning service delivery introduced by the Ministry of Health
- iv To identify long-term methods that are preferred by clients and the general attitude of clients towards some of these methods
- v To learn more about AIDS/HIV services
- vi To provide a basis for the realistic pricing of family planning methods and services

1.3 STUDY METHODOLOGY

The study sample was chosen such that a suitable representation of the major sources of family planning services was obtained. These were the public sector facilities of hospitals and clinics, PPAG facilities and private maternities associated with the Ghana Registered Midwives' Association (GRMA).

At each service delivery point, information was collected through observations and interviews on a single day for the following subsystems:

- Logistics/supplies
- Facilities/equipment
- Staffing/training
- Supervision/management
- Information, education, communication
- Recording keeping

This was accomplished through the use of several instruments. While every effort was made to keep the questions in the 1996 instruments similar to, if not the same as, those in the 1993 survey for purposes of examining trends, there were a few issues which had not been addressed adequately in the 1993 study. These included long-term methods, HIV/AIDS, reasons for certain restrictions on eligibility and costing issues. The instruments were updated to incorporate such additional issues.

The policy of the Statistical Service to collaborate with relevant institutions in all our research activities was given a new dimension in that the study design included teaming up with the Health Research Unit of the Ministry of Health to administer a set of three short instruments to examine the quality of general health care service delivery in the selected SDPs. The objective was to be able to assess the quality of health care with minimum cost and also to be able to place the quality of family planning service delivery within that of general health care as a way of explaining any major differences. Results of this module are presented as an Appendix to this Report. A secondary analysis at a later date will attempt to relate these results to the results of the main situation analysis study.

The number of facilities which formed the sampling frame in 1993 was 875. This comprised 223 private maternities, 66 hospitals, 551 clinics and 35 PPAG facilities. For the 1993 Situation Analysis Study, all the public hospitals and PPAG clinics were selected for inclusion in the sample while 50 per cent sample each of the maternities and public clinics were chosen. The result was a sample of 489 facilities, out of which 399 were visited. The sample was stratified by region such that the resulting number of public clinics and private maternities was proportional to the number of those facilities in each region.

For the 1996 study, 1178 facilities (114 hospitals, 707 MOH clinics, 44 PPAG clinics and 313 maternities) constituted the sampling frame. Although budgetary constraints did not permit the adoption of the same sample size proportions used in 1993, this need not in theory significantly affect the reliability of the results. Moreover, the use of the same selection methodology ensured the comparability of the two data sets. It was decided to keep all the 44 PPAG clinics because of the small number involved. For hospitals, it was agreed that a 50 per cent sample would yield a number quite close to the 66 selected in 1993. By the same token, a third each of clinics and maternities would have yielded comparable sample sizes as in 1993, but this could not be supported within the budget. It was decided therefore to select 25 per cent each of maternities and public clinics. The final sample of SDPs was therefore made up of 60 hospitals, 176 public clinics, 44 PPAG clinics and 80 maternities or a total of 360 facilities which was quite close to the 399 canvassed in 1993.

1.4 FIELD DATA COLLECTION AND MATTERS ARISING

Five instruments were used in the Situation Analysis Study, these covered the following areas:

- inventory of available facilities and services,

- observation of provider-client interaction,
- family planning client exit interview,
- MCH client exit interview,
- family planning service provider interview

The inventory instrument identified equipment available on the day of the interview, commodities on hand, recordkeeping and, in general, the physical layout and condition of the facility. During the counselling for the provision of family planning and reproductive health services, an observer recorded, in the second instrument, what transpired, including questions asked of the client, information provided to the client, procedures followed during provision of family planning methods, explanation of appropriate use of method, the circumstances under which the client should return to the clinic, and so on.

A companion instrument to the provider-client interaction one, collected information on the client's perception and assessment of the visit, including what questions were answered, whether they were answered satisfactorily, whether the client was satisfied with services rendered, and the client's level of knowledge of family planning methods following her session with the service provider. This instrument examined these issues separately for new users, continuing clients with no problems and for clients who visited because of a problem concerning the method they were using.

The fourth instrument was used to determine what level of knowledge women who were not attending the family planning clinic had of contraception, their level of usage and whether they were aware that family planning methods could be obtained at the facility which they were attending for other purposes. In a sense, this group formed the "background" data against which the results of the family planning client group could be compared. The final instrument sought data on the kind of training the service providers had received, when the training took place, what their knowledge about specific methods was, their knowledge of AIDS and their willingness to discuss AIDS with their clients.

All the instruments were pretested in different types of localities and facilities in Accra, Aburi, Tema, and Amasaman. A two-week training session was organized for the field staff at which time data collection instruments were reviewed, role-playing was practiced, roles and responsibilities discussed and scheduling of the site visits prepared. Training was a joint effort of the Ghana Statistical Service and the Population Council. Fieldwork was conducted by 12 research teams each consisting of one researcher and two nurse/midwives.

A one-day visit to each service delivery point was considered adequate. It was expected that this effort would take not more than 30 working days to cover all 360 SDPs. At the end of each day, the researcher/statistician, serving as team leader, was expected to review the day's work, look at documents for completeness, validity and coding errors. Field work began on schedule on 21st October and finished by end of November 1996 with the exception of one or two teams which were 2 days behind in completing.

1 5 DATA PROCESSING AND ANALYSIS

Initial coding and checking of all data collection forms were undertaken in the field by the team leader. After the first two weeks of data collection, the forms were sent to Accra for further data checks and commencement of data entry. A small team of research assistants also provided codes for the few open-ended questions. All these were done under the supervision of the Data Processing Manager. After the initial data cleaning, preliminary frequencies were generated to assist the analysts prepare the first draft.

Tabulations and accompanying graphical presentations were reviewed during a one-day data interpretation workshop attended by the collaborating agencies and other participants. The purpose of this workshop was to share preliminary results of the Study with key users and to have opportunity to think through the implications of the results. Towards this end, we aimed at the following:

- Present initial findings regarding facilities, services rendered, quality of care, and functioning of the subsystems
- Highlight the strengths and weaknesses of family planning service delivery in Ghana
- Develop a list of priority problems which could be addressed in strategic programme planning
- Obtain suggestions for further analysis of the data
- Involve programme managers in the interpretation and analysis of the data

1 6 DISSEMINATION AND USE OF RESULTS

Basic frequency distributions and graphic presentations of the study were prepared for presentation and discussion at the Data Interpretation Workshop in July 1997. During this workshop, policy and programme recommendations were made by programme managers based on the results. The results were disseminated at the national level in Accra in September 1997. It is expected to conduct three zonal seminars throughout the country to disseminate the results.

It is our expectation that the Ministry of Health, National Population Council, and other users of family planning and reproductive health data will find the resources and commitment to base policy and programme decisions on the results of the study.

II PRINCIPAL FINDINGS OF THE STUDY

2.1 STUDY POPULATION CHARACTERISTICS

The study objective was to obtain a snap-shot of activities in the life of service delivery points on the day of visit. The rationale is that if these activities were routine and randomly spread over the year, then the aggregate of observations would give a fairly accurate picture of the strengths and weaknesses of the family planning delivery system in the country. At each facility that was visited, an inventory of infrastructure, equipment and supplies was taken for that day, interactions between providers and family planning clients were observed and note taken of relevant information, without interfering with proceedings, all clients seen that day interviewed, all staff on duty at the time of visit interviewed, and up to ten female MCH clients interviewed. If there were no family planning clients that day, work was still carried out in the other areas.

The teams were able to successfully complete work in 313 of the 360 facilities selected for study, representing 86.9 per cent coverage rate. Table 1 shows that level of coverage was much higher in the public sector facilities (100% for hospitals and 89.8% for MOH clinics) than in private sector facilities (75.0% for PPAG and 77.5% for maternities).

Table 1 Regional Distribution of Selected Sites by Type of SDP

Region	Hospitals		MoH Clinics		PPAG Clinics		Pr. Maternities		Total		Cover Rate
	Visited	Sample	Visited	Sample	Visited	Sample	Visited	Sample	Visited	Sample	
Western	12	12	15	18	7	7	5	6	39	43	90.7
Central	5	5	11	16	4	9	2	6	22	36	61.1
Gt Accra	4	4	8	8	4	7	11	17	27	36	75.0
Volta	8	8	36	37			4	5	48	50	96.0
Eastern	7	7	15	17	6	7	8	13	36	44	81.8
Ashanti	8	8	22	23	7	8	17	18	54	57	94.7
B Ahafo	7	7	23	24	2	3	12	12	44	46	95.7
Northern	3	3	8	8	3	3	1	1	15	15	100.0
U West	3	3	10	11	-	-	1	1	14	15	93.3
U East	3	3	10	14	-	-	1	1	14	18	77.8
Tot Sample	60	60	158	176	33	44	62	80	313	360	
Cov Rate	100.0		89.8		75.0		77.5		86.9		86.9
Total SDPs	114		707		44		313		1178		

Most PPAG clinics operate on specific days, this means that if the day of the team visit did not coincide with the opening days, then the facility would not be covered. It was observed that many maternities were owned and manned by retired nurse-midwives who were not in the position to employ other qualified staff. In such a situation, if the owner-midwife was indisposed or had travelled, the facility would be closed down and therefore would not be covered if the team visited on such a day. It was also observed that the sampling frame for the private maternities, in particular, was not up-to-date and therefore many selected facilities were found to have been closed down or relocated to other unknown locations.

In terms of regional coverage, Western (90.7%), Volta (96.0%), Ashanti (94.7%), Brong Ahafo (95.7%), Northern (100%) and Upper West (93.3%) did much better than the national average. This may be because the factors that account for the relatively low coverage of PPAG clinics and private maternities operated less in

these regions. For the Upper East Region (77.8%), the low coverage resulted from the coverage of clinics, many of which operated on market days, so that if the visit did not coincide with the market days then the facility would not be covered.

Apart from the fact that some SDPs could not be canvassed for the reasons stated earlier, some SDPs provide certain services on specific days. It was observed, for instance in a few SDPs, that family planning was not being provided on the visit days. In many instances, also, even though providers were available, there were no clients on the specific days of visit. Table 2 gives an indication of the coverage rate for the specific types of interaction and for the different facilities. It was not surprising that staff interviews were conducted in almost all facilities, because the providers were always available in the SDPs covered. The few facilities where staff interviews were not conducted represent those SDPs which were not manned by qualified personnel at the time of visit. The other important observation was that SDPs were likely to have more MCH clients than family planning clients.

Table 2 Coverage by Type of Interaction and SDP Type

Type of Interaction	Hospitals		MOH Clinics		PPAG Clinics		Pr. Maternities		Total	
	No	Cov. Rate	No	Cov. Rate	No	Cov. Rate	No	Cov. Rate	No	Cov. Rate
Provider-Client Obs	42	70	106	67	30	91	29	47	207	66
FP Client Interview	40	67	104	66	31	94	31	50	206	66
MCH Client Interview	51	85	132	84	13	39	46	74	242	77
Staff Interview	48	80	156	99	29	88	58	94	291	93
Total SDPs Covered	60		158		33		62		313	-

Table 3 indicates that, in general, the facilities visited provided more MCH services than family planning services. On average, there were 4.1 MCH clients to 2.6 family planning clients. This picture was the case in all SDP types, except PPAG clinics, where there were 6.8 family planning clients to only 1.2 MCH clients. The picture appears to reflect the emphasis in service provision. While the PPAG was set up primarily to provide family planning services, maternities and public health facilities provide more MCH services, with family planning service riding on the back of the latter.

Table 3 Number of Interviews and Observations by SDP Type

Types of Interaction	Hospitals (n=60)	MoH Clinics (n=158)	PPAG Clinics (n=33)	Pr. Maternities (n=62)	Total (n=313)
Provider-Client Observation (n=207)	170 (2.8)	363 (2.3)	226 (6.8)	63 (1.0)	822 (2.6)
FP Client Interview (n=206)	162 (2.7)	365 (2.3)	225 (6.8)	63 (1.0)	815 (2.6)
MCH Client Interview (n=242)	356 (5.9)	703 (4.4)	41 (1.2)	194 (3.1)	1294 (4.1)
Staff Interview (n=291)	132 (2.2)	308 (1.9)	60 (1.8)	70 (1.1)	570 (1.8)

2.2 FUNCTIONAL SITUATION OF SUBSYSTEMS AT DELIVERY POINTS

The delivery of family planning service presupposes that a system is in place, by which is implied the availability and functioning of certain inputs. Some of these are clinical equipment, supplies of method, supporting infrastructure and personnel to provide the service. The quality of service provided depends very much on the strengths and weaknesses in these various subsystems. A strong system is able to identify needs, analyze problems and able to come up with solutions, while a weak one will lead to unpredictable and unpleasant situations, lack of communication, and wastage of resources, leading to failure.

The primary objective of the study, therefore, was to find out in all service delivery points (SDPs) visited what infrastructural facilities, clinical equipment and method range were available. For the inputs that were available, it was necessary to find out whether or not they were functioning, were adequate and were of acceptable standard to be able to provide quality service. Towards this end, issues of accessibility, infrastructure, equipment, method supplies, clinical facilities, range of health services, recordkeeping, supervision and staffing as well as cost of providing services were canvassed.

Accessibility

Family planning services may be available, but if they are not within reach of potential clients, little will be achieved. The situation analysis study was therefore interested in knowing how accessible the facilities were to the people. Information on issues like the opening hours, time that providers reported, number of days services were available, the erection of visible signs to indicate that such services were available was thus collected.

The official opening time for most SDPs (55.9%) was reported as 8.00 a.m., but less than a fifth (18.8%) of facilities actually opened at this time. Overall, there were 67.4 per cent of SDPs that reported an opening time of between 6.00 a.m. and 8.00 a.m., but only 42.2 per cent were observed to have opened during this time (in 80.8% of the facilities visited, the teams arrived before the official opening time).

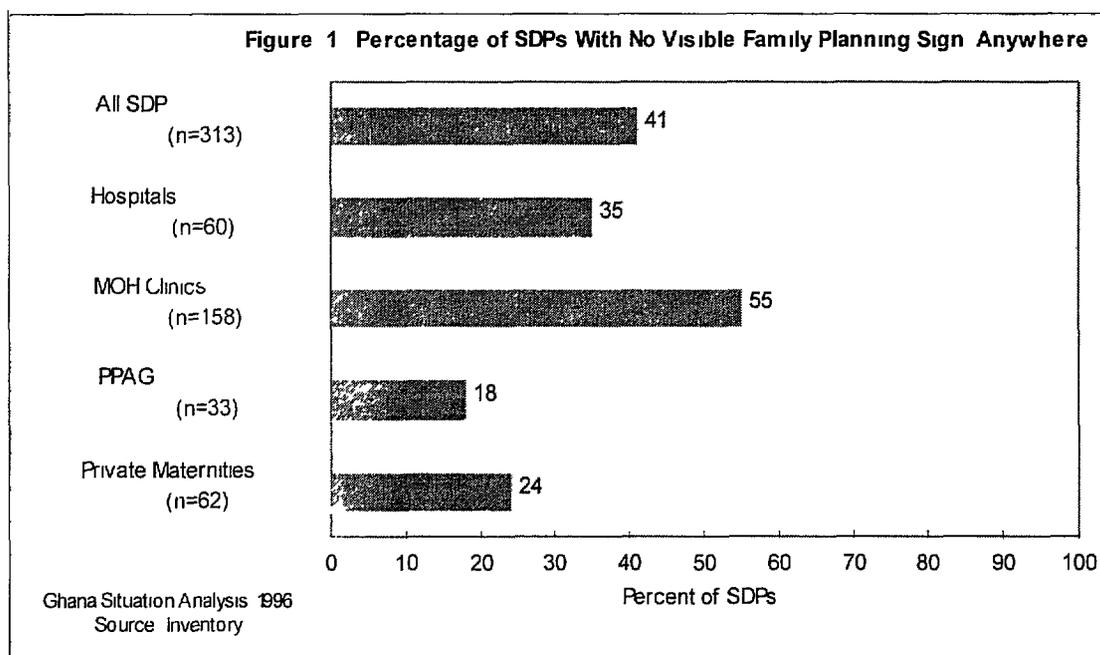
Transportation problems may explain the lack of punctuality, particularly in large towns, but actual practice of demand for services may also explain why most SDPs do not open at the time they are supposed to. For instance, while 38 per cent of providers were observed to have arrived before 8.00 a.m. (and an additional 26.8% between 8.00 a.m. and 9.00 a.m.), only 2.9 per cent of clients reported before 8.00 a.m., 31.7 per cent arrived between 8.00 a.m. and 10.00 a.m. while 24 per cent arrived after 10.00 a.m. (see Table 4). Naturally, only a few clients were attended to before 9.00 a.m. The nature of work of many clients (farming, trading) may account for the late reporting at SDPs for service. This is made possible by the fact that most SDPs (56.9%) close between 2.00 p.m. and 3.00 p.m., with an additional 21 per cent closing between 3.00 p.m. and 5.00 p.m., late enough for such workers to have come back from their economic activities. It is not surprising, therefore, that 94 per cent of clients indicated that the opening hours were convenient for them.

Table 4 Time of Arrival of First Family Planning Client and First Provider

Time of Arrival	First Provider	First Client
6 - 8 00a m	38 0	2 9
8 - 9 00a m	26 8	12 5
9 - 10 00a m	4 2	19 2
After 10 00a m	2 6	24 0

More than half (54%) of SDPs offered five days of family planning services in the week, while a further 28.1 per cent (primarily private maternities and community health centres) offered services at the weekend. Indeed, many maternities indicated that they operated 24-hour-7-day family planning services on the same lines as maternity services.

The significance of these operating times is that family planning service is easily accessible to most family planning clients. The services as well as the opening times, however, would be useful if the public was made aware of them. It was important, therefore, to know whether there were visible signposts that could announce the availability of family planning services to potential clients. The picture is not very encouraging, for only half (50.5%) of SDPs had a sign on the outside of the facility, an additional 8.3% had a sign on the inside of the building. This means that as many as 41.2 per cent of SDPs had no visible sign either on the outside or inside to indicate that the services they provide were available (see Fig 1). What makes the situation a matter of much greater concern is the fact that the 1993 study had only 23 per cent of SDPs not having a visible sign.



The reason for the rather large proportion without a visible signpost in 1996 may be that many of the existing signposts may have fallen down or been defaced with wear and tear over time and had not been rehabilitated or re-erected, indeed some of the teams observed a few such signposts stuck in some corner of the facility. This probably reflects the general lack of a maintenance culture within the family planning

delivery system. It should, however, be an issue for policy consideration, given that signposts are very important in the advertisement and promotion of family planning. Figure 1 shows that the absence of a visible signpost was more apparent in public facilities (hospitals and clinics) than in the private ones. This is surprising, because one would have expected the public facilities to be more capable of regular maintenance. It again seems to reflect the general apathy and lack of concern of the system in taking care of state property. On the other hand, the private concerns have a better businesslike attitude and therefore see the need to advertise themselves to attract clients.

The study units were health facilities that usually provided family planning services and, therefore, it was expected that the service would be available in all SDPs. The results, however, indicate that in 45 per cent of SDPs family planning service was not available in any part of the facility. While this service was available in all PPAG clinics, it was absent in 6 per cent of hospitals, 4 per cent of public clinics and 5 per cent of maternities. This is explained partly by the fact that the lists of family planning facilities were not up-to-date (many selected SDPs were found to have closed down or relocated) and partly by the fact that in some of the SDPs, the service was not being provided because the only provider (in many cases) had been transferred and no replacement had been effected at the time of visit.

The other health services available could be grouped in two: maternal and child health (MCH), and general reproductive health services. With regard to MCH services, most hospitals and public clinics provided the whole range of services while most private maternities appeared to concentrate more on maternal health than child health issues. On the other hand, very few PPAG clinics provided MCH services of any kind (see Table 5).

Table 5 Percentage of SDPs Providing Maternal and Child Health Services by SDP Type

Type of Service	Type of SDP				Total
	Hospital	MoH Clinic	PPAG Clinic	Pr Maternities	
Ante-natal Care	95	91	36	100	87.9
Maternity Care/Delivery	87	81	15	98	78.9
Post-natal Care	95	86	24	92	82.7
Nutrition	88	90	42	96	78.6
Child Immunization	95	92	21	42	75.1
Child Growth Monitoring	92	93	21	44	73.5
Oral Rehydration Therapy	95	88	30	79	81.4

Concerning reproductive health services, most SDPs of all types appeared to provide counselling services (on HIV/AIDS, other STDs and infertility) more than diagnosis and/or treatment (see Table 6). In these three areas of counselling, there were greater proportions of hospitals, followed by PPAG clinics, offering services than others; public clinics were the least likely to offer such counselling services. Finally, it was observed that more hospitals than any other SDP type were likely to provide reproductive health services of all kinds.

Table 6 Percentage of SDPs Providing General Reproductive Health Services by SDP Type

Type of Service	Type of SDP				Total
	Hospital	MoH Clinic	PPAG Clinic	Pr Maternities	
HIV/AIDS Counselling/IEC	97	55	70	64	66.1
HIV/AIDS Testing	70	7	6	16	20.5
Other STD Counselling/IEC	85	56	82	63	65.8
Other STDDiagnosis	78	25	24	32	36.4
Other STD Treatment	85	37	36	37	46.3
Consultation for Infertility	91	47	76	53	60.1
Abortion Complications	83	35	30	38	44.4
Pre-Abortion Counselling	60	25	39	37	35.8
Menstrual Regulation	43	26	27	22	31.6

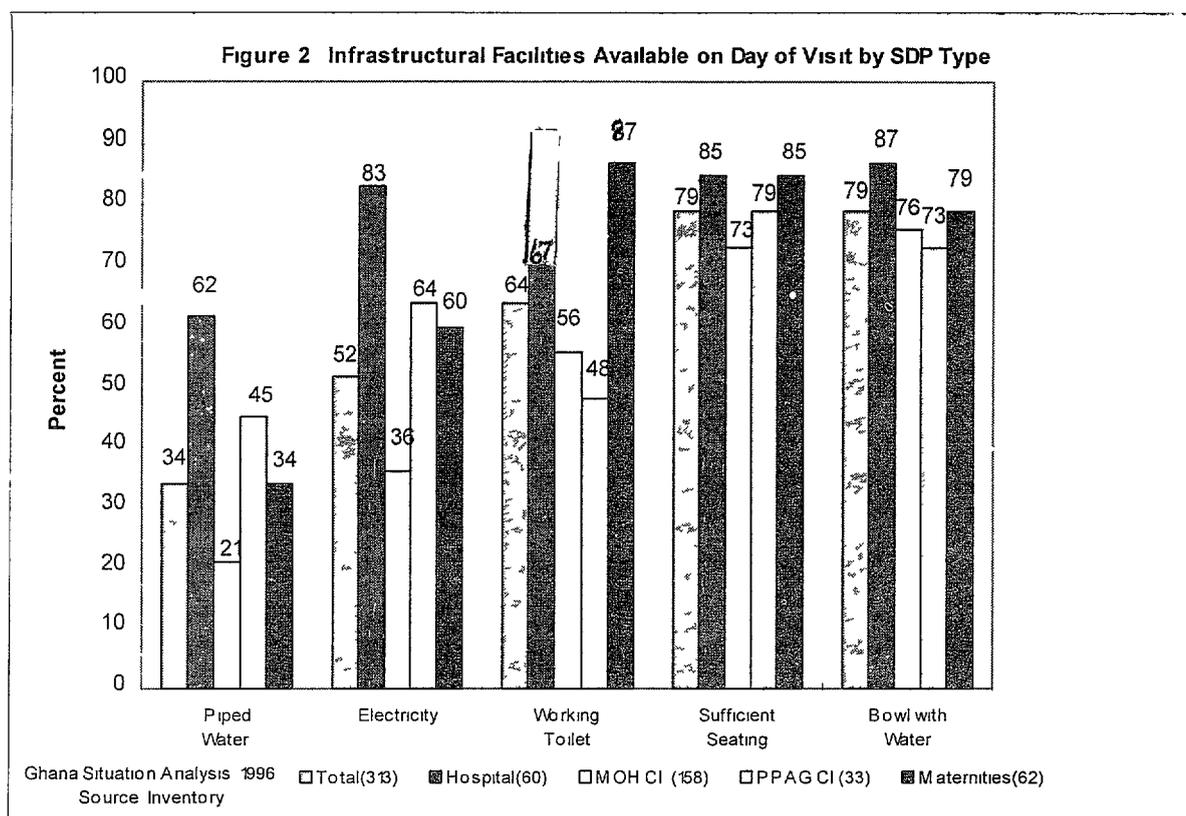
What is obvious from Table 5 and Table 6 is that there were more SDPs offering MCH services than reproductive health services. This is not surprising, given that MCH, until recently, had been the focus of the facilities. While the lowest proportion of SDPs providing an MCH service (child growth monitoring) was about three-fourths (73.5%), the highest proportion providing a general reproductive health service (HIV/AIDS counselling) was about two-thirds (66.1%). Another interesting finding is that while hospitals, public clinics and private maternities provided more MCH services than reproductive health services, the opposite was the case for PPAG clinics.

Infrastructural Facilities

The efficient and effective functioning of any system depends very much on the infrastructural base. Within the family planning and health system, the infrastructure, apart from the building, consists of the utilities: water, electricity, working toilet, sufficient seating for clients' comfort and bowls of water to wash hands. Results of the study, as shown in Figure 2, show that 34 per cent of SDPs had piped running water, with 52 per cent having electricity. These utilities are community based, in the sense that they could become available in the facility only when the wider community has them. Their non-availability may, therefore, reflect the rural-urban disparity in the provision of such infrastructure. This explains why hospitals, which are urban based, were more likely than others to have them. The relatively higher proportions of SDPs having electricity, as compared to piped running water, may be the result of the rural electrification programme which has connected many rural areas to the national grid.

The other three infrastructural facilities could be provided independently of the community and also differ in type and quality. This explains why relatively larger proportions of SDPs had working toilet than those that had piped running water. The exception appears to be hospitals which, being urban-based, would most likely have flush toilets which depend on running water to function, unless containers were used to store water for such purpose. This may also explain why most private maternities, which are mostly home-based, had this facility. The non-availability or non-functioning of the necessary infrastructure should be a matter of grave concern to all because of the health problem the insanitary conditions may pose. In the areas of sufficient seating for clients and bowls of water for washing, it appears that significant numbers of SDPs of all types made provision for them.

There is the need to work towards all SDPs having these utilities, because they directly influence the client's perception of quality service, an essential ingredient for sustainable demand for the service



Staffing

Every system requires qualified and knowledgeable people to operate and move it forward. It was necessary, therefore, to have an idea of the kind of personnel who usually provide family planning services and how many were actually available on the day of visit. On the whole, there were, on average, 3.9 full-time staff who provided family planning services, but the average on duty on the day of visit was 3.0, that is, 23 per cent absenteeism (Table 7). In terms of SDP type, hospitals had an average of 7 providers as against 3 for the private-sector facilities. The category of staff most commonly used in all facilities was a nurse of one type or another (nurse, nurse-midwife, midwife, auxiliary etc), while the doctor was least expected as a full-time provider.

Table 7 Average Number of Staff Providing Family Planning Service by SDP Type

Designation of Staff	Number Providing FP Services					Number on Duty on Day of Visit				
	Total	Hosp	MoH CI	PPAG CI	Mat	Total	Hosp	MoH CI	PPAG CI	Mat
Medical Doctor	0.1	0.6	0.02	0.1	0.5	0.1	0.4	0.01	0.03	0.02
Nurse/Midwife/Nurse Mid	1.9	3.0	1.6	1.5	1.5	1.3	2.0	1.2	1.0	1.0
Auxiliary Nurse	1.6	3.0	1.8	0.4	0.4	1.3	2.0	1.3	0.1	0.3
Extension Worker	0.3	0.4	0.3	0.8	0.3	0.3	0.3	0.2	0.8	0.2
Total	3.9	7.0	3.7	2.8	2.7	3.0	4.7	2.7	1.9	1.5

IEC Materials and Activities

A programme of information, education and communication (IEC) service is very important as a form of advertisement and/or dissemination, particularly for the uneducated, because it reduces a message to very simple, pictorial form that can be provided in a short time. The study was interested, therefore, to know the kind of materials and activities SDPs used to gain the attention and interest of clients and potential clients.

Table 8 shows that posters, contraceptive samples and flipcharts were the materials used most by SDPs while anatomical models and educational materials were the least available. This is true for all four SDP types. The non-availability of these materials in about 20 per cent of SDPs should be a matter of concern and efforts need to be made to ensure adequate supply to all SDPs. The situation is even less satisfactory with availability of IEC materials for the different kinds of MCH and reproductive health services provided. The only IEC materials that were available in some fairly decent proportion of SDPs (40-55%) were posters on HIV/AIDS and child welfare (and to a lesser extent antenatal/postnatal care).

Table 8 Percentage of SDPs Having Family Planning IEC Materials by SDP Type

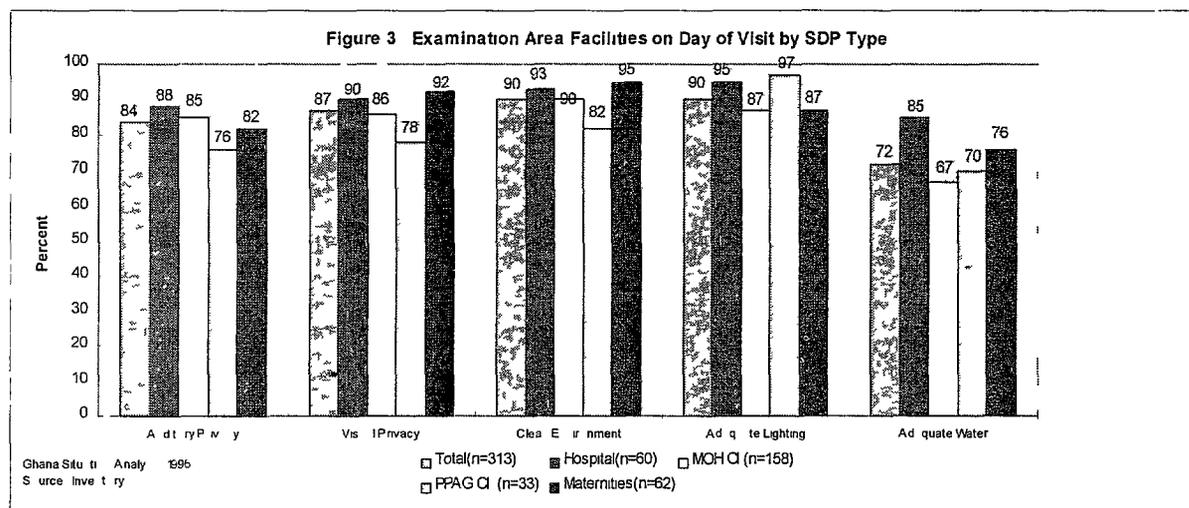
Type of IEC Material	Type of SDP				Total
	Hospital	MoH Clinic	PPAG Clinic	Pr. Maternities	
Flipchart	75	72	79	53	69.3
Brochure/Pamphlet	52	41	45	50	43.5
Posters	85	82	79	89	83.7
Contraceptive Samples	75	78	97	69	77.6
Anatomical Models	48	34	67	29	39.3

A very useful service in some SDPs is a "health talk", which takes the form of a short lecture or presentation by a provider to the clients gathered at the facility, followed by questions and answers or discussion. It is very useful in clearing doubts and reassuring clients. It was observed, however, that in only 26.5 per cent of SDPs did a "health talk" take place on the day of visit. In those cases where such a talk was given, family planning (64%) and nutrition (46%) were the topics that featured most prominently, followed by antenatal care (36%), child immunization (36%) and breastfeeding (35%). This was the picture with all SDP types. Reproductive health issues featured only rarely or not at all in most SDPs of all types. This is a reflection of the slow pace of integrating FP/MCH within the broader reproductive health concern.

Medical Examination Facilities

To be able to advise on the appropriate method for the new client, it is necessary to examine the client on the first visit. Such medical examination needs to be conducted in sufficient privacy to give the client a feeling of comfort and trust. The study, therefore, sought information on the availability of a separate room that was clean, had adequate light, had water for washing hands, had the relevant equipment and that ensured auditory and visual privacy.

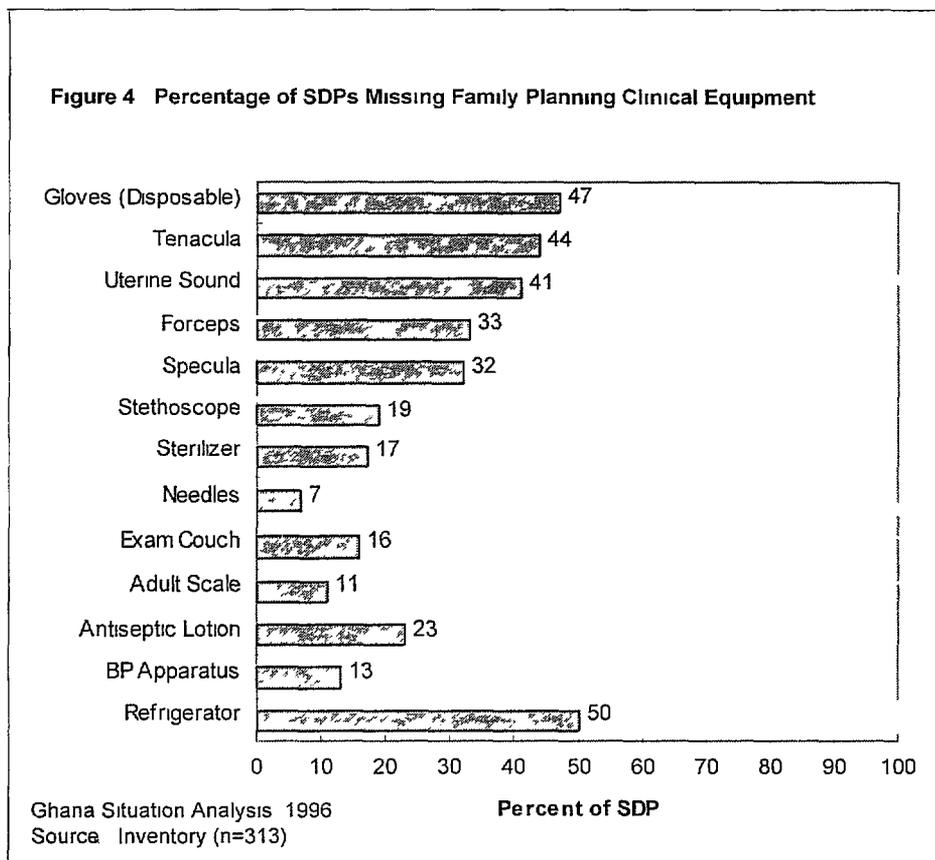
Figure 3 shows that quite an appreciable proportion of SDPs satisfied these needs. More than eight out of ten SDPs provided these facilities (the exception is adequate water, which only 72% provided). It is worth noting that the proportion of hospitals having any of these facilities was greater than the national average, while MoH clinics and PPAG clinics almost always had proportions lower than the national average.



The below average performance of public clinics may be due to the fact that they often operated in relatively small room units in rural communities, such conditions did not allow for much auditory and visual privacy, in addition to the obvious inadequate supply of water and electricity. The situation was even worse in the case of PPAG clinics which operated largely from rented premises in homes and other health facilities and were therefore limited in the examination area facilities they could provide. The general poor situation with the provision of adequate water for washing is unacceptable because every SDP should be able to provide one or two large containers to store water (not necessarily potable) for washing hands and equipment during and after the examination.

Equipment and Commodities

The point has been made that an initial medical examination of the new client is important in providing quality and relevant service. Such an examination can only be performed with the use of certain clinical equipment. Most SDPs did have many of these clinical equipment. Figure 4 presents the percentage of SDPs that did not have the equipment necessary for such clinical service.



The reason for non-availability would often be due to the fact that some of the SDPs did not offer certain family planning services that would require those equipment. For instance, few SDPs had minilap kit (7%) or laparoscope (4%) because many SDPs did not perform sterilization (see Table 9). Many SDPs also did not have their own laboratories, and this explains why only 11 per cent owned a microscope.

Table 9 Percentage of SDPs Missing Family Planning Clinical Equipment by SDP Type

Type of Equipment	Type of SDP				Total
	Hospital	MoH Clinic	PPAG Clinic	Pr. Maternities	
Disposable Gloves	45	53	30	40	49
Tenacula	30	49	21	56	44
Uterine Sound	20	46	21	56	41
Sponge-holding Forceps	30	35	36	32	33
Specula	18	42	21	27	32
Functioning Refrigerator	28	39	94	79	50
Antiseptic Lotion	13	32	15	13	23
Stethoscope	17	26	6	11	19
Sterilizer *	5	16	33	21	17
Examination Couch	8	24	15	3	16
BP Apparatus	10	20	0	5	13
Adult Weighing Scale	7	13	15	10	11
Needles/Syringes	4	8	10	3	7
Gynaecology Lamp/Torch	35	75	27	48	57
Scissors	13	20	18	8	16
Child Weighing Scale	15	8	91	26	22
Thermometer	32	34	64	16	33
Microscope	80	90	97	90	89
Laparoscope	87	100	94	97	96
Mini-lap Kit	77	98	88	97	93

* Defined to include any equipment (coal pot stove chemical) that could assist in sterilizing clinical kit

For the most part, more than three-quarters of SDPs had the other needed equipment. The essential item that was most conspicuously missing was a functioning refrigerator (in half of the SDPs). The other items that were missing the most were gloves, tenacula, sponge-holding forceps, uterine sound, specula, and antiseptic lotion. The missing equipment in some cases could be attributed to the supervisor keeping them in the house, either for safe-keeping or for home consultation.

This was confirmed by some providers who indicated that the space available to the family planning unit was too small to carry a cupboard that would contain all the needed equipment. In such conditions, many of the equipment that were not being used for lack of qualified staff had been kept in the homes of providers. In several rural and farming communities also, SDPs had adopted very flexible consultation hours that enabled clients to report to the homes of providers for re-supply. It is conceivable that providers under such flexible working hours would keep some essential equipment, such as the stethoscope, in their homes. For instance, it is known that the stethoscope and blood pressure apparatus go hand-in-hand, and yet, while 13 per cent did not have the blood pressure apparatus, as many as 19 per cent did not have the stethoscope. Another area of concern is with the 16 per cent that did not have an examination couch.

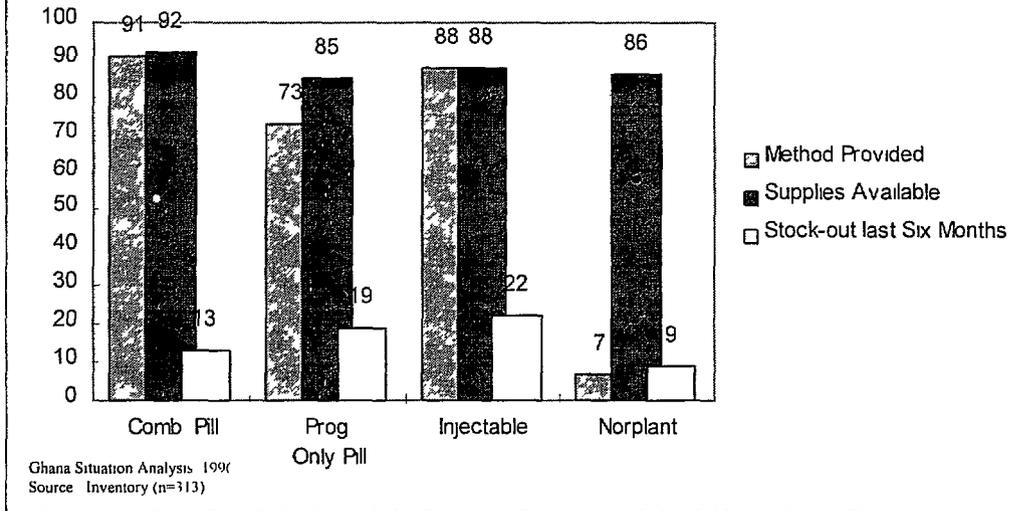
Family Planning Methods and Supplies

While infrastructural facilities, equipment and staffing are all very important components of the family planning programme, it is the range of methods that are usually provided as well as the availability of supplies which are at the core of the service delivery. At each SDP that was visited, therefore, information was gathered on the contraceptive methods that were usually offered, after which a physical count was made of supplies of each method, noting the stock level over the immediate past six months.

On the whole, more than half of all SDPs offered six of the eight major contraceptive methods. The method most offered was the combined pill (91%), followed by the condom (89%) and the injectable (88%). The methods least offered were the norplant and the diaphragm (7% in each case). It was also noted that quite a large proportion (about 90%) of SDPs that offered particular methods did have supplies available on the day of visit, even though quite a number (10-20%) had experienced a stockout at one point or another over the six months prior to the visit.

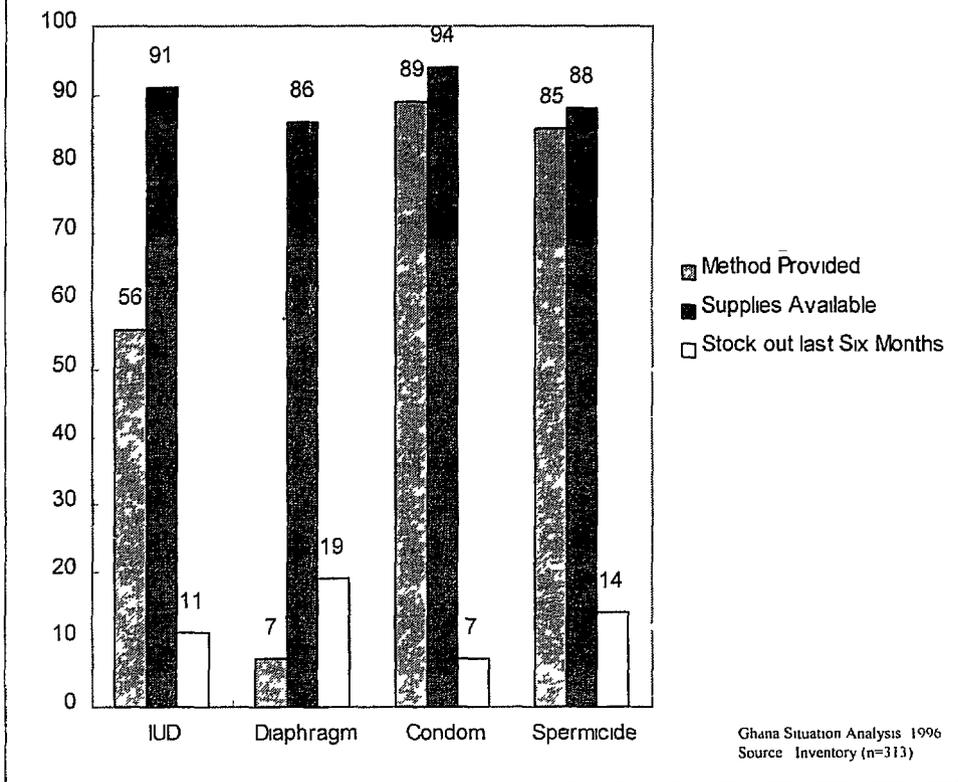
Figure 5 presents the availability of supplies as it pertained to hormonal contraceptive methods. With the exception of norplant, about three-quarters of SDPs offered the remaining three methods. The relatively low level of offer of progestin-only pill should be a matter of concern since that is the more appropriate pill for women who are breastfeeding.

Figure 5 Indicators of Availability of Hormonal Contraceptives



With regards to the IUD and barrier methods (Fig 6), the level of offer was much lower than with hormonal methods. Even with condoms and spermicides, probably the cheapest and easiest to use, 10-15 per cent of SDPs did not offer them. The relatively low level of offer of IUD probably reflects the myths and misconceptions associated with the use of the IUD.

Figure 6 Indicators of Availability of IUD and Barrier Contraceptives



There were substantial proportions (between 85 and 94%) of SDPs that had the different methods they offer available on the day of visit. This is encouraging, because it assured the client of ready supply and re-supply. It is important, therefore, that all SDPs monitor supplies closely to ensure regular supply to satisfy client need. The fact that a tenth to a fifth of SDPs had experienced stockouts in the six months preceding the visit should therefore be a matter of great concern.

The usage of modern contraception in the country is very low, so efforts at improving the prevalence level should not be frustrated with stockouts which may discourage some uncommitted users from continuing with the programme. It calls for close monitoring and supervision so that low stock could be detected early and the necessary requests initiated in good time to ensure timely replenishing of stocks.

The relative levels of indicators of contraceptive availability for the different programme types are presented in Table 10. With the exception of the Norplant (where hospitals predominated), more PPAG clinics than any other SDPs offered all other contraceptive methods. This is not surprising, given that such clinics were set up primarily to provide family planning services. Not only that, but in terms of availability of supplies on the day of visit, the PPAG clinics performed better than others on all methods, except Norplant and diaphragm. The stockout levels do not appear to have any clear pattern in terms of SDP type. The differentials are rather in terms of type of method.

Table 10 Indicators of Availability of Contraceptive Methods by Type of SDP

Method of Contraception	Hospitals			MOH Clinics			PPAG Clinics			Pr. Maternities		
	Meth Prov	Sup Avail	Stock-out	Meth Prov	Sup Avail	Stock out	Method Prov	Sup Avail	Stock out	Meth Prov	Sup Avail	Stock out
Combined Pill	85	92	12	92	92	12	100	100	9	89	87	22
Progestin only Pill	75	84	17	73	82	18	97	97	10	61	84	32
Injectable	83	92	12	87	83	27	97	100	16	90	93	14
Norplant	27	94	6	1	50	0	12	75	33	5	0	0
IUD	80	94	8	51	85	13	85	100	11	39	92	13
Diaphragm	3	100	100	0	0	0	48	88	7	5	67	33
Condom	87	92	8	91	91	6	97	100	9	85	94	8
Spermicide	82	92	16	85	87	16	100	100	12	81	90	8

Other Family Planning Services

Delivery of family planning services goes beyond the provision of the known contraceptive methods. It involves counselling, the use of procedures to eliminate the discharge of the female egg or the male sperm as well as the use of methods after sexual intercourse. Information was solicited on these other family planning services to see how comprehensive the programme was. The evidence is that more SDPs offered counselling services than those that did provide more direct procedures that would ensure that pregnancy did not occur (Fig 7). The spate of rape in the country and the fact that sexual partners may occasionally find themselves in situations where they may engage in unprotected sex, all call for greater attention to the provision of emergency contraception.

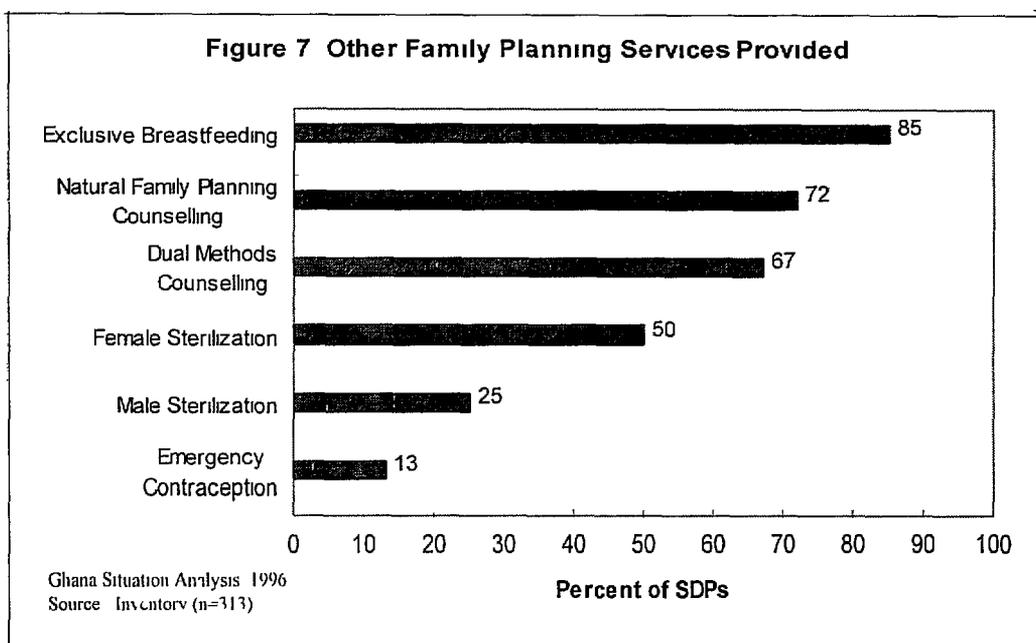


Table 11 indicates that SDPs of all types follow this general trend. Significantly, more PPAG clinics than others offered dual method counselling and emergency contraception. The remaining services were offered more in hospitals than in other SDP types.

Table 11 Percentage of SDPs Providing Other Family Planning Services by SDP Type

Type of Service Provided	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Exclusive Breastfeeding Counselling	90	85	79	82	84.7
Natural Family Planning Counselling	83	65	79	74	71.9
Dual Methods Counselling	72	66	82	58	67.1
Female Sterilization	73	42	58	44	50.2
Male Sterilization	33	23	33	15	24.6
Emergency (Post-Coital) Contraception	12	9	33	11	13.4

Screening and Diagnostic Facilities for Non Family Planning Services

One of the overriding concerns of birth control is to improve the health of the mother and child. The current emphasis in family planning service therefore is a shift from method delivery only to one that includes non-method services that affect general reproduction. It is for this reason that information was canvassed on laboratory tests that would help identify the presence of HIV, other sexually transmitted diseases (STDs), cancer of the sexual organ and pregnancy. Some SDPs carried out the laboratory tests themselves, others took the specimen and referred clients to another outfit for the test while others referred clients to have the screening done elsewhere.

The results of the study indicate that only 32 per cent of SDPs offered laboratory test facilities. Figure 8 shows that pregnancy test is the one that is carried out extensively. This is not surprising because the main objective of the unit of analysis is to provide methods for the spacing and limiting of pregnancies. This is made even

more forcefully by the fact that the next common test (gonorrhoea) is done in just about half of the facilities. Another point to note is that for almost all tests, a lot more screening and diagnosis is done at the SDP rather than elsewhere.

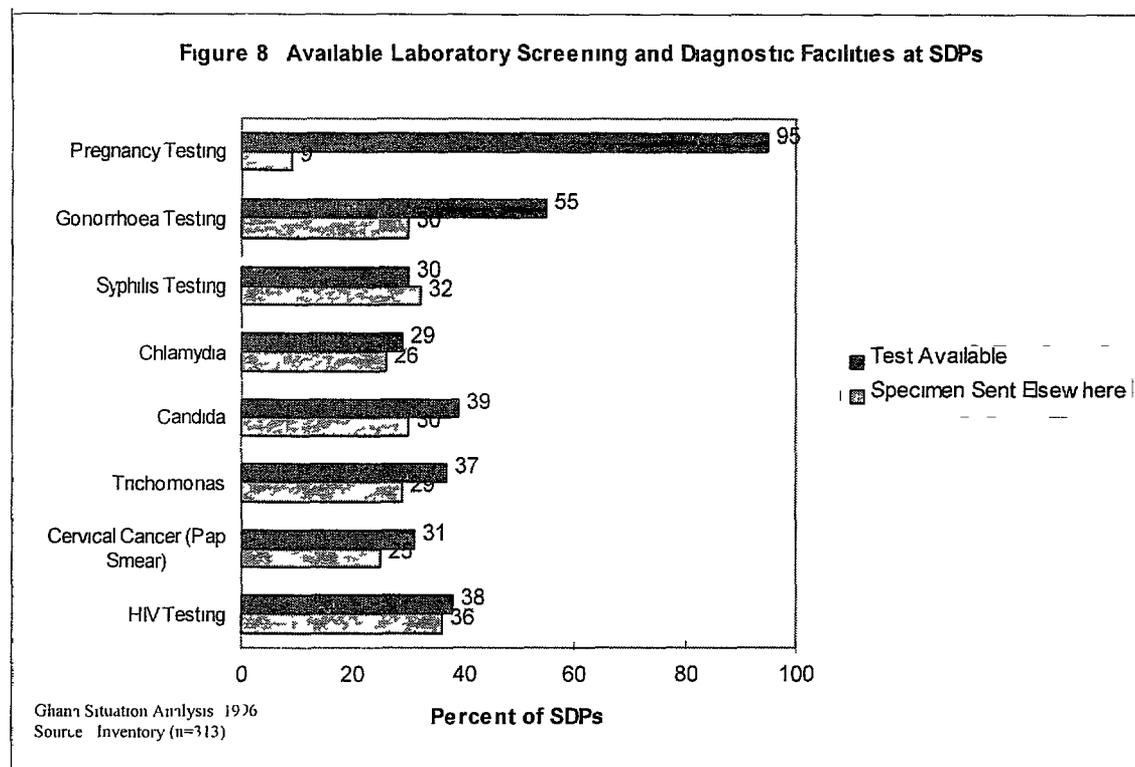


Table 12 reveals some very important differences among types of facility. For all types of health facility, except PPAG clinics, pregnancy test is the commonest carried out. Indeed, pregnancy test and, to a lesser extent, the other tests were not carried out in PPAG clinics. This may be understandable, because most PPAG facilities are outreach posts, what is not clear is why they also did not refer clients to other facilities for pregnancy screening even though they did for other tests. Similarly, maternities and MOH clinics also depended on other laboratories than on their own facilities in screening and diagnosing tests other than pregnancy. Apart from not having the equipment to perform laboratory test, it could also be that the staff were not sufficiently trained to do so. This may be evidenced by the fact that only 23 per cent of the SDPs (49% hospital, 21% clinics, 9% PPAG and 13% maternities) had a copy of the guidelines for the management of sexually transmitted diseases.

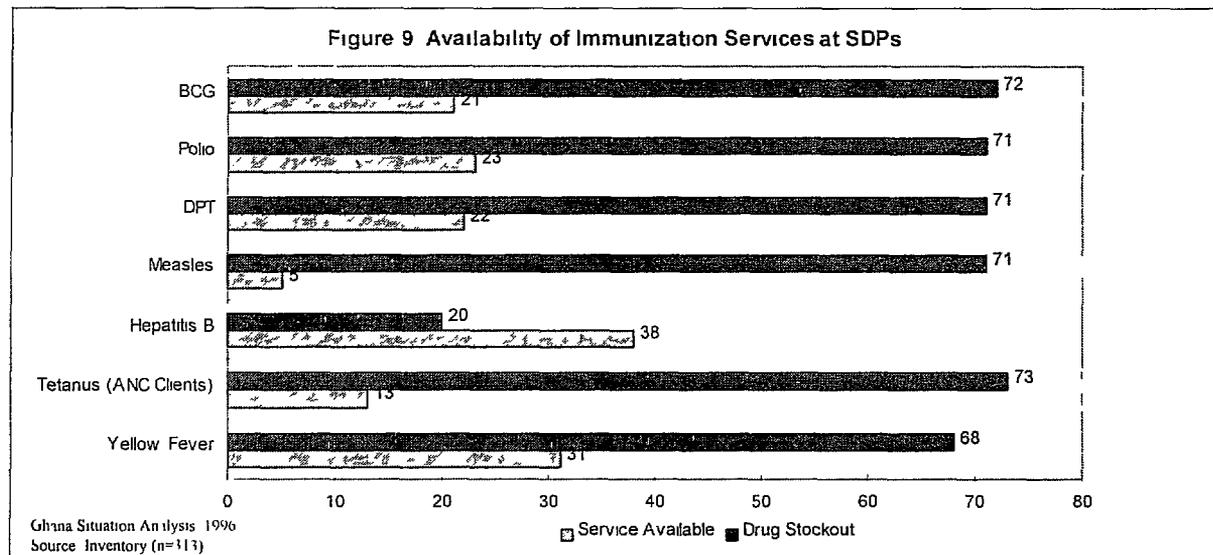
Table 12 Availability of Screening and Diagnostic Facilities by SDP Type

Laboratory Test	Hospitals		MOH Clinics		PPAG Clinics		Pr Maternities	
	At SDP	Elsewhere	At SDP	Elsewhere	At SDP	Elsewhere	At SDP	Elsewhere
Pregnancy	75	10	100	4	0	0	21	3
Gonorrhoea	67	12	38	33	9	73	8	11
Syphilis	42	18	16	29	9	73	3	10
Chlamydia	35	17	8	25	9	73	3	8
Candida	52	17	13	25	9	73	6	10
Trichomonas	50	13	8	29	9	73	6	10
Cervical Cancer	27	18	13	25	9	64	3	11
HIV/AIDS	58	18	8	33	0	82	2	13

Immunization Services

Just as MCH clients are seen as potential family planning clients, so should most family planning clients be seen as potential MCH clients. This, indeed, may be the reason for integrating family planning and maternal and child health services in the first place. This integration should be reflected in the service-mix that SDPs provide. In seeking to know of immunization services that were available at the SDP, therefore, the study sought to know the proportion of SDPs that provided for both family planning and MCH clients.

Apart from hepatitis B and yellow fever, more than 70 per cent of SDPs provided all the major types of immunization (see Fig 9). The position is encouraging and one would hope that the remaining 30 per cent would work towards providing this service. The general level of stockout in the last 6 months is much higher than that for family planning methods, which again shows the bias of the SDPs.



The picture is not the same for all types of SDPs and this is demonstrated quite clearly in Table 13. Public facilities (hospitals and clinics) provide immunization services to a much higher level than the private facilities. While over 90 per cent of hospitals and clinics provide immunization of all types (hepatitis B excluded), just about a fifth of PPAG clinics and maternities do so. Even for hepatitis B, the proportion of hospitals that provide the service is twice the national average.

The apparent lack of interest of PPAG clinics and maternities in non-family planning services may be explained by the fact that these are outside their scope of activity. For maternities, there is an understanding with MOH that the latter would provide the related service of immunization for ante-natal care clients and for babies. For almost all types, the level of stockout is slightly lower in public than in private facilities though in general the level is much higher than in the case of family planning service. Level of stockout also appears to be high for hepatitis B and yellow fever.

Table 13 Availability of Immunization Services by Type of SDP

Type of Immunization	Hospitals		MOH Clinics		PPAG Clinics		Pr Maternities	
	Provide Service	Stockout last 6 mo						
BCG	98	22	92	21	15	20	26	12
Polio	97	19	92	21	15	40	24	47
DPT	97	21	92	22	15	20	23	21
Measles	95	2	93	6	15	20	23	7
Hepatitis B	40	42	22	40	3	100	5	0
Tetanus for ANC Clients	97	12	91	13	12	25	37	13
Yellow Fever	92	42	91	27	6	100	16	40

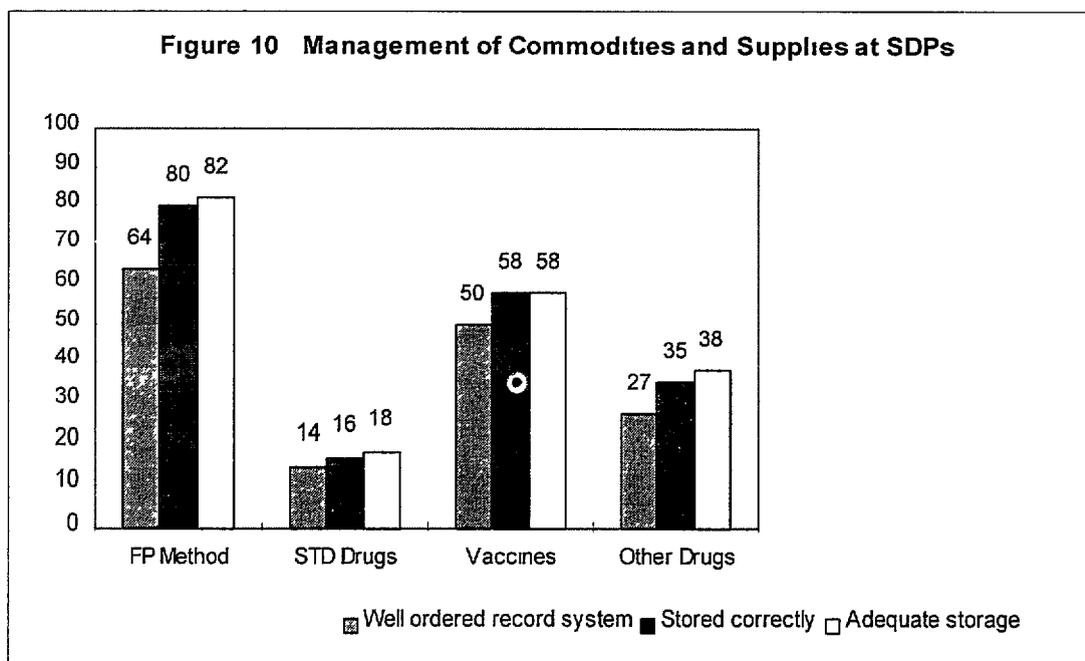
Commodity Management

An important way in ensuring quality service is to have commodities and supplies that are properly stored such that there are enough supplies of the required potency. If the recording system is not well ordered, there is the possibility of exhausting commodities with late expiry dates, leaving those with early expiry date which may consequently become useless.

About three-quarters (73%) of SDPs visited had a written record system of one kind or another for tracking family planning commodities. The proportion of SDPs that had a similar system was not as high for drugs for STD treatment (15%), vaccines (56%) and other medicines (29%). Of more interest is the proportion of SDPs with an up-to-date, legible and complete record system. It is worth noting that about 90 per cent of SDPs with a record system were well-ordered along these criteria. Thus, 64 per cent of SDPs had a well ordered record system as against 14 per cent for STD treatment, 50 per cent for vaccines and 27 per cent for other medicines.

The study also collected information on SDPs that stored commodities by expiry date and under satisfactory conditions, that is, protected from rain, sun, adverse temperatures, rodents and pests. Figure 10 presents the results for the different types of commodities and supplies. A few comments are worth making here. First, it appears that family planning gets the greatest attention of SDPs, while STD treatment is of least concern or interest. This is explained by the fact that STD treatment is currently carried out in the clinical section, efforts are being made to integrate STD treatment and family planning delivery (pilot project in the Eastern Region). Second, irrespective of commodity type, storage facilities received greater attention followed closely by storage by expiry date, coming much further down is a well-ordered record system.

It is a good thing that SDPs give greater attention to issues of storage than the system of recording, but the proportions involved are too small to be enthused about. The commodities and supplies are rather expensive and not readily available when needed (the level of stockout is a pointer) and therefore greater effort is needed to preserve and manage these items efficiently. A training workshop in commodity management for providers will be necessary in addressing this problem.



Very interesting differences between types of SDPs are revealed in Table 14. That family planning is the primary focus of PPAG clinics is demonstrated in their better management of family planning methods in all three indicators. Particularly significant is the difference between the proportion of PPAG clinics and that of any other facility type which keeps a well-ordered record system. The proportion of hospitals keeping a well-ordered record system is rather disappointing. It was observed that even though 76 per cent of hospitals kept a written inventory of commodities and supplies, only 45 per cent of these (or 34 of all hospitals) kept an up-to-date, legible and complete record of commodities. It is hoped that an attempt will be made to improve the situation. Hospitals appear to do better with vaccines for immunization than they do with family planning methods. This is not unexpected, because hospitals provide a greater range of health services, a major one of which is child care. Hospitals, again, appear to be well ahead of other facilities in managing drugs for the treatment of STDs even though only about 30 per cent of hospitals do so.

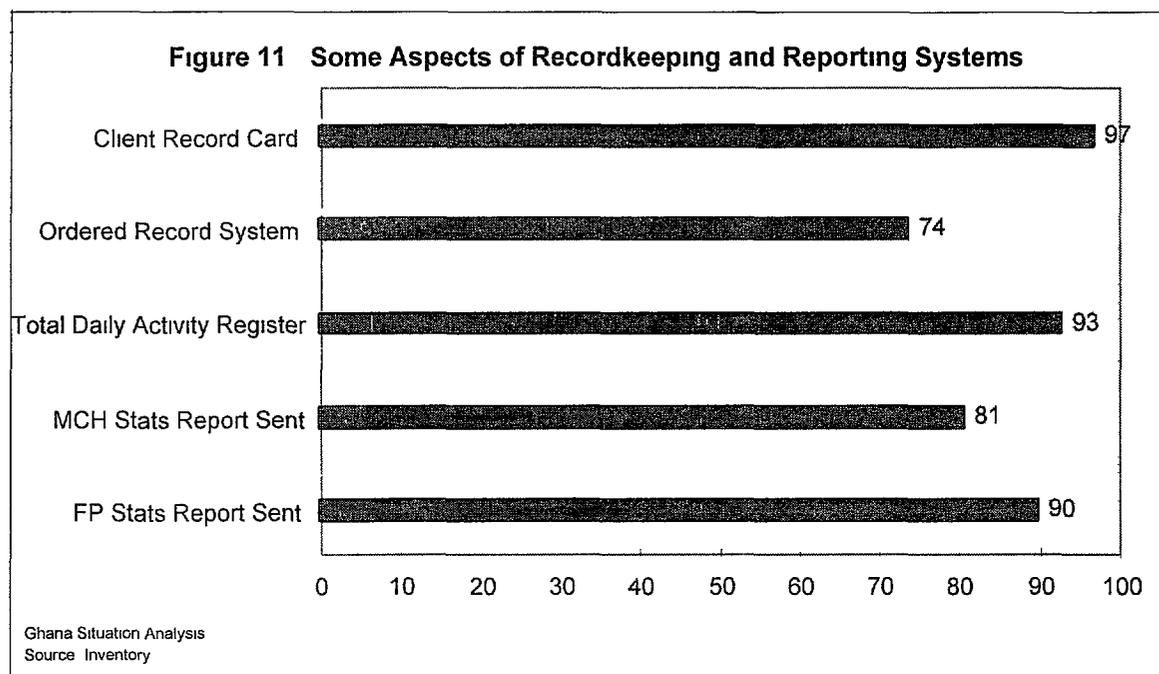
Table 14 Indicators of Commodity Management by Type of SDP

Commodities	Hospitals			MOH Clinics			PPAG Clinic			Pr Maternities		
	Ord Rec	Sto Corr	Ade Stor	Ord Rec	Sto Corr	Ade Stor	Ord Rec	Sto Corr	Ade Stor	Ord Rec	Sto Corr	Ade Stor
FP Methods	34	77	77	56	82	81	91	88	97	32	75	81
STD Treatment Drugs	28	30	32	2	16	16	3	6	6	3	8	15
Vaccines	73	83	80	45	70	72	3	9	9	15	26	27
other Medicines	39	38	42	10	33	35	6	15	15	19	45	53

Recordkeeping and Reporting

Another administrative practice that is important for quality service relates to the system of keeping records and reporting on activities to a higher unit. It is only when record of activities are kept in an orderly manner and reported on at frequent and regular periods that a proper assessment can be made of performance and corrective measures taken to redress problem areas.

Figure 11 shows that 97 per cent of SDPs had cards on which clients' visits and actions taken on the visit are recorded. This proportion is made up of 88 per cent which kept such client record cards at the SDP and 9 per cent that let clients themselves keep the cards. As with recordkeeping of commodities, it was observed that not all the SDPs that kept record cards did so in an orderly manner. Of the 88 per cent that kept record cards at the SDP, 84 per cent kept it up-to-date, legible and complete, thus, only 74 per cent of SDPs had a well-ordered record card system. When the cards are not kept in order, it takes much longer to locate a client's card and this could increase waiting time for clients unduly. It is important therefore that all SDPs work towards improving the situation.



Almost all SDPs (98%) had a daily activity register of one kind or another which becomes a summary of the day's activities. For these, 26 per cent had one register for all services, while 67 per cent had a register for each service provided, an additional 5 per cent had a register for only selected services. These differences in practice may be dictated by the volume of services provided. As stated earlier, the purpose of keeping record and report of activities is to provide a system for assessing performance, so that areas of weakness may be improved. For this to be achieved, the attention of the supervisor or a higher unit would need to be drawn to the report. Results of the study show that more than four-fifths of SDPs did prepare a service statistics report which they did forward to a higher unit. Such statistics report related mainly to MCH and family planning services and about three of five of such reports were prepared and sent monthly.

As is expected, there were significant differences between SDP types (see Table 15). In almost all components of recordkeeping and reporting, hospitals and PPAG clinics were at par and far better than public clinics and private maternities, which were also at par.

Table 15 Recordkeeping and Reporting System by Type of SDPs

Type of System	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Pr. Maternities	
Client Record Card at SDP	96	83	97	85	88
Record Card kept by Client	4	11	3	13	9
Record Card Well Ordered	88	68	88	69	74
Record Card Partially Ordered	8	15	9	16	47
Daily Register for all Services	25	16	64	29	26
Separate Register	73	77	24	60	67
Register for Same Services	0	4	12	10	5
MCH Statistics Report Sent	88	91	18	82	81
MCH Stats Report Sent Monthly	65	68	12	77	64
FP Stats Report Sent	85	92	97	85	90
FP Stats Report Sent Monthly	63	80	82	81	77

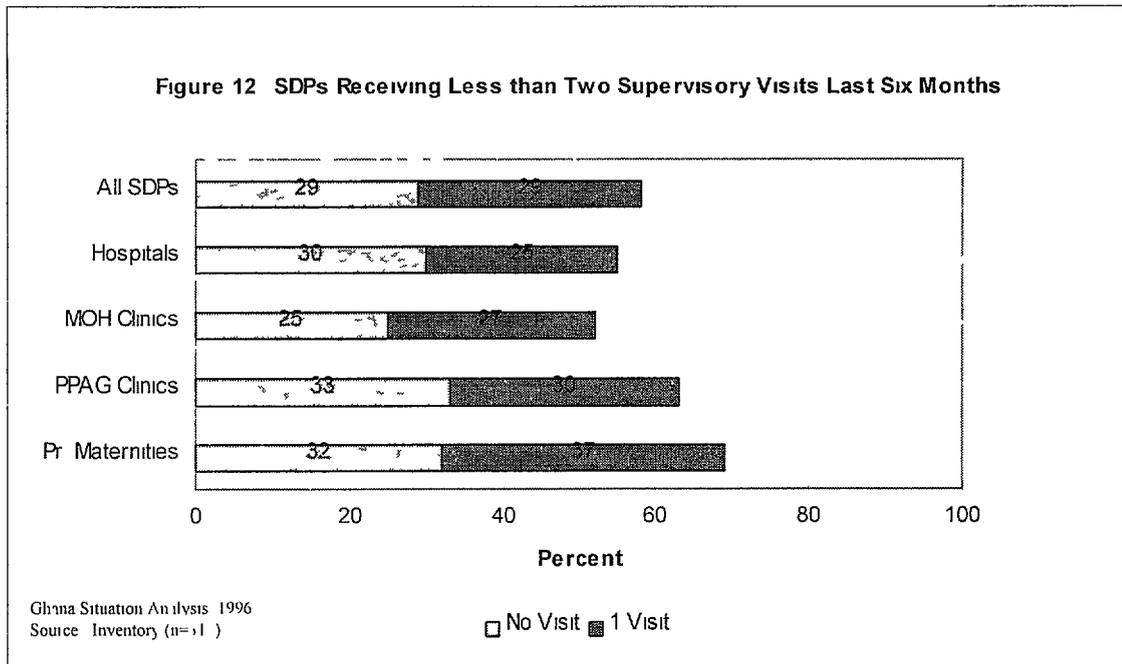
Management and Supervision

The success or failure of any programme depends largely on the effective and efficient implementation of the programme which, in turn, depends on how those in charge of managing the programme monitor the various stages of implementation. It is only when there is regular and constant monitoring that lapses in the system may be identified and addressed before they are able to pose difficulties for implementation. One very essential tool for effective management of the family planning programme is supervision. The study therefore sought information on level of supervision within the 6 months prior to the data collection activity.

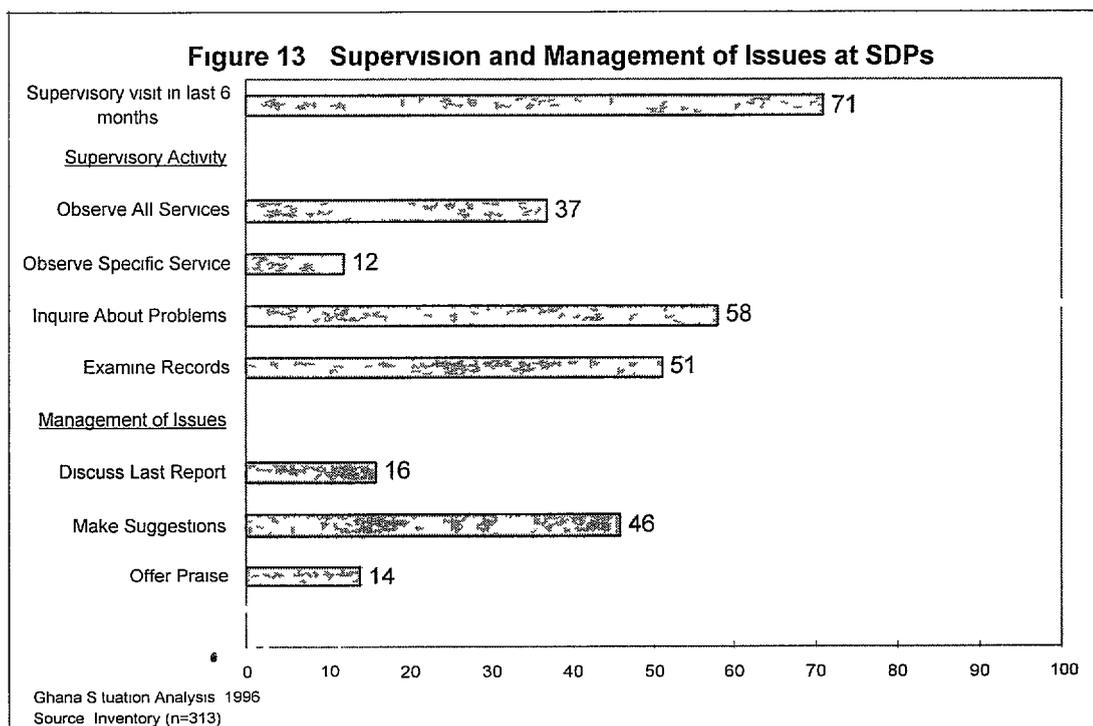
At the minimum, the Ministry of Health expects supervisory visits to be fielded once a month at the district and lower levels and once a quarter at the regional level. The evidence on the ground, however, points to a less than satisfactory monitoring system. Of the 313 SDPs visited, more than a quarter (28.7%) had received no supervisory visit during the preceding 6 months. A similar proportion (28.8%) had received only one visit. Thus, less than half (42.5%) had received at least one visit every quarter which would be the absolute minimum acceptable frequency of supervisory visits.

The picture is not too different for the various types of facilities, as Figure 12 shows. In general, public facilities performed slightly better than the national average while the private facilities were much worse than the national average. Public clinics had the least unsatisfactory supervisory schedule (52%) while private maternities had the most unsatisfactory (69%). This is an area where all programmes need to reassess their performance and work towards improving on it, because it is through regular supervision that wrong procedures can be detected and corrected to ensure quality of service.

Supervisory visits, it has been pointed out, are a tool for assessing effectiveness and efficiency of programme implementation and for identifying difficulties for possible remedial action.



Towards this end, the study collected information on specific supervisory action as well as follow-up action of identified problems. The results, as shown in Figure 13, are again not very encouraging. In 58 per cent of SDPs, the major supervisory action related to enquiries about any problems the SDP may be encountering while in 51 per cent of SDPs, examination of records was the major activity.



These activities are very useful, but they leave room for the perpetration of unacceptable procedures in the sense that the supervisor would not know for himself or herself if information given by the provider was necessarily correct. Such information can only be verified through an actual observation of provider action.

during service delivery, which was done in only about a third of SDPs. In terms of follow-up action, suggestions for improvement were provided in 46 per cent of SDPs. The previous service report was discussed in only 16 per cent of SDPs, while praise for good work was offered in 14 per cent of the cases.

Table 16 presents the results on these indicators for the different facility types and the pattern is basically the same for all. Total or complete supervision (defined to include an observation of provider action for the day) was better in public clinics and hospitals than in maternities and PPAG clinics. As mentioned earlier, this is at the heart of supervisory visits and therefore shows a lack of commitment on the part of supervisors.

Table 16 Supervisory Activity and Management of Issues by Type of SDP

Type of Activity	Type of SDP			
	Hospital	MOH Clinics	PPAG Clinics	Private Maternities
Supervisory Visit in Last 6 Months	70	74	67	68
<u>Supervisory Activity</u>				
Observe Delivery of Different Services	33	42	24	35
Observe Only Service of Responsibility	8	10	12	18
Inquire about Service Problems	62	59	61	48
Examine the Records	57	53	36	50
<u>Supervisory Follow-up Action</u>				
Discuss Last Report Submitted	25	13	15	16
Make Suggestions for Improvements	47	43	55	48
Offer Praise for Good Work	13	13	21	11

If less than half of SDPs (irrespective of type) do receive a visit a quarter (on average) and if an observation of service delivery does not feature as a prominent supervisory activity even in those few visits that are made, then there is a great danger that quality of service delivery will be low. The absence of a feedback on reports submitted is also a matter of grave concern, because it means that supervisors probably do not read such reports but simply pass them on to a higher unit and that providers would continue to do things their own way, whether right or wrong.

Service Statistics

Statistics of services provided are useful in monitoring progress and acceptance of the programme. It is encouraging to note that most SDPs compiled service statistics or had the required data for such a compilation and that such information covered continuous periods. Data on family planning service for a continuous period of 12 months existed in more than 80 per cent of SDPs. This was true for both new and repeat clients (see Table 17). This proportion drops substantially for the other services. There are a few interesting observations though from the Table. The first is that irrespective of type of service or type of SDP, the proportion of SDPs that kept statistics on new clients was higher than the case with repeat clients. The second is that the proportion of SDPs that kept statistics followed very closely the emphasis in service provided. Thus, hospitals and public clinics had better statistics for family

planning, followed by antenatal or child welfare services while private maternities had better statistics records for antenatal, followed by family planning and delivery services. Finally, most SDPs had a very low priority for HIV and other STD services.

Table 17 Percentage of SDPs with Statistics on New and Repeat Clients by Type of Service

Type of Service	Type of SDP								All SDPs	
	Hospitals		MOH Clinics		PPAG Clinics		Pr Maternities			
	New	Repeat	New	Repeat	New	Repeat	New	Repeat	New	Repeat
Family Planning	90	83	84	80	88	82	85	84	85.6	81.8
Antenatal Services	68	63	74	60	15	6	94	81	70.6	58.8
Delivery Services	50	18	63	9	-	6	87	15	58.8	11.5
Postnatal Services	53	17	56	13	9	3	68	16	52.7	13.1
Child Welfare	75	63	71	56	6	6	6	6	52.1	42.2
HIV/AIDS Services	27	13	1	-	-	-	-	-	5.8	2.6
STD Services	17	7	6	1	6	3	6	5	8.3	3.2

Whenever there is a complaint with low utilization of health services, the oft-repeated cause has been inadequate facilities to provide the service and, not surprisingly, as a solution has been the increase in the numbers of these services. Often missing from such an analysis is an assessment of the level of capacity utilization of the existing facilities. Most SDPs open for an average of 5 days in the week and offer family planning services for an average of 6 hours a day. If we assume one hour a day for group discussions and off-duty activities and also allow for 12 days statutory public holidays, it means that each SDP would offer, on average, 1250 effective hours of service in the year. For most services, it required not more than half an hour of consultation with a client. This means that most facilities had the capacity to offer services to about 2500 clients a year per provider.

Figure 14 looks at the mean number of clients that were offered family planning services over the 12 months prior to the study. In computing the means, those SDPs that did not keep service statistics were excluded. For the over 80 per cent of SDPs that kept statistics on family planning services, the average number of clients for the year was 744, less than a third of what one provider could have done in the year. The level of utilization was higher in hospitals (1564) and PPAG clinics (1324) than in maternities (485) and public clinics (398), but even among the former, there is much room to accommodate more clients.

That the facilities generally were heavily underutilized is not in doubt. What still needs to be explored is why the demand for family planning services has been so low in the country. There is enough capacity within existing facilities that could be utilized to increase access to many more potential clients. It remains to work out the strategy and programme to attract these potential clients.

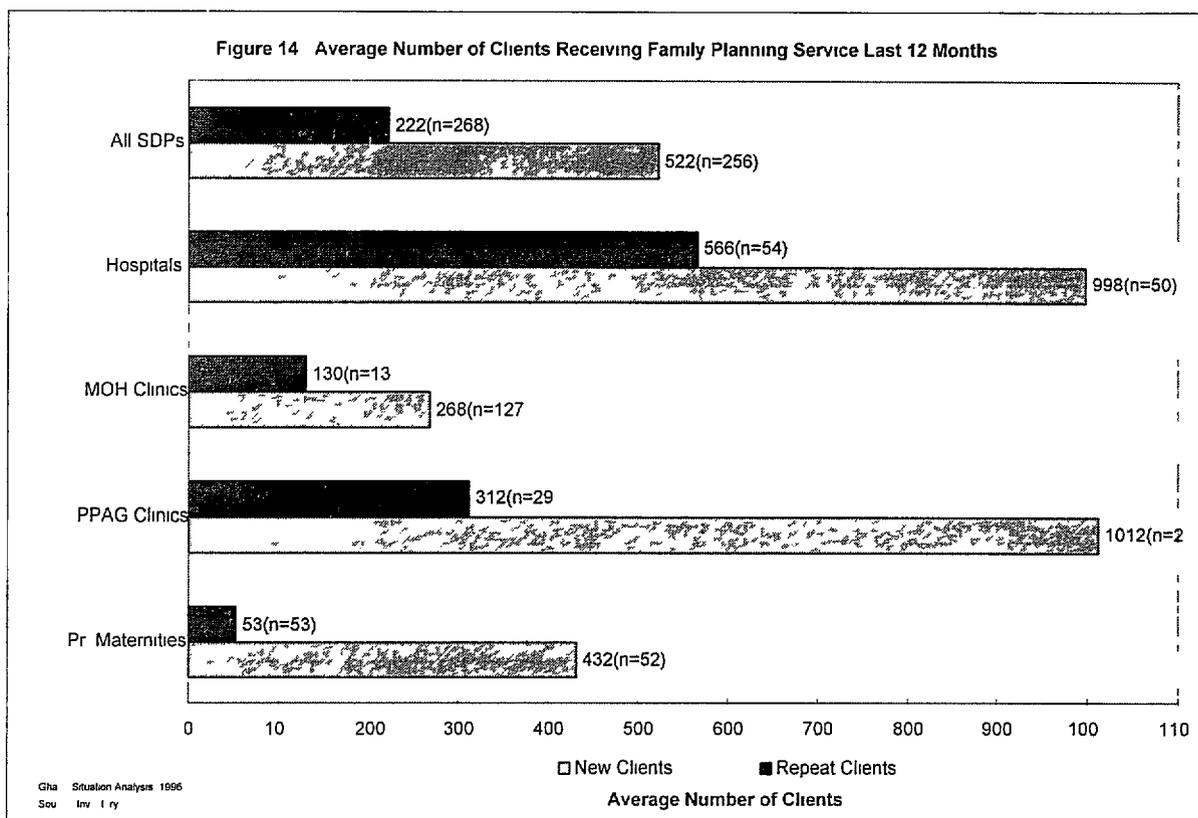


Table 18 presents results from the different SDP types for all types of services offered and the indication is that the SDPs offered services in maternal and child health to more clients than it was the case with family planning. This was the case in all types of facility. The low demand for family planning services is therefore not the result of lack of access but rather has to do with client acceptance of the services provided.

Table 18 Average Number of New and Repeat Clients Last 12 Months by Type of Service and Type of SDP

Type of Service	Type of SDP								All SDPs	
	Hospitals		MOH Clinics		PPAG Clinics		Pr Maternities			
	New	Repeat	New	Repeat	New	Repeat	New	Repeat	New	Repeat
Family Planning	566	998	130	268	312	1012	53	432	222	522
Antenatal Services	2254	7609	621	1919	438	1796	217	432	814	2689
Delivery Services	1217	2467	169	167	29	29	120	140	326	855
Postnatal Services	987	635	304	861	20	97	87	249	376	638
Child Welfare Serv	1652	6286	699	2437	404	879	150	284	945	3456
HIV/AIDS Services	194	548	30				-		176	548
STD Services	290	353	1051	18	68	9	21	15	524	150

This gap between demand for family planning and that for other services was influenced, to some extent, by the number of SDPs involved. In all cases, more SDPs had statistics on family planning than for other services (see Table 17) and this was likely to affect the means, if there happened to be one or two SDPs with very extreme values. For instance, only 10 MOH clinics kept statistics on STD service for new clients. Five of the 10 SDPs reported new clients of less than 4, while the other 5 SDPs reported values greater than 4, with the highest reported figure being 10289. This obviously accounts for the high average value of 1051. On the other hand, there were 132 MOH clinics with statistics on new family planning clients. Half (66) of the SDPs have values below 79, while the remaining half have values greater than 79, with 759 being the highest, hence the low average of 130.

The other observation to make is that for almost all services and in all facilities, many more repeat clients than new clients had been offered the relevant services. This may mean that clients receive satisfactory services to want to return. The level of repeat clients for family planning, however, is not very encouraging, given that this is a continuous service and the programme has been around for a long time. It is necessary that even as the programme seeks to recruit new clients, efforts should be made to encourage the current as well as one time users to continue or resume as active users. Such clients, when really satisfied, could become advocates for the programme.

Cost of Obtaining Family Planning Services

The saying goes that money is not everything. In the money market where one's consumption of a commodity depends to some extent on one's purchasing power, however, the cost of goods or services can contribute to the difference between availability and accessibility. An attempt was made, therefore, to collect information on the fees charged for services in the facility. Three main services are identified for our purposes: consultation, test or procedure or commodity, and others (including drugs, bed, meals and supplies). The practice on the ground, it was observed, was that many facilities did not charge for separate services but rather gave one bill that was all-inclusive. For almost all methods and facilities, about 95 per cent of the SDPs that reported charging fees had a charge for commodity or test/procedure. About a third had a charge for other services, mostly the payment for drugs and supplies provided by the facility. Only about a tenth had a separate charge for consultation.

Table 19 gives an indication of the level of fees charged by the different types of SDP and for the three specific services on the day of visit. These figures should not be taken at the face value because of the practice of some SDPs subsuming all fees under one service (either consultation or commodity). One observation that is worth making though is that maternities, on the average, charged higher fees than the other three SDP types and this is true for almost all methods and all services. This stems from the fact that the other three facility types receive donor assistance whereas the maternities receive their methods and supplies from the competitive market.

Table 19 Average Charges for Obtaining Family Planning Services by Method and SDP Type

Type of Method	Consultation					Commodity/Test/Procedure					Other				
	Type of SDP				Tot	Type of SDP				Tot	Type of SDP				Tot
	Hosp	Clin	PPAG	Mat		Hosp	Clin	PPAG	Mat		Hosp	Clin	PPAG	Mat	
Combined Pill	100	164	237	708	481	160	143	147	394	195	334	193	277	544	315
Progestin Only Pill		200	250	610	448	284	153	131	384	215	321	193	277	534	306
IUD	500	483	264	1800	800	440	431	443	1584	565	628	837	436	1564	806
Injectable		204	250	1323	822	345	255	339	1164	456	524	298	345	776	445
Norplant			400	200	300	2379	677	4000	167	1992	500				500
Condom		48	250	1370	805	62	63	20	152	73	201	59	155	427	172
Diaphragm			225	500	317	10	615	200	210	338			200	200	200
Spermicide		18		1400	1054	242	96	250	279	170	102	91	220	520	200
Female Sterilization			400		400	8849	200	5000	30000	8925	500			1000	750
Male Sterilization			400		400	7500	300	5000	2000	4460	500		200		350
N F P Counselling	500			1700	1500				3250	3250	300		200	750	543
Breastfeeding Couns				1250	1250						200		200	750	475

After the normal period of a pregnancy, which is 9 months, it is observed that most women resume their menses after 3 months. Under the circumstances, a woman normally could be pregnant only once a year. In looking at the cost of family planning, therefore, it is customary to analyze it in terms of the cost in preventing a pregnancy within the year. What makes it particularly relevant is the fact that some methods provide protection beyond one year while others require several doses within the year.

Table 20 presents the estimated average cost of protection for the different methods and for the different SDP types. It is assumed that couples who go in for sterilization would have achieved their desired number of children (which, on average, would be 3 or 4) before the end of the natural childbearing age. This average is often achieved when the women would be in the 30-39 age group. Sterilization therefore would provide protection for an average of 12.5 years. It is also assumed that couples would require no more than a counselling session on the rhythm method and breastfeeding for purposes of family planning.

Table 20 Mean Annual All Inclusive Costs of Family Planning to Clients by Method

(in cedis)

Type of Method	Unit Cost (All Inclusive)					Number Required for Couple Year of Protection	Cost of Couple Year Protection				
	Hospitals	Clinic	PPAG	Maternities	Total		Hospitals	Clinic	PPAG	Maternities	Total
Comb Pill	284 90	191 60	311 61	806 96	342 13	13 00	3703 70	2490 80	4050 93	10490 48	4447 69
Prog Only Pill	400 31	201 06	298 28	812 70	356 19	13 00	5204 03	2613 78	3877 64	10565 10	4630 47
IUD	748 94	766 28	710 71	2559 09	978 11	0 40	299 58	306 51	284 28	1023 64	391 24
Injectable	505 57	335 60	510 34	1631 82	644 68	4 00	2022 28	1342 40	2041 36	6527 28	2578 72
Norplant	2485 71	676 67	4200 00	175 00	1996 96	0 29	720 86	196 23	1218 00	50 75	579 12
Condom	78 37	67 88	56 61	350 82	116 00	100 00	7837 00	6788 00	5661 00	35082 00	11600 00
Diaphragm	10 00	615 00	346 15	258 33	365 40	0 29	2 90	178 35	100 38	74 92	105 97
Spermicide	248 75	103 56	264 42	526 46	222 83	100 00	24875 00	10356 00	26442 00	52646 00	22283 00
Fem Ster	8894 54	200 00	5233 33	31000 00	9046 25	0 08	711 56	16 00	418 67	480 00	723 70
Male Ster	5166 67	300 00	2800 00	2000 00	3342 86	0 08	413 33	24 00	224 00	160 00	267 43
NFP Coun	550 00		200 00	2000 00	1608 33	1 00	550 00		200 00	2000 00	1608 33
Breastfeeding Coun	200 00		200 00	1000 00	733 33	1 00	200 00		200 00	1000 00	733 33

The first set of values indicate the relative all-inclusive cost of obtaining family planning service at the facility level. With the exception of Norplant and Vasectomy, maternities have the highest unit cost of providing family planning service. The permanent and long-term methods (sterilization, IUD, Norplant) also show a higher unit cost than the short-term methods. On the other hand, the second set of values show that the permanent and long-term methods are the cheapest in terms of the average number of years of protection, while the hormonal and barrier methods are the most expensive. It is not clear how many couples would consider the cost of contracepting beyond the time of purchase (most certainly not beyond one year) and therefore most people are going to decide on the basis of effectiveness of method and unit cost of service at the time of need, if cost is even a factor in method choice.

Cost of Obtaining Non Family Planning Services

Table 21 shows that the cost of obtaining non-family planning services is far higher than the cost for family planning methods (the exceptions are the male and female sterilization procedures). The cost is particularly high for those services that require some risk to life and involve some medical procedures (delivery, abortion services,

and STDs) In general, the cost of obtaining these services is higher in maternities and hospitals than in others PPAG clinics traditionally do not provide non-family planning services, so when they do their cost is either the lowest or rather minimal

Table 21 Average All Inclusive Cost of Non Family Planning Services by SDP Type

Type of Service	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Antenatal Care	1090 00	932 24	220 00	3124 07	1656 67
Delivery Services	7196 88	2767 82		11888 89	6434 10
Postnatal Care	778 57	545 00		1563 54	1022 84
HIV/AIDS Testing	5356 25	2525 00		5500 00	4908 33
RTI/STD Treatment	1326 67	3500 00		3500 00	1870 00
RTI/STD Testing	5592 86	2400 00	100 00	7062 50	4312 00
Child Immunization	181 88	179 90	200 00	581 25	224 59
Child Growth Monitoring	116 67	120 92	225 00	266 67	137 48
Infertility Consultation	1087 50	90 60	500 00	2569 23	1423 53
Oral Rehydration Therapy	208 33	174 43	200 00	788 10	339 82
Mangt of Abortion Complications	8000 00	2600 00	237 50	6133 33	4913 16
Nutrition Counselling	350 00	300 00		3000 00	1395 00
Fam PI Counselling Only		50 00		1640 00	1375 00
Menstrual Regulation	1675 00	100 00		2250 00	1755 56
Abortion Services	11750 00	500 00			9500 00

2 3 OBSERVATION OF PROVIDER AND CLIENT IN SERVICE DELIVERY SITUATION

One of the basic objectives of the study is to assess the quality of services rendered to clients by the family planning programme To do this effectively and objectively, provider-client interactions relating to counselling, examination, supply of methods were observed by trained nurse/midwives The observer listened attentively during the consultation period and noted all that transpired between the provider and client An observation guide, in the form of structured questions, was used to record the discussions between the provider and the client Other provider actions from the examination to the prescription of the method were also recorded

Family Planning History

Some aspects of clients' consultation with providers included clients preferred methods, reproductive goals and marital status among others The main methods preferred by new or restart clients are given in Figure 15 It is interesting to note that as many as 79 per cent of clients came to the clinic with preference for a method in mind Similar preferences are observed in relation to facility type For instance, PPAG clinics, MOH clinics and hospitals reported client preference rates of 76, 76 and 84 per cent respectively for contraceptive methods, while the maternities recorded 50 per cent

For the specific contraceptive methods which either the provider asked or client mentioned spontaneously, the data show that new clients (47%) preferred the injectable to other methods The higher preference for the injectable could probably be attributed to its convenience as well as the privacy afforded by the method The next preferred method was the combined and progestin only pill which accounted for 30 per cent while 13 per cent of clients preferred the IUD The least preferred method was the female sterilization

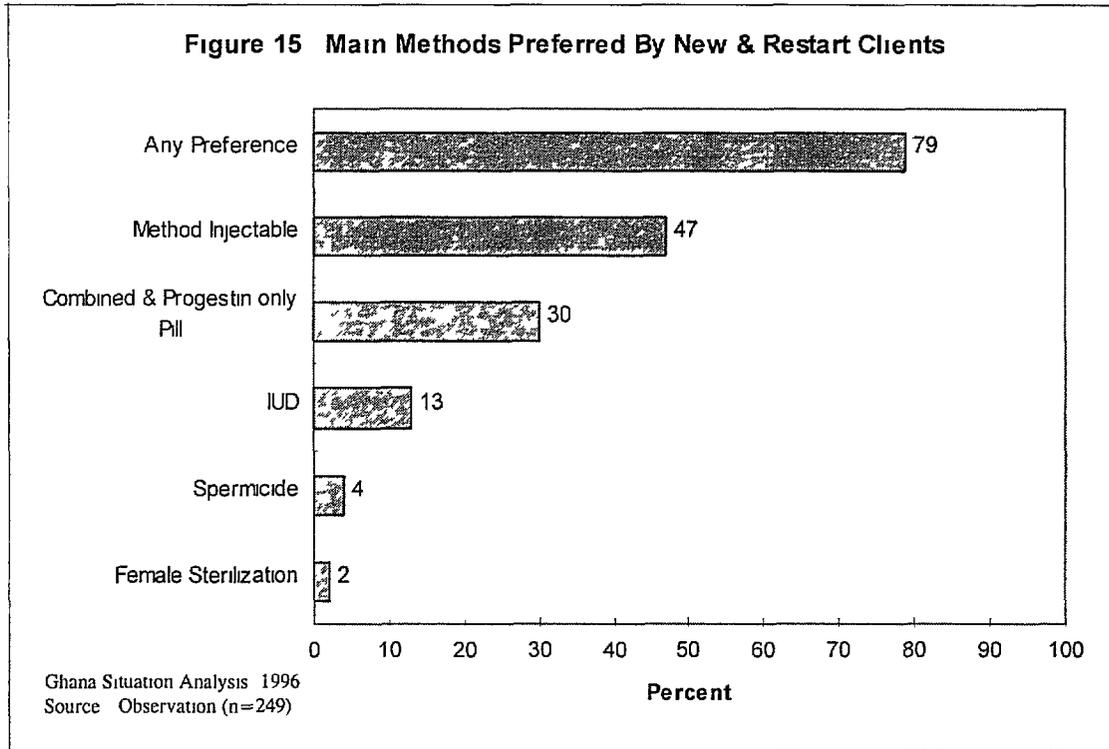
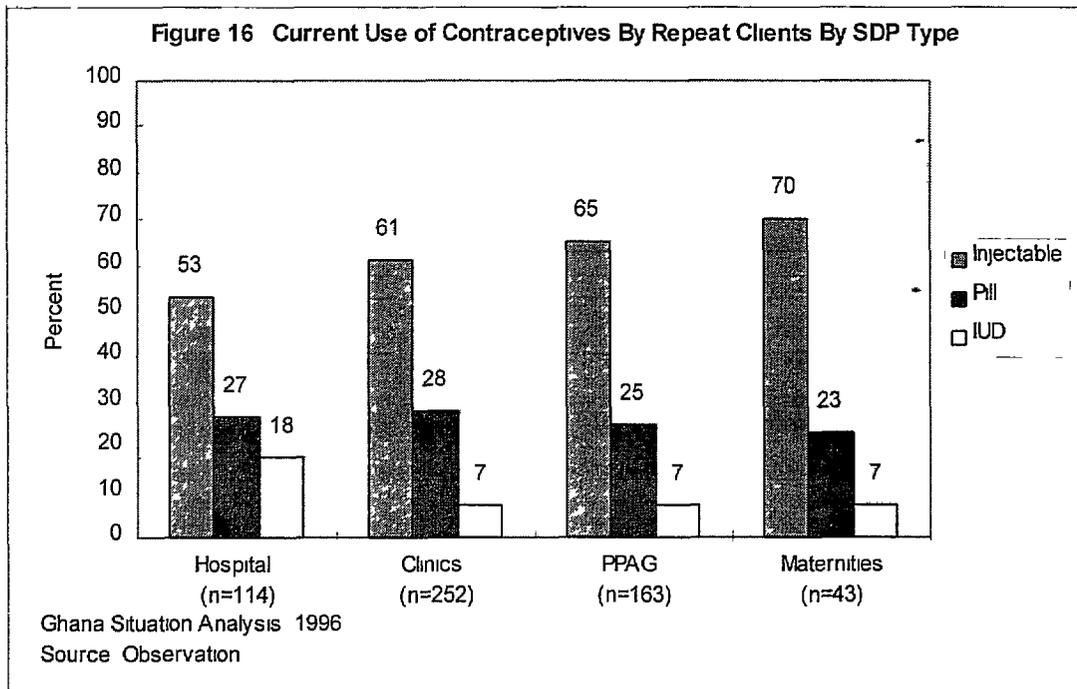


Figure 16 shows the three main methods mentioned by revisit or repeat clients as what they were using. The injectable appears to be the most popular method clients were using, as reported in all the facilities. For instance, injectable users accounted for 70 per cent of maternity clients on the day of visit. In addition, pill users also constituted slightly more than a quarter of revisit clients to the clinics and the hospitals. Except for the hospitals where 18 per cent of clients were IUD users, the other facilities each reported 7 per cent.



The discussion on the knowledge of methods in the course of the interaction with clients is presented in Table 22. Popular methods discussed were the injectable (86%), combined pill (81%), IUD (74%), spermicide (67%) and condom (64%). A breakdown by SDP type also reveals a similar picture. Except with the maternities where more clients (95%) heard about the pill, the injectable was reported to be the highest method heard about by clients in the other facilities.

Table 22 New and Restart Clients Hearing About Each Method by Type of SDP

Methods Heard About	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Injectable	89	87	79	80	86
Combined Pill	79	84	71	95	81
IUD	76	76	64	73	74
Spermicide	75	67	52	80	67
Condom	70	67	48	65	64
Female Sterilization	29	26	32	40	29

Reproductive Health History

The interaction between the provider and client, it is expected, would involve the use of procedures in family planning service delivery to achieve effective screening for methods. The reproductive health information exchanged between the provider and clients is given in Table 23.

Table 23 Information Obtained During Counselling With New Family Planning Clients by SDP Type

Type of Information	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Marital Status	66	71	71	90	74
Age of youngest child	66	76	76	80	72
Discuss FP with Partner	70	71	71	70	68
More children desired	52	66	66	60	59
Timing next birth	27	56	56	40	43
Concerns about method	36	41	41	40	39
If breastfeeding	32	27	27	30	28
If client had more than 1 partner	16	24	24	15	21
Concern about STD / HIV	9	13	13	10	12

The general picture is that in all cases, majority of new clients were asked questions pertaining to their reproductive goals. Quite a high proportion of clients (74%) for all facility type and (90%) for maternities discussed their marital status. Only 21 per cent of them however did discuss with providers the number of sexual partners they had in the past year. Similar low figures are observed by type of facility. With respect to STDs/HIV/AIDS, only 12 per cent of new clients expressed any concern about the subject. It is observed that the low level of discussion with clients on STDs cut across all facility types. This could probably be attributed to the little knowledge clients and possibly providers had on the issue and how it relates to their health problems.

Information, Education and Communication Materials

The use of Information, education and communication (IEC) materials in teaching clients about the family planning concept is a very important means of getting people

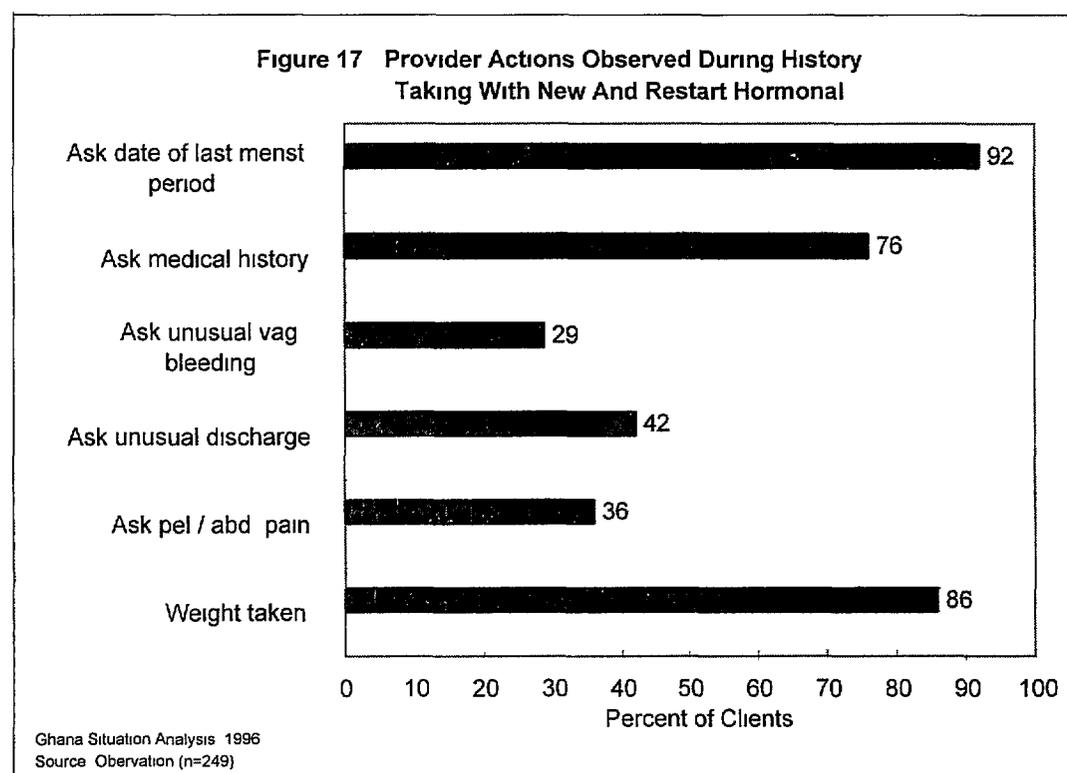
to understand the issues involved. As such, the observation on the counselling included the extent to which IEC materials were used to explain procedures to clients. Overall, 71 per cent of new clients were shown contraceptive samples during the counselling. Similar proportions were reported for the specific SDPs, except in the hospitals where the lowest figure was reported. The proportion of clients who had education on family planning with the use of other IEC materials appears to be low (Table 24). Perhaps, non-availability or shortage of IEC materials in the SDPs visited could be a reason for the low use of the educational materials in counselling.

Table 24 New Clients With Whom IEC Materials Were Used During Counselling by SDP Type

Type of IEC Materials	Type of SDP				Total
	Hospitals	Clinics	PPAG Clinic	Maternities	
Contraceptive Samples	59	74	71	80	71
Flip Chart	54	39	52	30	45
Anatomical Models	21	6	27	10	15
Posters	11	8	9	15	10
Brochure / Pamphlet	7	5	14	10	8
None used	27	12	10	10	15

Examination of Clients

For clients who might be screened for some hormonal methods, it is necessary as part of the consultation to ask certain pertinent questions as well as examine them. Provider actions observed during history-taking with new and restart hormonal clients are presented in Figure 17.

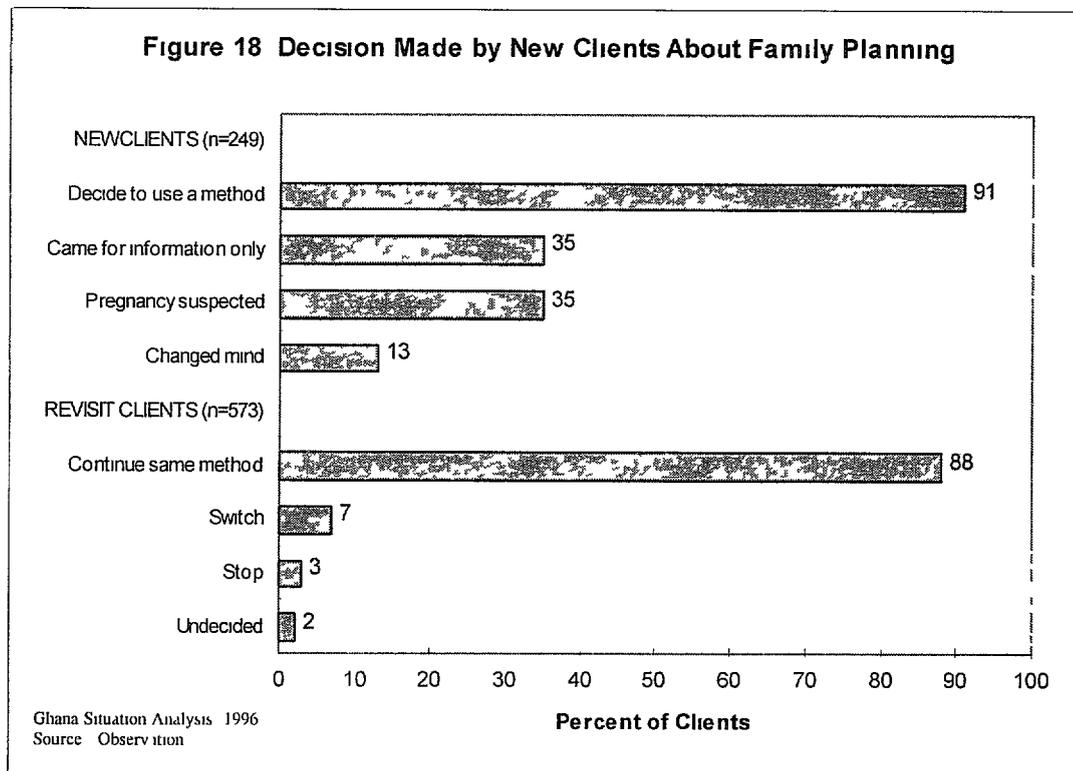


Nine out of ten (92%) clients were asked about their date of last menstruation. In addition, the weight of 86 per cent of them was taken and also 76 per cent gave their medical history to providers. As the data indicate, lower proportions of clients were asked questions relating to problems such as unusual vaginal bleeding (42%) and vaginal discharge (29%).

Decision to Use any Contraceptive Method

The decision on use of a method made by new and revisit clients about family planning is shown in Figure 18. Among the new clients who made a decision, as many as 91 per cent wanted to use a contraceptive method. The rest who did not decide gave reasons such as came for information only (35%), and pregnancy suspected (35%).

With regard to revisit clients, 88 per cent opted to continue with the same method, while 7 per cent made up their mind to switch to other methods, 3 per cent decided to stop and 2 per cent were undecided. The large proportion of clients deciding to continue with their methods suggests the willingness of people to use family planning methods if the right counselling and education are given. Where clients switched to other methods, 35 per cent chose the injectable.



For clients who had a preferred method in mind, 64 per cent had the method of their choice. The reason why others were not given the method of their choice was attributed to the requirement of returning to the clinic in their menses because of the fear of a pregnancy. As many as 42 per cent of clients were of this group. They were

however given temporary methods such as spermicide (47%) and condom (27%) pending the assessment of the situation on the return visit

In order to ensure that the use of methods was continued by clients, 96 per cent were told when to come for resupply, 86 per cent were given written reminders for routine checks and 96 per cent were told where to go for their resupply

Other Health Issues Discussed

It is expected that providers would give information and counselling to clients on other health issues such as STDs, sexual behaviour and abortion management on demand Table 25 shows that only a small proportion of clients discussed or mentioned other health issues with providers On average, only one out of five of clients discussed their sexual behaviour with providers Other health issues were even less often discussed or mentioned The fact that these other health issues were not commonly discussed during counselling could possibly be due to providers not integrating these issues in their family planning service delivery programmes Discussion of STDs/HIV/AIDS needs to be encouraged, given their health and mortality implications

Table 25 Clients With Whom Other Health Issues Were Discussed/Mentioned During Counselling by Health Facility Type

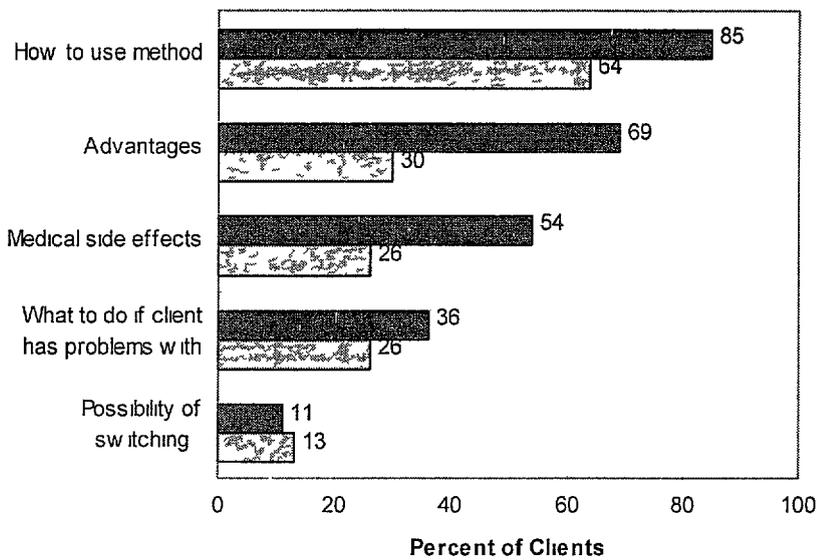
Type Of Issues Mentioned	Type of SDP				Total
	Hospitals	Clinics	PPAG Clinic	Maternities	
Sexual Behaviour	19	17	29	29	20
HIV/AIDS	5	6	13	13	9
STDs	10	15	13	13	15
Infertility	2	2	3	3	2
Abortion	3	2	3	3	3
Nutrition	7	4	13	13	5
Other	4	6	2	2	6

Method Use and Possible Effects

Clients need always to remember some key issues about the methods of their choice Some of these important points are how to use the method, the benefits, what to expect and also what to do if minor and major problems appear The proportion of new and restart clients with whom providers discussed these important key points is given in Figure 19

For new clients who accepted to use various methods, 85 per cent were counselled on how to use the methods The 64 per cent of repeat clients who were switching also had similar information given to them When using a method, there are a variety of problems that could be encountered Similarly, some women are more likely than others to encounter problems with a specific method Thus, it is necessary to make clients well informed about what to do in such circumstances The data show that only 36 per cent of new and 26 per cent of switching family planning clients were told what to do when they had problems with the method

Figure 19 New And Switching Clients Counsellled on New Methods Accepted



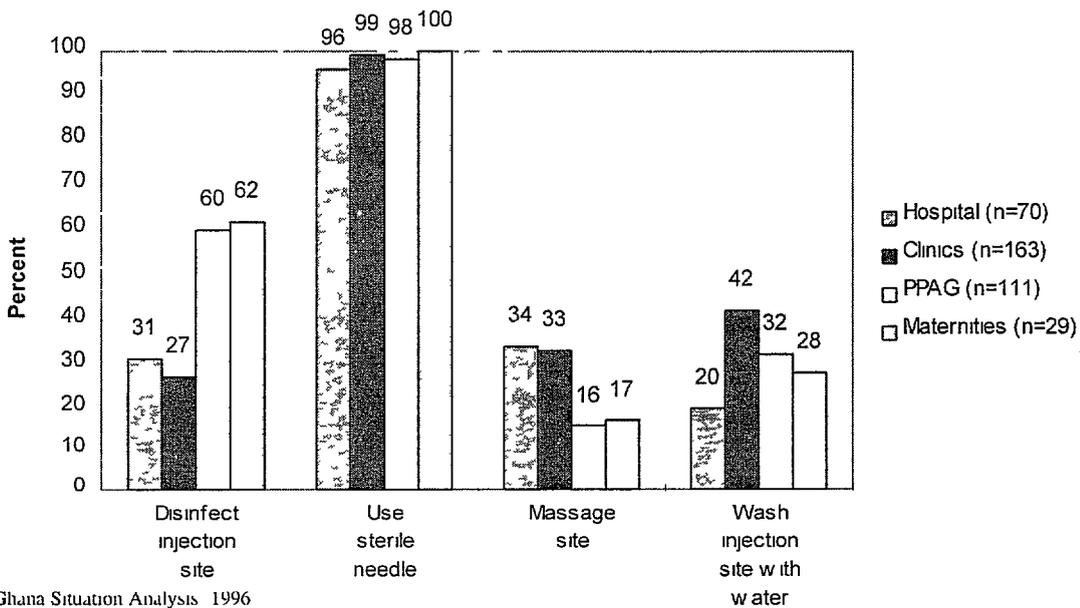
Ghana Situation Analysis 1996
 Source: F P Client Interview

Switching (n=39) New (n=231)

Quality Procedures

Provider action in regard to procedures followed in administering hormonal methods was observed. The results on provider actions with injectable clients show that the injectable was given to almost all clients using a sterile needle. Overall, 98 per cent of clients had the injection with a sterile needle. A breakdown of the data by type of SDP also shows that most providers use sterile needles for the injection.

Figure 20 Provider Actions with Injectable Clients by SDP Type



Ghana Situation Analysis 1996
 Source: Observation

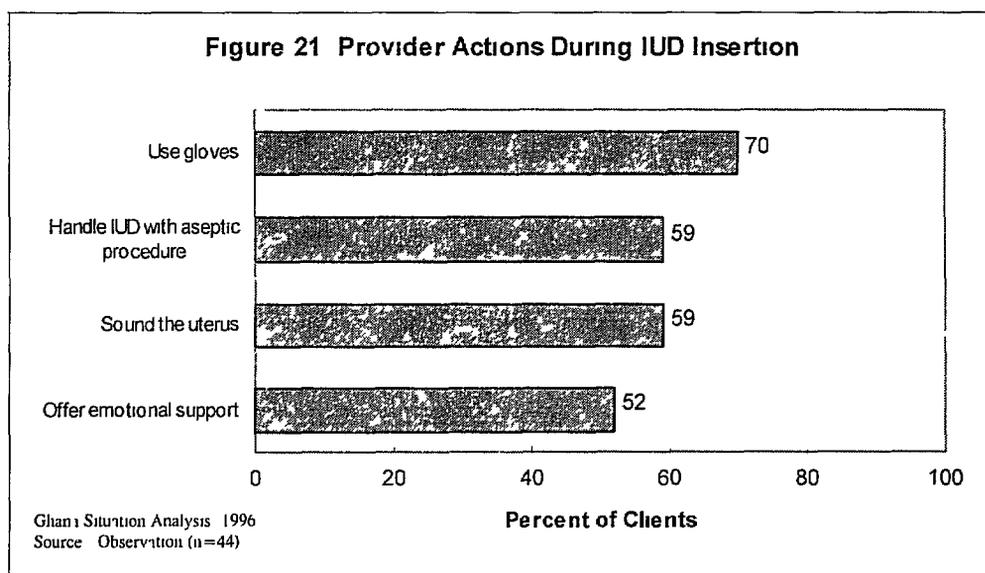
The habit of massaging and washing the injection site with water was still found to be the practice with some providers. A closer look at the results by type of health facility shows that massaging the injection site is common in the MOH facilities, this accounted for 33 per cent for clinics and 34 per cent for hospitals (Fig 20). Unlike the normal injection, for which these procedures would be proper, the injectable's potency may be compromised somewhat with these practices.

For those on whom pelvic examination was performed, it was noted that a high proportion of clients were examined according to the laid down procedures. In almost nine out of ten cases, providers used gloves. It was observed, however, that apart from PPAG clinics where 72 per cent of clients were informed about the outcome of the examination, few clients were told the results (Table 26).

Table 26 Provider Actions During Pelvic Examination by Type of Facility

Type of Action Taken	Type of SDPs				Total
	Hospitals	Clinics	PPAG Clinics	Maternities	
Use gloves	89	91	90	89	90
Inform clients before exam	74	76	84	67	77
Wash hands before	95	70	67	67	74
Wash hands after	74	82	84	78	81
Inform Results	53	48	72	33	56

Provider actions with respect to IUD insertion is given in Figure 21. While gloves were used in 70 per cent of cases where clients had an IUD insertion, 59 per cent of clients had their uterus sounded and the IUD handled with aseptic procedure. With the emergence of STDs/HIV/AIDS, it is important that gloves are used in all cases on IUD insertion. As regards the offer of emotional support, only slightly more than half the clients were reported to have had it.



The proportion who were given emotional support appears to be low. This aspect of provider service could help dismiss the fear surrounding IUD insertion and hence encourage and assure more clients to accept this method, there is the need therefore to promote it in SDPs where the IUD is offered.

2.4 CLIENT ASSESSMENT OF SERVICE PROVIDED

After the consultation, family planning clients were interviewed about the service provided. This was done mainly to find out about their general impression of the services they received as well as their knowledge about the family planning programme as a whole. In all 815 clients were interviewed. The remaining 7 who had been observed declined the exit interview.

Client Satisfaction

The indicators used to measure client satisfaction show generally positive results on most of the services rendered (Table 27). Overall, clients expressed satisfaction on the way providers answered their questions (99%), how issues were made clear and easy to understand (98%), and how adequate privacy was provided (90%). The indicator with the lowest rating was waiting time (76%). A breakdown of the data by facility type reveals that this was the picture in all sectors. Apart from the maternities, where 81 per cent of clients said the waiting time was reasonable, the other SDPs reported values below 80 per cent. Programme managers need to take another look at the waiting period because it is a sore point in the health sector. In the current study, for instance, about 40 per cent reported that they waited for more than 30 minutes before they were attended to.

The dissatisfaction with waiting time expressed by clients could be associated with heavily patronised hospitals and clinics offering the service. Travel time spent by providers in reaching clients on outreach programmes could also explain the situation.

Table 27 Indicators of Client Satisfaction by SDP Type

Indicators	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Questions answered	100	99	100	100	99
Easy to understand	100	99	96	96	98
Sufficient Privacy	91	90	85	92	90
Sufficient time	85	88	81	89	86
Desired service	85	87	82	87	86
Waiting time reasonable	75	78	72	81	76

Accessibility

Since the whole issue of family planning programme is not coercive but mainly rests on the individual to make an informed choice, it becomes important that opening times of services and affordability questions are carefully addressed. It is against this background that clients were asked questions about the cost of service delivery and the convenience of opening times. Overall, 94 per cent reported that the opening

hours were convenient (Table 28) For clients who did not find the usual opening time convenient, 75 per cent would prefer a time that was earlier than the usual time

With respect to cost, generally, 80 per cent of clients were of the opinion that the cost was acceptable Clients in the hospitals (77%) and the maternities (79%) were less likely to accept the cost as reasonable and this probably may reflect higher cost of providing service in these facility types

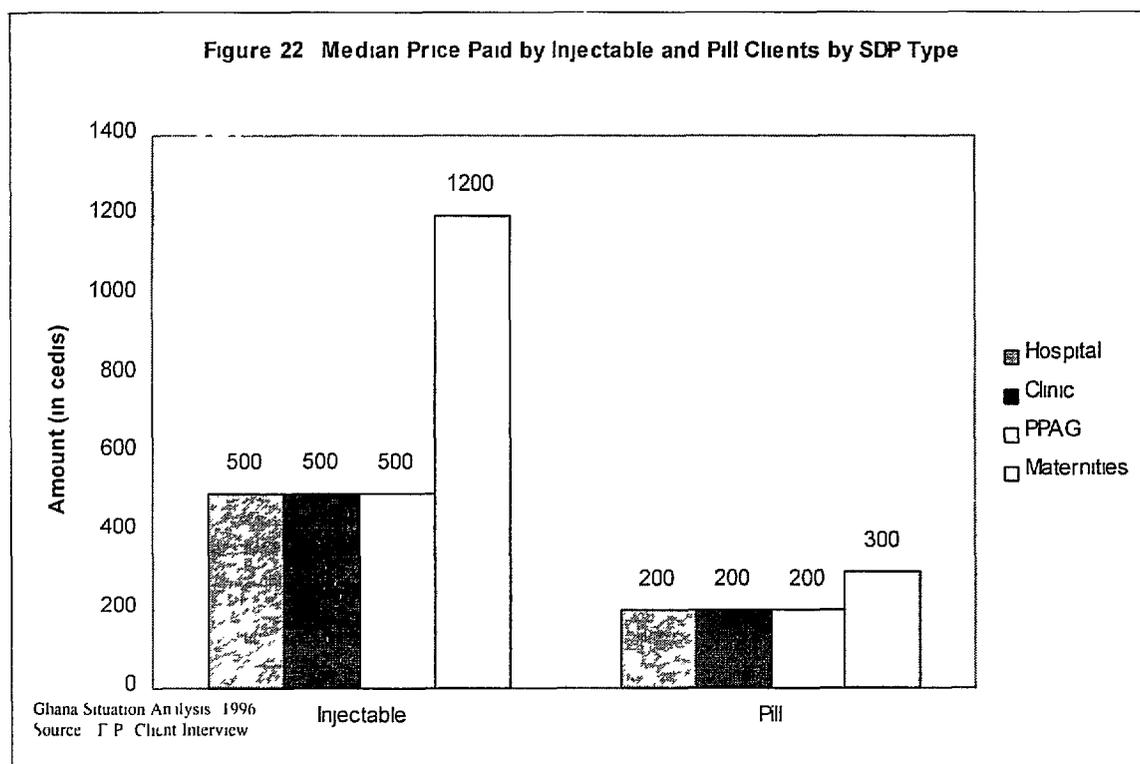
Table 28 Accessibility of Family Planning Services To Clients by SDP Type

Accessibility Indicator	Type of SDP				Total
	Hospitals	MOH Clinics	PPAG Clinics	Maternities	
Opening hours convenient	94	94	90	94	94
* If not want earlier	50	86	73	NA	75
Cost acceptable	77	80	92	79	80

* Did not apply to most maternities since they open 24 hours to clients

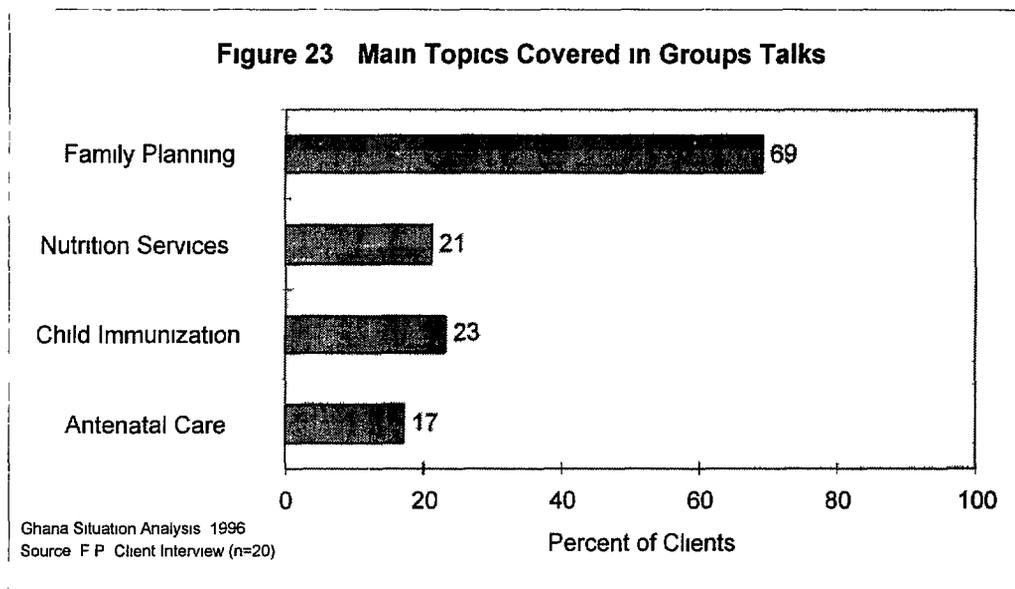
Cost of Method

The median price paid for the two most popular methods for clients is calculated by facility type The data reveal that the median price of $\text{¢}500$ for injectable and $\text{¢}200$ for the pill per visit were charged by the MOH facilities and the PPAG clinics Clients in the maternities were however reported to have paid higher prices for the methods Perhaps the fact that maternities were less dependant on donors for their supply of methods could have accounted for the higher prices charged (Fig 22)



Group Talks Given to Clients

Clients who visit the clinics for family planning services are usually given group talks to help them understand the issues relating to the family planning concept. Very often, such discussions do not focus on family planning issues alone but on other health-related issues as well. Overall, only 9 per cent of clients reported that they had taken part in group talks. Even lower values were observed by SDP type. The clients who benefitted from such group talks indicated that the major areas of focus were family planning (69%), nutrition services (21%) and antenatal care (17%). Furthermore, only 7 per cent of clients were given educational materials to take home. The shortage of educational materials or the level of education of clients could be the possible reason for this.

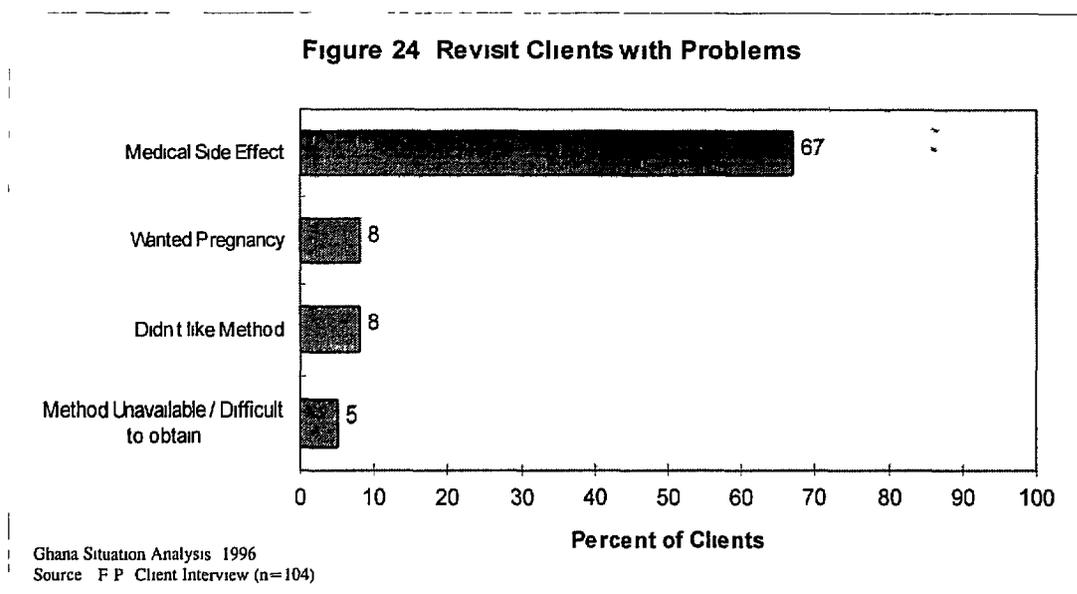


Problem with Method

Many clients experience problems from contraceptive use, as with all drugs and medication. Among the clients who had experienced problems, 52 per cent said they were told of the likely problems they might encounter. Except for the maternities, where 38 per cent were told of problems, higher values ranging from 52 to 62 per cent were reported for the other facilities. Among the repeat clients experiencing problems with their various methods, the common complaint why most of them came back to the clinic was a medical side effect. Figure 24 shows that 67 per cent of clients had suffered one medical side effect or the other.

As a result of the problems that clients came to the clinics with, when they were asked about the new decision they would like to make about family planning, 34 per cent decided to change to other methods, while 51 per cent decided to continue with the same method, only 9 per cent decided altogether to stop using any method. The methods chosen by the switching clients were mainly the injectable (43%) and the combined pill (31%). The larger proportion of clients deciding to continue to use family planning methods, in spite of their experiencing side effects, may probably result from

reassurances given by providers and on what to do It could also be indicative of the desire of people to use something to prevent or space child birth



Method-Specific Knowledge of Clients

A good knowledge of the mechanisms of specific contraceptive methods could help users identify minor problems and those that are danger signs when such problems appear. Among the pill users, 75 per cent knew when to take the pill and 70 per cent knew what to do in the event of forgetfulness. While 32 per cent could not mention any problems associated with pill use, 45 per cent mentioned severe chest pains/shortage of breath and 23 per cent severe headaches as some of the problems that one needed to go back to the clinic for attention. Table 29 presents the percentage of clients who mentioned various problems which required that clients return to the clinic, this is classified by facility type.

Table 29 Problems Requiring Return to Clinic Mentioned by Pill Users Classified by Facility Type

Problems	Type of SDP				Total
	Hospital	Clinic	PPAG	Maternities	
Severe headaches	57	39	88	50	45
Severe abdominal pain	27	31	39	40	28
Severe chest pain/shortage of breath	19	21	52	30	23
Late period	31	28	78	20	31
No problem mentioned	26	36	34	17	32

The results indicate that PPAG clients were probably more knowledgeable in the pill related problems that could require a client to go back to the clinic for medical attention. This is because for each of the problems mentioned, there was a larger proportion of PPAG clients than clients of other facilities who identified with the problem.

A high proportion (72%) of IUD users knew when to return for first check up after an insertion. Similarly, 84 per cent of users were aware of what to do to ensure that the IUD was in place. With minor problems that could crop up from method use, 51 per cent of users mentioned abnormal cramps while 31 per cent stated heavy bleeding. For major problems which should need prompt medical attention, more than half (55%) of the IUD clients reported expulsion or when the thread cannot be felt as a serious problem (Fig 25)

Among the injectable users, almost every client (99%) was aware that the injection should be received every 3 months. It was observed that 68 per cent of injectable users had medical side effects as their problem. While 38 per cent said they were told about what would happen, another 54 per cent reported that they were not aware of what would happen. For those who were told about likely medical side effects, almost all reported they were told what to do in such circumstances

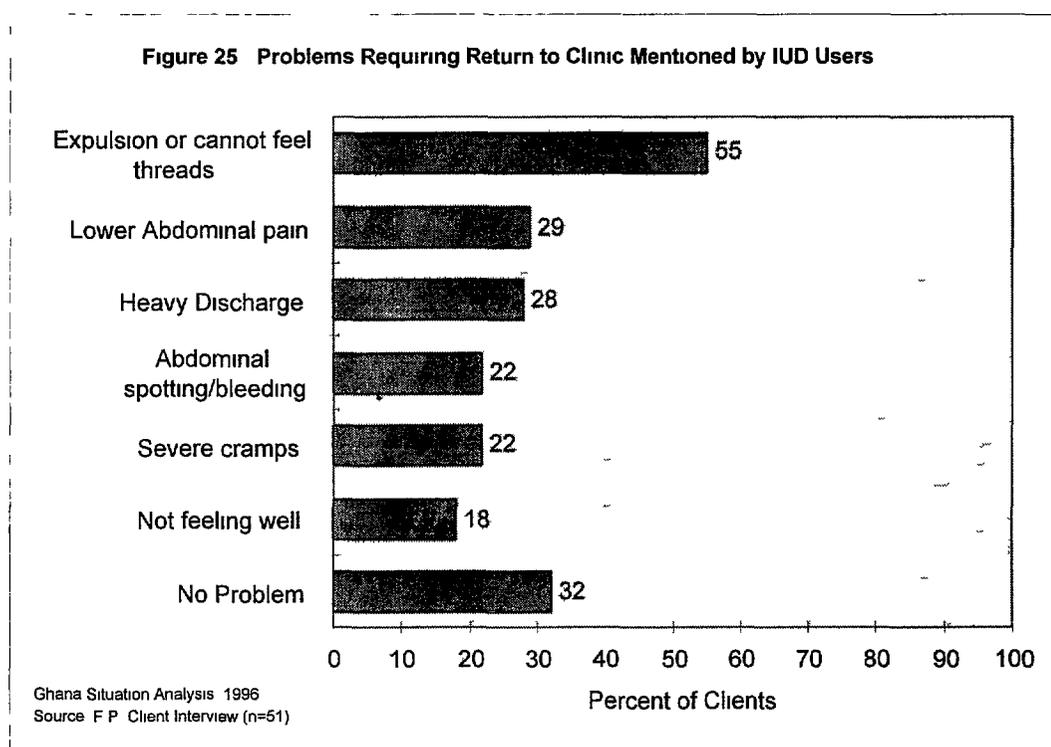
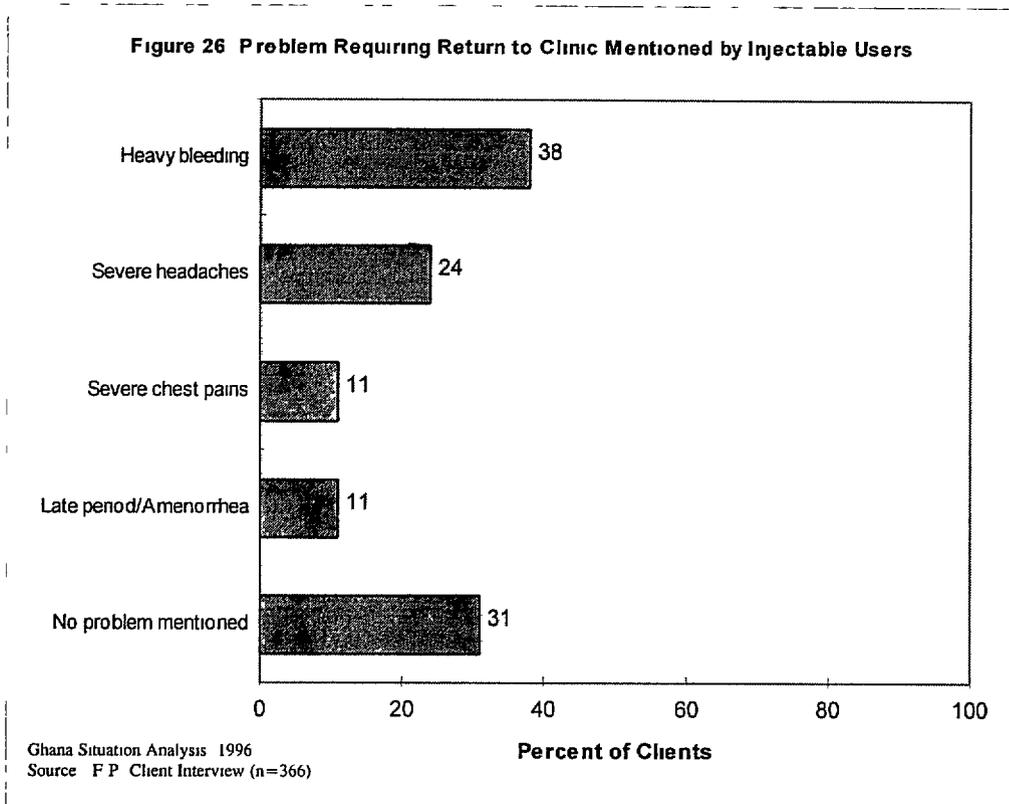


Fig 26 gives the percentage of clients who mentioned various problems that would require going back to the clinic for attention. Overall, 38 per cent of injectable users felt that heavy bleeding associated with the injection must be reported immediately at the clinic. While 24 per cent mentioned severe headaches, 11 per cent each stated severe chest ache and amenorrhea as serious problems. As many as 31 per cent could not mention any problem related to injectable use



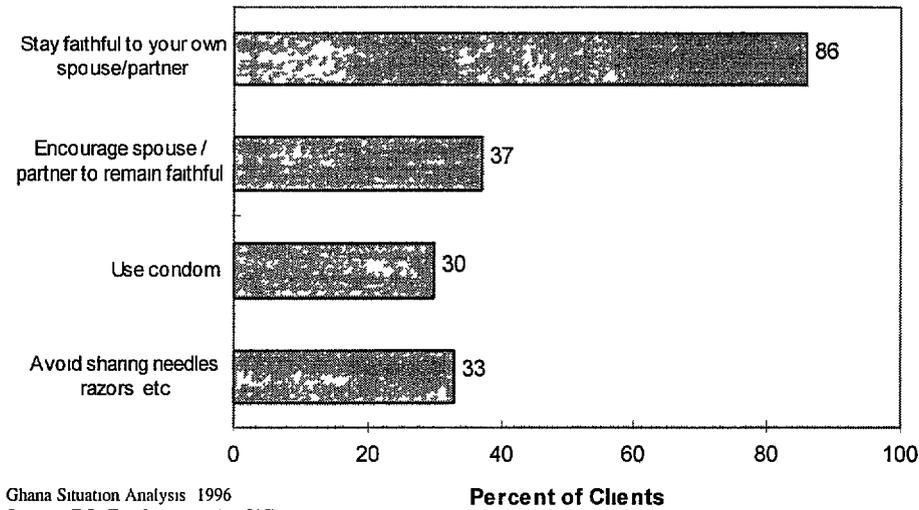
STD/HIV/AIDS Issues (Knowledge, Mode of Transmission and Protection)

Clients were asked about the various ways, known to them, for getting HIV/AIDS. Most (95%) clients indicated that the main source of infection is through sexual intercourse. Furthermore, 46 per cent knew of items like contaminated needles or razor blades as a way of getting the disease. Knowledge of transmission through blood transfusion (9%) and mother to baby (2%) was low among clients.

Since HIV/AIDS is a new emerging health issue, clients were asked about the common signs and symptoms they could easily identify with a person with HIV/AIDS. Slightly more than half of clients reported loss of weight, 31 per cent gave painful urination and 23 per cent identified long duration of diarrhoea as common symptoms of the disease.

The information on ways to protect oneself against HIV/AIDS shows that 86 per cent considered staying faithful to one's spouse/partner as an important way of protection (Fig 27). This may have found support with a little more than one third (37%) of clients who would want spouse/partner to be encouraged to be faithful. A further 30 per cent of clients reported that the use of condoms could offer protection. The low knowledge of clients about the use of condoms to protect HIV/AIDS may be due to the fact that being women, the clients may not have easily identified with the condom. This is confirmed in the consultation with clients when only 25 per cent of them explicitly mentioned the condom in their discussions.

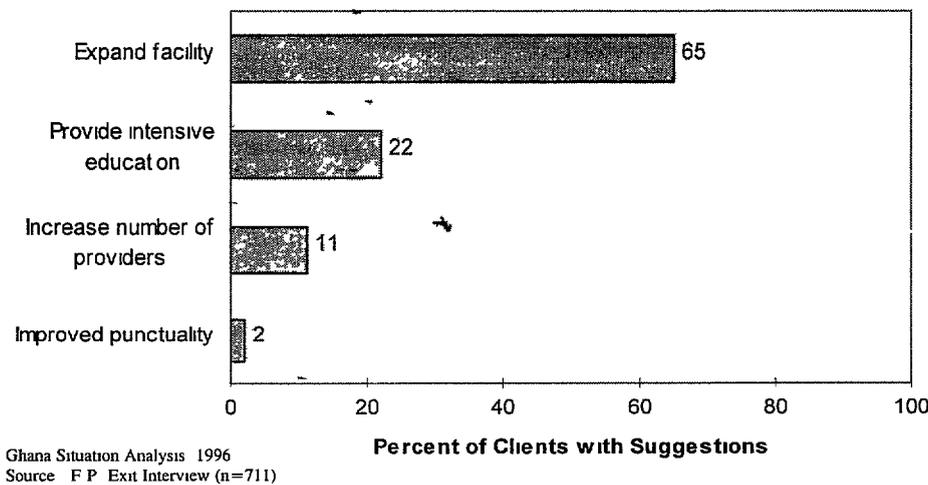
Figure 27 Ways of Protecting Oneself Against HIV/AIDS



Suggestions from Clients

Clients were asked to give at least one improvement they would like to see in the provision of family planning services. Figure 28 presents the various suggestions given. Majority of clients were of the opinion that the facilities where services were provided needed to be expanded. A number of such clients felt that entire facilities should be expanded, while others stated that it was the family planning unit in the SDPs that needed to be expanded. In addition, 22 per cent of clients suggested the need for intensive education on family planning, while 11 per cent felt the need to increase the number of providers.

Figure 28 Client s Primary Suggestion for Improving Services



2 5 MATERNAL AND CHILD HEALTH CLIENT AWARENESS OF FAMILY PLANNING

To find out how far women who attend the facilities for reasons other than family planning have knowledge in family planning, clients aged 15-49 years who visited the facilities for maternal and child health (MCH) services were interviewed. MCH clients were specifically targeted because they constituted potential family planning clients. Thus, the study sought clients' opinion on the types and quality of services available at the facilities. Further information was obtained on respondents' socio-demographic characteristics, approval and practice of family planning, fertility status and preferences, as well as reproductive health issues.

This section attempts comparisons among clients in the various types of facilities (ie, hospitals, MOH clinics, PPAG clinics and maternities) as means of investigating inter facility-type variations. In some cases, the comparison is with family planning clients.

Types and Quality of Service

To solicit views regarding the quality of services provided at the various facilities, MCH clients were asked if they were generally satisfied with the services they had received on the day of visit. In each of the different types of facilities, more than 90 per cent of clients responded in the affirmative. With regard to specific types of services, however, the responses were not always favourable. For instance, in terms of privacy during consultations with clinical staff, the national average was 75 per cent, while for the different facility types, it ranged from 66 per cent in PPAG to 85 per cent in hospitals. PPAG clinics were particularly observed to have relatively limited accommodation (space) facilities to offer needed privacy for clients. Clients dissatisfaction with low level of privacy in the SDPs is capable of discouraging revisits as well as potential clients. Efforts at improving the level of privacy in all facilities should therefore be intensified.

In all the different types of facilities, more than half of the clients did not attend the group talks, giving a general non-attendance rate of 58 per cent, (ranging from 51% in hospitals to 79% in PPAG facilities). The generally high non-attendance level might be due mainly to clients arriving at the facilities much later than the opening times when group talks are given. Topics covered in the group talks centered mainly on nutrition services(36%) and family planning (35%) and the picture is not too different for the various types of facilities.

In order to ascertain the level of knowledge in the types of services provided at the facilities, respondents were asked to mention the types of services which, to their knowledge, were available at the SDPs. It is worth noting that, apart from PPAG facilities where family planning featured most (78%), all other types of facilities were dominated by "other curative services"(ranging from 78% in hospitals to 83% in MOH clinics). That views of PPAG clients differed from the others in favour of family planning might probably be explained in terms of the fact that PPAG facilities were established primarily for family planning services.

How long clients wait before receiving services goes a long way to influence their desire to make subsequent future visits to the same facility, as well as recommending it to other clients. The study therefore obtained information on this

MCH clients in non-public owned facilities generally seemed to have waited for relatively shorter period. For instance, 51 per cent of clients in maternities and 59 per cent in PPAG Clinics waited for up to thirty minutes before receiving services, compared to only 41 per cent of clients in MOH clinics and 39 per cent in hospitals (Table 30). A comparison of the general situation of MCH and family planning clients, however, suggests that the latter waited for a relatively shorter duration. Thus, whereas only 43 per cent of MCH clients waited for up to thirty minutes before receiving services, the corresponding proportion for family planning clients was 61 per cent.

Table 30 Clients Waiting Time Before Service at SDPs

Waiting Time (Minutes)	Type of SDP				All MCH Clients	All Family Planning Clients
	Hospitals	MOH Clinics	PPAG Clinics	Maternities		
0-30	39	41	59	51	43	61
31-60	18	16	10	16	16	11
61-90	3	3	7	2	3	1
91-120	8	7	0	8	8	2
121+	13	5	10	3	7	3
Don't Know	19	28	14	20	23	22
Total	100	100	100	100	100	100
N	356	697	41	194	1288	733

The general client turn-out level is likely to be relatively higher at public-owned facilities, because most people probably presume cost of services to be relatively lower at these facilities. The comparatively higher client turnout at the public-owned facilities therefore require on average, a relatively longer time in attending to these clients. For similar reasons, MCH clients tend to outnumber family planning clients at most SDPs and therefore more likely to wait for a relatively longer period, on the average.

In a developing country like Ghana, where the level of poverty is quite high, cost of services plays a vital role in determining the level of patronage of such services. MCH clients' perceptions of the cost of services were therefore solicited. It is worth noting that in each type of facility, at least three-quarters of the clients suggested that costs were acceptable, with an average acceptable level of 82 per cent (and ranging from 75% for hospital clients to 88% for maternity clients). That maternities have the highest level of cost acceptability could be an indication of clients' consideration of nominal charge in relation to quality of services.

Knowledge, Approval and Use of Family Planning Methods

About four in every five (81%) MCH clients knew of at least a method for delaying or preventing pregnancies, and an even higher proportion (84%) approved of family planning methods to avoid pregnancy.

The known methods of pregnancy prevention mentioned most often by clients in all facilities were the combined pill (80%), injectable (68%) condom (36%) and the IUD (35%). Except in the PPAG facilities where spermicides emerged as one of the most popular methods, the situation at the different facility-types was not much different from that at the national level. The methods mentioned the least by clients at the national as well as the facility-type level were vasectomy and diaphragm. This could probably be explained in terms of a relatively low publicity given to these methods.

Clients were asked to indicate any one method they or their partners were currently using. Whereas, as mentioned earlier, more than 80 percent of all clients knew and approved of at least a method, only 10 percent of them or their partners were currently using a method. The situation at the facility-type level is not much different from the national (Table 31). The great disparity between knowledge and approval of family planning methods on the one hand, and current usage of these methods on the other, suggests a substantial level of unmet need. It is therefore recommended that the distribution network of the family planning services should be extended to all parts of the country through outreach programmes.

Table 31 Knowledge and Current Use of Family Planning Methods by MCH Clients

Type of Method	Type of SDP								All MCH Clients (1288)	
	Hospital (356)		MOH Clinics (697)		PPAG Clinics (41)		Maternities (194)			
	Know	Use	Know	Use	Know	Use	Know	Use	Know	Use
Combined Pill	80	2	80	3	78	2	80	3	80	2
Progestin only pill	14	1	14	1	12	0	21	1	15	0
IUD	34	2	34	1	29	0	41	1	35	1
Injectable	62	5	70	2	15	1	68	2	68	2
Norplant	8	1	3	0	2	0	4	1	4	0
Condom	33	2	39	2	49	1	26	1	36	1
Diaphragm	1	0	1	0	2	0	0	0	1	0
Spermicide	19	1	17	0	32	0	13	1	18	0
Female Sterilization	5	3	2	0	0	0	3	0	3	0
Vasectomy	1	0	2	2	0	0	0	0	1	0
Nat Fam Planning	4	5	8	0	12	1	8	2	9	2
Exclu Breastfeeding	1	0	1		0	0	0	0	1	0

It is said that Ghanaian women generally resort to family planning methods only after they have achieved their desired number of children. Certain socio-demographic characteristics and fertility indicators of family planning and MCH clients appeared to confirm this. Whereas only 27 per cent of all MCH clients desired no more children, the corresponding proportion for family planning clients was 40 per cent (Table 32). In addition, as many as 67 per cent of family planning clients, compared to only 39 per cent of MCH clients, had three or more children.

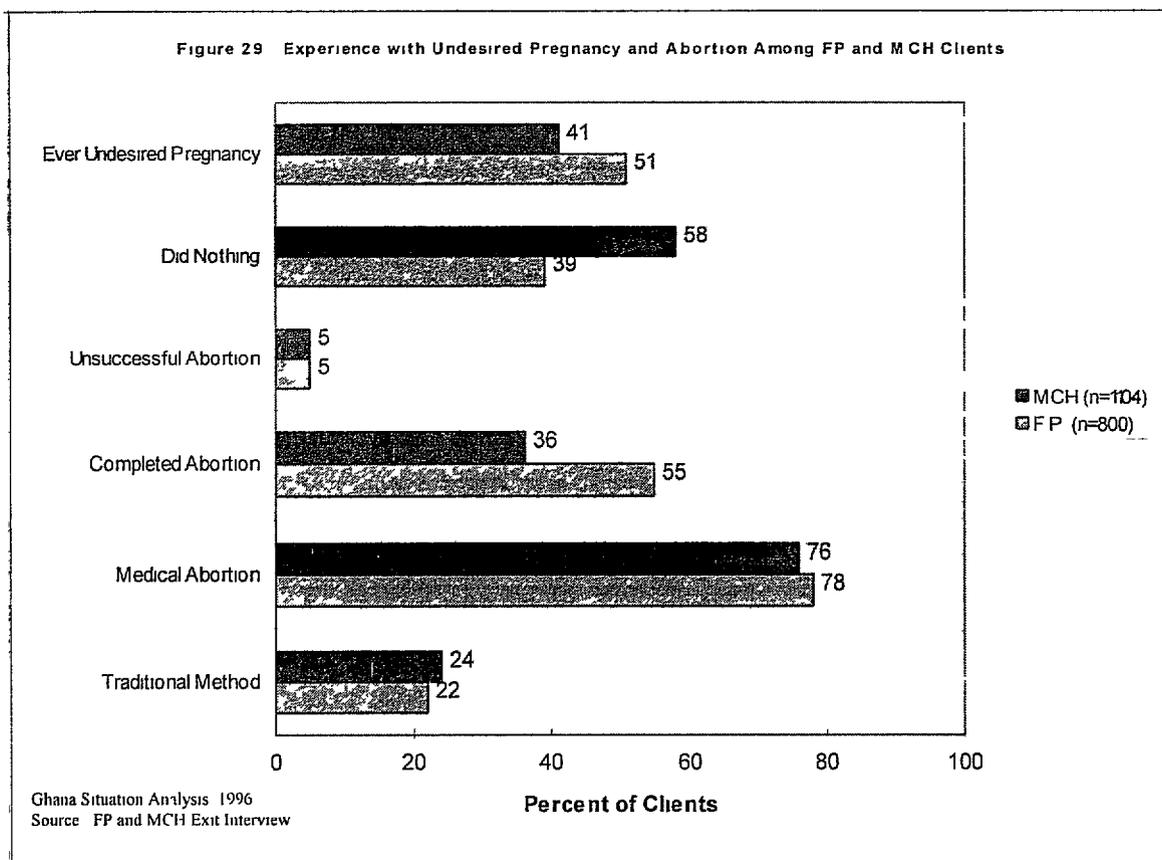
The family planning clients on the average seem to be relatively older than their MCH counterparts. Almost half (48%) of family planning clients, relative to just under a third (31%) of MCH clients, were above 29 years of age (Table 32). Indeed, the mean ages of the two groups were 30.5 years for family planning clients and 27.6 years for MCH clients. This, perhaps, explains why a relatively higher proportion of the former group indicated no desire for more children, which tend to further buttress the earlier statement regarding the relationship between fertility status and the use of family planning methods.

Table 32 Some Socio Demographic Characteristics and Fertility Indicators of MCH and Family Planning Clients

Socio Demographic / Fertility Indicators	Type of SDP				All MCH Clients	All Family Planning Clients
	Hospitals	MOH Clinics	PPAG Clinics	Maternities		
Age of Clients	N=353	N=692	N=41	N=193	N=1279	N=791
15 19	7	5	5	6	6	2
20 24	28	24	34	30	26	16
25 29	31	24	24	26	26	26
30 34	14	19	17	14	17	23
35 39	10	9	14	10	10	15
40 44	3	3	2	4	3	8
45 49	1	1	2	1	1	2
Age unknown	6	15	2	9	11	8
Marital Status	N=353	N=696	N=41	N=194	N=1279	N=788
Married(Mcnogamous)	80	67	81	76	71	67
Married(Polygamous)	14	25	7	12	19	21
Consensual Union	4	5	2	7	6	5
Single/Never Married	1	2	7	4	3	3
Divorced/Separated/Widowed	1	1	2	1	1	4
Education Status	N=353	N=697	N=41	N=196	N=1285	N=789
No Education	30	41	34	31	36	37
Basic Education	54	52	59	57	53	54
Secondary/S S S	9	5	5	11	7	6
Post Secondary	4	2	2	1	2	3
Other	2	0	0	0	2	1
Number of Children	N=353	N=693	N=41	N=193	N=1279	N=789
No Children	17	10	22	13	13	2
1 2 Children	49	48	32	15	48	31
3 4 Children	23	29	32	20	26	39
5 6 Children	8	11	14	11	10	19
7 + Children	3	2	0	5	3	9
Desire For More Children	N=356	N=700	N=41	N=194	N=1291	N=791
No More children	26	26	34	26	27	40
Desire More Children	66	65	61	59	64	54
Other Response	8	9	5	11	9	6
Religion	N=353	N=699	N=41	N=194	N=1287	N=792
Pros estant	20	18	15	21	19	24
Catholic	24	22	5	14	20	16
Other Christian	35	35	61	43	37	41
Muslim	14	13	7	16	13	11
Other Response	7	12	11	6	11	8

Not much disparity was observed in the proportions of clients of the two groups as regards marital status, level of education and religious affiliation. For instance, 93 per cent of family planning clients and 95 per cent of MCH clients were in union (marriage of some kind). This tends to confirm the near universality of the institution of marriage in Ghana.

Clients' experience with undesired pregnancy and abortion showed that 51 per cent of family planning, compared to 41 per cent of MCH clients, had ever had an undesired pregnancy (Fig 29). Two-fifths (39%) of family planning clients and three-fifths (58%) of MCH clients who ever had an undesired pregnancy did nothing to stop the pregnancy, while 55 per cent of the former and 36 per cent of the latter had completed abortion. Among those who aborted, 78 per cent of family planning clients, relative to 76 per cent of MCH clients, had medical abortion.

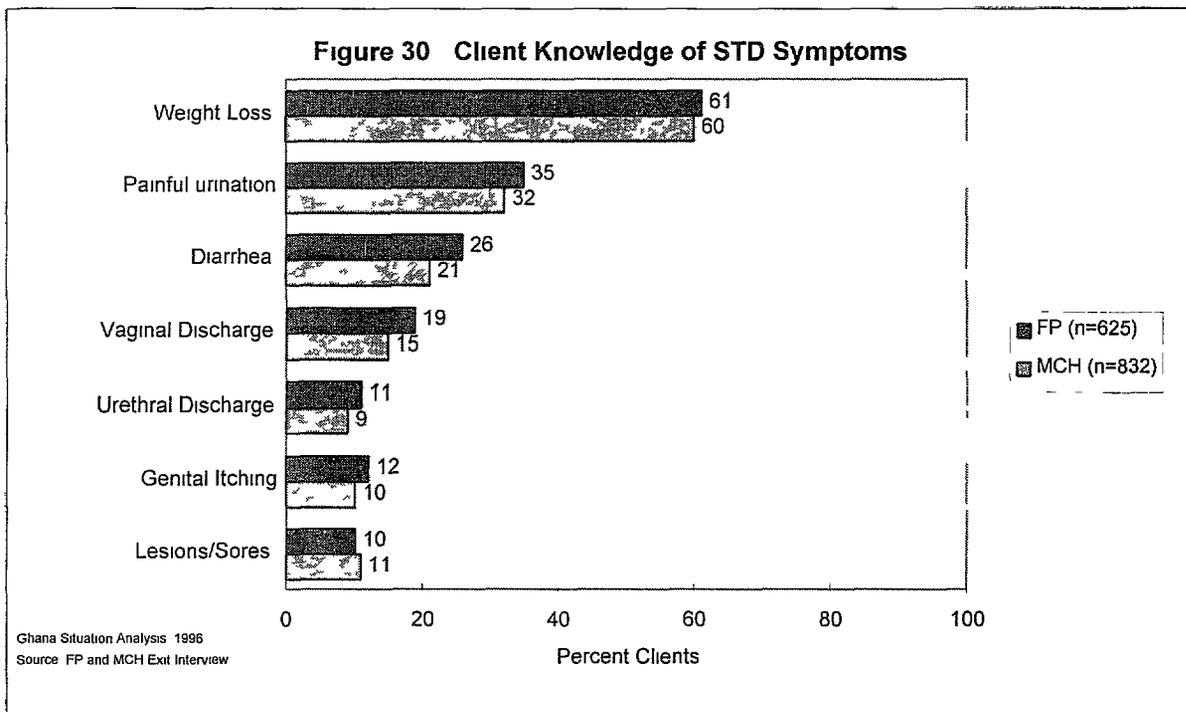


Reproductive Health Issues

Almost nine in every ten (89%) MCH clients in all SDPs knew of diseases that could be transmitted through sexual intercourse (STDs). The proportion ranged from 87 per cent of clients in MOH clinics to 93 per cent of those in hospitals. Quizzed further to mention some common signs and symptoms of STDs, the highest proportion (nearly 75%) of clients in all SDP types, except PPAG facilities, mentioned "loss of weight". PPAG clients (46%) mainly mentioned 'painful urination' as the commonest symptom.

Results of the study further suggest minor variations in the proportion of family planning and MCH clients' knowledge of STD symptoms, 70 per cent of family planning clients, compared to 68 per cent of MCH clients, could name at least one symptom (Fig 30). Similarly, there was a slight difference in the proportion of the two groups as regards knowledge of specific STD symptoms.

It must be noted, however, that in all symptoms mentioned, except lesions, the proportion of family planning clients was slightly larger than that of MCH clients. For example, 61 per cent of family planning clients, relative to 60 per cent of MCH clients, mentioned 'weight loss' while the proportions that mentioned 'genital itching' were 12 per cent (for family planning clients) and 10 per cent (for MCH clients). In the case of lesions, however, 10 per cent of family planning clients, compared to 11 per cent of MCH clients, mentioned it as a symptom. It is heartening to observe that there was almost universal awareness of AIDS among MCH (98%) as well as family planning (98%) clients.

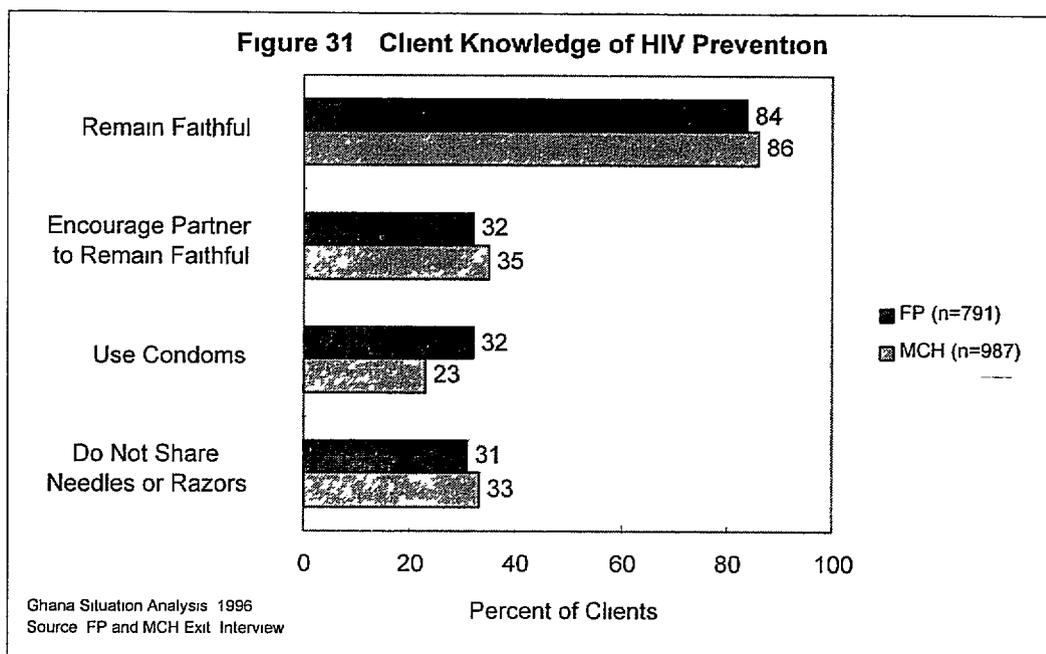


Regarding the means of transmission of HIV/AIDS, the largest proportion of clients in all types of facilities mentioned "sexual intercourse". This ranged from 85 per cent of clients in PPAG clinics to 100 per cent of those in MOH clinics, giving a national average of 95 per cent (Table 33). Interestingly, the transfer of disease from mother to baby was mentioned by the lowest proportion of clients in all facilities. It must be noted also that the response pattern of family planning clients is not much different. This outcome is not unexpected, since Ghanaians generally attribute AIDS to irresponsible sexual habits. It is therefore recommended that education on the various ways of transmitting AIDS must be intensified so as to bring the awareness of other ways (other than sexual intercourse) of getting the disease to the general populace.

Table 33 Percentage Distribution of Ways of Getting HIV/AIDS by Clients

Means of Transmission	Type of SDP				All MCH Clients	All Family Planning Clients
	Hospitals	MOH Clinics	PPAG Clinics	Maternities		
Sexual Intercourse	87	100	85	98	89	95
Blood Transfusion	7	6	17	6	7	9
Sharing items like needles	48	40	15	47	44	46
Mother to Baby	2	1	2	0	1	2
Other	1	8	2	2	3	6
Number Interview (N)	347	687	41	191	1266	773

Clients' responses, as regards ways of protecting oneself against AIDS, were mainly directly related to those of the means of acquiring the disease, as 86 per cent of MCH clients and 84 per cent of family planning clients mentioned "clients staying faithful to their spouse or partners" (Fig 31). Moreover, 85 per cent of family planning clients and 88 per cent of MCH clients could name at least one way of protecting oneself against HIV infection.



2.6 ABILITY OF PROVIDER TO RENDER QUALITY SERVICE

Introduction

The study solicited information on the training, knowledge and practices of family planning providers. The main objective was to determine the quality of services that clients were likely to receive from providers or how effectively provider knowledge was being translated into provider actions. The results are to assist programme managers to design training programmes targeted to the specific needs of staff.

Distribution of Providers by Designation and Type of SDP

As part of the study, an inventory of all categories of staff providing family planning services in the 313 SDPs, were taken on the day of visit. The summary results are presented in Table 34. The results show that more than half of all the staff (51.8%)

Table 34 Percentage Distribution of Providers by Designation and Type of SDP

Designation of Staff	Type of SDP				Total (n=568)
	Hospital (n=133)	MOH CI (n=301)	PPAG (n=62)	Maternity (n=72)	
Doctor (n=24)	7 5.3	13 4.3	3 4.8	1 1.4	4.2
Professional Nurse/Midwife (n=294)	75 56.4	133 44.2	33 53.2	53 73.6	51.8
Auxiliary Nurse (n=202)	45 33.8	146 48.5	3 4.8	8 11.1	35.6
Extension Worker (n=19)	0 0.0	4 1.3	13 21.0	2 2.8	3.3
Other (n=29)	6 4.5	5 1.7	10 16.1	8 11.1	5.1
Total	23.4	53.0	10.9	12.7	100.0

were professional nurse/midwives. The second largest group of staff providing family planning service at the SDPs were auxiliary nurses who accounted for about 36 per cent.

There were proportionately more doctors providing family planning services in hospitals (5.3%) than in PPAG (4.8%) and MOH clinics (4.3%), doctors were virtually absent from maternities (1.4%). Indeed, hospitals and PPAG facilities had more than their proportionate share of doctors and professional nurse/midwives. On the other hand, it was observed that even though more than 50 per cent of all the providers were found to be working in the MOH clinics, nearly half of this number (48.5%) were auxiliary nurses. In addition, PPAG clinics had proportionately more extension and other workers, they accounted for about 68 per cent of extension workers and 35 per cent of other providers. Not surprisingly, nearly three-quarters of providers in maternities were professional midwives or nurse-midwives. Maternities also had more than a proportionate share of other workers, a confirmation that most maternities did not employ many other professionally qualified personnel.

About a seventh (14.4%) of all providers were located in urban areas while close to half (46.3%) were in rural areas, with the rest (39.3%) being in semi-urban areas (Table 35). A study of their designation and area of location indicates that the urban areas had proportionately more skilled and qualified providers than the rural areas. For example, about 70 per cent of urban providers were professional nurses/midwives and 4.9 per cent were doctors as against 4.2 per cent doctors and 48.3 per cent professional nurses/midwives in rural areas. On the other hand, auxiliary nurses predominated the rural (38%) and semi-urban (41.3%) areas.

Table 35 Distribution of Providers by Locality

Designation of Staff	Locality			Total	
	Rural	Semi-Urban	Urban	%	N
Doctor	4.2	4.0	4.9	4.2	24
Professional Nurse/Midwife	48.3	49.3	69.8	51.8	294
Auxiliary Nurse	38.0	41.3	12.2	35.6	202
Extension Worker	3.8	1.8	6.1	3.3	19
Other	5.7	3.6	7.3	5.1	29
Total	46.3	39.3	14.4	100.0	
N	263	223	82		568

Services Provided by Staff

To determine the range of services that staff provide to clients, information was collected on services provided by individual providers. Table 36 shows that majority of the staff at SDPs provide family planning (97%), ante-natal care (65%), post-natal care (66%) and child welfare services. Generally, the provision of reproductive health services was not accorded much priority. For example, only 3 per cent of staff were providing HIV/AIDS testing and 13 per cent other STD diagnosis. It is also significant to note that fewer staff of PPAG, compared to other institutions, were providing maternal and child health services.

Table 36

Staff Who Provide FP/MCH/STD Services to Clients by Health Facility

Type of Service	Type of SDP				Total
	Hospital	MOH Clinic	PPAG Clinic	Maternities	
Family Planning	98	95	100	100	97
Ante-natal Care	64	68	18	94	65
Maternity Care/Delivery Services	25	45	3	96	42
Post-natal Care	70	71	13	79	66
HIV/AIDS Counselling/IEC	52	47	73	53	52
HIV/AIDS Testing	5	3	2	3	3
Other STD Counselling/IEC	52	55	78	57	57
Other STD Diagnosis	8	12	18	21	13
Other STD Treatment	10	16	23	29	17
Child Immunization	77	89	8	20	69
Child Growth Monitoring	76	87	7	23	68
Consultation for Infertility	39	40	32	43	39
Oral Rehydration Therapy Services	66	77	22	74	68
Management of Abortion Complications	15	21	23	27	21
Nutrition Services	73	82	25	51	71
Other Curative Services	47	57	38	70	54
Menstrual Regulation	23	22	18	16	21
Pre-abortion Counselling	25	23	33	24	25

Staff Basic Training and Refresher Training

Family planning, as a concept, involves using methods that intervene in the natural human reproductive process, such that sexual intercourse does not lead to pregnancy. It is quite essential, therefore, for providers of family planning service to have some basic training in order to have a better understanding of the mode of operation of programme methods as well as the ability to perform procedures and solve problems arising from the use of a method. Additionally, periodic refresher courses serve to introduce providers to new guidelines and procedures as well as new health issues in the field of discipline.

The study solicited information on the highest level of institutional training the staff had received for their present position. For example, a nurse/midwife might have been through the same training as a nurse, plus some additional long-term midwifery training. In such a case, 'basic training' refers to the midwifery training because it is the highest level of training received and that qualified her for the current position. For a nurse, however, basic training would be the nursing training.

From Table 37, it is observed that 50 per cent of providers received their most advanced long term training less than 10 years before the survey. This compares with 14 per cent of staff who had their training at least 20 years ago. It is generally expected that the length of service would influence the kind of experience and expertise that the provider brings to her work.

That some providers, though few (4%), had no basic training should be a matter of concern because of the dangers this might pose to clients. It is likely that such staff might have learned on the job, understudying other qualified staff. The health field is very dynamic, with new concepts and practices being evolved all the time. Regular refresher training courses are therefore necessary to update the knowledge of providers and improve their performance.

Table 37 Length of Service at Present Status after Basic Training

No of Years	Percent of Staff
0 - 4	24
5 - 9	26
10 - 14	20
15 - 19	12
20 - 24	8
25 - 29	4
30+	2
No Basic Training	4
Total	100

Table 38 shows that the largest proportion of providers had received both basic training and refresher training more in family planning than in any other service provided. Even though consultation for infertility and management of abortion complications are key components of reproductive health, they were the least areas in which staff had received some training. While 69 per cent of the staff had received refresher training in family planning, less than 40 per cent of staff had ever received refresher training in the other services.

Table 38 Percent Distribution of Staff Receiving Basic Training and Refresher Training

Type of Service	Content of Basic Training	Received Refresher
Family Planning	89	69
Ante-natal Care	86	32
Maternity Care	72	29
Post-natal Care	84	28
Child Immunization	83	37
Child Growth Monitoring	83	30
Consultation for Infertility	43	13
Oral Rehydration Therapy	80	33
Management of Abortion Comp	42	14
Nutrition Services	85	23
Other Curative Services	70	24

Table 39 shows that less than a third of the providers had been exposed to post-basic training in any specific long-term methods of family planning. The Table also suggests that fewer still had been exposed to post-basic training in reproductive health issues. For example, only about a tenth of providers had post-basic training in menstrual regulation (11%) and abortion issues (12%). The results also show that only 37 per cent of the providers had received training in recordkeeping. This is quite discouraging, considering the importance of record keeping in programme assessment and evaluation.

Table 39 Exposure of Staff to Post Basic Training by Type of Course

Type of Course or Programme	Percent of Staff
General Clinical Skills in Family Planning	47
Family Planning Counselling	54
IUD Insertion/Removal	29
Norplant Insertion/Removal	11
Female Sterilization (ML/LA) Surgical Procedure	14
Vasectomy (Surgical procedure)	13
Exclusive Breastfeeding (LAM)	36
Natural Family Planning	39
Management	31
Supervision	31
Recordkeeping	37
Stock-keeping	32
STD Risk Assessment/Screening	15
STD Counselling	27
STD Laboratory Diagnosis	5
Syndromic Approach to Diagnosis and Treatment	7
HIV/AIDS Counselling	26
HIV/AIDS Testing	3
Menstrual Regulation	11
Abortion Issues	12
Reproductive Health Updates	21
Other	2

Current Provision of Family Planning Services

Results from Table 40 indicate that in the last 3 months preceding the survey, the largest proportion of staff provided or referred clients for family planning methods in injectables (91%), the combined pill (91%) and condoms (88%). If the services provided is taken as indication of the demand for method by clients then most clients are going in for injectables, combined pills and condoms while fewer of them are going in for vasectomy and the diaphragm.

Table 40 Staff Who Have Currently Provided or Referred Clients

Service Provided or Referred in Last 3 Months	Percent of Staff
Combined Pill	91
Progestin-only Pill	72
IUD	55
Injectable	91
Norplant	20
Condom	88
Diaphragm	8
Spermicide	71
Female Sterilization (ML/LA)	29
Vasectomy	5
Natural Family Planning	45
Exclusive Breastfeeding (LAM)	64
Emergency Family Planning	13
Multiple Methods	21
Dual Methods (simultaneous)	38
Other	1

Provider Perception of Eligibility

Providers were asked whether there were any restrictions regarding the provision of specific methods since such restrictions (whether they are policy decisions or are imposed by the staff themselves) are likely to influence user rates. The following are the responses obtained:

- a) Age The question on age was to determine whether the provider used age as a sole criterion for providing a contraceptive method to a client. Although there is no official policy that limits the provision of family planning methods to certain age brackets or range, the data obtained indicate that, on the average, no person below 15 years would receive a prescription or be referred for any method of contraception and no one above 50 years could obtain any method (see Table 41). The lower age limit was least for the condom and spermicide (15 years) and highest for vasectomy (32 years) followed by female sterilization (29 years). The highest upper age limit was observed for the condom and vasectomy (50 years). Thus, with respect to age, providers were more willing to provide the condom and the spermicide to a wider age range of clients than the permanent methods of family planning (ie female sterilization and male sterilization).

Table 41 Provider Perception of Eligibility Restriction by Method and Restriction

Type of FP Method	Average Minimum Age	Average Maximum Age	Party	Husband s Consent Required	Require Woman to be Married	Woman Menstruating at Time of Visit Necessary
Pill (CoC)	16	41	2	50	29	17
Condom	15	50	2	48	9	87
IUD	18	45	2	54	48	15
Injectable	20	44	2	49	39	15
Norplant	19	44	3	43	56	10
Spermicide	15	46	2	41	18	71
Female Sterilization	29	46	4	75	76	19
Vasectomy	32	50	4	-	-	-

- b) Party In order to ascertain whether providers use a minimum number of children as a sole criterion for providing contraceptive method to a client, providers were asked to state the minimum number of children that a woman must have before they would prescribe or refer a client for a contraceptive method. Table 41 shows that to qualify for the pill, condom, IUD, injectable and spermicide, the provider expected a client to have at least 2 children. The average number of children increased to 3 for the Norplant while clients wanting female sterilization and vasectomy were expected to have at least 4 children before being sterilized. Thus, providers were prepared to offer permanent methods of family planning on condition that the client had achieved the perceived Ghanaian ideal family size.

- c) Husband's Consent The Table shows that 75 per cent of providers would require the consent of a client's husband before providing her with female sterilization. It is interesting to note that even with the other methods of family planning, more than 40 per cent of providers would require a husband's consent before service is provided. The question of a husband's consent is therefore important in determining whether a woman would be provided with a family planning method or not. It is therefore important to specifically target men and make them partners in family planning and reproductive health issues. An increase in women's education could also widen their choices and make them less dependent on men.
- d) Unmarried Client Providers were least likely to refuse condoms (9%) and spermicide (18%) to unmarried women than any family planning method. About a half of all providers were turning away potential IUD and Norplant clients because they were not married. The method least likely to be prescribed for unmarried clients was female sterilization (see Table 41).
- e) Women not Menstruating An understanding of a woman's menstrual cycle can help plan for a pregnancy, prevent one as well as help to understand and diagnose many medical problems. Menstruation is evidence that there is no pregnancy. It is thus better to start providing family planning method when menstruation begins since this helps the provider to monitor the effect of the method and to ascertain that the person receiving the method is not pregnant.

Information on family planning methods that the provider would not prescribe to a woman not menstruating at the time of her visit was solicited. Table 41 shows that providers were less likely to prescribe Norplant (10%), injectables (15%) and IUD (15%) to clients who were not menstruating at the time of visit. The staff were more likely to provide the condom (87%) and spermicide (71%) to clients not menstruating at the time of visit.

Provider Perception on Health and Family Planning Methods

- a) Methods Recommended for Delaying/Spacing Even though people now have the option to choose the number and spacing of their children, the use of contraceptives still raises basic questions. One basic question asked from a medical stand point is the appropriate method for a woman at a given time and place. To a question as to whether or not there were methods of family planning which providers would recommend for most people who would like to delay or space their next birth, assuming there were no health problems, 91 per cent answered in the affirmative, 3 per cent said they would not recommend any, while 6 per cent said that their recommendation would depend on the client's preference. An examination of the types of method they would recommend, in the absence of any known health problem, shows that over 70 per cent of them were more likely to recommend the combined pill, injectable, IUD and the condom, less than 10 per cent would recommend methods like female sterilization, vasectomy and traditional means of contraception (see Table 42).

Table 42 Conditions Under Which Family Planning Method Would be Provided or Recommended

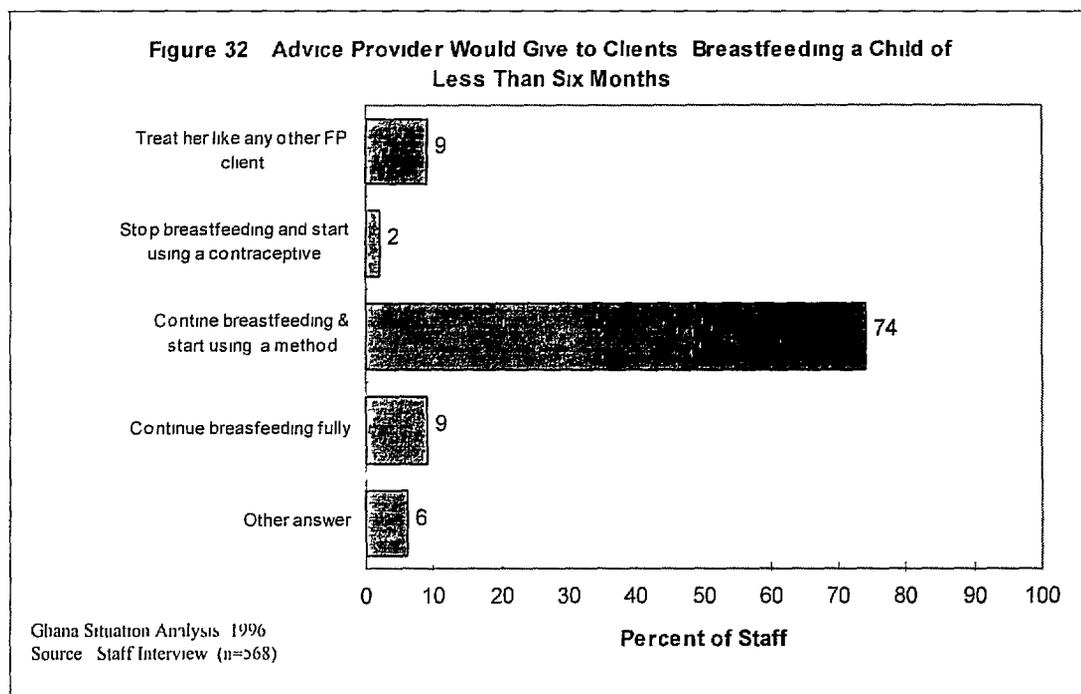
Type of Method	No Health Problems Exit	No More Children and No Health Problems	Client has RTI/STD	Under No Circumstance
Combined Pill	82	16	15	99
Progestin only pill	51	9	5	99
IUD	76	40	72	99
Injectable	79	50	15	99
Norplant	45	24	5	99
Condom	72	7	6	99
Diaphragm	24	3	6	99
Spermicide	66	8	12	99
Female Sterilization	8	83	7	98
Vasectomy	6	57	4	98
Nat Family Planning	31	6	2	100
Exclusive Breastfeeding	13	2	1	100
Multiple Methods	7	1	1	100
Dual Methods	8	1	1	0
Traditional	3	1	1	0

- b) No Health Problems Women with a medical problem may need contraception. Providing a contraceptive method under such circumstances, however, could be complicated as the underlying medical problem may limit the number of methods that are appropriate. As a consequence, special knowledge about the interaction between the medical problem and the various contraceptive methods is required on the part of the provider although she/he could be influenced by personal biases on the choice of methods. A question was asked in the survey to determine the attitude of providers towards clients with no health problems and would like to have no more children. Results, as indicated in Table 42, show that female sterilization (83%) and vasectomy (57%) are the methods that were highly recommended. Exclusive breastfeeding, multiple and dual methods as well as traditional methods were the least recommended methods for clients wanting no more children.
- c) RTI/STD Clients Reproductive Tract Infection (RTI) and Sexually Transmitted Diseases (STDs) are major causes of secondary infertility. While some contraceptive methods help protect against STD, others may increase the risk of infection. For example, whilst a barrier method like condom may help decrease STD infection, the IUD may increase the risk of STD infection. From Table 42, it is observed that an overwhelming majority of providers (72%) would not recommend IUD for clients with RTI or STD. The combined pill and injectable (15%) are the other methods least likely to be recommended. It must be noted that even though oral contraceptives like the combined pill may exert a protective effect against the development of pelvic inflammatory disease, it may at the same time make a woman to become prone to monomial infections.
- d) Methods Never Recommended According to Table 42, nearly all providers were willing to recommend all types of family planning methods. Only a few would never recommend the traditional (3%) and female sterilization or vasectomy (2%). Although these figures are low, they undoubtedly undermine the role of the provider in assisting a client to make an informed choice.

Advice Given to Breastfeeding Clients

During the first month of childbirth, the likelihood of pregnancy is low because the woman is amenorrhoeic during this time. After menstruation resumes, however, the chances of pregnancy are increased. It is known that the intensity of breastfeeding can influence the onset of menstruation. Since the time when menstruation will resume varies greatly, a woman does not know when the protection of lactational amenorrhoea will end. It is possible, therefore, for a woman to become pregnant while she is still breastfeeding. For continued protection, mothers are thus advised to begin using a complementary family planning method even while continuing breastfeeding for the sake of the child's health.

Data collected from providers on the type of advice they would give to clients breastfeeding a child of less than six months shows that a great many of them (74%) would ask the client to continue breastfeeding and also start using a contraceptive method (Fig 32)



Provider Action For New Clients Who Want Hormonal Methods But Are Not Having Menses

If a client is not having her menses, then the possibility of pregnancy can only be ruled out by examination or pregnancy test. As part of the study, providers were asked what they normally did for a new client who wanted the pill or another hormonal method but who was not having her menses. Table 43 shows that 51 per cent of providers would perform a pregnancy test while another 51 per cent would supply condoms and ask the client to return when she had her menses. Ten per cent of providers were however willing to supply hormonal method even when the client was not in her menses.

Table 43 Provider Action for New Clients Desiring Hormonal Method but not Having Menses

Type of Action	Percent of Staff
Perform a pregnancy test	51
Supply condoms and ask to return with menses	51
Tell her to come back at next menses	21
Supply hormonal method	10
Supply hormonal method and condoms	5
Try to induce menses	1
Other	4

Reproductive Health Practices

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system including its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often, to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice for regulation of fertility which are not against the law, as well as the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

With this understanding of reproductive health, reproductive health care could be defined to include the access to the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases (STDs).

- a) Provider Advice Given to Clients at Risk of Infection with STD or HIV/AIDS The barrier methods of family planning (that is, condom and diaphragm) if used correctly, particularly together with a spermicide are highly effective in preventing the transmission of many STDs and HIV/AIDS.

Table 44 shows that 84 per cent of providers were likely to recommend the condom when the client appeared to be at high risk of infection with STD or HIV/AIDS. A small number of providers (1%) indicated that they would advise the client to continue to use the current method alone and 2 per cent would advise the client to stop using any type of contraception. Though such provider advice was limited to only a small proportion of cases, it is important to train providers against making these remarks because they could fuel the spread of STD and HIV/AIDS which are easily transmitted through sexual intercourse.

Table 44 Types of Advice Given to Clients Who Come for Check-up/Resupply and Appear to be at High Risk of Infection

Type of Advice Given by Staff	Percent of Staff
Continue to use the current method but use condom also	68
Switch from current method to the condom	16
Other responses eg advice to see a doctor, counselling	11
Stop using any type of contraception	2
Continue to use the current method alone	1
Don't know	2

b) Provider Actions for STD Clients In addition to the advice given, information was solicited on the types of action that providers would give to clients they suspected to have STD. Most of providers (69%) would refer clients with STD for treatment while about a half (49%) would provide counselling (Table 45). The fact that only 4 per cent would do a diagnosis could be an indication that many SDPs lacked the facilities for doing a diagnosis. Even though the treatment of STDs and other conditions of the reproductive system is one of the services expected of the reproductive health programme in the country, only 13 per cent of providers could provide such a service. There is therefore the need to equip more providers to be able to give treatment in such areas.

Table 45 Action Taken by Providers for Clients Who May Have STD

Type of Action Taken	Percent of Providers
Refer for Treatment	69
Provide Counselling	49
Refer for Diagnosis	32
Request Laboratory Test	23
Partner/Contact Tracing	19
Treat	13
Refer for counselling	7
Diagnose	4
Other	17

c) Provider Action for HIV/AIDS Clients Table 46 presents the range of possible types of action to be taken by service providers for clients who may have HIV/AIDS. A little over half of them said they would either provide counselling (55%) or condoms (50%). Although actions such as these are commendable, the figures do not represent an impressive programme to prevent the spread of HIV/AIDS. It is also disturbing to note that only 16 per cent of providers would be interested in partner/contact tracing because it could erode the advantages of providing counselling and condoms, since these partners could also be spreading the disease.

Table 46 Provider Actions for Clients Who May Have HIV/AIDS

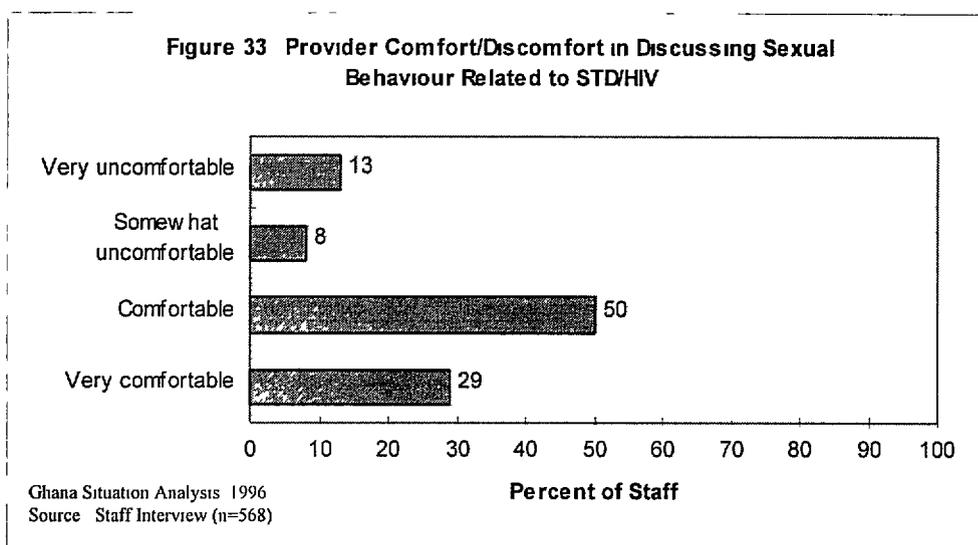
Type of Action Taken	Percent of providers
Provide Counselling	55
Provide Condoms	50
Refer for HIV Test	37
Provide or Refer for Treatment of Complications	29
Refer/Request for Counselling	22
Partner/Contact Tracing	16
Request HIV Test	13
Other (advice on diet, spread of disease, personal hygiene)	9

- d) Syphilis Test for Antenatal Clients If an infection of syphilis occurs in the mother early in pregnancy, there is a grave risk of fetal death, if it occurs later, the baby usually develops active congenital syphilis at about the age of six weeks. It is probable that if conception occurs within the first 12 months of infection, the fetus will be killed, with a resultant abortion. The early detection and treatment of syphilis is thus essential.

In order to know whether providers have knowledge about syphilis and its consequences they were asked whether they routinely requested a syphilis test for antenatal clients they see at their facilities since full antenatal test is one of the most effective ways of putting the disease at bay. Interestingly, the results of the survey show that less than a tenth (8%) of providers routinely requested such tests.

Since family planning services and maternal health/antenatal care services offer an important opportunity for both diagnosis and treatment of such STDs, as well as information about their prevention, providers should be encouraged and equipped to handle such issues.

- e) Provider Comfort with STD/HIV Discussion Figure 33 shows that half of the providers indicated that they were comfortable when discussing sexual behaviour related to STD/HIV with clients. The 21 per cent of providers who felt uncomfortable were more likely to be biased and hide vital information from clients. Clients may therefore not be encouraged to make informed decisions/choices in respect of their reproductive lives.



- f) Termination of Pregnancies Pregnancy termination (abortion) is one of the most important health risks that a woman faces during her reproductive years. Deciding whether or not to have an abortion can be difficult, therefore, in making a decision, most women would wish to benefit from warm, respectful advice and friendly support. Although abortion is not to be promoted as a family planning method, women who have unwanted pregnancies are to be given ready access to reliable information and compassionate counselling.

To have an idea of the prevalence of such cases, providers were asked whether women came to their facilities for advice on termination of pregnancies or for medical treatment as a consequence of an incomplete, induced abortion. The results of the study showed that 62 per cent of providers confirmed that women came to their facilities for advice on termination of pregnancies. In addition, 51 per cent of providers indicated that women visited their facilities for medical treatment as a consequence of an incomplete, induced abortion.

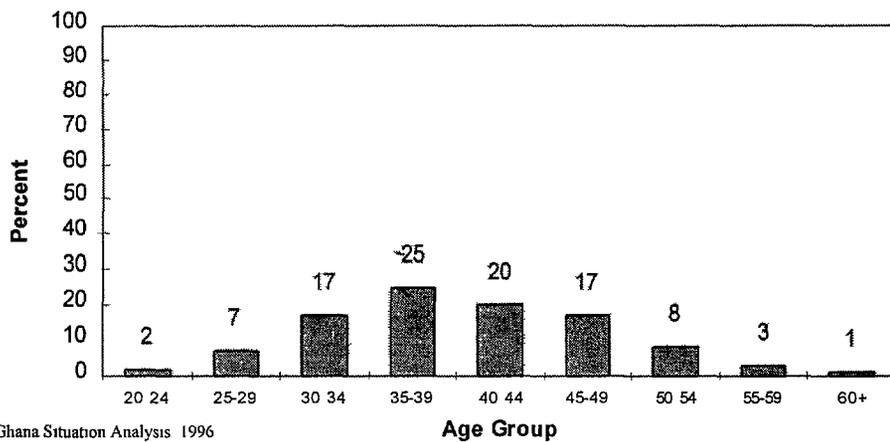
The implication of this is that there are a lot of women who do not want to be pregnant and yet are not using contraceptives. What is not clear and which can be extremely dangerous is if the incomplete, induced abortions sent to these facilities were done at home, by untrained persons, and in unclean conditions.

Socio-Demographic Characteristics

Other important factors that could influence the behaviour of providers in the provision of quality care and services are their socio-demographic characteristics. The study therefore solicited information on their sex, age, marital status, number of living children, religion and the method of family planning currently being used by staff or partner.

An overwhelming majority of the providers (97%) were female. The average age of all the providers was about 40 years. The age distribution (Fig 34) shows that nearly 80 per cent of them were between 30 and 49 years with about a tenth (9%) below 30 years.

Figure 34 Age Distribution of Staff



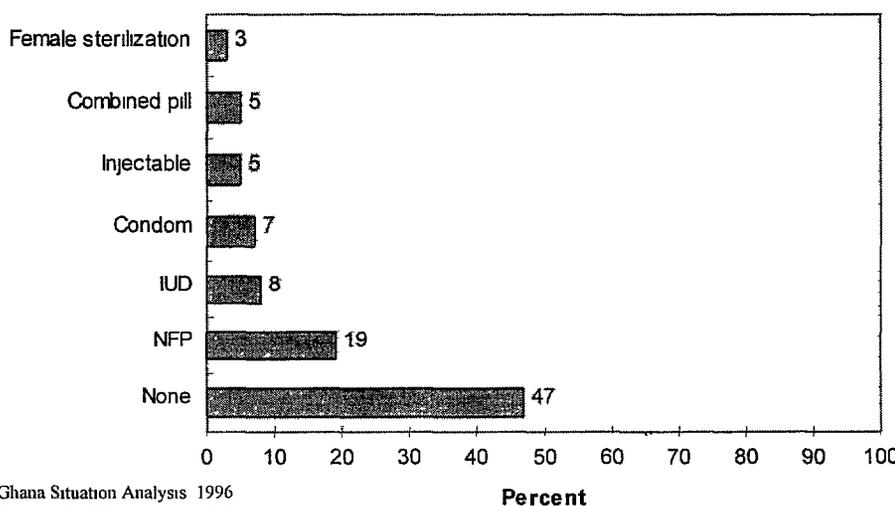
Ghana Situation Analysis 1996
Source: Staff Interview (n=568)

An examination of the current marital status of providers shows that 63 per cent were in monogamous unions while 9 per cent were in polygamous unions. The rest were single (10%), separated or divorced (12%), widowed (5%) or living together in consensual unions (1%). The providers had an average of 3 children each. In terms of religion, 93 per cent were christians, 5 per cent were moslem and 2 per cent belonged to other religious organizations.

Family Planning Used by Providers

Figure 35 shows that a substantial proportion of providers (47%) were not using any method of contraception at the time of study. Most providers who were using any method of contraception preferred the natural family planning method (19%) to any of the scientific or modern methods. The highest percentage of staff using any modern method (IUD) was 8 per cent.

Figure 35 Methods of Family Planning Used by Providers



Ghana Situation Analysis 1996
Source: Staff Interview (n=568)

These findings are quiet surprising because it is normally expected that as providers they would practice what they were helping to promote. One wonders if this was not likely to affect the provider's empathy and expert advice given to clients. The findings are even more surprising when looked against the background that most of the providers were still in the reproductive age group and also in sexual unions. On the other hand, it could be that the providers, being knowledgeable about the long-term side effects of contraceptive methods as well as the reproductive cycle, were able to detect more accurately the periods to avoid unprotected sex and could therefore use the rhythm method more effectively.

III CONCLUSIONS, PROGRAMMATIC IMPLICATIONS AND RECOMMENDATIONS

The results presented in this report have, in most part, been national findings. In some cases, results have also been presented for the four SDP types. A comparative analysis of the results of the 1993 and 1996 situation analysis studies is published separately. The results presented here were disseminated nationally at a seminar on 25-26 September 1997 in Accra. Certain issues were raised and their policy implications as well as specific recommendations for implementation were discussed, with full participation of implementing agencies in the public and private sectors, researchers and donor agencies. This chapter captures the spirit of these discussions.

3.1 SUMMARY FINDINGS AND CONCLUSIONS

Results of the study of family planning delivery points show that family planning services are generally available and accessible. We still need, however, to review and consider carefully not only the spatial coverage of SDPs but also their accessibility in terms of visibility, advertisement and hours of opening. Many facilities lack even the most basic amenities such as electricity, water for washing hands and instruments as well as a good sanitary environment.

There is lack of materials needed to promote knowledge and disseminate information. The simplest information sheets or posters are often unavailable while health talks are given in only a quarter of the facilities. Models and samples of methods which are important as teaching aids are also in increasingly short supply.

Many SDPs lack the essential equipment necessary to ensure delivery of a wide range of services, including diagnostic laboratory services. Only about a third of SDPs have facilities to carry out pregnancy tests or take samples or do laboratory tests to help identify clients with sexually transmitted diseases. Most facilities provide immunization against several of the major diseases, but many often run out of vaccines for periods of six months or more.

While the global shift in emphasis away from family planning per se to a more comprehensive concern for provision of reproductive health services is accepted in principle by all, it has not been easy to implement with the family planning programme in Ghana.

The study shows that very few SDPs receive regular monthly supervisory visits. Management of resources also leaves much to be desired, with inadequate inventory of supplies and storage facilities in many cases.

In spite of the poor state of the infrastructure and equipment available to them, service providers in many SDPs have a high level of commitment to duty. Service providers offer clients adequate counselling on the use of available methods. Counselling on medical side effects and on what to do in the event of major problems, however, appears to be inadequate.

Provider biases in the delivery of family planning persist. Generally, providers will withhold services from clients outside of the reproductive ages of 15-49. Providers will also not provide short-term methods to women with fewer than 2 children while in the case of the long-term and permanent methods, women with fewer than 3 or 4 children will be denied services. Many providers will also require that the woman is married and has the husband's consent before offering service.

These findings provide much important information, not only regarding barriers to potential clients' access but also regarding the need for training and retraining through refresher courses and workshops. They also call for an urgency in the testing and wide dissemination of the policies and procedures.

3.2 POLICY IMPLICATIONS FOR FAMILY PLANNING PROGRAMME

The findings and issues raised in this report obviously have implications for policy design and programme implementation. One such area is the pace of integrating reproductive health issues with family planning. Much of the emphasis continues to be on family planning and maternal and child health care rather than the collective welfare of the family as a group. Education in the advantages of integrating maternal and child health, family planning and general reproductive health, with the family as centre, needs to be intensified if Ghana is to fall in line with the global shift. These issues of integration of the different aspects of reproductive health require policy discussions at all levels and may even require further operational research if effective programmatic responses are to be designed.

It is going to be difficult for efforts at increasing modern contraceptive prevalence rate to succeed considerably if certain categories of sexually active potential clients are denied service, particularly in the face of the virtual abandonment of traditional methods of birth control, albeit ineffective. A formal document on policies and standards needs to be put in the public domain and distributed widely for the education of providers and clients as well as the larger society. Broad acceptance of such a document will be made easier if the family, rather than individuals in the family, is seen as the primary focus of the services provided.

The appropriate IEC materials are either not available or in sufficient quantities to facilitate the attraction of new clients. It is necessary for all family planning agents to agree on what materials are appropriate and need to be made available. It may then be necessary for all to agree to centralize the preparation and production of these materials, so that it will not be in doubt the source of such materials. When this is agreed upon, specific materials could be produced for special groups, using drama, talks, workshops and seminars and informal group meetings, as the case may be.

The fact that most clients are never told the results of a diagnosis or given the relevant information about the range of methods available may discourage some clients, leading them to discontinue with the method if they should encounter problems later. On the other hand, providing as much information as is necessary can lead to clients having more confidence in service providers. This calls for

periodic retraining of service providers in new procedures and the current state of the art, particularly in the area of interpersonal communication and counselling skills. It may be necessary to develop a package of incentives and sanctions to encourage providers to give quality service. This will also be an acknowledgment that efficiency is something worth striving for.

There is the need to have a meeting ground for cultural values, personal biases, moral issues and the individual's rights to public services. It is important to recognize that more girls have become sexually active at a younger age than was the situation some time back and that most of these girls do not enter permanent sexual unions as early as it was in the past. While society may frown on such behaviour, it is necessary to counsel the youth, through folk groups, plays and workshops, on the need to acquire education, skills and a trade as well as the dangers of an active sexual life outside marriage. If all these fail and they seek family planning service as a right, then they would have to be provided, because of the greater danger to society of their engaging in unprotected sex.

The traditional focus on mother and child in the provision of family planning has tended to alienate males. The tendency therefore has been that men think that it is not their responsibility to seek protection. The irony is that while many will not actively help the woman to seek the right kind of protection, many others expect their wives to seek their express consent before going for this protection. It is time to intensify efforts at drawing males into the main stream of the programme as partners in seeking the welfare of the family.

There is no gainsaying that the quality of staff directly affects the quality of service and care for clients. The fact that many providers lacked up-to-date training and reorientation in tune with the state of the art is likely to affect quality of service delivery negatively and to weaken client commitment. There is a general concern that staff who provide family planning service are not the ones sponsored to undertake refresher training courses while those who do are often put on schedules that would not benefit from the family planning training.

To ensure that staff training yields the maximum benefit possible to the family planning programme, it is important to involve a broad spectrum of providers in a holistic refresher training programme. The frequent changes in the field of health generally, as well as the current need to take account of the full range of reproductive health needs of clients, make a comprehensive refresher training for providers very necessary.

3.3 SPECIFIC IMPLEMENTABLE RECOMMENDATIONS

To function effectively and efficiently, it is essential that family planning service delivery structures and operating procedures evolve in the most appropriate manner. The study results have provided an indication of the rate at which these structures are evolving as well as what and where the obstacles to improvement have been. In this final section, specific and (we believe) implementable recommendations are made regarding what suitable interventions are needed.

General Recommendations

Information was made available at the Dissemination Seminar that the Ministry of Health had produced two documents, "National Reproductive Health Service Policy and Standards" (April 1996) and "National Reproductive Health Service Protocols" (October 1996), which were aimed at addressing issues that were raised in the 1993 study. The first document has been pretested and finalised while the second is still being pretested. A quick skimming through the documents shows that these protocols address many of the issues that were raised in the 1993 Situation Analysis Study Report and which have been highlighted again in the current report, because providers did not have access to the documents at the time of the study. It is recommended, therefore, that the Ministry of Health should undertake these follow-up activities

- Give the protocols to all stakeholders in the reproductive health area (PPAG, GRMA, etc) for a final review, after the current field testing is over, to ensure that the needs of all agents are addressed
- Disseminate the protocols widely once they are finalized and published (at least one copy at each SDP)
- Use the protocols to revise training curricula
- Use the protocols to revise supervisory checklists
- Establish adequate structures to ensure that the protocols are being adhered to by providers

Reproductive Health Policy and Operational Research

It was agreed that the area of reproductive health is of concern to many other agencies besides the Ministry of Health. For any policy in this area to have a chance of being implemented, there is the need to create a forum for all stakeholders to discuss issues of mutual concern and interest. The Dissemination Seminar, therefore, agreed that it was necessary to establish a national consortium of all groups with a stake in family planning and general reproductive health issues. In addition to the Ministry of Health (MOH), PPAG and GRMA, the Catholic Secretariat, Christian Health Association of Ghana (CHAG), Muslim Family Life Council, Ghana Social Marketing Foundation (GSMF), Association of Voluntary Surgical Contraception (AVSC) and other non-governmental organisations (NGOs) in reproductive health should be invited to constitute such a national consortium.

It was noted that the National Population Council (NPC) already plays a coordinating role in bringing some of the identified organisations together under some of its programmes. It was therefore felt that the NPC would be the appropriate organisation to coordinate this national consortium. The Ministry of Health should liaise with the NPC to set up the consortium either under the NPC's existing structures or with a new structure. The following specific policy and research recommendation were made

- ◆ The national consortium of family planning and general reproductive health organisations, to be coordinated by the National Population Council, should ensure that all stakeholders in family planning and general reproductive health make agreed-upon financial contribution to the Health

Education Unit of the Ministry of Health for the development and provision of family planning IEC materials

- ◆ The national consortium is to review the basic nursing training curriculum to ensure that it incorporates reproductive health issues
- ◆ Provider training need to routinely include family planning logistics management, management information system and recordkeeping
- ◆ All family planning agencies have to offer special training for providers on how to handle adolescent issues
- ◆ Community-based distribution (CBD) programmes need to be revised to reach out to more males
- ◆ Pre-service curriculum for nurses (both public and private) should be revised to allow for more males to train as family planning providers
- ◆ All family planning agencies are to spell out the specific job description for all providers in order to make staff aware of their roles and responsibilities
- ◆ All family planning agencies will work out a scheme of incentives and sanctions to guide provider work conduct
- ◆ Family planning contraceptives are to be added to the essential drug programme to ensure better management
- ◆ Family planning education should be part of the curriculum at all educational levels

With regard to operational research, it was recommended that

- * The Health Research Unit of MOH, in collaboration with the Ghana Statistical Service, should research into the need for, and feasibility of, expanding outlets for disseminating family planning findings and have the findings incorporated in policy
- * All agencies that research into family planning issues need to release their findings and publications on a timely basis
- * All MOH departmental family planning research activities at the regional or district level must be well planned and incorporated in workplan/budget proposals and the appropriate funding sought to implement them

Information, Education and Communication (IEC)

The general feeling is that family planning information can be more effective as an educational tool if it is centralised, rather than letting each agency go its own way. The many divergent emphases and competition that will result from each going its own way is likely to confuse the target groups. The recommendations, then, are

- The Health Education Unit of MOH will have the responsibility to provide all family planning IEC materials for distribution to all members of the family planning consortium
- The national consortium of all family planning agencies will provide an improved and structured reproductive health (including family planning) education programme for religious and opinion leaders, using the districts as focal points
- The national consortium will form a watchdog group to monitor the media for inconsistencies and misinformation about family planning

- The national consortium will strengthen its programmes to educate the media and the public about family planning and general reproductive health issues
- The national consortium will help prepare educational materials suitable for each educational level

Quality of Service Delivery

Two main issues were raised in connection with the quality of care given to clients. One relates to the quality of staff providing services and the other to the ease with which clients who need family planning services get such services. The general staffing position, quality of training, information to clients and increasing access were therefore addressed.

- ◇ Logistics, transport and equipment will need to be made more easily available to improve quality of service at SDPs and to increase the number of outreach sites
- ◇ Education on STDs and the protection provided by specific methods is to be integrated into family planning services
- ◇ Information on the side effects of each available family planning method will be explained to clients
- ◇ Menopausal and/or long term or permanent method users are to be targeted for reproductive health services to protect them from STDs
- ◇ To improve the staffing position as well as to ensure quality of care, the Human Resource Development Division of MOH will ensure that staff with specialist training in family planning are utilised in providing family planning services
- ◇ Supervisors (district, regional and national) are to make a minimum of four supervisory visits per year, at regular intervals, and are to use the appropriate comprehensive checklists designed for the purpose
- ◇ All family planning agencies are to implement the scheme of incentives and sanctions in order to motivate providers to give good quality care and to have job satisfaction

Staffing, Training and Counselling

As has been pointed out, the staffing position and quality of staff influence the quality of service offered. The need for frequent refresher training for all providers, including seminars and workshops on contraceptive technology updates, is therefore well appreciated. Specifically,

- The national consortium is to coordinate contraceptive update training for all providers, probably modelled on the annual PPAG training programme
- Appreciation and clarification of societal values and ethical issues need to be included in the training curriculum for providers in order to address barriers to access based on individual provider biases
- Provider training has to lay great stress on the need for providers to explain medical barriers for the available methods to the clients

- Training programmes of all family planning agencies (MOH, PPAG, GRMA, CHAG, etc) must place special emphasis on interpersonal and counselling skills to address attitudinal problems of providers
- Provider training in family planning logistics and commodity management, recordkeeping and management information system should be held, at least twice in the year, at national, regional, district and subdistrict levels
- All family planning agencies are to offer special training for providers on how to handle adolescent issues, including the use of appropriate counselling and methods for sexually active adolescents

3 4 CONCLUDING REMARKS

The results of the first situation analysis study in 1993 were widely disseminated and used by family planning programme managers. For instance, the results assisted the Ministry of Health in preparing its documents on standards and reproductive health service protocols to guide service delivery. It is our hope that the results of this second study will be equally disseminated and utilised. There are bright prospects that if the specific recommendations that have emanated from discussion of the results are fully implemented, it will lead to a qualitative improvement of life for all Ghanaians.

A QUALITY OF HEALTH SERVICE DELIVERY IN GHANA

1 INTRODUCTION

One of the essential goals of human development is for people to lead a long and healthy life. A major strategy towards this end is an accelerated restructuring of the health sector with the view to increasing efficiency in the resource allocation in this sector so as to achieve maximum returns. In Ghana, this becomes particularly more assertive if the government's policy of "health for all by the year 2020" is to be accomplished.

This calls for regular assessment of the quality of health care in the country. In the present study, this was done by observing health delivery services on the day of visit, taking inventory of infrastructure, equipment and supplies to see if the required resources for health delivery were available and if so, in what condition. Out-patients and patients on admission were also interviewed about the quality of care they received.

2 RESOURCES NEEDED FOR QUALITY HEALTH SERVICE DELIVERY

The starting point of quality health care has to do with the availability of infrastructure, equipment and materials, the functional status of those available and the accessibility of the available and functioning resource. For those health facilities visited, an inventory was taken of required resources.

General Condition in the Health Facilities

For all the facilities visited, it was observed that 80 per cent had their syringes and needles properly stored. In terms of waste disposal, nearly 60 per cent tried to dispose of wastes to prevent children and animals from getting at them, while 70 per cent had their drains clear. It was observed that three out of every four health facilities had their Out Patient Department (OPD) floor scrubbed and clean. In service delivery points (SDPs) where there were laboratory services, it was noted that nine in every ten did not have stained floors.

Furthermore, more than two thirds had clean windows and nearly 70 per cent had the area clear of cobwebs. For toilets, only a fifth of them had their toilets soiled, with more than half the number having clean toilets while slightly more than a quarter did not have toilets at all. Regarding the records of patients, it was observed that the health facilities kept record of almost all patients (93%). Only 6 per cent of patients kept their own records. Four-fifths (82%) of SDPs had a record/card system which was found to be well ordered.

The study solicited information on the availability of some essential equipment/materials which should be in the OPD area at all times. Table 1 gives the status of these equipment. Apart from the thermometer, which was available and functioning in slightly more than two-thirds of the health facilities, other equipment appear to be missing in a significant proportion of the OPD units. For instance, it

was noted that 85 per cent of the SDPs had no aspiration set Furthermore, more than half (56%) did not have wheel chairs, while 62 per cent also did not have stretcher trolleys

Table 1 Percentage Distribution of Equipment/Materials in OPD Area

Equipment/Materials	Available and Functional	Available but not Functional	Not Available
Wheel chair	39.0	4.8	56.2
Stretcher trolley	32.0	5.7	62.3
Weighing scale(Adult)	49.6	7.0	43.4
Weighing scale(Babies)	30.8	7.6	61.6
Thermometer	67.3	3.5	29.2
Stethoscope & Sphig	51.8	7.5	40.7
Aspiration set	7.9	7.0	85.1
Height measure	21.4	9.8	68.8
Clock	27.6	7.0	65.4

Source: Situation Analysis Study of Quality of Clinical Care, 1996 (N= 231)

Essential Equipment/Materials in Consulting Room

Essential equipment/materials available in the consulting room were observed. As shown in Table 2, consulting rooms in most cases were found to have a wash basin with soap (91%) There were thermometers (71%) and stethoscopes (86%) that were functional. It was observed also that 82 per cent of the SDPs had functional dust bins in the rooms.

Table 2 Essential Equipment/Materials in Consulting Room

Equipment/Materials	Available and Functional	Available but not Functional	Not Available
Wash basin with soap	91.0	0.9	8.1
Thermometer	70.9	2.7	26.4
Stethoscope & Sphig	85.5	5.0	9.5
Tray with gloves, etc	56.3	4.1	39.6
Diagnostic set	37.0	5.5	57.5
Dust bin	81.7	1.3	17.0
Desk diary	19.5	5.0	75.5
Calendar	77.7	--	22.3
Essential drug list	49.6	1.8	48.6
Standard treatment	27.1	5.4	67.0

Source: Situation Analysis Study of Quality of Clinical Care, 1996 (N = 231)

On the other hand, It was observed that more than half of the consulting rooms (57.7%) did not have a diagnostic set. Furthermore, significant proportions did not have the standard treatment book (67%) and the essential drug list (48.6%), even though all health facilities were expected to have been supplied with these two documents.

Essential Basic Equipment In Injection/Treatment Room

A large proportion of health facilities had syringes (96%), needles and scissors (94%) and dust bins (87.7%) available in the injection rooms visited (Table 3). The

data also show that sterile gauze was available in nearly 60 per cent of injection rooms observed, while 68 per cent had bandages and 50 per cent had hydrocortisone. It was also noted that eight out of every ten injection rooms observed had a wash basin with soap while slightly more than three-quarters (76.8%) had plaster for use.

Table 3 Essential Basic Equipment/Materials in Injection/Treatment Room

Equipment/Materials	Available	Missing
Syringes	95.6	4.4
Needles	94.2	5.8
Spirit	69.1	30.9
Sterile gauze	58.4	41.6
Plaster	76.8	23.2
Bandages	68.0	32.0
Hydrocortisone	49.5	50.5
Gloves	73.0	27.0
Dustbins	87.7	12.3
Scissors/forceps	94.5	5.5
Sterilizer	64.9	34.1
Wash basin with soap	84.8	15.2

Source: Situation Analysis Study of Quality of Clinical Care, 1996 (N = 231)

Drugs Supposed to be Available in Hospitals at all Times

It is expected that certain essential drugs should always be available, especially in the hospitals, at all times. As a result, an inventory of the quantity of such drugs was taken and is presented in Table 4. All the hospitals that were visited had chloroquine tablets and chloroquine syrup available in acceptable quantities. Apart from insulin which was available in less than half (47.6%) of hospitals visited, the availability of other drugs ranged between 77 per cent and 98 per cent of hospitals.

Table 4 Drugs Supposed to be in Hospitals at all Times

Type of Drugs	Available	Missing
Chloroquine tablets	100.0	--
Chloroquine injections	96.8	3.2
Chloroquine syrup	100.0	--
Crystalline penicillin	93.7	6.3
Septin	98.4	1.6
Iron & Folic acid	85.7	14.3
Oral Rehydration Salt	95.2	4.8
Normal Saline	95.2	4.8
Ergometrine injections	85.5	17.5
Paracetamol tablets	96.8	3.2
Mebendazole tablets	92.1	7.9
Sepasil/Brinerdin tablets	93.7	6.3
Aminophiline injections	90.3	9.7
Insulin	47.6	52.4
Adrenaline Im/IV	77.4	22.6
Valium injections	92.3	7.7

Source: Situation Analysis Study of Quality of Clinical Care, 1996 (N = 64)

Drug Supposed to be Available in Health Centres and Clinics at all Times

Inventory was also taken of drugs which are supposed to be always available at the clinics and health centres. The results (Table 5) show that generally, most of these health facilities had sufficient quantities of the drugs. For instance, it was noted that nearly all the health centres and clinics had enough chloroquine tablets (96%), chloroquine syrup (98%) and paracetamol tablets (96%). The drug which was least available was ergometrine injection (59.6%).

Table 5 Drugs Supposed to be Available in a Health Centre/Post/ Clinic at all Times

Type of Drugs	Available	Absent
Chloroquine tablets	96.4	3.6
Chloroquine injection	93.4	6.6
Chloroquine syrup	97.6	2.4
Paracetamol tablets	95.8	4.2
Septin	83.1	16.9
Iron and folic acid	85.6	14.4
Oral Rehydration Salt	86.8	13.2
Normal Saline	82.4	17.6
Ergometrine injection	59.6	40.4
Mebendazole tablets	72.0	28.0

Source: Situation Analysis Study of Quality of Clinical Care, 1996 (N = 167)

3 QUALITY OF OUT-PATIENT CLINICAL CARE

In restructuring the health sector, the out-patient department (OPD) is quite paramount, for it is the department that caters for the largest proportion of sick patients. Clients at the OPD of the various service delivery points (SDPs) were therefore interviewed to solicit their views on the quality of service they received at the SDPs. They were quizzed to ascertain whether on the day of visit the systems were in place to provide services, if in place, whether services were being provided, and if being provided, whether the quality of service was to their satisfaction.

Waiting Time Before Service

The largest proportion (56.2%) of out-patients on the day of visit attended the health facilities because they (the respondents) were sick while almost a third (31.8%) sent their wards for medical attention. Asked to comment on the waiting period before medical attention, 61 per cent of the clients responded that the waiting time was about right while about a third indicated that the time was either too long (27.6%) or too short (10%).

How long people stay at the various sections in the OPD before receiving attention go a long way in determining their subsequent visits to the same facilities in future. Table 6 presents clients' views regarding the length of time spent at the various sections of the respective SDPs. Of the various sections in the facilities, it is the laboratory where almost half (49.3%) of the respondents who obtained service indicated that they stayed for far too long before being attended to.

Table 6 Clients Estimation of Length of Time Spent at Different Sections of the SDP

Section	Stayed Too Long	Did not Stay Too Long
Card Room	13.9	86.1
Screening Room	9.0	81.0
Consulting Room	5.0	95.0
Laboratory	49.3	50.7
X-Ray	15.6	84.4
Pharmacy	17.0	83.0
Treatment Room	9.4	90.6
Other	33.3	66.7

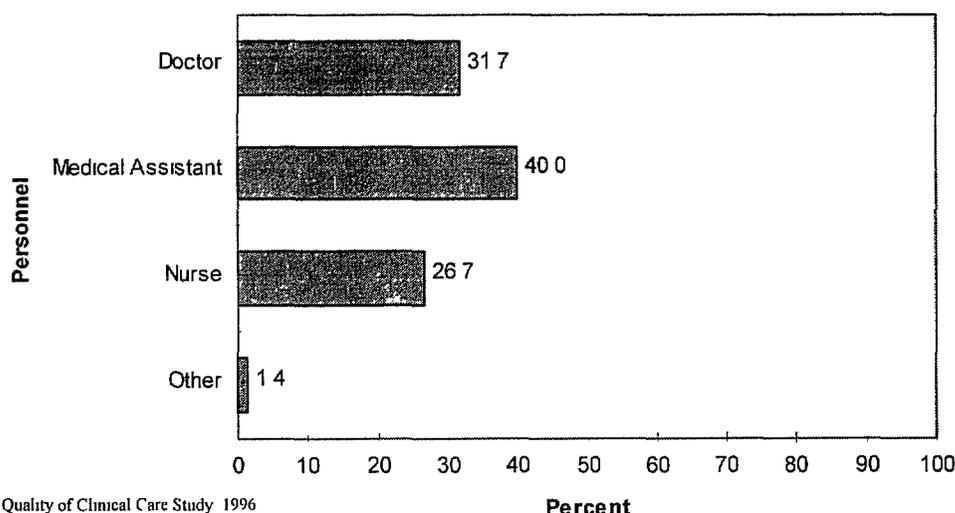
Situation Analysis Study of Quality of Clinical Care 1996 (N= 231)

Quality of Consultation

Even though a substantial proportion of the respondents (24.5%) could not estimate the time (duration) spent with the health provider during consultation, most were satisfied. The largest proportion of those who were able to do so (41%), however, estimated it at between five and ten minutes while 28.9 per cent put it under five minutes. About three-quarters (76.8%) of the patients said the duration for consultation with the health provider was about right while 16.5 per cent indicated that it was too short and 3.2 per cent said it was too long.

Figure 1 illustrates the different categories of health personnel from whom respondents obtained consultations. Most (40%) of the clients received consultations from medical assistants and the least were attended to by nurses. Incidentally, these are the practitioners available to patients in rural and remote areas. The 31.7 per cent of patients who consulted doctors were mostly resident in cities and large urban areas. In view of this, the rather high patient-doctor ratio often quoted should be seen as the expected rather than what actually pertains on the ground.

Figure 1 Percentage Distribution of Personnel Who Give Consultations



About nine in every ten (92.6%) of the respondents expressed no concern about health issues that required discussion with the health provider. A similar proportion (95.5%) of those who claimed to have concerns about health issues were able to discuss with the provider. The largest proportion (49%) of those who were unable to discuss their concerns with the provider said they did not have enough time to do so. Almost two in every three (65.2%) of the respondents indicated that the health provider conducted health examinations on them but almost half (49.5%) of these indicated that no one explained the examination nor the procedures before they were performed and an even higher proportion (54.8%) claimed that the results of the examinations were not explained to them.

Health providers are urged to explain examination results to clients to enhance confidence in the profession. Almost three out of five (59%) of respondents also claimed that their illness was not explained to them, neither were they given instructions about their illness. Over a half (57.5%), however, indicated that they received instructions on the need to return to the health facility.

Asked of their views on the level of privacy in the facilities, 92.6 per cent of the clients claimed that they had enough privacy during consultation with the health providers. Furthermore, 96.7 per cent of the respondents claimed that the health provider was easy to understand when explaining things to them.

Quality of Other Services

About a tenth (10.5%) of patients had their blood specimen taken in the laboratory and only 39.9 per cent of these had the procedure explained to them. A little over four-fifths (81.3%) of the clients stated that the needle used on them were removed from a new covering. The remaining either did not know (15.2%) or claimed that already utilized needles were used on them (3.5%). The health implications of shared needle are widely known in relation to the Acquired Immune Deficiency Syndrome (AIDS) disease. Health providers should therefore always endeavour to use new (disposable) needles for every operation, no matter how minor it is, to avoid the spread of AIDS.

Over four-fifths (86.5%) of the clients stated that they were given a prescription for drugs and of these, 93.5 per cent obtained the drugs from the facility's dispensary, and almost all (96.4%) of them said they understood the instructions given them about how to use the drugs.

About three-quarters (76.9%) of the respondents claimed that the total cost of obtaining services was acceptable while 17.2 per cent said it was too expensive and 3.3 per cent said it was too cheap. Regarding how much would be a reasonable total charge, the largest proportion (22.9%) suggested ₦2,000.

Almost a third (32.2%) of patients claimed they were not given official receipts for any of their payments whereas 14.5 per cent indicated that they were given receipts for some but not all payments. Only 53.3 per cent stated that they were given receipts for all payments. This revelation is rather disturbing in view of the Government's efforts at raising revenue through the "Cash and Carry" system in our

health establishments. The question is how to account for the monies collected without the issuance of official receipts.

About nine in every ten (95.2%) of clients expressed satisfaction with the visit to their respective health facilities, and 97.7 per cent claimed they would encourage friends and relatives to come to the same facilities if the need arose.

4 QUALITY OF IN-PATIENT CLINICAL CARE

Depending on the severity of the condition with which a patient visits the hospital, he could be detained for observation (up to 24 hrs) or admitted for a longer period. Sick people generally, if they can help it, do not want to go on admission. The longer the patient stays in the hospital therefore, the more anxious he becomes and it is psychologically reassuring to the patient and family if they know that the sickness would not end in death. The long stay in the hospital could also have implications in terms of cost and social responsibilities.

Quality of General Care

The purpose of admission is to give total attention relating to the patient's disease, such as appropriate treatment, psychological provision of love, support, and comfort, and good nutrition. Results of the survey show that 97 per cent of in-patients received attention anytime they needed it, though the kind of attention received was not specified.

By right the patient has to know the status of his or her condition, however, depending on the patient's emotional state, providing such information immediately or directly could lead to disastrous consequences as it can worsen the condition. The results of the survey suggest that majority of patients (75 %) were told what their medical problem was.

Giving instructions to the patient about his/her illness is very important for his/her recovery, as in a condition like diabetics, which is diet related. Patients therefore have to be guided by nurses as to how to follow the instructions. Almost three-fifths (58.8%) of in-patients were given instructions about their illness while 41.2 per cent did not receive any instructions.

Staff are expected to be understanding and to show concern. At times the patients may need empathy. The survey results show that majority (83%) of the patients were happy with the attitude of the staff towards them.

Concerns About Other Issues

Patients normally raise a lot of concern about their health, especially when they have been on admission for a long period. When concerns are raised, it is important for the doctor/nurse to discuss it with them and if necessary bring in a third party, such as a social worker or religious leader whose presence could help address the concerns raised. The survey results show that only 13 per cent of in-patients had concerns about other issues that they wanted to discuss with the doctor/nurse. It is encouraging to note that 98 per cent of patients who had concerns were listened

and responded to satisfactorily by the doctor/nurse. This shows a high level of professionalism on the part of the doctors/nurses, since some of these concerns have to be handled tactfully.

Health Examination

Health examinations or procedures like stool, urine haemoglobin level and so on are sometimes routinely done. Depending on the cause of admission, however, specific examinations like x-rays may be done. Most patients (86%) who were surveyed reported that health examinations or procedures were conducted on them.

The examination or procedure, however, has to be explained to the patient to psychologically reassure him because the fear or pain of some of these procedures could have consequences on his prognosis or recovery. Results of the survey show that examinations or procedures were explained to 61 per cent of in-patients before such examination was conducted.

If the results of the examination or procedure are not favourable, informing the patient has to be done professionally, that is with much reassurance and tact. The survey results show that examination results were not explained to more than half of the patients (54 %).

Quality of Facilities Available to Patients

Every hospital is expected to have a pharmacy or means of selling essential drugs and these should be readily available. The results of the survey, however, shows that 62 per cent of in-patients had to buy their drugs from outside the hospital, while the rest (38 %) bought from within the hospital. This has implications on the health delivery system, since time spent outside to buy drugs may lead to worsening of patients conditions or even death of the patient. Additionally, the risk of buying imitation drugs is increased when drugs are purchased from outside the hospital.

Currently, patients have to pay for all drugs and other items bought from the hospital excepting in cases of tuberculosis, leprosy and patients declared paupers. In most cases, though, drugs and supplies are provided to the patient and billed on discharge. About seven-tenths (70.9 percent) of patients interviewed during the survey said they did not need to pay immediately for everything they buy in the hospital. This is reassuring, because treatment for many patients could be started without necessarily paying immediately for items that they buy. The fact that nearly a third of in-patients had to pay immediately for everything they buy from the hospital, however, should be a matter of great concern.

Food

An important aspect of total care includes the nutritional and/or health content of food taken by the patient. There is therefore the need to supervise the kind of food that the patient takes to ensure that restrictions (eg. no salt) imposed on the patient are followed to help speed his recovery. There are some patients who are supplied food from home. The results of the survey shows that 62 per cent of patients

provide their own food. Of the 38 per cent who ate from the hospital, more than three-quarters (76.3%) like the food provided by the hospital while the rest did not. The high proportion of patients who provide their own food could affect their recovery rate if they are on drugs but do not eat food with the required nutritional value. The added problem is the difficulty in monitoring the nutritional value of home-prepared foods.

Sanitary Environment

It is difficult to maintain the personal hygiene of the patient and the sanitary environment of the hospital in the absence of neat bathrooms and toilets. The results of the survey show that 68 per cent of the patients liked the bathrooms, 25 per cent did not like them while 7 per cent did not have bathrooms. Similarly, 58 per cent of patients liked the toilets in the hospitals, 34 per cent did not like them while 8 per cent had no working toilets.

The proportion of patients who did not have access to bathrooms and especially toilets, although small, raises very serious questions for patients whose conditions may make them visit the toilet more often than normal.

The proportion of patients who did not like the bathrooms and toilets could also be an indication of the lack of maintenance of sanitary conditions at these places. These unhygienic conditions could predispose patients to infection which in turn may adversely affect their health.

More than a third (38%) of patients indicated that mosquitoes disturbed their sleep at night. The rather large proportion should be a cause for concern since they could get malaria and thus delay the rate of their recovery.

Generally, about 90 per cent of patients did not need to bring blankets, bedsheets and pillows from home because they were available in the hospital. The remaining 10 per cent who brought these items could include those who did so for personal reasons, but many could represent patients who were forced by overcrowding to sleep on make-shift beds in the corridors.

Patients in Advocacy Role

If a facility is good, has good staff and generally makes the patient happy, the likelihood is that the patient would recommend other people to come to the facility. The role of patients in advocacy is important and needs to be nurtured through quality care. The survey reveals that 96 per cent of patients would recommend to their friends or relatives to come to the facility. Two per cent would ask them to go elsewhere while another 2 per cent said they were not sure.

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